Audit, Risk and Assurance Committee

Tue 28 November 2023, 09:30 - 12:00

Microsoft Teams

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Agenda

1.
Preliminary Matters

1.0 Audit Risk & Assurance Committee Agenda V3.pdf (3 pages)

1.1.
Welcome and Introductions

Oral *Chair*

1.2.
Apologies for Absence

Oral *Chair*

1.3.
Declarations of Interest

Oral *Chair*

1.4.
Draft Minutes of the last Meeting on 18th of September 2023

Attached *Chair*

1.4 ARAC Minutes 12th Sep v4 Approved by RD and IJ.pdf (7 pages)

1.5.
Committee Action Log

Attached *Chair*

1.5 Draft Audit Risk Assurance Committee Action Log November 2023 LW edits.pdf (6 pages)

2.
Items for Approval/Ratification/Decision

2.1.
Ratification of the use of Single Tender Waivers

Attached *Director of Finance and Procurement*

2.1 Single Tender Action Report 28.11.2023.pdf (4 pages)
2.1a Appendix 1 - Single Tender Action 01.09.2023 - 10.11.2023.pdf (1 pages)

2.2.
Discuss and note the Financial Governance, and Ratify Financial Control Procedures, including Patients' Travel Costs Policy and Cash and Bank

Attached *Director of Finance and Procurement*

2.2 Governance Report 28.11.2023.pdf (9 pages)

2.2.1.
Cash and Bank

Attached *Director of Finance and Procurement*

2.2.1 Appendix 1 ABUHB_Finance_0250 FCP Cash and Bank Final.pdf (29 pages)

2.2.2.
Patients' Travel Costs Policy

Attached *Director of Finance and Procurement*

2.2.2 Appendix 2 ABUHB_Finance_0247 FCP Patients Travel_Issue Final.pdf (25 pages)

2.2.3.
Capital Procedures and Guidance Notes

Attached *Director of Finance and Procurement*

2.2.3 Appendix 3 ABUHB_Finance_0243 Capital Procedures and Guidance Notes Final.pdf (112 pages)

3.
Items for Discussion

3.1.
To Receive the Report of Losses and Special Payments

Attached *Director of Finance and Procurement*

3.1 Losses Report 28.11.2023.pdf (6 pages)

3.2.
To Receive a Quarterly Report on Counter Fraud Activity

Attached *Head of Counter Fraud*

3.2 ARAC Counter Fraud Report Q2 23-24 .pdf (5 pages)
3.2a Appendix 1 List of Reactive Cases Nov 23.pdf (2 pages)

3.3.
To Receive a Mid-Year update in respect of Post-Payment Verification Activity

Attached *Post Payment Verification Officer*

3.3 PPV Mid-Year report 1st April - 30th Sept.pdf (5 pages)
3.3a Mid-Year report 2023 ABUHB1.pdf (1 pages)

3.4.
To Receive an Update on Job Planning Arrangements

Attached *Medical Director*

3.4 ARAC Job Planning Arrangements 23 v2.pdf (5 pages)
3.4a Appendix 1 audit plan Job Planning v2.pdf (8 pages)
3.4b Appendix 2 EJobplanning Benefits Realisation Log.pdf (1 pages)
3.4c Appendix 3 Draft Implementation Plan.pdf (1 pages)

3.5.
To Review the Committee Programme of Business

Attached *Director of Corporate Governance*

- 3.5 Audit Risk and Assurance Committee Forward Work Programme Cover Report.pdf (3 pages)
- 3.5a Appendix A MASTER_ARA_Committee Work Programme 2023-24. Final.pdf (5 pages)

3.6.
To Receive the Audit Risk & Assurance Self-Assessment Outcome Report

Attached *Director of Corporate Governance*

- 3.6 Self Assessment of Committee Effectiveness Cover Report (1).pdf (7 pages)
- 3.6a Appendix A_Audit Committee Self Assessment Template Final.pdf (10 pages)
- 3.6b Appendix B _Audit, Risk and Assurance Committee Self-Assessment Responses.pdf (23 pages)

3.7.
To Receive Assurance on Implementation of the Governance Priorities set out within the IMTP 2022-25

Attached *Director of Corporate Governance*

- 3.7 Governance Priorities Update_ARAC_Nov 23 RD.pdf (9 pages)

3.8.
To Receive an update on Compliance with Ministerial Directions and Welsh Health Circulars (WHCs)

Attached *Director of Corporate Governance*

- 3.8 WHC and Min Dir Update Oct 2023.pdf (5 pages)
- 3.8a WHC Database reported to ARAC November 2023 (WHC 2023).pdf (5 pages)
- 3.8b WHC Database reported to ARAC November 2023 (WHC 2022).pdf (4 pages)
- 3.8c WHC Database reported to ARAC November 2023.pdf (3 pages)

3.9.
To Review the Internal and External Audit Recommendations Tracking

Attached *Director of Corporate Governance*

- 3.9 Internal and External Audit Recommendation Tracker Cover Report.pdf (7 pages)
- 3.9a Appendix 1) Audit Recommendation Dashboard- Position following update for Quarter 2 2023-24 (June-September).pdf (1 pages)
- 3.9b Appendix 2) 2017-2021 Overdue Recommendations - Pre Update.pdf (5 pages)
- 3.9c Appendix 3) 2022-2023 Overdue Recommendations - Pre Update.pdf (3 pages)
- 3.9d Appendix 4) Internal Audit Overdue Recommendations-IT0092173.pdf (2 pages)
- 3.9e Appendix 5) Internal Audit Revised Timescale Recommendations Following Return for Approval- IT0092173.pdf (2 pages)
- 3.9f Appendix 6) Internal Audit Completed Recommendations.pdf (2 pages)
- 3.9g Appendix 7) External Audit Overdue Recommendations Position Following Return.pdf (1 pages)
- 3.9h Appendix 8) External Audit Revised Timescale Requests Following Return For Approval.pdf (1 pages)
- 3.9i Appendix 9) External Audit Completed Recommendations Position Following Return.pdf (1 pages)
- 3.9j Appendix 10) Not Yet Due.pdf (4 pages)

3.10.
To Receive the Committee Risk Report

Attached *Director of Corporate Governance*

- 3.10 Committee Risk Report.pdf (5 pages)
- 3.10a Appendix A Strategic Risk Register.pdf (2 pages)
- 3.10b Appendix B Strategic Risk Dashboard and Risk Assessments.pdf (37 pages)
- 3.10c Appendix C SRR 009 Service Delivery_Director of Public Health & Strategies.pdf (1 pages)

3.10.1.
Risk Management & Assurance Framework

to follow *Director of Corporate Governance*

3.10.2.
Risk Appetite and Tolerance Statement

to follow *Director of Corporate Governance*

3.10.3.
Risk Management Policy

to follow *Director of Corporate Governance*

3.10.4.
Risk Management Standard Operating Procedure

to follow *Director of Corporate Governance*

3.11.
To Receive the Internal Audit Progress Report

Attached *Deputy Head of Internal Audit, NWSSP*

3.11 ABUHB November 2023 Audit Committee Progress Report v2.pdf (9 pages)

3.12.
To Receive Internal Audit Reports, Reasonable Assurance;

3.12.1.
Clinical Coding

Attached *Deputy Head of Internal Audit, NWSSP*

3.12.1 ABUHB 2324-15 Clinical Coding Final Internal Audit Report client issue.pdf (18 pages)

3.12.2.
Business Continuity Planning

Attached *Deputy Head of Internal Audit, NWSSP*

3.12.2 ABUHB-2324-10 Final Business Continuity Report.pdf (16 pages)

3.12.3.
Putting Things Right (Advisory)

Attached *Deputy Head of Internal Audit, NWSSP*

3.12.3 AB 2223-13 FINAL Advisory Review Report - Putting Things Right v2.pdf (20 pages)

3.13.
To Receive the External Audit Progress Report

Attached *Performance Audit Lead, Audit Wales*

3.13 Audit Risk and Assurance Committee Update - November 2023.pdf (12 pages)

3.14.
To Receive the Structured Assessment

Attached *Performance Audit Lead, Audit Wales*

3.14 ABUHB Structured Assessment 2023_final (1).pdf (38 pages)

4.

Items for Information

There are no items to note at this time.

5.
Other Matters

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

Oral *Chair*

5.2.
Any Other Urgent Business

Oral *Chair*

5.3.
Date of the Next Meeting is Thursday 8th February 2023

Oral *Chair*

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

AUDIT, RISK & ASSURANCE COMMITTEE AGENDA

Date and Time	**Tuesday 28th November 2023 at 09:30**
Venue	**Microsoft Teams**

Item	Title	Format	Presenter
1	**PRELIMINARY MATTERS**		
1.1	Welcome and Introductions	Oral	Chair
1.2	Apologies for Absence	Oral	Chair
1.3	Declarations of Interest	Oral	Chair
1.4	Draft Minutes of the last Meeting held on 18th September 2023	Attached	Chair
1.5	Committee Action Log	Attached	Chair
2	**ITEMS FOR APPROVAL/RATIFICATION/DECISION**		
2.1	Ratification of the use of Single Tender Waivers	Attached	Director of Finance and Procurement
2.2	Discuss and note the Financial Governance, and Ratify Financial Control Procedures; - • 2.2.1 Cash and Bank • 2.2.2 Patients' Travel Costs Policy • 2.2.3 Capital Procedures and Guidance Notes	Attached	Director of Finance and Procurement
3	**ITEMS FOR DISCUSSION**		
3.1	To Receive the Report of Losses and Special Payments	Attached	Director of Finance and Procurement
3.2	To Receive a Quarterly Report on Counter Fraud Activity	Attached	Head of Counter Fraud
3.3	To Receive a Mid-Year update in respect of Post-Payment Verification Activity	Attached	Post Payment Verification Manager
3.4	To Receive an Update on Job Planning Arrangements	Attached	Medical Director
3.5	To Review the Committee Programme of Business	Attached	Director of Corporate Governance

3.6	To Receive the Audit Risk & Assurance Self-Assessment Outcome Report	Attached	Director of Corporate Governance
3.7	To Receive Assurance on Implementation of the Governance Priorities set out within the IMTP 2022-25	Attached	Director of Corporate Governance
3.8	To Receive an update on Compliance with Ministerial Directions and Welsh Health Circulars (WHCs)	Attached	Director of Corporate Governance
3.9	To Review the Internal and External Audit Recommendations Tracking	Attached	Director of Corporate Governance
3.10	To Receive the Committee Risk Report	Attached	Director of Corporate Governance
3.10.1	To Receive the Risk Management Update • 3.10.1 Risk Management & Assurance Framework • 3.10.2 Risk Appetite and Tolerance Statement • 3.10.3 Risk Management Policy • 3.10.4 Risk Management Standard Operating Procedure		
3.11	To Receive the Internal Audit Progress Report	Attached	Deputy Head of Internal Audit, NWSSP
3.12	To Receive Internal Audit Reports, Reasonable Assurance; - • 3.12.1 Clinical Coding • 3.12.2 Business Continuity Planning • 3.12.3 Putting Things Right (Advisory)	Attached	Deputy Head of Internal Audit, NWSSP
3.13	To Receive the External Audit Progress Report	Attached	Performance Audit Lead, Audit Wales
3.14	To Receive the Structured Assessment	Attached	Performance Audit Lead, Audit Wales
4	**ITEMS FOR INFORMATION**		
	There are no items to note at this time.		
5	**OTHER MATTERS**		
5.1	Items to be Brought to the Attention of the Board and Other Committees	Oral	Chair
5.2	Any Other Urgent Business	Oral	Chair
5.3	Date of the Next Meeting:		

	• Thursday 8th February 2023 09:30 – 12:30

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

Motion to Exclude Members of the Public and the Press

There may be circumstances where it would not be in the public interest to discuss a matter in public. In such cases the Chair shall move the following motion to exclude members of the public and the press from the meeting:

"Representatives of the press and other members of the public shall be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest".

Motion under Section 1(2) Public Bodies (Admission to Meetings) Act 1960

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

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

DATE OF MEETING	Tuesday 12th September 2023
VENUE	Microsoft Teams

PRESENT	Iwan Jones – Independent Member, Committee Chair Richard Clark– Independent Member, Committee Vice Chair Shelley Bosson - Independent Member
IN ATTENDANCE	Rani Dash- Director of Corporate Governance Rob Holcombe - Director of Finance and Procurement Mark Ross - Assistant Finance Director Stephen Chaney - Acting Head of Internal Audit, NHS Wales Shared Services Partnership (NWSSP) Andrew Doughton - Audit Manager (Performance), Audit Wales Seth Newman – Auditor, Audit Wales Danielle Jackson – Secretariat Emma Guscott – Secretariat
APOLOGIES	Tracy Veale – Audit Lead (Finance), Audit Wales Lucy Windsor – Head of Corporate Risk and Assurance

ARAC 1209/1	**Preliminary Matters**
ARAC 1209/1.1	**Welcome and Introductions** The Chair welcomed everyone to the meeting. It was noted that Rani Dash, Director of Corporate Governance, was reviewing committee membership with the Health Board's Chair to ensure all Board Committees could operate effectively with a quorum.
ARAC 1209/1.2	**Apologies for Absence** Apologies for absence were noted.
ARAC 1209/1.3	**Declarations of Interest** There were no declarations of interest raised to record.
ARAC 1209/1.4	**Minutes of the previous meeting** The minutes of the meeting held on the 18 July 2023 were agreed as a true and accurate record.

ARAC 1209/1.5	**Committee Action Log** The Committee reviewed the action log, noting actions completed, actions in progress, and actions that were not yet due.
ARAC 1209/2	**Items for Approval / Ratification/ Decision**
ARAC 1209/2.1	**Report on the use of Single Tender Action.** Mark Ross (MR) provided the committee with a summary on Single Quotation and Tender Actions –24th March 2023 – 30th August 2023. The Single Tender Action (STA) report contained a summary of the five STA requests that had been submitted and approved. It was noted that there had previously been an issue with the spreadsheet that had resulted in some double counting of figures, which had now been corrected. Shelley Bosson (SB), Independent Member Raised a query surrounding the £130k cost of the Endoscopy mobile decontamination unit and whether the spend was an additional cost or intended to be spent within the existing financial plan. Rob Holcombe (RH), Director of Finance and Procurement, could not provide a definitive response, but advised it was the intention to have a temporary location while the endoscopy building was being constructed. RH agreed to look into it further and report back to the Committee. **ACTION: Director of Finance and Procurement** It was agreed that future reports of the use of STA would confirm whether there was sufficient budget in place to support the expenditure. The Committee **NOTED** the Report for assurance.
ARAC 1209/2.2	**Ratification of Financial Governance, Reporting and Control Procedures.** Mark Ross (MR) provided the committee with a summary of financial governance, reporting and controls. There were two financial control procedures presented that required approval. The first was the Procurement Policy, and the second was the Prepayment of Goods and Services, which was specifically created because of COVID-19.

	It was proposed that the FCP Prepayment of Goods and Services be discontinued because there is a process outlined in the Standing Financial Instructions (SFI) for making a prepayment if necessary. Iwan Jones (IJ), Committee Chair, inquired about the procurement policy wording and suggested adding/changing wording to ensure procurement remained in-line with delegated budgets. Rob Holcombe (RH), Director of Finance and Procurement agreed to reword the section so that the process was clear. **ACTION: Director of Finance and Procurement** The Committee was informed that actions were being taken to improve NHS invoice payment and that the current position was below the 95% target for non-NHS payments at 88%. There were just under 400,000 non-NHS invoices compared to just under 5000 NHS invoices, indicating a 4% improvement in August. It was also mentioned that the Board would be receiving an updated set of standing financial instructions and standing orders later this month. RH informed the Committee that the Capital Procedures and Guidance Notes, as well as the Contract Management policy, would be presented at the November ARAC Meeting. The Committee **APPROVED** the amendment to the Procurement Policy and the removal of the Prepayment Policy.
ARAC 1209/3	**Items for Discussion**
ARA 1209/3.1	**Review of Committee Programme of Business** The Committee Noted the Committee Programme of Business.
ARAC 1209/3.2	**Annual Review of Committee Effectiveness 2023/24** Rani Dash (RD) - Director of Corporate Governance provided the Committee with a summary of the report and requested approval of the self-assessment template and timeframe for the circulation and completion of the template. The committee raised that the answer options for some self-assessment questions would be difficult to score numerically, and that a Yes/No option would be more appropriate. RD agreed to

	refine the template so that the scoring/answer options were appropriate for the question. **ACTION: Director of Corporate Governance** The Self-Assessment Outcome Report would be presented to the Committee at its meeting in November. **ACTION: Director of Corporate Governance / Secretariat** The Committee **APPROVED** the self-assessment template and timeframe for completing the template.
ARAC 1209/3.3	**Review of Audit Recommendations Tracking** Rani Dash (RD), Director of Corporate Governance, provided the Committee with a summary of the Internal and External Audit Recommendation Tracker and requested that the Committee endorse the 43 actions with proposed revised timescales. The position at the end of quarter one was presented with the residual position reported as 75 internal recommendations overdue and 4 external recommendations overdue. It was highlighted to the Committee that for the 75 internal outstanding 10 of the 75 relate to 2020, 25 of the 75 relate to 2021 and 40 relate to 2022. Therefore, legacy actions from 2017,18 and 19 had now either been completed or provided with an updated timescale. The committee expressed concern surrounding the accuracy and tracking of revised deadline dates. RD reassured the Committee that work was ongoing to ensure the accuracy of the tracker. In addition, the Committee queried some of the revised deadlines, highlighting that they had been requested previously. RD agreed to undertake a look back exercise of the proposed revised deadlines. **ACTION: Director of Corporate Governance / Head of Corporate Risk and Assurance** It was also raised by the Committee that further information surrounding the completion or revised dates would be useful in the "progress underway" section to provide greater assurance of the status of the recommendation. The Committee **NOTED** the report and **ENDORSED** the revised deadlines.
ARAC 1209/3.4	**Committee Risk and Assurance Report** Rani Dash (RD), Director of Corporate Governance, presented the Committee with a summary of the Committee Risk and Assurance Update Report.

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	It was stated that work was being undertaken to focus on the development of the Strategic Risk Register in response to the risks approved by the Board at its meeting in July, and that the purpose of the Strategic Risk Register was to provide an overview of the assurances and management of identified strategic risks. It was also noted that escalation hierarchy arrangements were being developed following a review of current risk management arrangements; and that this would help to inform the development of the revised Risk Management Strategy and Framework. The Committee **NOTED** the update on the refreshed approach to Risk Management
ARAC 1209/3.5	**Internal Audit Progress Report** Stephen Chaney (SC), Acting Head of Internal Audit, NHS Wales Shared Services Partnership (NWSSP), provided a summary of the Internal Audit Progress Report to the Committee. It was reported that the plan was on schedule, that engagement had been positive, and that some changes to the schedule had taken place, but that this would not affect the delivery of the 2023-24 plan. SC informed the Committee that Shared Services had been tasked to make savings. Rob Holcombe (RH), Director of Finance and Procurement, inquired as to whether the savings would be returned to the Health Boards. SC stated that there was no agreement in place for savings to be returned to client's but would clarify the process and provide a response. **ACTION: Acting Head of Internal Audit, NHS Wales Shared Services Partnership (NWSSP)** The Committee **NOTED** the report.
ARAC 1209/3.6	**Receive Internal Audit Reports**
ARAC 1209/3.6.1	**Internal Audit Reports - Reasonable Assurance** Stephen Chaney (SC) - Acting Head of Internal Audit, NHS Wales Shared Services Partnership (NWSSP) provided the Committee with a summary of the following reasonable assurance reports. • Bank Office and Temporary Workers Final Internal Audit Report

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	• IMTP • Safeguarding The Committee Chair requested that final reports should contain an agreed delivery date rather than Q1/Q2. **ACTION: Acting Head of Internal Audit, NHS Wales Shared Services Partnership (NWSSP)**
ARAC 1209/3.7	**External Audit Progress Report** Andrew Doughton (AD), Audit Manager (Performance), Audit Wales provided the Committee with a summary of the External Audit Report. It was explained that discussions would be held with the Audit Wales finance team and the Director of Finance to agree on timings for funds held in trust, but that the plan was still on track to meet the deadline. The structured assessment review had begun. The original plan included a structured assessment deep dive module that was supposed to look at digital, but due to the financial situation, this was changed to focus on saving opportunities. The primary care services follow-up review would be issued within the next two to three weeks and submitted to the next Committee meeting. Rob Holcombe (RH), Director of Finance and Procurement, inquired about the fee plan for 2023-24. AD advised that fees would not be reduced but would rise at a rate lower than inflation.
ARAC 1209/4	**Items for Information**
	No items for information.
ARAC 1209/5	**Other Matters**
ARAC 1209/5.1	**Items to be Brought to the Attention of the Board and Other Committees** Iwan Joes (IJ), Committee Chair, raised a question following several recent press reports (including the Countess of Chester Hospital) regarding the adequacy of whistleblowing arrangements. It was mentioned that the most recent Whistleblowing Internal Audit review was several years ago. Rani Dash (RD), Director of Corporate Governance, proposed that the People & Culture Committee consider whether this would be

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	beneficial, based on other assurances and intelligence from the staff wellbeing survey. Welsh Government had also requested a self-assessment from the Health Board in respect of speaking up safely processes which would be presented to the People & Culture Committee. **ACTION:** Director of Corporate Governance The Committee agreed to escalate to the Board the number of legacy (pre-2022) Internal and External Audit Recommendations that remain active on the tracker and the need to drive improvements and close longstanding recommendations. **ACTION:** Secretariat
ARAC 1209/5.2	**Any Other Urgent Business** No items for any other business.
ARAC 1209/5.3	**Date of the next meeting;** • Tuesday 28th November 09:30 – 12:00

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

Heading required

Outstanding	In Progress	Not Due	Completed	Transferred to another Committee

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
Dec 2022	**ARAC0112/03** Consultant Job Planning	Following the implementation of the automated job planning process an update report is to be received at a future meeting to close off Audit Recommendations.	Secretariat / Medical Director	**February 2024**	**Complete** Full report on Job Planning included in the agenda for the November 2023; item 3.4
July 2023	**ARAC1807/3.3** Internal Audit Progress Report Consultant Job Planning	An assurance note and those in charge of implementing the Job Planning system to attend the November 2023 meeting to provide an update on progress and assurance on how the controls would be improved, with a full report to the Committee in February 2024.	Medical Director / Director of Workforce & OD	**November 2023**	**Complete** Full report included in the agenda; item 3.4.

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

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
July 2023	**ARAC1807/2.1** Clinical Audit	A completed Ward Assurance Audit to be included within the activity update scheduled for the Committee meeting in February 2024 for information.	Medical Director	**February 2024**	**Not yet due.**
September 2023	**ARAC1209/2.5** Single Tender Action.	To look further into the cost of the Endoscopy mobile decontamination unit it further and report back to the Committee.	Director of Finance and Procurement	**November 2023**	**Complete.** The cost of the mobile Endoscopy Decontamination unit of £3.5m is included in the new unit and is being reported within the financial position of the Medicine Division.
September 2023	**ARAC 1209/2.2** Ratification of Financial Governance, Reporting and Control Procedures.	Reword the procurement policy wording to ensure procurement remained in-line with delegated budgets.	Director of Finance and Procurement	**November 2023**	**Complete.** The Financial Control procedure has been amended (section 7.4.1).

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

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
September 2023	**ARAC 1209/3.2** Annual Review of Committee Effectiveness 2023/24	Refine the template so that the scoring/answer options were appropriate for the question.	Director of Corporate Governance		**Complete.** The recommendations were implemented, and the Self-Assessment Form was circulated to key stakeholders on 02 October 2023 for completion.
September 2023	**ARAC 1209/3.2** Annual Review of Committee Effectiveness 2023/24	Self-Assessment Outcome Report would be presented to the Committee at its meeting in November.	Director of Corporate Governance	**November 2023**	**Complete.** Included on the agenda; item 3.6.

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

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
September 2023	**ARAC 1209/3.3** Review of Audit Recommendations Tracking	Undertake a look back exercise of the proposed revised deadlines.	Director of Corporate Governance/Head of Risk and Assurance.	**November 2023**	**Complete.** A review has been undertaken and an explanatory note provided to the Chair.
September 2023	**ARAC 1209/3.5** Internal Audit Progress Report	Clarify the process of savings and provide a response	Acting Head of Internal Audit, NHS Wales Shared Services Partnership (NWSSP)	**November 2023**	**Complete.** Information shared with members on 20th of November 2023.
September 2023	**ARAC 1209/3.6.1** Receive Internal Audit Reports	Revisit Final reports to contain an agreed delivery date	Acting Head of Internal Audit, NHS Wales Shared Services Partnership (NWSSP)	**November 2023**	**Complete.** Updated report shared with members on the 20th of November 2023.
September 2023	**ARAC 1209/5.1** Other matters	Present self-assessment from the Health Board in respect of speaking up safely	Director of Corporate Governance	**November 2023**	**Complete.** Included in the Board agenda on 22nd of November 2023.

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
		processes to the People & Culture Committee.			
September 2023	**ARAC 1209/5.1** Other matters	Escalate to the Board the number of legacy (pre-2022) Internal and External Audit Recommendations that remain active on the tracker and the need to drive improvements and close longstanding recommendations via the Committee Assurance Report.	Secretariat	**November 2023**	**Complete.** Included in the Committee Assurance Report at the meeting of the Board on the 22nd of November 2023 at 3.3

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

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

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

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	28 November 2023
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	**Update on Single Quotation and Tender Actions –1st September 2023 – 10th November 2023**
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	**Director of Finance, Procurement and Value Based HealthCare**
SWYDDOG ADRODD: **REPORTING OFFICER:**	**Katy Jones – Deputy Head of Procurement**

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

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

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

Appendix A provides specific detail regarding the Single Quotations / Actions that have been submitted and approved for the period 1st September 2023 – 10th November 2023

Cefndir / Background

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

Assurance Committee's work plan includes a standing item for review of the following at each meeting:

- Review of Single Quotation and Tender Requests.

Asesiad / Assessment

The Audit, Risk and Assurance Committee should note the detail of the attached table (Appendix A) and should monitor the number and value of business that are being submitted for a Single Tender or Single Quotation approval. The overarching guidelines on spending of public money are that it should be carried out in a fair, transparent, and open manner, ensuring that competition is sought wherever possible. Therefore, the number of single action requests should be kept to a minimum.

There have been 3 requests submitted which have been approved during the period with an annual value of £83,537.50 Ex VAT.

The largest of these relates to £31k re qualifications that relate to the Medical Gas Pipeline system as part of the Endoscopy project. M&M Medical are already engaged by the Health Board and given the urgency of the work to be undertaken to address the qualifications it was felt that an STA would save 7 weeks of the department running at risk. Frameworks were reviewed but none identified to meet the needs of this requirement.

Of these 3 approved requests, 2 were classified as either licensing or maintenance/ service type arrangements. There was 1 classified as goods purchased.

Argymhelliad / Recommendation

The Audit, Risk and Assurance Committee is asked to note the content of this report for assurance.

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

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

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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment: • **Workforce** • **Service Activity & Performance** • **Financial**	**Is EIA Required and included with this paper** A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following: Not Applicable Yes, outlined within the paper Yes, outlined within the paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	Choose an item. An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk

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

Appendix 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	roved / Reject	EO Approval Dat	Chairs Approval Date (If Applicable)
25/08/2023	Single Tender Action	ABU-STA-54301	North Gwent Gritting until April 2024	£26,322.50	MRI Whistance Ltd	Service	Extension for current gritting & snow clearing is due to not being able to Tender due to South region being in contract/SLA till April 2024. All documents are ready to go out to market in April 24.	In order to align the requirements of all areas of Gwent a short-term extension of the current agreement is required. The value and term of the contract will ensure that there is minimal risk and the current provider has maintained current pricing to ensure value is achieved in the current climate. The tender for the wider Gwent area will be issued to coincide with the end of this agreement and the current SLA for south Gwent.	Approved	04/09/2023	
13/09/2023	Single Tender Action	ABU-STA-54502	Extension of postvention Support	£26,000.00	Jacob Abraham Foundation	Service	This request is to ensure the extension of a vital service, until the end of the financial year, to provide postvention support for people in Gwent who have been affected by a death by suicide of someone aged 25 and above. Jacob Abraham Foundation have been providing this service within Gwent since April 1 st 2023. At the time ABUHB commissioned this service it was anticipated that a national postvention service would imminently be available in Wales, as indicated in the Welsh Government's Integrated Impact Assessment of a proposal for a Suicide Liaison Bereavement Service. To date, no confirmed details of this service have been made available. It is now anticipated that this service will be available at the start of the new financial year (1 st April 2024).	Given the delays in establishing the All Wales service and the timescales to run a tender process we are left with no option than to extend the current agreement with the encumbent service provider. This will ensure that the service remains in place whilst the All Wales service is finalised	Approved	02/10/2023	
26/09/2023	Single Tender Action	ABU-STA-54518	Maxillofacial Air Plant	£31,215.00	M&M Medical	Goods	Relates to £31k re qualifications regarding the Medical Gas Pipeline system as part of the Endoscopy project. M&M Medical are already engaged by the Health Board and given the urgency of the work to be undertaken to address the qualifications it is felt that an STA would save 7 weeks of the department running at risk. Frameworks were reviewed but none identified to meet the needs of this requirement.	Given the urgent requirement and the health & safety risk it is agreed that a single tender action is approproate in order to resolve the issues as quickly as possible. A review of possible frameworks has been undertaken but none could be identified that met the needs of this requirment. The future measured term contract will cover for these requirements once established - negating the need for future single tender requests.	Approved	12/10/2023	
				£83,537.50							

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	28 November 2023
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	**Financial governance, reporting & control.**
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	**Robert Holcombe, Director of Finance, Procurement and Value Based HealthCare**
SWYDDOG ADRODD: **REPORTING OFFICER:**	**Estelle Evans, Head of Financial Services and Accounting**

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

Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

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

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

The Audit, Risk and Assurance Committee is requested to:

- Note the contents of this report.

- Approve the updated financial control policy and procedures.

    - Cash and Banking (Appendix 1)
    - Patients' Travel Costs (Appendix 2)
    - Capital Procedures and Guidance notes (Appendix 3)

Cefndir / Background

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

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

A table has also been included to provide an update of the action taken to date to ensure compliance with the review date for all financial control procedures.

Asesiad / Assessment

1.Financial Control Procedures (FCP)

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

- Cash and Banking (Appendix 1)
- Patients' Travel Costs (Appendix 2)
- Capital Procedures and Guidance notes (Appendix 3)

These policy/procedures were presented and approved at the Executive Committee on 9th November 2023.

A summary of the main changes to each of the Financial Control policy/procedure is set out below. The full revised FCPs are included in Appendix 1 - 3.

Cash and Bank

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

The procedure sets out the requirements to ensure adequate controls over the handling of cash and the operation of the Health Boards Bank Accounts.

The overall objective of the Cash and Bank Financial Control Procedure is to ensure that sufficient controls exist for the management of cash resources and that there are sufficient cash resources available, on a daily basis, to enable the Health Board to meet its commitments.

The document has been circulated for comment as follows:

- Assistant Head of Financial Services

- Head of Financial Services and Accounting
- NWSSP – Accounts Payable
- NWSSP – Payroll Services
- NWSSP - Audit and Assurance Services

Main changes to the document

Paragraph	Summary of change
All	Organisational change - Director of Finance changed to Director of Finance, Procurement and Value
All	Intranet links added for internal documents
All	Bank name change – from RBS to NatWest account within the Royal Bank of Scotland (RBS) Group
7.2.1	Strengthening of controls – Cash and cheques should always be kept on Health Board premises
7.6.5	Clarification of process – Payable Orders to be voided if not presented for payment within six months
7.7.3	Change of process – receipts now recorded digitally (rather than retaining hard copies)
7.8.4	Change of Faster payments limit – from 250k to 1m as per the Government Banking Services (GBS) guidance. Any payment that exceeds 1m are processed as a CHAPS payment which incurs additional charges
7.10	Clarification of process – When cheques are received through the post, all mail is opened by one Finance Officer, recorded and counter signed by another Finance Officer
7.11.2	Change of process – BACS payments to Trade Creditors processed more frequently, daily rather than weekly

Patients' Travel Costs

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

This policy details the financial help available to those patients who do not have a medical need for non-emergency patient transport but who require assistance with their travel costs.

The Health Board must ensure that the claimant is entitled to such help, no fraudulent claims are processed, and that accurate and timely entries are made in the financial ledger to record such expenditure.

The document has been circulated for comment as follows:

- Assistant Head of Financial Services
- Head of Financial Services and Accounting

- NWSSP - Audit and Assurance Services

Main changes to the document

Paragraph	Summary of change
All	Organisational change - Director of Finance changed to Director of Finance, Procurement and Value.
All	Welsh Government guidance – links added to online guidance and forms
6.4	Roles and responsibilities – Treasury Officer role added to reflect responsibilities in the processing of claims
7.2.1	Government Allowances – note added to clarify that by the end of 2024/25 the majority of benefit allowances are migrating to Universal Tax Credit
7.3	Clarification of process – Details of the retrospective reimbursement process added
7.5.4	Taxis – New paragraph added clarifying the reimbursement for taxi fares if no consultant approval for taxi usage is provided i.e., the Health Board will reimburse the lesser of the estimated cost of fuel actually used, or the equivalent public transport cost
Appendix 1	Working Tax Credit (WTC) – threshold updated from 15,050 to 15,276

Capital Procedure and Guidance Notes

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

The procedure is designed to ensure that ABUHBs Capital programme is established and managed appropriately. Managing the Health Board's Capital programme is a statutory duty.

The procedure is applicable to all Capital expenditure ranging from equipment to minor capital schemes approved as part of the Health Board Discretionary programme and major schemes funded as part of the All-Wales Capital programme.

The document has been circulated for comment as follows:

- Divisional Capital Planning Teams
- Head of Capital Finance
- Assistant Director of Finance
- Capital Group
- Strategic Capital & Estates Board
- NWSSP - Audit and Assurance Services

Main changes to the document

Paragraph	Summary of change
All	Organisational change - Director of Finance changed to Director of Finance, Procurement and Value
1.1	NHS Wales Infrastructure Investment Guidance link updated
1.3	Capital definition updated
2.2	Divisional Risk Register and Planning – requirements updated
2.4	Approval for Capital Projects to Proceed – Projects requiring All Wales Capital Funding via a BJC – financial limit updated
2.6	Capital Governance Hierarchy – process map and terms of reference added
5.3	Internal reporting – reference to internal reporting via FBI added
6.2	Procurement Strategy – financial threshold updated
7.9	Post Contract – 'Prior to the final payment being made, the contract should be subject to an independent review whether it be internal or external with documentation available for internal audit to review' added
9.1	The Minor Works Service – financial thresholds updated
11.2	Acquisition of Land & Property – reference to Accommodation Group added
11.4	Disposal of Surplus NHS Property – reference to Estate code guidance added
Annex 2	Capital Governance Hierarchy – process map and terms of reference added
Annex 3	Capital Group role updated
Annex 5	PPD template updated
Annex 23	A69 Scrutiny Document – updated document

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

Summary Position on Financial Control Procedures

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

2.Technical Accounting Issues

Technical updates

There have been two technical accounting updates issued by Welsh Government since the last Audit, Risk and Assurance Committee meeting.

Update note 1 covered the following areas.

- Timetable for the month 6 agreement of balances exercise
- A template to be completed and returned to Welsh Government re transfers between NHS bodies in 2023-24

Update note 2 covered the following areas.

- Guidance re requesting strategic and working capital cash support.
- 2023-24 Land and Building Indices for financial years 1st April 2023 to March 2028.
- AME Non-Cash returns – notification of submission dates for returns to WG.
- Technical Guidance documents issued by HMT re:
  - Impact of IFRS16 on PPP Contracts to be implemented from 01.04.2023.
  - IFRS17 insurance contacts to be implemented on 01.04.2025.

3. Public Sector Payment Policy (PSPP)

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

Category	Invoices	In Mth %	YTD %
NHS	Value Number	99.7 92.0	92.7 88.8
Non NHS	Value Number	97.4 97.0	96.8 97.1

On a cumulative basis the Health Board have achieved 97.1% compliance of the number of non-NHS creditors paid within 30 days which is slightly above the required performance target.

With regard to the NHS percentage the Health Board percentage achieved is below the 95% target with 92.0% achieved in month and 88.8% on a cumulative basis.

However, there has been an improvement in October with 92% achieved in month for NHS invoices compared with an average of 87% in the previous 3 months. The exercise undertaken previously for April to June will be repeated in November for those NHS invoices that breached the payment terms for months 4 to 7 and the requisitioners contacted to take the appropriate action to ensure achievement of the 95% target going forward.

4. Payments in Excess of £100K

There were no exceptional issues to report.

5. Standing Financial Instructions

There is no further update on the standing financial instructions.

Argymhelliad / Recommendation

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

- Cash and Banking
- Patients' Travel Costs
- Capital Procedures and Guidance notes.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability 3.5 Record Keeping Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Finance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	FCP – Financial Control Procedure PO – Purchase Order PSPP – Public Sector Payment Policy RBS – Royal Bank of Scotland GBS – Government Banking Service CHAPS – Clearing House Automated Payment System FBI – Finance Business Intelligence BACS – Bankers Automated Clearing System PPD – Project Proposal Document BJC – Business Justification Case
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau) Impact: (must be completed)

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

Aneurin Bevan University Health Board

Financial Control Procedure Cash and Bank

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

Status: DRAFT
Approved by: Audit Committee
Owner: Director of Finance, Procurement & Value

Issue date: DRAFT
Review by date: DRAFT
Policy Number: ABUHB/Finance/0250

Contents:

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Aims 3
Objectives 3
Scope 3
Roles and Responsibilities 4
Main Body (General) 7
Implementation 27
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1 Introduction

This procedure covers the cash and banking procedures for Aneurin Bevan University Health Board (ABUHB).

2 Policy Statement

The procedure sets out the requirements to ensure adequate controls over the handling of cash and the operation of the Health Boards Bank Accounts.

This procedure is compliant with the ABUHB Standing Financial Instructions and should be read in conjunction with them and the Petty Cash Financial Control Procedure.

3 Aims

The purpose of this document is to set out clearly the responsibilities of staff within ABUHB with regard to Cash and the Health Boards Bank Accounts.

4 Objectives

The overall objective of the Cash and Bank Financial Control Procedure is to ensure that sufficient controls exist for the management of cash resources and that there are sufficient cash resources available on a daily basis to enable the Health Board to meet its commitments.

5 Scope

This document relates to the following staff:

- Staff within the Corporate Finance Department and in particular the Treasury Management Office.
- Staff within the Payroll Department of NHS Wales Shared Services Partnership (NWSSP).
- Staff with n the Accounts Payable Department of NHS Wales Shared Services Partnership (NWSSP).
- Staff in general offices
- Budget holders within ABUHB

6 Roles and Responsibilities

6.1 Treasury Manager-Corporate Finance

Is responsible for:

- Agreeing with the Head of Financial Services and Accounting and the Head of Capital Finance the amount of cash to be drawn down from the Welsh Government on a monthly basis ensuring that there should be sufficient cash to cover payment commitments and that the balance left in the bank account at the end of each month is within Welsh Government best practice limits.
- Ensure the Bank mandate and the list of signatories are up to date and comply with the Health Board's Standing Financial Instructions.
- Ensure all Bank statements are obtained and reconciled to the General Ledger Control Account on a monthly basis and urgently report to Head of Financial Services and Accounting unexplained entries.
- Maintain Daily Cash flows using actual and forecast amounts of cash required.
- Validating the Daily Cash flow to the ledger balance of the Natwest Bank Account.
- Pay over if required and reconcile all General Ledger Control Accounts relating to payments to Her Majesty's Revenue & Customs (HMRC).
- Ensuring the Financial Control Procedure is followed for Petty Cash.
- Liaising with Accounts Payable Manager for payment runs.
- Liaising with General Offices re banking and relevant documentations.

6.2 Higher Treasury Officer-Corporate Finance

Is responsible for:

- Receiving and recording of Income.
- Obtaining all Bank statements and reconcile to the Cash books and General Ledger Control Account.

6.3 Cashier –Corporate Finance

Is responsible for:

- Receipting all cheques received and preparing for collection by the Health Board's designated security Company.
- Issuing Controlled Stationery.
- Entering Cash and Deposit (C&D) sheets on to the Oracle System.
- Preparing Payable Orders from authorised request for Accounts payable (NWSSP) urgent payments and Petty Cash and placing "on stop" payable orders when required.
- Processing all faster payments, including but not limited to, Internal Transfers, CHAPS, Foreign Payments

6.4 Payroll Manager - NWSSP

Is responsible for:

- Submitting details of HMRC Payments to be made and details of the superannuation payments that payroll will be making.
- Resolving with the Treasury Manager any issues that cause the General Ledger Payroll Accounts not to be reconciled.
- Requesting the Treasury Management Department to issue CHAPS, faster payments and payable orders.
- Sending Copies of Bankers Automated Clearing System (BACS) recalls to cashiers.

6.5 Accounts Payable-NWSSP

Is responsible for:

- Liaising with Treasury Manager for BACS and Payable Order payment runs.
- Liaising with Treasury Manager for processing Faster Payment requests and Foreign Payments

6.6 General Office –Facilities Division

Is responsible for:

- Cashing up tills in staff restaurants in line with local procedures.
- Preparing and submitting C&D sheets to the Treasury Management Dept.
- Preparing bankings for collection by the Health Board's designated Security Company.

- Ensuring the Financial Control Procedure is followed for Petty Cash.

7 Main Body (General)

7.1 Drawdown of Cash Allocation from the Welsh Government

The total monthly cash allocation for Aneurin Bevan University Health Board will be received into the Government Banking Services (GBS) NatWest Account.

7.1.1 The Health Board's Treasury Manager, following discussion with the Assistant Head of Financial Services or the Head of Financial Services and Accounting and the Finance Manager for Capital, calculates the actual cash to be drawn down on a monthly basis, taking into account known commitments and current bank balances. The cash drawn down will reflect both revenue and capital allocations. The draw down is requested on a "FIS" form, which must be submitted to Welsh Government on dates specified on a timetable issued by Welsh Government.

7.1.2 The Health Board's Treasury Manager and Assistant Head of Financial Services will, on a daily basis, verify the cash balances on the bank account, and assess whether a second drawdown of cash will be required later in the month. This is referred to as an emergency draw down, and Welsh Government require 5 working days' notice to process this request.

7.1.3 The Health Board's Treasury Manager and Assistant Head of Financial Services will ensure that the total cash balance for Aneurin Bevan University Health Board is in line with cash best practice targets issued by the Welsh Government. The cash balance held must be sufficient to cover payment commitments, at the same time ensuring that cash is not drawn down in advance of need.

7.2 Physical Security

7.2.1 All premises where cash, cheques or payment cards are kept must be physically secure. Doors to offices where money is handled must be kept locked. Cash and cheques should be kept on Health Board premises, in a locked cashbox or safe at all practical times.

7.2.2 When money is received through the post it must be recorded in a post-book which shows the date, remitter's name, cheque number, amount and any other relevant information. This should be completed immediately after the mail is opened and subsequently signed as accurate by two officers. Cheques should be passed to the Cashier as soon as possible after receipt.

7.2.3 Any cash, cheques or the equivalent received outside the Cashier's department should be passed to the cashier's department forthwith and recorded in the post book and signed as above.

7.2.4 The amounts of money held as petty cash balances at each cash holding location should be minimised to reduce security risks. Petty Cash holders will be contacted regularly to ensure that they review their cash balances and re-bank any balances which are no longer required or requested to reduce the Petty Cash float where necessary.

7.2.5 Access to offices where money is kept should be restricted to authorised personnel only with adequate facilities made available for holding monies in use and out of working hours. Access must be strictly controlled.

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

7.2.7 Specialised cash handling contractors, such as the Health Board's designated Security Company should be used wherever practicable.

7.2.8 Bank paying in books must be pre-printed with the Health Board's official name and account number and are only available from the main Treasury office.

7.2.9 Income must be banked as soon as it is received. A full analysis of amounts paid must be provided on the paying-in slips together with other supporting details.

7.2.10 A controlled stationery register should be maintained and updated with the receipt and issue of all the following:

- Cheques, Cash and Deposit (C&D) Sheets.
- Petty Cash vouchers.
- Health Board's designated Security Company bags.
- Other controlled items.

7.2.11 The Bank Mandate clearly establishes the liability for loss between the Health Board and its Bankers.

Under the GBS the Health Board holds an account with the Royal Bank of Scotland (RBS) Group. The Health Board account is a NatWest Account within the RBS Group. Transactions will take place in these accounts as detailed below. GBS also have a high level

bank account with the Bank of England. This account processes the end of day and intraday transfers (sweeps) of GBS customer funds from the RBS group back into the Bank of England when required.

7.3 Bank Account

7.3.1

NatWest	BACS, CHAPS, Standing Order payments, Faster payments.
	Receive CHAPS, BACS Direct Credits, Standing Order and other types of electronic payments.
	Pay direct debits.
	Make and receive internal transfers to/from our own account or other GBS customers.
	Make and receive foreign currency payments and receipts.
	Merchant Acquiring receipts.
	Issue payable orders.
	BACS recalls.
	Local banking services (General Office banking's, encashment of petty cash reimbursements. Etc.)

7.3.2 The Health Board also operates NatWest Bank Accounts under the GBS umbrella for Patient's Private Monies and Charitable Funds and these are covered by a separate procedure.

7.3.3 Operation of the Health Board's bank accounts is strictly controlled and may only be altered by written instruction signed by two authorised signatories.

7.3.4 Only the Director of Finance, Procurement & Value is authorised to open bank accounts in the Health Board's name.

7.3.5 The bank mandate and list of signatories should be monitored and routinely reviewed by the Treasury Manager and updated for changes in staffing. The Mandate should be checked to ensure compliance with the Health Board's Standing Financial Instructions, and signed as evidence of such a check.

7.3.6 A copy of the SLA (Service Level Agreement) between the Health Board and the GBS for the new Government Banking Service is retained on file in the Treasury Management Section.

7.4 Corporate Purchasing Card

7.4.1 The Health Board has the Welsh Purchasing Card operated by Barclaycard. Its use is restricted to certain key areas of expenditure. The Barclaycard statements are accessed through the Barclaycard Spend Management System by the Treasury Manager or Higher Treasury Officer and are reconciled to the Ledger Control Account on a monthly basis. There is a separate Financial Control Procedure which deals with the requirements for the purchasing card.

7.5 Authorised Signatories

7.5.1 There is a designated approved list of authorised signatories set up for the NatWest Account.

7.5.2 The official lists of original signatures must be kept on the bank signatories file by the Treasury Manager and updated as in 7.3.5 above.

7.5.3 The signatures required on the authorisation process for payable orders is set down in the Health Board's Standing Financial Instructions. The payable orders are pre-signed by Paymaster, as part of the authorisation process in Oracle, in accordance with the Standing Financial Instructions.

7.5.4 The authorisation of payments is conducted manually by the designated authorised signatories. If circumstances do not allow for manual signatures to provide authorisation of payments, authorisation is instead conducted electronically, utilising the Adobe "Fill & Sign" function. This function allows authorised signatories to provide an electronic signature on payment instructions, which can then be utilised as authorisation of the payment.

7.6 Reconciliation of Bank Accounts

7.6.1 On a daily basis the cash flow balance will be verified and balanced to the bank account end of day ledger amount.

7.6.2 Each month the balances on all accounts must be reconciled with:

- The Cashbook; and
- The Financial ledger

7.6.3 Monthly bank statement reconciliations should be undertaken in accordance with the published month end timetable. This should be

completed by staff independent of Accounts Payable and Income systems, and staff should be made aware of the steps to undertake if unexplained or untoward items are found.

7.6.4 The basic purpose of the reconciliations is to explain the causes of any differences e.g. unpresented payable orders or unpaid BACS payments, and to ensure that action is taken to clear the items where required. Most reconciling items will be resolved by the passage of time e.g. an unpresented payable order will normally be presented before the next monthly reconciliation is due.

7.6.5 In circumstances where payable orders have not been presented for payment within six months of issue by the Health Board they become invalid. When this happens, all payable orders will be voided by the Treasury Manager/Higher Treasury Officer; i.e. the original accounting entries that gave rise to the payable orders issue will be reversed. Before write-off a list of any payable orders relating to payroll which are more than six months old is sent to the Payroll Manager for review/comment.

A schedule of payable orders written back each month must be retained and filed with that month's bank reconciliation.

7.6.6 All reconciliations must be prepared in accordance with the prescribed format as identified in the standing operating procedure

7.6.7 All the reconciliations together with any supporting documentation must be reviewed and signed by the Treasury Manager, who will check that the details of the reconciliations are correct, particularly that the figures taken from the ledgers and the bank statements are accurate. (In the absence of the Treasury Manager, the reconciliation is to be signed by the Assistant Head of Financial Services or the Head of Financial Services and Accounting)

7.6.8 The Treasury Manager must maintain a daily cash-flow spreadsheet which should be updated from forecast figures to actuals from bank statements and other known information (e.g. submitted Accounts Payable runs and weekly payroll runs) on a daily basis.

The process for validating the Cash-flow balance is as follows:

- On a daily basis, the Higher Treasury Officer will provide an up to date balance statement of the cash at bank balance of the Main Revenue Account, in the form of a screenshot, to the Head of Financial Services & Accounting and the Assistant Head of Financial Services.

- This balance statement will show the previous day's cleared balance and that day's bank account opening balance.
- The Treasury Manager or Assistant Head of Financial Services must enter the "Last Night's Ledger" balance on the Cash-flow, and initial to confirm that the figure has been entered and validated against the cash flow balance.
- The Head of Financial Services will check that the balance has been entered correctly, and figures have not been transposed.
- Both the Treasury Manager and Assistant Head of Financial Services will log into Bank line at a minimum of twice a week to verify the cash at bank balance, against the balance statement provided.
- The Assistant Head of Financial Services will ensure that the cash held at the end of the month does not go below £4m.
- There will be weekly cash forecast reviews held between the Assistant Director of Finance – Financial Systems & Services, Head of Financial Services & Accounting and the Assistant Head of Financial Services.

7.6.9 Any discrepancies, such as the bank statement not reconciling with the cashbook, which cannot be explained and rectified by the Treasury Manager, must be notified as a matter of urgency to the Assistant Head of Financial Services and Head of Financial Services and Accounting, who will take the appropriate steps.

7.7 Operation of the NatWest Account

7.7.1 Receipts into the NatWest Account fall into four categories which are as follows:

- Cash drawn down from Welsh Government on a monthly basis as part of the resource allocation, as in Section 7.1
- Other receipts, for general services supplied to other Health bodies and other Government bodies
- Refunds of VAT from H.M.R.C.
- Other miscellaneous receipts.

7.7.2 Each day the Higher Treasury Officer obtains a list of receipts into the NatWest Account for the previous day via the online "view account balance" from the menu.

7.7.3 NatWest Account receipts should be entered onto the Oracle Receipting system as promptly as possible.

A list of daily NatWest Account receipts should be recorded on the Receipt Register Spreadsheet, which forms part of the cashbook for

the NatWest Account reconciliation. The receipts are applied, via the Oracle Accounts Receivable module to the relevant invoice at the time of receipting, thus simultaneously updating the debtors ledger.

7.7.4 Payments from the NatWest Account are of three types.

- Payroll and Accounts Payable payment runs.

  The Payroll file will be generated from the ESR system to pay the Monthly or Weekly payroll payments. The Treasury Manager will be notified by a BACS file transmission report of the value of each payment to be processed.

  The Accounts Payable payment runs will be processed by the NWSSP - Accounts Payable Manager and authorised by the Assistant Head of Financial Services or Head of Financial Services & Accounting. The Accounts Payable Financial Control Procedure deals with the requirements of the Accounts Payable payment runs.

- Income Tax and National Insurance payments to HMRC.

  The Payroll Manager must send the Treasury Manager an Inland Revenue Payment request detailing the amount to be paid, quoting the tax office reference number and the required payment date along with a copy of the P35 for filing. The Treasury Manager must prepare a monthly reconciliation of the ledger PANISU (PAYE, National Insurance and Superannuation) figures to payments made to the Inland Revenue. Any discrepancies must be resolved and discussed with the Payroll Manager.

  GBS requires these payments to be made via BACS. Therefore, a Debit Note is completed by the Treasury Manager following notification by the Payroll Manager, as above, detailing the amount of the payment, the Bank details and the ledger coding. This is signed by the Treasury Manager or Assistant Head of Financial Services and authorised by the Assistant Director of Finance – Financial Systems & Services or delegated responsible officer.

  This Debit Note is then sent to the NWSSP Account Payable department for inclusion on the appropriate payment run, to ensure payment reaches HMRC by the 19th of the month.

- Payments to the NHS Pension Scheme

  The Payroll department completes the necessary online forms to make the payment to the NHS Pensions Agency electronically. The Payroll Manager emails a copy of the payment form in advance to the Treasury Manager for cash-flow purposes.

  The Treasury Manager prepares a monthly reconciliation of amounts paid to the NHS Pensions Agency with deductions for superannuation appearing in the ledger. Any discrepancies must be resolved and discussed with the Payroll Manager.

  The payments are to be entered onto the Oracle general ledger system and will form part of the RBS Account cashbook payments and hence part of the RBS Account reconciliation.

7.8 BankLine

7.8.1 BankLine is the GBS owned system which is accessed online by the Treasury Officers, Treasury Manager and Authorised Signatories. The purpose of this is to enable the Health Board's Treasury Management department to view the NatWest account statements and process Faster Payments, CHAPS, Inter Account Transfers to other Health and Government Bodies banking with GBS and foreign payments.

7.8.2 Access to the BankLine system is controlled by the systems "Administrators" and are allocated to:

- Assistant Head of Financial Services
- Treasury Manager
- Treasury Officers, and
- Authorised Signatories.

Administrators of Bankline for the Health Board are the Assistant Directors of Finance.

(For security purposes, the BankLine system prompts users to change their unique password every 28 days.)

7.8.3 Each workday morning the Treasury Officer or the Treasury Manager will obtain from the BankLine system a printed / downloaded pdf statement showing the balance on the Health Board's bank account and details of the previous day's transactions.

The Treasury Manager will enter this information on the daily cash-flow spreadsheet, updating forecast figures to actuals and making adjustments where necessary.

7.8.4 Approval of payments is carried out using smartcards and smartcard readers, as issued by BankLine. Smartcards and smartcard readers are the personal responsibility of each BankLine user. If they are no longer required, they should be returned to the Treasury Department for correct disposal.

For all payments up to £500,000, one signatory is required as part of the authorisation process. For payments that exceed £500,000, two signatories will be required as part of the authorisation process.

The limit for a faster payment is £1,000,000. Any payment (excluding Internal Transfers) that exceeds £1,000,000 are processed as a CHAPS payment. (CHAPS payments incur additional charges.)

Internal Transfers are faster payments that are processed between organisations that are within the GBS umbrella. There is no charge for processing an Internal Transfer, regardless of value.

7.9 Bank Account Transactions

7.9.1 Amounts paid via the Payroll (ESR) and Accounts Payable (Oracle Accounts Payable) systems automatically appear in the NatWest Account when the payable orders and BACS payments are presented. To ensure that these payments are entered in the cashbook the amounts should be obtained from the payroll and Accounts Payable departments. Amounts payable via the Accounts Payable daily payments run should be obtained from the Accounts Payable Manager. Details of payroll runs being processed are e-mailed by IBM (bureau) to the Payroll department and the Health Board's Assistant Head of Financial Services and Treasury Manager are also notified.. This e-mail details the amount of the run and the date of payment so that the Treasury Manager is able to enter these amounts on the cash-flow forecast.

When the bank statements are downloaded the amounts of these runs are compared to the figures provided by the Accounts Payable and Payroll departments, and any differences must be fully investigated.

7.9.2 Urgent payable orders are produced by the Cashier on the Oracle Accounts Payable System for creditor payments (weekly) and Petty Cash reimbursements (daily). The system shows the last pre-signed payable order number used and the Cashier must ensure that the next payable order used follows in sequence and no payable orders are unaccounted for.

Supplies of the payable orders secure stationery must be kept in the safe in the Cashier's department with access restricted to nominated Treasury staff.

7.9.3 The payroll department email requests to the Treasury Management department for pay amounts to be made by "CHAPS", faster payments and Payable Orders. This is for payments missed off the payment runs due to such things as late timesheets or missed enhancements. The requests must be signed by the requesting payroll officer and authorised by those people who are on the Authorised Signatory List (ASL).

7.9.4 The Health Board's Petty Cash holders submit periodic reimbursement claims to the Treasury Management department. These claims must be checked to ensure that a properly authorised receipt is provided for each item of expenditure, that the claim is coded and calculations are correct.

The claim should be prepared in line with the Health Boards Petty Cash Procedures, a copy of which must be provided to each petty cash holder. The petty cash holder is to be advised of any discrepancies.

The Cashier should summarise the reimbursement claim onto a payment request, which is to be authorised by the Treasury Manager or Higher Treasury Officer and should draw the payable order as outlined above.

The payable orders for Petty Cash reimbursement can be taken by the Petty Cash holder to any NatWest branch, where on presentation of two forms of photographic identification, the payable order will be cashed, up to a limit of £500.

7.10 Banking of Cash and Cheques Received

Money is received on behalf of the Health Board in four main forms and all monies received should be banked intact and promptly.

7.10.1 Cheques (and very occasionally, cash) are received through the post at the Finance Department. All mail is opened by a member of

the Financial Services & Accounting team. Cheques received are to be entered in a post book by one finance officer and signed for and countersigned by another officer. The post book and the cheques are then passed promptly to the Treasury Officer responsible for receipting.

The cheques should be entered onto the Oracle Accounts Receivable system as promptly as possible. Cheques are to be entered onto the system either as "cash", (that is cheques in payment of a Health Board's invoice), or "miscellaneous", (that is non-debtor income which is then coded directly to a general ledger income code).

Cheques which are entered as cash are to be simultaneously applied to the invoice being paid, thus updating the Debtors ledger. Any problems or discrepancies encountered when applying payment to invoices must be reported to the Debtors and Income Manager.

Cheques which are non–debtor income must be coded as instructed on accompanying documentation. If a code is not provided, enquiries should be made to determine the correct coding of the cheque.

Once the cheque has been receipted, a Treasury Officer is to sign it off in the post book.

Any documentation that arrives with the cheque, such as a remittance advice, is to be cross-referenced to the system receipt number and filed in the Cashiers department.

A daily receipt register is to be produced from the Oracle system. The cheques receipted are to be listed on a triplicate paying in slip and totalled. The total of the listed cheques should be agreed to the receipt register and the receipt register filed in the Cashier's department. The day's cheques received per the post book are to be totalled and compared to the total on the paying in slip and the receipt register and the book should be ruled off and signed by the Cashier. The receipted cheques are then placed in the safe, until they are collected for banking by the Health Board's specialised cash handling contractors.

The contractors are required to collect these banking's once a week on a Wednesday. Each day's paying in slip total is to be entered into a contractor log book and on a Wednesday the cheques plus one copy of the paying in slip should be placed in a secure bag

provided by the contractors and the bag must be sealed. The contractor's Agent scans the bag and allocates a seal number. A receipt is produced by the machine showing the seal number and this receipt is to be signed by the contractor's Agent and attached to the relevant page in the contractors log book, which is held in the Cashier's office.

The second copy of the paying in slip is to be attached to the relevant receipt register and filed and the third copy is to remain in the paying in book.

The contractor's log book must be signed with each week's banking by the Cashier and countersigned by the Higher Treasury Officer.

An official receipt for cheques received in payment of an invoice, in the form of an Oracle Accounts Receivable screen print, will not be issued unless specifically requested.

7.10.2 Catering/Shop Till sales should be cashed up daily and the values entered on the standard Health Board Catering/Shop Income spreadsheet as shown in Appendix A. The spreadsheet should be completed when the takings are being counted.

Two staff members must be present during the cashing up, and both should sign the aforementioned printed spreadsheet.

It is recommended that one of the two members of staff should, if possible be a member of staff from the General Office.

The General Office/Admin officer should refer to their local procedures for cashing up of Cash Registers/Tills. The local procedures of the General Offices vary in their form, however for the process of cashing up the Cash Receipts/ Tills they all incorporate the following key procedures:

- An individual float is allocated to each individual till.
- At the end of each day, a Z Reading (till report) is taken from each individual till (some hospitals take multiple readings throughout the day).
- The amount in each till is checked to balance against the Z read by a member of General Office staff and a restaurant supervisor.
- Any discrepancies between the Z read and the actual cash taken are then checked and recorded.
- The Receipt totals for each till are then recorded on the C&D Sheet, entering the information on a separate receipt for each till.

- The Card transactions from each till are entered on a spreadsheet.
- The money to be banked is then placed in the Health Board's designated Security Company bags, separate bags for cash and cheques, and the number of the bags recorded in a general account bank book. This is locked in a secure Safe in the General Office until Health Board's designated Security Company collect the money on a weekly basis.
- At the end of each month, the Z Readings spreadsheet and C&D receipts are sent to a Catering Administrator or Officer for their monthly account documentation and also sent to the cashier's department for reconciliation to the bank statements.

7.10.3 Monies are also receipted and banked on behalf of the Health Board at the various General Offices.

The General Offices should record all monies received on a Cash and Deposit Sheet (C & D Sheet). The C & D Sheets are in the form of pre-printed stationery and a receipt is produced when each receipt line on the sheet is completed. The Cashier in the Finance Department is responsible for issuing serially numbered C & D Sheets and C & D Receipts to General Offices on request. A record of such issues is kept in the Controlled Stationery Register. Acknowledgement slips are to be signed by the General Office Cashiers and returned to the Cashier's department, where they should be filed.

At the end of each week (or less frequently for the smaller General Offices, but monthly as a minimum) the C & D Sheet should be totalled and coded. The total per the sheet should be agreed to the amount of cash and cheques in the General Office safe awaiting banking, and a triplicate paying in slip completed.

The first copy of the paying in slip should be attached to the top copy of the C & D Sheet and forwarded to the Cashier's department without delay. The second copy of the paying in slip should be attached to the cash and cheques ready for banking. The third copy of the paying in slip should be left in the paying in book at the General Office.

For the larger General Offices the banking's are collected by specialised cash handling contractors. Banking's are collected once a week from each hospital site. The General Offices should place the amounts to be banked in the secure bags provided by the contractors and seal them. Separate bags are to be used for cash and cheques. A note should be made of the banking totals placed in each bag. When the contractor's Agent collects the bags they are

scanned and a receipt produced showing the unique bag number. This receipt should be attached to the record of banking's. An audit trail is then produced of the banking's in each bag handed to the contractors.

For the smaller General Offices a similar process is followed but two officers from the General Office take the banking's to the nearest branch of NatWest.

When the C & D Sheets are received at the Cashier's department, a Treasury Officer should enter the sheets onto the Oracle Accounts Receivable system as promptly as possible. If a line on the sheet represents payment of a Health Board's invoice, the amount is to be receipted as "cash", as above, and the debtors ledger updated accordingly; otherwise the receipt is to be entered as miscellaneous and must be coded as instructed on the C & D Sheet.

The amounts on the C & D Sheets are to be entered in the RBS Account cashbook and must be agreed to the bank statements as part of the bank reconciliation process. Any discrepancies in banking's must be fully investigated.

7.10.4 Monies received by the Health Board as direct credits to the bank account.

The bank statements are to be examined for direct credits. These credits should be identified either as "cash" or "miscellaneous", as above. The Accounts Receivable system is to be searched for invoice numbers, if no remittance advice is provided, and the invoice number or general ledger code is to be written on the bank statement. The direct credits should then be entered onto the Oracle Accounts Receivable system, as for normal receipting above, direct from the bank statements, and the debtors ledger updated where applicable. A receipt register is to be produced showing direct credits income and this is to form part of the RBS Account cashbook and bank reconciliation.

Any documentation relating to the direct credits, such as remittance advices, that is received in the Cashier's department should be cross referenced to the system receipt number and filed in the Cashier's office.

7.11 Payment of Trade Creditors

Payments must be accounted for properly, promptly and in full and authorised by a responsible officer at each expenditure threshold.

7.11.1 Payments to Trade Creditors are made by the BACS or by pre-signed payable orders held in the Cashier's department. An independent log of all payable orders issued and spoiled is to be kept by the Cashier to ensure that payable orders are issued sequentially. An independent review of this log must be carried out on a regular basis and any breaks in the sequence must be investigated and explained.

7.11.2 Before the daily BACS payment run the Accounts Payable Manager should produce a preliminary payment register from the Oracle Accounts Payable system, having set the dates on the system to comply with the 30 day and 10 day payment policies. The Accounts Payable Manager should then scrutinise the preliminary payment register for any errors – e.g. missed bank sort codes. The report should then be modified to correct any errors found and the Accounts Payable Manager should liaise with the Treasury Manager to ensure that sufficient funds are available to cover the payment run.

7.11.3 Once the payment run value has been agreed with the Treasury Manager, the Accounts Payable Manager should re-run the preliminary register on the system and generate a BACS file. A call is then logged by the Payment Run Team with NWSSP – Central Team via Service Point. The Central Team liaises with PayGate to process the BACS file for Payment on behalf of the Health Board. The Accounts Payable Manager should then confirm the payment and draw off a final payment register. The BACS Authorisation form and Final Payment Register and any other Documentation generated by the payment are saved on SharePoint. The totals on the final register are then to be emailed to the Treasury Manager and the total included on the daily cash-flow spreadsheet, the NatWest Account cashbook and bank reconciliation.

The Health Board is to pre-set limits with the bank for its various BACS payments runs and if the value of the run agreed with the Accounts Payable Manager exceeds this limit, the bank contacts the Treasury Manager for authorisation. When the actual payment run clears the bank statement, it must be checked against the figure on the cash-flow spreadsheet to ensure there are no discrepancies. If there is a discrepancy it must be reported to the Accounts Payable Manager and investigated.

7.11.4 Only nominated staff are able to initiate the transmission of BACS. The number of signatures required on BACS schedules must be established along with the maximum value of any payment within the schedule and the total value of the schedule. These limits must

be established with BACS. The BACS limits must be reviewed annually and may only be changed on the written instruction of the Director of Finance.

An input report for live submission is available online. The Accounts Payable Manager prints this off, reviews the report and signs it as evidence of review. The Treasury Manager should review the report to check that the value of the run is as expected and should sign the report as evidence of the review. The Treasury Manager is responsible for checking the total of the BACS run and the Accounts Payable Manager is responsible for checking individual payments within the run against pre-set limits and reviewing and investigating any exception reports, such as advice of unapplied automated credits or advice of wrong account numbers for automated credits. The report is then filed in the Cashier's department.

7.11.5 The same process should be followed for a payable order payment of trade creditors from the Oracle Accounts Payable system. Once the preliminary payment register has been scrutinised and modified and the final payment register produced, the payable orders are to be printed on the pre-signed payable orders held securely. The payable orders numbers used and the value of the run are to be entered in the log book maintained in the Cashier's department. The Treasury Manager should extract figures from this book daily for inclusion in the daily cash-flow spreadsheet. The payable order and the final payment register should be taken to an authorised signatory for scrutiny and signature. The Cashier's department then arrange for the payable orders to be distributed to the supplier.

7.12 Payment of Salaries and Wages

7.12.1 Details of payroll runs being processed are emailed by IBM (bureau) to Payroll department and the Health Board Treasury Manager is also notified. This email details the amount of the run and the date of payment so that the Treasury Manager is able to enter these amounts on the cash-flow forecast. The Treasury Manager will then ensure that funds are available in the NatWest Account to fund the payroll BACS payment.

This figure is also entered in the NatWest Account cashbook for bank reconciliation purposes.

The Payroll Manager follows a similar system of submission to BACS Limited and all reports and documentation are available online and

reviewed, evidenced and filed in the Payroll Department in Companies House, Cardiff.

7.13 Cancelled Payable Orders

7.13.1 Occasionally, a payable order is returned to the Cashier's department, relating to a payment of trade creditors. The payable order details are to be passed to the Accounts Payable Manager who should void the payment on the Oracle Accounts Payable system. By voiding the payment, the system will allow a replacement payable order to be drawn (for instance, if the payable order has been mislaid). If the payable order is to be cancelled altogether and not reissued, the payment must be both voided and cancelled on the system. A copy of the payable order and any supporting documentation is to be kept in the Accounts Payable department and the original is to be filed in the Cashier's department.

The cashbook payments figure should be updated for voided payable orders and hence the bank reconciliation and list of extant payable orders at the month end.

7.13.2 If a payable order needs to be stopped for any reason, the Cashier should check Bankline, the online banking system, to ensure that the payable order has not already cleared. The Cashier should then complete a payable order stop instruction and fax to the Government Banking Corporate Service team at the same time requesting a confirmation of stop. A replacement payable order may only be issued when the GBS team have confirmed that the stop has been actioned or if the original payable order has been returned to the Cashier.

7.13.3 The Accounts Payable Manager or the Payroll Manager will be responsible for requesting the Cashier to draw a replacement payable order.

7.14 BACS Recalls

When a BACS payroll payment needs to be recalled, the Payroll Manager must send details to the NatWest Customer Services team on a spreadsheet (provided by NatWest) via email, requesting that they execute the recall and also email the Treasury department mailbox.. The Cashier's department should file their copy and check the details when the funds are credited back on the bank statements. If no copy of a BACS Recall form is filed for a credit received, the payroll department should be informed and requested to investigate. If a BACS recall form is filed and no credit

subsequently appears on the bank statement, the Cashier should telephone the bank and the payroll department to investigate.

The recalls should be entered in the cashbooks and the bank reconciliation.

The cashbook coding must be entered on the copy of the BACS Recall form received at Cashiers.

7.15 Credit/Debit Card Receipts

7.15.1 Payment by Credit/ Debit Card

The Local Health Board accepts payment by credit/debit card. There is a Card terminal located in the Cashiers department office which has a dedicated phone line. There is also a card terminal in the Glan Usk Suite in Nevill Hall Hospital.

A contract has been set up with Barclaycard to provide this service. When setting up the contract the Health Board specified the bank account into which remittances should be paid, net of agreed charges.

The Health Board's invoices include details of how to pay by telephone using a credit or debit card. When a call is received, the following details are recorded on a daily Credit/Debit Card Log:

- Date and time of call
- Name of payee
- Invoice Number
- Amount
- Contact telephone number
- Further details if the receipt is miscellaneous

The credit card number and security code are entered directly into the terminal at the time of the call and are **never** recorded.

The Cashier will send the customer copy of the receipt issued by the Credit/Debit card terminal and the receipt from the Oracle Accounts Receivable ledger to the payee.

The credit/debit card log then becomes the input document to receipt the amounts received into Oracle and apply to the relevant invoices in the Accounts Receivable ledger. The Credit/Debit card log is filed, along with the matching Oracle receipt register and the

merchant's copy of the receipt from the credit/debit card terminal, in the Cashier's office.

The totals from this log are then entered in the RBS cashbook and form part of the bank reconciliation process.

7.15.2 Chip and Pin Machines in Restaurants and Shops

Chip and Pin machines have been installed in all restaurants/ canteens and shops on Health Board premises.

The amount of Card sales are clearly identified on the "Z read" from the tills when General Office staff cash up on a daily basis, in line with local procedures. General Office staff enter the details from the "Z reads" on a standardised spreadsheet provided by the Cashier's Department. At the end of the week the spreadsheets are sent to the Treasury Manager or the Higher Treasury Officer.

The Higher Treasury Officer checks the Card sales per the "Z reads" spreadsheet to the amount transmitted to the NatWest account and investigates any discrepancies.

The Card terminals are provided by Optomany and the funds are transmitted to the NatWest account by Worldpay. Each of the terminals installed has its own unique "merchant number" so that when the funds are transmitted to the Health Boards RBS account, the location of the terminal can be easily determined and hence accurately coded to the ledger.

7.16 Foreign Currency

The Accounts Payable department receive some foreign currency invoices for payment, or a memorandum from a department within the Health Board requesting payment of a foreign currency amount to an overseas supplier.

When the invoice has been passed for payment, the Accounts Payable department should notify the Cashier's department that a foreign payment is required and must provide backup documentation showing the creditor's name, address, the address to which payment is to be made, foreign currency type, amount and foreign bank details. A copy of the Bank Details as per the Oracle Accounts Payable system must be provided.

The Cashier's department should then enter the payment into the RBS Account foreign payments online service, print out the payment details and have this appropriately authorised online. The

Higher Treasury Officer should then prepare a journal to upload the foreign currency payments into the Oracle general ledger.

Where foreign currency is received from a debtor, e.g. a private patient, the Cashier's department will deposit the amount with the bank for conversion into sterling. When the converted amount appears on the bank statement it will be receipted as a direct credit and applied to the relevant debtor invoice, thus updating the debtor's ledger.

7.17 Cash Flow

As per 7.6.8, above, the Treasury Manager must maintain a daily cash-flow summary. This summary must cover all sources of income and payments and provides actual amounts up to date and provides reasonable projections for forecast income and expenditure. The daily cash-flow summary is subsequently summarised further into a monthly cash-flow.

The cash-flow summary is reviewed on a daily basis by the Assistant Head of Financial Services, to ensure that the cash balance remains at the best practice target set by Welsh Government during the financial year and achieves the year-end target.

The Assistant Director of Finance – Financial Systems & Services, Head of Financial Services & Accounting, and the Assistant Head of Financial Services meet on a weekly basis to discuss the cash forecast, to ensure there is sufficient cash to meet the Health Board's commitments and that cash is not being drawn down in advance of need.

On a monthly basis, a cash-flow forecast for the following month is provided to Welsh Government. The forecast is submitted to Welsh Government as per an issued timetable. The Treasury Manager is required to discuss the forecast requirements with the Assistant Head of Financial Services and Head of Financial Services & Accounting, based on the cash-flow statements above, and any other information provided (e.g. future income/ expenditure commitments).

The Health Board is also required to include a Capital cash-flow forecast in the above. The total Capital cash amount is provided by the Head of Capital Finance and must be separately identifiable..

7.18 Money Laundering

The 2007 Money Laundering Regulations extend Customs and Excise's supervision of businesses vulnerable to money launderers to include High Value Dealers (HVD'S). HMRC considers a high value payment to be:

- a single cash payment of €10,000 or more for goods
- several cash payments for a single transaction totalling €10,000 or more, including a series of payments and payments on account
- cash payments totalling €10,000 or more which appear to have been broken down into smaller amounts so that they come below the high value payment limit

HVDs are businesses that:-

- Deal in goods; and
- Accept (Or are prepared to accept) cash payment equivalent to €10,000 or more (Or equivalent in any currency), for any single transaction.

HVD's must register with HMRC for supervision under the Money Laundering Regulations 2007 and implement specific anti-money laundering procedures. However, if an NHS body has a clear policy of not accepting cash payments over the €10,000 (or equivalent) limit for any single transaction; it is not affected by the new rules.

The HMRC Money Laundering Policy Team stated that NHS bodies should consider whether they are covered by these regulations and, if so, they must register that fact.

It is felt that the Health Board is unlikely to be asked to accept payment in cash for a transaction value over the €10,000 (or equivalent) threshold, and hence is not registered at the present time.

8 Implementation

This document should be implemented with immediate effect.

9 Further Information

Enquiries regarding this policy should be directed to the Treasury Manager, Assistant Head of Financial Services, Head of Financial

Services and Accounting or the Assistant Director of Finance – Financial Systems & Services.

All are in Corporate Finance, Top Floor, C Block, Mamhilad House.

10 Audit

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

11 Review

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

Appendix A

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

Catering Department/Shop, …….Hospital		
Catering/Shop Income		
Today's Date:	Z Readings ref no.:	
Till Reading breakfast:		
Till Reading lunch:		
Till Reading Shop:		
Readings Total:		
Total money in till drawers: CASH TAKINGS: To be entered on C & D Sheet: **C&D Receipt No**.:	Less float £……..	
Difference between total readings and cash taken + or –		
First signature:	Second signature:	

Aneurin Bevan University Health Board

Financial Control Procedure Patients' Travel Costs Policy

Policy and Procedure

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

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1. Introduction

1.1. Policy Details

This policy details the financial help available to those patients who do not have a medical need for ambulance transport and who cannot meet the cost of travel to hospital.

1.2. Patients' Travel Claims Policy

The Patients' Travel Claims Policy is based on the provisions set out in the Welsh Government's Healthcare Travel Costs Scheme. (HTCS) found in Welsh Health Circular WHC/2017/006. This is a mandatory scheme under the National Health Service (Travelling Expenses and Remission of Charges) (Wales) Regulations 2007 which came into force on 1 April 2007 and was amended in 2010.

2. Policy Statement

Aneurin Bevan University Health Board is committed to ensuring that it has sound financial controls in place to ensure that there is good control and probity. An integral part of this is the reimbursement of patient's travel costs and is therefore subject to a Financial Control Procedure.

3. Aims

To ensure that there is a clear policy framework governing the reimbursement of patient's travel costs.

4. Objectives

Reimbursement of travel costs is made to those patients who do not have a medical need for non-emergency patient transport, but who require assistance with their travel costs. The Health Board must ensure that the claimant is entitled to such help and that no fraudulent claims are processed, and that accurate and timely entries are made in the financial ledger to record such expenditure.

5. Scope

This document relates to the following staff:

- Staff within Corporate Finance and in particular the Treasury Management Department.
- Staff in the Facilities Division and in particular the General Office Staff

- Staff in other Divisions dealing with Patients who would require financial help with travel costs

6. Roles and Responsibilities

6.1. The Director of Finance, Procurement & Value

The Director of Finance, Procurement & Value is responsible for the efficient operation of the Patients' Travel Claims Policy and the accurate recording of the resulting entries in the financial ledger.

6.2. Assistant Director of Finance – Financial Systems and Services

The Assistant Director of Finance – Financial Systems and Services is responsible for the day to day management of the policy.

The Assistant Director of Finance - Financial Systems and Services is responsible for authorising all retrospective patient travel requests.

6.3. The Treasury Manager

The Treasury Manager is responsible for liaising with Hospital General Office staff and Accounts Payable staff to ensure that reimbursements of patients' travel claims are made in accordance with the Patients' Travel Claims Policy.

6.4 Treasury Officer

The Treasury Officer is responsible for checking any forms received directly into the finance office, ensuring they have been stamped by the NHS Business Authority, and either that they have an appointment letter attached or have been approved by the relevant general office.

6.5 Hospital General Office Staff

The Hospital General Office staff are responsible for making reimbursements of travel costs, in cash, to patients who make their claims in person at the General Office and are eligible to do so under the HTCS.

6.6 Hospital Staff

Hospital Staff are responsible for ensuring that information about the HTCS is available to stakeholders and patients. In particular, notices about the HTCS should be prominently displayed in all patient areas.

Welsh Government guidance can be found here

Hospital Staff are also responsible for holding supplies of claim forms HC1W (Low income but not in receipt of benefits) and HC5W(T) (For people in receipt of benefits).

7. Main Body

7.1. Eligibility Criteria

Under the Regulations, eligibility for full or partial reimbursement of travel costs depends upon the following conditions being met:

7.1.1. Requirements

The patient must be:

- In receipt of one of the qualifying benefits or allowances specified in the 2007 regulations (or in certain cases be a member of the same family as a person receiving a qualifying benefit or allowance), or

- Be named on an NHS Low Income Scheme certificate HC2W or HC3W (or in certain cases be a member of the same family as a person named on an NHS Low Income Scheme certificate), and

- The journey undertaken must be made to receive services provided under Parts 1 and 2 of the National Health Service (Wales) Act 2006 in an NHS hospital for which the patient has been referred by a GP or dentist.

7.2. Basis of Entitlement

7.2.1. Patients who (and, where considered medically necessary, their escorts) are automatically entitled to reimbursement of hospital travel costs. (See Appendix 1)

Patient travel costs should only be reimbursed to patients in receipt of qualifying benefits, namely:

- Income Support (IS)
- Income Based Employment and Support Allowance (ESA(IB))
- Income-based Jobseekers Allowance (JSA(IB))
- Working Tax Credit (WTC) and/or Child Tax Credit (CTC)
- Pension Credit Guarantee (PCGC)
- Universal Tax Credit (See note below)

*(**Note** - By the end of 2024/25, the government intend to migrate all claimants of Income Support, Income Based Job Seeker's Allowance, Housing Benefit, Tax Credits and Income-Related Employment Support Allowance onto Universal Credit. People who get income-related Employment and Support Allowance (irESA) only or income-related ESA and Housing Benefit will not migrate until*

2028/29. The effect of this will mean that some of the benefits currently listed, will no longer be relevant.)

The patient seeking reimbursement must demonstrate that he/she is in receipt of qualifying benefit by producing evidence of such. Details of qualifying benefits and documents which evidence receipt of these benefits can be found in Tables 1 and 2 of the HTCS and Section 1a of the Good Practice Guidance.

7.3. Documentation

Where the patient does not have the correct documentation to be reimbursed in cash by the general office, the patient can be reimbursed by Payable Order by completing a HC5W(T) form (Refund claim form for travel where documentation confirming eligibility is available but not at time of travel) and submitting this to the NHS Business Services Authority for approval. Form available via the link below.

If approved, the form is received in the Finance Department for processing.

The Treasury Officer reviews the documentation received ensuring they have been stamped by the NHS Business Authority, and either that they have an appointment letter attached or have been approved by the relevant general office. All receipts must be verified, and the amounts submitted are checked to ensure they fully comply with this policy.

Once reviewed, the Treasury Officer completes a standard authorisation for payment form, and both the form and reimbursement claim is checked and signed by the Treasury Manager and then signed as authorised for payment by the Assistant Director of Finance – Financial Systems and Services.

The Treasury Manager sends this form and the HC5W(T) form to Accounts Payable Department. This may be as a result of a retrospective claim or if the patient was unable to produce evidence of eligibility to the Hospital general office at the time of their visit.

The Accounts Payable Officer checks that the HC5W(T) has been correctly completed and authorised for entitlement by the relevant office/authorised signatory. A payment will then be made to the patient within a reasonable timescale.

7.3.1. Patients not automatically entitled to a refund

Patients who are not in receipt of any of the benefits in point 7.1.1 may access other routes to provide eligibility. These routes are:

- People claiming on the grounds of low income (See Appendix 2)
- Persons living permanently in a care home or accommodation provided by a local authority
- Asylum seekers for whom support is provided under Part VI of the Immigration and Asylum Act 1989

Patients may be eligible for full or partial reimbursement under the HTCS on the basis of low income. The assessment of low-income entitlement to refund of travel costs is carried out by Patient Services Division of the Prescription Pricing Authority. Patients who may be entitled to help on low income grounds should be encouraged to read leaflet HC11 and to make a Low Income Scheme claim using form HC1W and a refund claim using form HC5W(T). Hospitals should hold stocks of these forms.

7.3.2. Patients assessed as eligible for low income help and holding a current entitlement certificate

Those patients assessed as eligible for help with travel costs to hospital on low-income grounds will receive a certificate from the Patients' Services Division.

When presenting for a reimbursement of travel expenses the patient should produce either a form HC2W or HC3W. (Certificates of Low income)

Form HC2W will show the period of validity and the people covered and will state that the patient is entitled to a full refund.

Form HC3W will show the period of validity, the people covered and the amount of travel costs each patient is expected to meet in any one week (7 days commencing midnight Saturday). Any costs incurred in any one week, over and above the amount shown, should be refunded.

Patients who have been assessed but are unable to produce either form HC2W or HC3W should be advised to complete form HC5W(T) to claim a refund.

7.3.3. Patients claiming but not yet assessed for low income help

Patients who claim low income entitlement but who have not applied for assessment should be given a claim form HC1 which they should be advised to complete and send to Patient Services Division, with a completed form HC5W(T).

Patients who have claimed but not received a certificate should be given a refund claim form HC5W(T) which they should send to Patient Services Division. Patients are required to include their hospital number, the department attended and the full name, address and telephone number of the hospital. They may need advice about this from the General Office. Patients should be advised that the completed HC5W(T) must be received by Patient Services Division (or other office shown on the HC5W(T)) within 3 months of travel.

Patient Services Division will carry out the assessment and, if the patient is entitled to a refund for journeys already made, will send the completed form HC5W(T), confirming entitlement, to the hospital, who should pay the patient. The patient should be paid either on their next visit or, if more appropriate, by Payable Order direct to their home address.

If the patient does not hold an HC2W or HC3W form Patient Services Division will also send out either a HC2W or HC3W form starting from the date the HC1 claim form was received. It should be noted that entitlement to certificates is based on the date of the claim, whilst entitlement to refunds is based on the date of travel. If the patient's circumstances have changed between the date of travel and the claim, the amount of the refund could be different from what the certificate says they have to contribute.

7.3.4. Persons living permanently in a care home or accommodation provided by a local authority.

To qualify the claimant must reside in a care home or residential accommodation and have satisfied the local authority that they are unable to pay for that accommodation. A letter from the local authority confirming their status as at the date the travel for healthcare needs to be provided and a HC1 form completed.

7.3.5. Asylum seekers for whom support is provided under part VI of the Immigration and Asylum Act 1999

A person who is an asylum seeker for whom support is provided

under part VI of the Immigration and Asylum Act 1999. The recipient and any dependents where a dependent is classified as someone in the UK who is a spouse or a child who is under the age of 18. To qualify a letter from the Home Office confirming their status as an asylum seeker being supported under the 1999 Act as at the date the travel was undertaken,

Or

A valid HC2W or HC3W certificate.

7.3.6. People not eligible for HTCS help

- Patients who attend an establishment to receive primary medical or primary dental services.
- Patients who attend a hospital to receive NHS Services but have not been referred for those services by a doctor or a dentist (e.g. self-referral)
- Patients being transferred between treatment centres.
- Patients with medical need for ambulance transport.
- Patients who discharge themselves from hospital at their own request.
- Visitors to patients in hospital.
- Private patients.

7.4. Claiming for Others

7.4.1. Carers and Escorts

If a Consultant or G.P. decides that it is medically necessary for the patient to travel with an escort (or escorts) when attending an appointment, then they too are entitled to reimbursement of travel expenses, solely on the basis of the patient's entitlement, if public transport is used. If the patient travels with an escort in a private car or a taxi, then only the cost of the journey will be refunded, not a per person refund. Claims made within this category must be supported by a letter from the consultant/GP confirming the necessity for an escort on medical grounds.

7.4.2. Children and Other Dependents

People receiving a benefit providing entitlement to HTCS can also claim for the reimbursement of travel costs where the healthcare appointment has been made for a child (under 16) or other dependent. Such claims should be assessed in the same way as all other HTCS claims.

7.5. Reimbursement

Once it is established that the patient is entitled to reimbursement of travel costs, the costs should be calculated on the basis of the cheapest form of transport available to the patient.

7.5.1. Travel by public transport

If the patient has travelled to hospital on the cheapest form of available public transport, he/she must produce the ticket as evidence and the full cost of the fare will be reimbursed.

7.5.2. Community Transport and Voluntary Car Schemes

Community transport or voluntary car schemes provide transport for people who are unable to use, or have difficulty with access to, more conventional local bus services. Local authorities and community transport operators will be able to provide details of local schemes. Schemes do vary, in terms of both the population groups they serve, the area they cover and the rates that they charge. For example, some schemes set a fixed price per journey, whilst others charge a set rate per mile or rely on donations or voluntary contributions. Patients should ensure that they obtain a receipt from the driver for each journey made using this type of scheme.

7.5.3. Travel by private car

Where the Health Board considers the use of a private motor vehicle is reasonable, they should pay the full estimated cost of fuel actually used in making the journey. The Health Board has agreed to set mileage rates for reimbursements to patients using private motor vehicles in line with the advisory fuel rates specified by Her Majesty's Revenue and Customs (HMRC) for company cars as a proxy for the cost of fuel.

Information on the current HMRC rates can be found here

If the Health Board considers that the use of a private vehicle was not reasonable and that the patient could have reasonably been expected to travel by using a local bus service, they should reimburse the lesser of the estimated cost of fuel actually used, or the equivalent public transport cost.

7.5.4. Taxis

Taxi fares should be reimbursed only if there is no other way the patient can travel for all or part of the journey, or in exceptional

circumstances, for example if the patient has restricted mobility. A letter would be required from the consultant confirming the medical need to travel by taxi before any reimbursement could be made.

Discussions regarding the use of taxis (if deemed necessary by the consultant) should be discussed and agreed with the patient prior to travel to ensure that they fully understand what will and will not be reimbursed.

If the letter confirming the medical need to travel by taxi from the consultant is not provided, the Health Board will reimburse the lesser of the estimated cost of fuel actually used, or the equivalent public transport cost.

7.5.5. Car parking charges

Car parking charges, including those at a hospital, may also be refundable for those patients that meet the above criteria where they are unavoidable but not penalties incurred as a result of illegal parking.

7.6. Paying the Patient

Patients can be paid on the day of travel, retrospectively and in advance.

7.6.1. Verifying the Claims

When considering a claim the Health Board should ask to see the following information.

- Evidence of the patient's entitlement to have their travel costs paid under HTCS (see Appendix 3);
- Evidence that they have attended, or plan to attend an appointment at the hospital (e.g. an appointment letter or card), and
- Proof of travel (e.g. bus or train ticket, taxi receipt), or details of proposed travel arrangements.

7.6.2. Payment on day of Travel

To claim reimbursement on the day of the appointment, patients will need to provide evidence of their entitlement (see eligibility section) and appropriate travel receipts. Where these requirements are met, patients should be paid the appropriate cost of travel immediately and in cash.

7.7. Retrospective Claims

Patients may claim help with travel costs up to three months after the date of travel. All the conditions applying to patients who claim at the time of travel apply equally in such cases.

Where patients wish to make retrospective claims for travel expenses or are unable to produce evidence of entitlement at the time of travel, they should be given a form HC5W(T) so that they may seek confirmation of entitlement. The completed HC5W(T) should be received by the relevant office within three months of the date of travel for which reimbursement is claimed.

When the authorised HC5W(T) is returned, the hospital must confirm attendance and the cost of travel on form HC5W(T). If the patient is entitled to a refund, the relevant office will then send the completed form HC5W(T), confirming entitlement, to the Treasury Manager.

Once the HC5W(T) form has been authorised by the Assistant Director of Finance it is then sent to the Accounts Payable

Department, who should then reimburse the patient by payable order to the patient's home address within four weeks of receipt of the claim.

7.8. Payments in Advance

If a patient states that he/she does not have sufficient money to fund travel to hospital and does not require an ambulance on medical grounds, he/she may ask the General Office at the hospital concerned to provide payment in advance.

In this situation, all the conditions applying to a normal reclaim re eligibility still apply and the rules governing the amount to be paid should be followed in the normal way.

The patient's details should be noted by the General Office dealing with the request on the Patient's Travel – Claims In Advance form provided by the Finance Department (See copy attached at Appendix 1).

These details should include the patient's full name and address, details of benefits being received, hospital and clinic to be visited and date and time of appointment. The amount of travel expenses due should be agreed with the patient at the time the form is completed.

The General Office staff should sign and date the completed form, keep a copy and send to the Aneurin Bevan University Health Board, Accounts Payable, Companies House, Crown Way, Cardiff. C14 3UB who will check the form and process a payment to be sent to the patient's home address.

As a check, the General Office should confirm that the patient subsequently attended the appointment detailed on the Claims in Advance form.
If not, the Income Recovery Section of the Finance Department should be informed so that they can take steps to recover the money, if appropriate.

The patient also has the option of applying to his/her local Job Centre Plus (Benefits Agency) office for a Social Fund Crisis Loan.

7.9. Further Clarification on the Claims Process

For further clarification on the claims process please refer to Appendix 5 and Appendix 6.

7.10. Fraudulent Claims

Hospital staff administering the HTCS, particularly those in Accident and Emergency Departments, should be on their guard against the possibility of fraudulent claims, for example, where patients arrive at Accident and Emergency Departments purporting to have injuries then claiming the fares home to very distant locations. Such claims will need to be scrutinised very carefully.

8. Monitoring and Effectiveness

The policy will be monitored to ensure it is kept up to date with guidance issued on this topic by the Welsh Government and HMRC Mileage rates
For more information please contact the Treasury Manager, Finance Department. Telephone (01495) 765429.

9. Further Information

Frequently asked questions are contained in Appendix 4.
Further information regarding the policy may be found in the Welsh Government's Healthcare Travel Costs Scheme (HTCS) found in Welsh Health Circular WHC/2017/006.

10. Equality

An equality impact assessment has been carried out.

11. Audit

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

12. Review

The procedure will be reviewed every 3 years.

Appendix 1

1. Benefit	2. Eligibility Criteria	3. Entitlement Covers
Income Support (IS)	All patients in receipt of Income Support are entitled to payment of NHS travel expenses through HTCS.	Recipient, partner and any dependents for whom the recipient or partner is responsible including children and young people under 20 named in the award. Some children and young people will not be included in the IS award. These will be covered by Child Tax Credit (CTC). Escorts: Where deemed medically necessary by a doctor or other health care professional involved in the provision of services to a patient, the travelling expenses of escort(s) may also be claimed as part of the patient's cost. Where children under 16 are travelling for treatment escort costs may be paid for a parent or guardian attending the appointment with the child.
Income Based Employment and Support Allowance (ESA (IB))	All patients in receipt of Income based Employment and Support Allowance	Recipient, partner and any dependents for whom the recipient or partner is responsible including children and young people under 20 named in the award. Some children and young people will not be included in the award. These will be covered by Child Tax Credit (CTC). Escorts: Where deemed medically necessary by a doctor or other health care professional involved in the provision of services to a patient, the travelling expenses of escort(s) may also be claimed as part of the patient's cost. Where children under 16 are travelling for treatment escort costs may be paid for a parent or guardian attending the appointment with the child.

Income Based Jobseekers Allowance (JSA (IB))	All patients in receipt of Income Based Jobseekers Allowance	Recipient, partner and any dependents for whom the recipient or partner is responsible including children and young people under 20 named in the award. If a child is no longer included, entitlement should be through Child Tax Credit (CTC). Escorts: As for IS above
Working Tax Credit (WTC) and Child Tax Credit (CTC)	Patients who are receiving or are named on an award certificate for: (a) WTC with CTC; (b) WTC with a disability element or a severe disability element, or (c) CTC but is not eligible for WTC, provided that the relevant income of the person to whom the tax credit is awarded is not more than £15,276 on their award letter.	Recipient, partner and any dependents including children and young people under 20 named in the award letter. Escorts: As for IS above
Pension Credit – Guarantee Credit (PCGC)	All patients in receipt of PCGC Pension Credit – Savings Credit awarded on its own does not automatically provide entitlement through HTCS. However, patients in receipt of this benefit may qualify for full or partial payment of their travel expenses via the NHS Low Income Scheme (see below)	Recipient, partner and dependents Escorts: As for IS above.
Universal Tax Credit	The roll-out of Universal Credit in Wales is ongoing and will replace some of the means tested benefits noted above. Universal Credit is being introduced in phases depending on where an individual lives and their personal circumstances.	Recipient, partner and dependents Escorts: As for IS above.

	The earning thresholds are: ▯ A lower threshold of £435 net income per month for households with no dependent child and/or limited capability for work/disability, and ▯ A higher threshold of £935 net income per month for households with a dependent child and/or limited capability for work/disability.	

Appendix 2

Passport To Support	Eligibility Criteria	Entitlement Covers
People claiming on the grounds of low income	Patients who are not in receipt of a qualifying benefit but are on a low income and whose savings are less than £16,000 (or £24,000 if in a care home) may be eligible for assistance with their NHS travel expenses. The calculation of a patient's entitlement is carried out by the PPD. Where patients have not yet made an NHS Low Income Scheme claim they should be provided with the following for completion and forwarding to PPD: HC1 – assessment form HC1(SC) – assessment form if the patient is in a care home or supported by a local authority because they are 16 or 17 and have recently left local authority care HC5W(T) – refund claim form. If the patient has already made a claim but has yet to receive their certificate, they need only complete and forward the HC5W(T). Patients who might not consider themselves to be on a low income should be encouraged to make a claim if their savings are below the current limits. Where successful, they will be sent a certificate showing how much they would be expected to pay for their travel per week and would be entitled to a refund of anything above this amount.	Recipient, partner and dependent children or young people under 19 whose names are shown on the notice of entitlement (known as a HC2W or HC3W certificate). Escorts: Where deemed medically necessary by a doctor or other health care professional involved in the provision of services to a patient, the travelling expenses of escort(s) may also be claimed. Their costs should be added to the patient's costs and it is the patient's income that will count, not the escorts.
Persons living permanently in a care home or accommodation	To qualify the claimant must reside in one of the following and have satisfied the local authority that he is unable to pay	Claimant only.

provided by a local authority	for that accommodation at the standard rate or, as the case may be, the full rate: • a care home; • residential accommodation provided by a local authority for persons aged 18 or over who by reason of age, illness, disability or any other circumstances are in need of care and attention which is not otherwise available to them; • residential accommodation for expectant and nursing mothers who are in need of care and attention which is not otherwise available to them.	
Asylum seekers for whom support is provided under Part VI of the Immigration and Asylum Act 1989	A person who is an asylum seeker for whom support is provided under Part VI of the Immigration and Asylum Act 1999.	Recipient and any dependents where a dependent is classified as someone in the UK who is: • A spouse; • A child of his, or of his spouse, who is under 18 and dependent upon him.

Appendix 3

PATIENT'S TRAVEL – CLAIMS IN ADVANCE FORM

Patient Name	
Patient's full address	
Proof seen of Patient entitlement to eligible benefits?	
Hospital and clinic to be attended	
Appointment Date and Time	
Amount of travel claim agreed with patient	£
General Office staff signature and date	

Confirmation of Patient Attendance	Y/N
If N, copy of this form sent to Income Recovery , Finance Department, "C" Block, Mamhilad House, Mamhilad.	Y/N

Appendix 4

Frequently asked Questions

Q. *Can I claim under the HTCS for a visit for to the dentist?*

A. No, you must be either attending a hospital or Healthcare Local Health Board/Trust organisation under the care of an NHS consultant.

Q. *I am an NHS patient attending a non-NHS hospital can I still claim under the HTCS?*

A. Yes providing you are in receipt of one of the qualifying benefits or have been awarded either a HC2W or HC3W certificate. Contact your local Health Board for further details. Do we need to provide contact details within the HB?

Q. *My husband is in hospital, can I claim under the HTCS for my visits?*

A. Unfortunately the HTCS does not apply to visitors.

Q. *My premature baby is still in hospital, I need to visit every day to feed him. Can I claim under the HTCS?*

A. Unfortunately the HTCS does not apply to visitors.

Q. *I live in a rural area, if I was to use public transport I would not get to the hospital in time for my appointment. Can I get a taxi and claim back the cost through the HTCS?*

A. Yes providing you are in receipt of one of the qualifying benefits or have been awarded either a HC2W or HC3W certificate and there is no other suitable means of transport.

Q. *I have chosen to take an outpatient's appointment at a hospital in a neighbouring city, I intend to use the train to get there, and my wife will be coming with me. Can I claim under the HTCS for her train fare as well as my own?*

A. Yes you can claim under the HTCS providing you are in receipt of one of the qualifying benefits or have been awarded either a HC2W or HC3W certificate. However, you will only be able to claim the cost of your wife's fares if you have a medical need (approved by a medical practitioner) for an escort.

Q. *I have recently claimed a reimbursement under HTCS, I travelled in my own car and was reimbursed at a rate of only 13.5p per mile. Is this correct?*

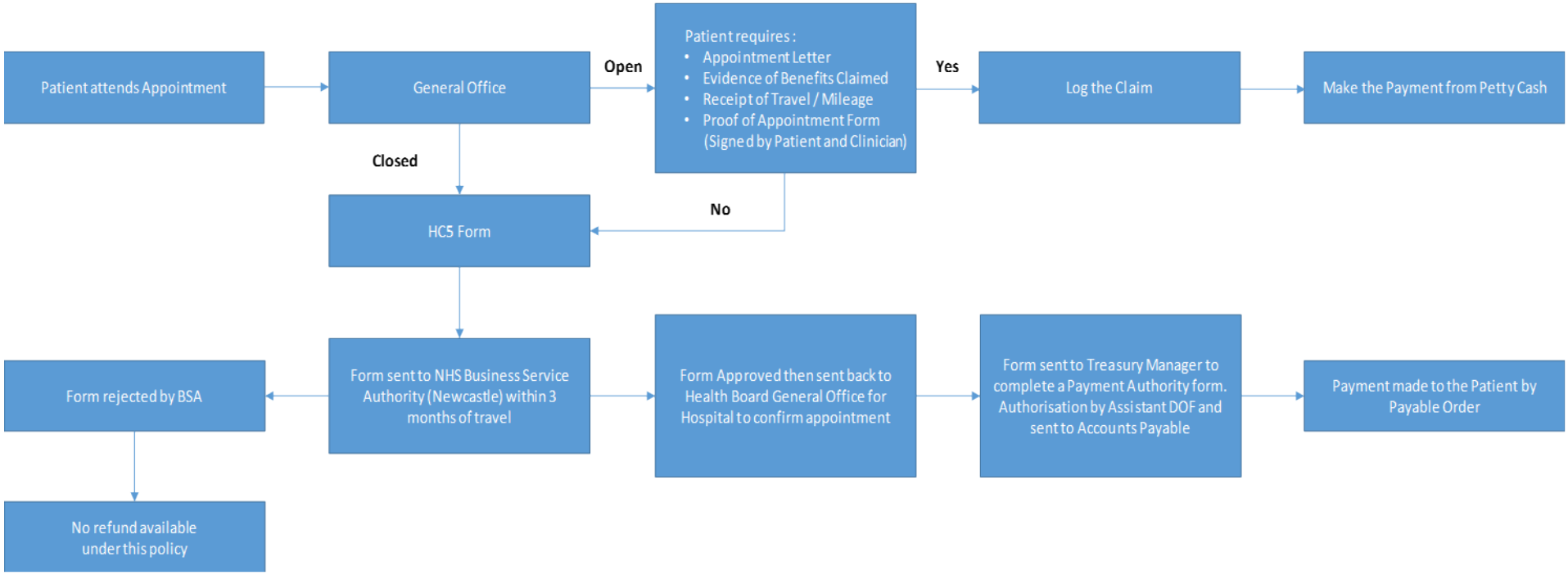
A. . Reimbursement should be in line with HMRC advisory fuel rates.

Q. *I have an outpatient's appointment at the hospital, my GP has arranged a hospital car to take me to the hospital and take me home. I have had a bad experience of using the hospital car in the past. So I have cancelled it for this time, I propose to use a taxi instead. Can I claim under the HTCS?*

A. If hospital transport has been offered to you on the basis of your medical need, you are unable to claim under the HTCS, though previous dissatisfaction should be taken-up with the hospital concerned.

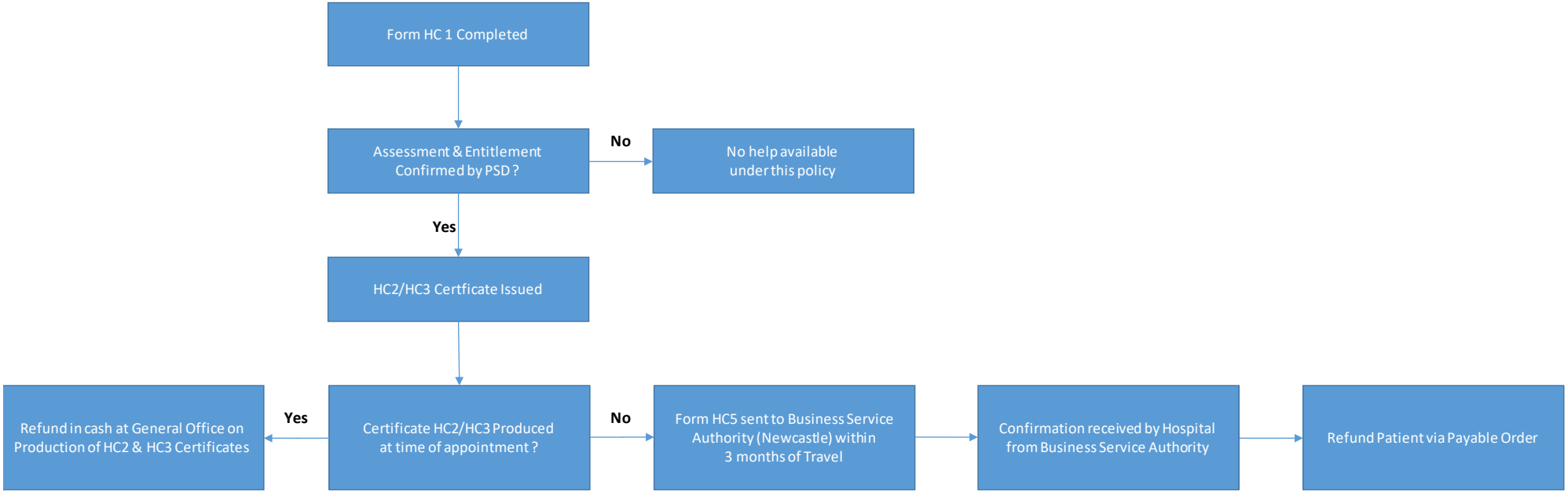
Appendix 5

Entitlement to Benefits



Appendix 6

Patients claiming refund of Travel Costs on the basis of Low Income



Form HC1	⇒	Assessment Form to claim help with Health Costs on the basis of low income
Form HC1 (SC)	⇒	Assessment Form to claim help if in a care home or supported by Local Authority
From HC2	⇒	Notice of Entitlement
Form HC3	⇒	Notice of Entitlement

Aneurin Bevan University Health Board

Capital Procedures

And

Guidance Notes

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ANEURIN BEVAN UNIVERSITY HEALTH BOARD
CAPITAL PROCEDURES
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ANEURIN BEVAN UNIVERSITY HEALTH BOARD
CAPITAL PROCEDURES

1 INTRODUCTION AND BACKGROUND INFORMATION

1.1 Overview

This document comprises Capital Procedures for the Aneurin Bevan University Health Board (ABUHB).

The Health Board is responsible for a capital programme combining strategic capital investment funded from the All-Wales Capital (AWCP) Programme with an ongoing programme of local investments funded from Discretionary Capital expenditure.

The Health Board has Capital Procedures because the successful execution of the initiation and project management of capital schemes or procurements is of major importance in the delivery of service objectives, prioritisation, value for money, financial performance, and corporate governance.

NHS Wales Infrastructure Investment Guidance can be found on the link below:

NHS Wales infrastructure investment guidance (gov.wales)

1.2 Aims and Scope

This guidance is designed to ensure that:

- The Aneurin Bevan University Health Board capital programme is established and managed appropriately - managing the Health Board's Capital Programme within the "Capital Resource Limit" is a statutory duty.
- The Health Boards Capital cash drawing limit is managed alongside resource.
- Capital projects within Aneurin Bevan University Health Board are delivered successfully.

Successful delivery of a Capital Project is defined as a project that: -

- is achieved within programme.
- is achieved within budget.
- meets the stated objectives.
- achieves value for money.

It is applicable to all capital expenditure ranging from equipment to minor capital schemes approved as part of the Health Board Discretionary Capital Programme and major schemes funded as part of the All-Wales Capital Programme.

It also applies to any items bid for and funded as capital as part of specific Welsh Government initiatives.

1.3 Definition

Property, Plant and Equipment expenditure is deemed to be capital if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the UHB;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has a cost of at least £5,000; or
- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or

items form part of the initial equipping and setting-up cost of a new building, ward, or unit, irrespective of their individual or collective cost (referred to as "commissioning costs").

For expenditure to be classified as a capital scheme the above criteria must be met.

If there is any doubt about the suitability of a specific proposal for capital funding this should be discussed with the Capital Finance Team.

1.4 Roles

To ensure successful Capital Programme management, individuals must have a clear role and responsibility as well as delegated authority. Each project must have a specific lead person identified.
- Annex 1 contains detailed role specifications for key individuals.

- Annex 4 contains specimen appointment letters for Project Directors and Project Managers.

The Capital Group is responsible for overseeing the management of the ABUHB Capital Programme. It provides regular reports to both the Executive Team and the Health Board. It is the responsibility of the Capital Group to ensure that Project Management roles and responsibilities are clearly defined and where necessary are "project-specific" based on the needs of the project and the named individuals identified to lead the project.

- Annex 3 contains details of the Terms of Reference of the Capital Group.

1.5 Sources of Capital

The Health Board receives an annual allocation from the Welsh Government for Discretionary capital schemes and Capital Funding from the All-Wales Capital Programme for approved major schemes either individually or as part of an agreed National Programme.

Additional capital allocations or "badged funds" from Welsh Government are also available from time to time (including regional partnership funding). Bids submitted via these funding routes are not exempt from the requirements of this document.

Where proposals are appropriate for consideration for funding from alternative sources such as Charitable Funds bidders will be encouraged to explore this option.

Irrespective of the source of funds a process which reflects the procedures in this document must be used. This includes the initial investment decision. This is particularly relevant where a proposal is likely to impact on other areas and/or has a revenue consequence.

1.6 Capital Resource Limit (CRL)

Spending within the Capital Resource Limit (CRL) is a statutory financial target for the Health Board.

The CRL is the maximum amount of capital expenditure the Health Board may incur in one year and is based on gross expenditure incurred in any one year on an accruals basis.

There is a need for accurate forecasting of in-year scheme costs and the Health Board is required to forecast and manage total capital expenditure.

Reporting and monitoring arrangements are in place between ABUHB and Welsh Government. The CRL and individual All Wales Capital Programme projects are reviewed bi-monthly at Capital Review meetings and via Project Progress Reports. In addition, actual and forecast capital expenditure is included the Monthly Monitoring Return submitted to Welsh Government.

Capital Projects exceeding £1million or those that will extend over two financial years will require a monthly spend profile over and above the quarterly profile submitted within the Project Proposal Document. See Section 5.

2. CAPITAL PROGRAMME DEVELOPMENT AND MANAGEMENT

2.1 Overview

Aneurin Bevan University Health Board is required to have an Annual Capital Programme. and a three-year Capital Programme. Each Division is to have a schedule of prioritised bids in readiness to submit for capital funding for the opening programme or should additional funding become available. By having a list of planned capital schemes extending across three financial years, ABUHB can ensure better medium-term alignment between service and capital planning and where necessary realign timing, phasing and duration of expenditure in order to ensure compliance with Capital Resource Limit (CRL) requirements.

Discretionary capital is normally allocated directly to NHS organisations for the following priority areas:

- meeting statutory obligations, such as health and safety and fire safety;
- maintaining the fabric of the estate;
- replacement equipment.

2.2 Divisional Risk Register and Planning

Divisions are required to identify their capital requirements as part of their annual planning. This should include:

- Statutory Requirements relating to a risk assessment of the estate and equipment.
- Equipment replacement – this should be based on asset register-derived equipment replacement programmes but is normally a response to the most critical breakdowns and obsolescence.
- Planned changes resulting from the planning process including service reconfiguration/development, equipment developments and invest to save proposals.

Divisions must develop and maintain a self–assessed risk ranked spreadsheet of their capital requirements. This is the Divisional Capital Risk register and is a major determinant in capital prioritisation within the Health Board.

The risk scores applied should be in accordance with the Health Board's Risk Management Strategy and Processes.

Divisions are expected to examine and moderate the individual Directorate bids to ensure that capital is appropriately prioritised throughout the Health Board.

The Divisional Capital Risk register document must be reviewed and updated monthly and will be reviewed during monthly Divisional Capital meetings. These schedules will:

- Identify all capital requirements in one spreadsheet.
- Include risk rating and prioritisation of capital requirements.
- Inform the development of the annual Discretionary Capital Programme
- Include benefits associated with bids.
- Include details of how risk scores 20 and over are currently being mitigated.

Developments on existing hospital sites will need to be evaluated in the context of the following:

- Service and investment plans
- IMTP/ Annual Plan.
- Clinical Futures Strategy
- ELGH Strategy
- The relevant Estate Strategy and/or Development Control Plans.
- Accommodation Strategy

2.3 Pre-Investment Panel (PIP)

The ABUHB Pre-Investment Panel process is a critical part of investment decision making within ABUHB. This panel deals with the revenue impacts of capital investments or the revenue plans that require capital as an enabler. However, the new process does not apply to the following types of investment proposals:

- Equipment / ICT Replacement – planned and contingency – with no changes to services or additional revenue costs.
- Recurring allocations and in-year approvals such as Fire Safety and Estates Statutory Compliance
- Upgrades and minor works schemes with no service or revenue implications

The scrutiny provided by PIP can become an important element in determining our capital priorities and improving the quality of business case for both Discretionary and All-Wales Capital.

This means that any substantial capital project intended for Welsh Government AWCP funding and any proposal with significant revenue/service implications must undergo PIP scrutiny.

2.4 Approval for Capital Projects to Proceed

Value of proposal	Capital Documentation required	Responsibility	Scrutiny	Approval
Less than £25,000	Project Proposal Document (Annex 5)	User with sign off from Divisional General Manager or equivalent	Head of Capital Planning /Head of Capital Finance.	Head of Capital Planning
Less than £50,000	Project Proposal Document (Annex 5)	User with sign off from Divisional General Manager or equivalent	Head of Capital Planning /Head of Capital Finance.	Assistant Director of Planning
Less than £75,000	Project Proposal Document (Annex 5)	User with sign off from Divisional General Manager or equivalent	Head of Capital Planning /Head of Capital Finance.	Director of Planning
£75,000-£100,000	Project Proposal Document (Annex 5)	User with sign off from Divisional General Manager or equivalent	Head of Capital Planning /Head of Capital Finance/	Chief Executive
£100,000-£500,000	Project Proposal Document (Annex 5) for low risk items such as replacement equipment or ICT or Business Justification Case (Annex 6) depending on complexity of proposal	User with sign off from Divisional General Manager or equivalent	Capital Group Pre-Investment Panel (if appropriate) Executive Team	Chief Executive and Chairman/(Deputy Chief Executive/ Vice Chairman in their absence)
£500,000 - £1,000,000	Project Proposal Document (Annex 5) for low risk items such as replacement equipment or ICT or Business Justification Case (Annex 6) depending on complexity of proposal	User with support from Capital Team and Divisional General Manager	Capital Group Pre-Investment Panel (if appropriate) Executive Team	Board
Over £1,000,000	Normally a Scoping Document to be agreed with WG prior to	Capital Team with support from users	Capital Group	Board WG

	development of costed Business Justification Case following Welsh Government requirements.		Pre-Investment Panel (if appropriate) Executive Team	

Project requiring All Wales Capital Funding

Requirements:

- Projects intended for Welsh Government capital funding normally require a **Scoping Document** to be agreed with WG and must follow the WG BJC or "5-case" Business Case process.

- Strategic Outline Programme (SOP) business cases should be developed to:
  - Set the direction of travel of a programme of work;
  - Outline the funding envelope for the programme;
  - Identify the projects within the programme, which will require business cases to be developed, and their critical path;
  - Set out the programme delivery and governance arrangements.

- Major projects should develop through three key iterations – Strategic Outline Case (SOC), Outline Business Case (OBC) and Full Business Case (FBC).
  - The SOC is intended to confirm the strategic context of the proposal and to make a robust case for change.
  - The OBC should revisit earlier SOC assumptions and analysis in order to identify a "preferred option" which demonstrably optimises value for money. It should also clarify the procurement strategy.
  - The FBC is the procurement stage which should recommend "the most economically advantageous offer", document the contractual arrangements and confirm the delivery and post evaluation arrangements.

- Business Justification Cases (BJCs) are normally used for less technical schemes. There is no specific financial threshold however guidance and approval must be sought through Special Estate Services to ensure correct approach is taken Typically, the BJC may be used for the purchase of equipment.
- Before embarking on any business case preparation, NHS organisations are required to agree the nature, type and content of each business case with the Welsh Government.
- Contracts in excess of £1m require Welsh Government approval. Where this is required you are to contact Procurement Services to obtain the current form/s for submission to WG. here a substantial development is intended for Discretionary Capital Funding the sponsoring Division must prepare an Internal Scoping Document (Annex 7) for initial review by the Planning Director and possible submission to the Pre-Investment Panel.
- For each capital project over £2m, the Health Board is required to ensure that the Welsh Government Project Bank Accounts policy is applied unless there are compelling reasons not to do so. Where a project bank account is proposed not to be utilised, an application is required to be made to Welsh Government officials for exemption from use of Project Bank Accounts, setting out the compelling reasons.

2.5 Programme Management

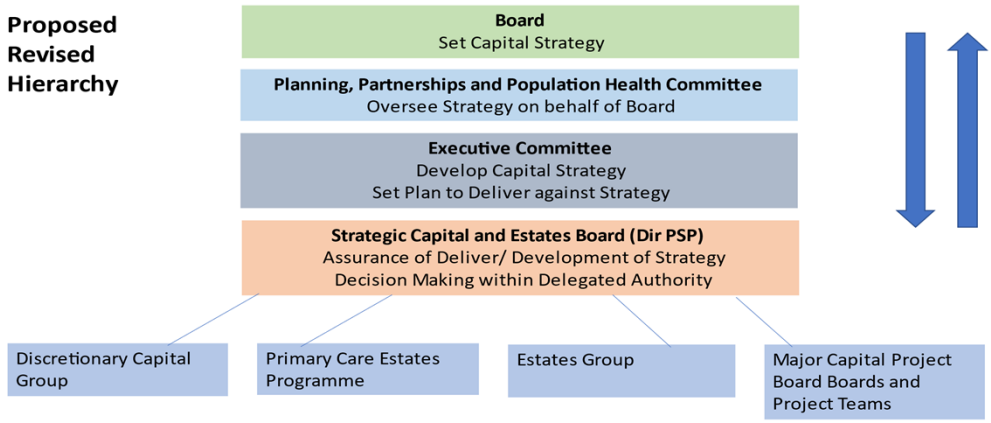
The annual cycle for the Capital Programme is set out below.

MONTH	ACTIVITY

December	Divisions to provide final priorities for the Discretionary Capital opening programme
January	Submit to Estates Strategic and Capital Group to ensure alignment with ABUHB strategic intent.
February/March	Draft Capital Programme to Capital Group and Executive Team
	New Capital Programme to Board for Approval

2.6 Capital Governance Hierarchy

The Capital Governance Hierarchy is detailed below:



2.6.1 Terms of Reference

- Please see Annex 2 for above terms of Reference

2.7 Capital Scrutiny

Prior to submission for approval, bids will be scrutinised using the table in Annex 24 and signed off by the Head of Capital Planning and Head of Capital Finance.

3 DELIVERING CAPITAL PROJECTS

3.1 Overview

All schemes, from a minor departmental upgrade to a procurement of a major item of medical equipment or major capital scheme to deliver a significant service change, are only successful if the following principles are reflected: -

- There is a clear Case for Change
- Any case must clearly set out the Benefits expected to be delivered and how these are to be measured (i.e., SMART)
- There is a clear brief and/or mandate agreed with the principal stakeholder(s) including a high-level operational policy.
- The whole project is adequately defined and is the responsibility of a named individual with a clear set of duties and responsibilities.
- There is a BJC or PPD with an appropriate level of documentation for the level of investment proposed.
- There is a transparent decision-making and option appraisal process.

- Identification and management of risks and contingency planning
- Project management arrangements are resourced appropriately and are clear and workable.
- Fees and other scheme feasibility or development costs are approved and funded during the approval process.
- Satisfactory and comprehensive costing at all stages including a predicted post-approval cashflow.
- Control mechanisms are in place.
- Evaluation and Audit are planned.
- There is compliance with Health Board Standing Orders, Health Board Standing Financial Instructions and Health Board Tendering and Contracting Procedures
- There is regular reporting of progress and costs.
- The Project Manager ensures records are kept for review and audit purposes.

3.2 Project Management

The Chief Executive/Director of Planning has overall responsibility for any Capital project and shall ensure (normally through delegation to the Project Director) that:

- The Project is the responsibility of one named individual with clear duties and responsibilities.
- A clearly established management structure is, given responsibility for the project. Ownership of the project is retained by the Health Board and not delegated to external contractors.
- The Project Team includes representatives of all interested departments.
- The Project Team has:
    - a clear brief
    - clear responsibilities;
    - a budget and cash-flow
    - a timetable for key events;
    - co-ordinated plans;
    - guidance notes;
    - monitoring information
- There is a clear scheme of delegation that supports each individual's levels of responsibility.
- Appropriate project files and documentation are kept in such a way that will allow auditors to examine the project.
- If indicated by the size and/or complexity of the project the requirement for a Project Initiation Document should be discussed with the Capital Team.
- Any change of key staff roles and responsibilities must be formally recorded, and the Capital Team notified.

3.3 Business Cases

In preparing a PPD or BJC the Project Manager or Project Director shall ensure that:

- A clear "Case for Change" is identified prior to the formal development of any costed proposals including justification for replacement bids.
- The planned project meets the requirements of the Health Board's IMTP/ Annual Plan and the including Estate Strategy.
- It is a priority for the Health Board.
- All key staff are consulted on the need for the Capital Project.
- The development is deliverable.
- An assessment of value-for-money is a key component of the case.
- A post-approval cashflow suitable for monitoring purposes is provide in the PPD (Annex 5) or BJC (Annex 6)
- The Risk Management Pro-forma (Annex 11) is developed as soon as possible.
- Funding is explicitly identified to support the revenue implications of the capital asset.
- Each of the options is subjected to the same level of analysis as specified in relevant guidance.

- The project planning and appraisal process for all schemes follows the following stages:-

    - set the investment within strategic context;
    - define objectives and identify benefit criteria;
    - generate a wide range of options including non-capital solutions;
    - measure the benefits;
    - identify and quantify the costs;
    - assess sensitivity to risk;
    - identify the preferred option ensuring that Value-for-money is a key part of the evaluation;
    - present the business case for approval;

- The project appraisal process is regularly audited and reviewed by the Project Board to ensure that delegated authority is being exercised appropriately.

3.4 Development of Scheme Costs

The receipt and endorsement of a robust Project Brief (Annex 8) and fee proposal will be required to release the expenditure of fees to develop a design firm costs prior to the development of a Capital PPD (Annex 5) or Business Justification Case (Annex 6).

The Project Director will be expected to provide an agreed Project Brief prior to the engagement of external consultants or a significant commitment of internal design resources from the Works and Estate department for anything other than a high-level review of feasibility.

It needs to be recognised by bidders that if costs are incurred on a scheme which does not eventually become a capital project, costs may need to be re-classified as revenue – this is in line with Audit requirements.

4 IMPLEMENTATION OF CAPITAL PROJECTS

4.1 Overview

When funding has been approved the management requirements of a Capital Scheme change. Although the principles of capital management still apply the roles of key personnel change and the process becomes one of a procurement.

The role of the internal project manager is critical in leading the project on behalf of the Project Director and ensuring that agreed actions are carried out, risk management is integral to the project and cost, scope and timing remain on track.

The Health Board Standing Orders, Tendering and Contracting Procedures and Standing Financial Instructions should be referred to during this stage of any Capital Investment Project.

Summary guidance notes on "Delivering Successful Projects" is included in Annex 12

4.2 Frozen Design Brief

For implementation to be successful and to meet audit requirements the Project Manager must finalise or "freeze" the brief. In other word they must be satisfied that the investment that is proposed will meet the stated objectives of the project and deliver the agreed benefits.

The Project Team should review and confirm the expected and agreed outcomes of the investment, specific product quality requirements, programming and planning issues, project goals and approach to monitoring and reporting.

4.3 Project Execution Plan

Dependant on the size or complexity of the scheme, the Project Board and/or Capital Team may require the preparation of a **Project Execution Plan (PEP) or Project Initiation Document (PID).** Should this be a requirement a list of contents is given in Annex 13.

4.4 Implementation, Monitoring and Progress Reporting

The Project Director/Manager is responsible for ensuring that the Project Board receives enough information to ensure that the project is being successfully executed.
Information will include:

- Work and cost authorisation including product descriptions/work packages/terms of reference/acceptance/record keeping.
- Monitoring and assessing progress – including risks
- Review and identify variations of change leading to additional costs. Identify change under the heading of 'Client' or 'Design Team' and act accordingly.
- Financial position of the scheme including projections and mitigations.
- Remedial Actions as necessary.

The Project Manager and/or Project Director should ensure that a single structure of meetings and reports exists that will allow appropriate authorisations, reporting, monitoring and review of risks and issues using guidance in A11 and A12.

The project structure, management processes and reporting requirements must be appropriate to the scope, risks, and size of the project.

Project Directors and Managers are required to work closely with Finance colleagues and key stakeholders. It is essential that programme and progress information is presented clearly and concisely; appropriate Gantt charts and realistic programmes are to be developed and monitored regularly, and document version control clearly maintained.

5 FINANCIAL MONITORING

5.1 Overview

It is essential that expenditure on individual capital projects is closely and regularly monitored to ensure that:

- Expenditure is within the allocations provided by Welsh Government (WG) and UHB.
- Issues are identified and mitigation carried out as necessary.
- The work is completed within the profiled financial years. Allocations are available only for the financial years agreed at project approval stage. There is no automatic facility to carry forward expenditure into the succeeding financial year.

It is the responsibility of the Project Manager to monitor the expenditure and compare it against their project cashflow and allocation. The Capital Finance Team must be advised of any issues as soon as they arise. This is essential as any potential over or under spends, or changes to the timing of expenditure on a project will have a knock-on effect and action will be required to avoid breaches of the capital limits set by Welsh Government.

Any request for additional capital funding above the approved sum must be made to the Capital Finance Team before expenditure is incurred. The additional funds will only be released following approval by the Director of Planning or a nominated Deputy on receipt of a recommendation from the Capital Finance Team.

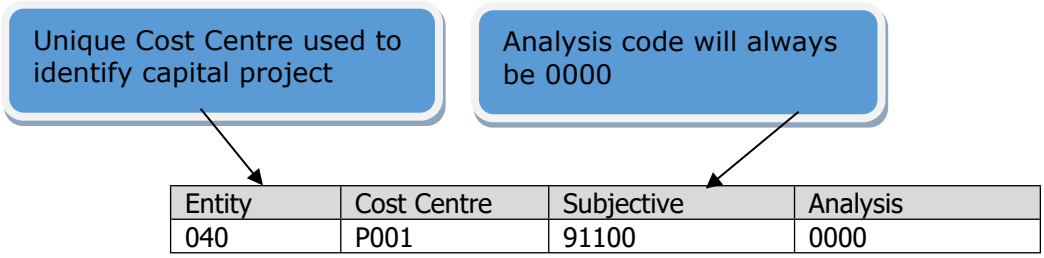
In addition to this, any underspend against an approved capital allocation cannot be assumed to be utilised within the project. It must be notified to the Capital Team.

5.2 Capital Cost Codes

Capital projects are identified by an alpha numeric cost centre. Cost Centers start with a P followed by 3 digits e.g. P001, P002 etc. The default analysis code of 0000 should be used.

A typical capital code will look like this:

Capital Code Structure



Entity	Cost Centre	Subjective	Analysis
040	P001	91100	0000

A full list of Capital subjective codes is available from the Head of Capital Finance.

5.3 ABUHB Internal reporting

Expenditure against capital projects is available to Budget Holders via the FBI system. An expenditure report is circulated by the Capital Finance Team to Divisions and Capital Group monthly.

5.5 External Monitoring Returns

Project Managers must liaise with the Head of Capital Finance and the Head of Capital Planning to ensure that information is provided consistently and punctually for Financial and Estates returns to WG/NWSSP – SES.

The Monthly Monitoring Return for WG includes specific capital tables for completion. For each All Wales Capital Programme scheme and each category of discretionary expenditure (Equipment, Estates, IT and Statutory Compliance) the following information is required:

a. Capital plan on monthly basis
b. Actual expenditure on a monthly basis
c. Updated forecast for each remaining months
d. The forecast outturn for the year

The Monitoring Return is required to be submitted to WG by Working Day 9 each month.

Project Progress Reports are submitted bi-monthly to Welsh Government for specified All Wales Capital projects.

6 DESIGN, TENDERING AND CONTRACTING

6.1 Overview

This section sets out a very brief overview of the Design, Tendering and Contracting phase of a capital estates project. It includes:

- The steps necessary to deliver a capital project
- The role of Works and Estates
- The role of external professional advisers and consultants

Detailed advice on Design, Tendering and Contracting is contained within Annex 15 and a number of key documents are attached as further Annexes.

In addition, the SFI's and SO's should be consulted particularly when Welsh Government Consent or Noting is required for contract awards.
A short summary is set out in the following paragraphs, but it should be noted that procurement frameworks are constantly being reviewed and advice should be sought from Works & Estate, Procurement or Capital Planning & Finance as appropriate.

6.2 Initiating a Scheme

Background

Schemes will differ dependent upon complexity; each scheme will consider and identify the roles and responsibilities for the service/client project manager and technical project manager (whether external appointment or internal). In broad terms construction projects will follow the stages of the current Royal Institute of British Architects (RIBA) Plan of work.

Procurement Strategy

The choice of procurement route will affect the project structure and can include:

- The Welsh Government Designed for Life Construction Procurement Framework (Annex 16)
- Works and Estates Frameworks,
- Shared Services procurement led models including "Buy for Wales".
- Competitive Tender
- Measured Term Contract/Minor Works

Each scheme will also need to consider any requirements resulting from Government Procurement Policy Notes (PPN), WTO's GPA procurement requirements etc. The current threshold for construction projects is £5,336,937 (inclusive of Vat).

Accessing Works and Project resources

With the exception of high-level feasibility work professional Estates advice and technical support is normally only available for a project that has had a case for change and brief signed off by the ABUHB Capital Group or scoping document agreed with Welsh Government as set out in Section 3.4 of this document. This process will identify the need for a fee line to fund internal/external fees to develop the scheme further if deemed appropriate.

Feasibility Stage

To ascertain whether a scheme is technically feasible a feasibility study may be undertaken utilising a project team comprised of internal/external resources as agreed. Once approved in principle every project should be taken forward by a multidisciplinary team including those both directly and indirectly affected by the project.

6.3 Design – Approved Scheme

Design Phase
On completion of the feasibility stage and successful application of the PPD/BJC/OBC the preferred option can be worked up into a detailed design proposal.

Development of the Brief
The project team/design team will further develop the outline brief in association with the ABUHB stakeholders to ensure the brief translates into the project requirements.

Compliance/Standards/Derogations
At this stage internal/external designers will ensure full compliance with all current applicable statutory and NHS Standards.

Design Sign-off
The design and any derogation from standards must be signed off by service user and ABUHB PM/PD prior to tender. The existing position/'line in the sand' must be clearly identified and documented to ensure that it is available for future review.

Design Team
The design team is responsible for the technical content of the design and the project manager has authority over the design team in matters of design management.

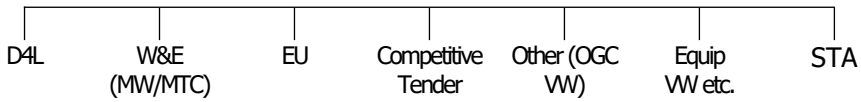
The design should sufficiently set out the requirements of the ABUHB to enable a tender to be drawn up and costs to be apportioned to the works in question.

On completion of design the user/client will be required to sign the Certificate of Readiness to Proceed to Tender (Annex 18).

6.4 Tender

Tendering for schemes is to be carried out in accordance with the ABUHB Standing Financial Instructions and the guidance set out in Annex 16.

The procurement route will be dependent on scheme value and complexity, options as follows:



(D4L- Design for Life, W&E MW/MTC – Minor Works Measured Term Contract, EU European Union, OGC VW Other Government Contracts Value Wales, Equip VW Equipment Value Wales Framework, STA Single Tender Action)

It is to be noted that some of these frameworks are not currently in place and there is an expectation that discussion will take place with the Head of Procurement/Director of Facilities as required.

6.5 Construction Phase

Detailed guidance on the Contract and Construction phase is given in Annex 15.

The key requirement from a Capital perspective is that the Project Manager must continue to monitor and report on the key areas of cost, programme, risks and expected outcome using the process set out in Section 5.

7 COMMISSIONING

7.1 Overview

Commissioning is the planning required to bring a new facility/existing facility or department into or back into use. The successful realisation of the commissioning process is to ensure a smooth transition to the new working arrangements and realisation of the anticipated benefits.
The Project Director shall ensure that appropriate Commissioning Plans are developed and enacted.
For large schemes a separate Commissioning Manager appointment may be required.

7.2 Commissioning Plan

The commissioning of a new building or department usually embraces two distinct tasks, the technical commissioning, and the operational development. The technical commissioning will normally be undertaken by the Works & Estates Department in liaison with the contractors/external project managers. The operational commissioning will normally be managed as part of the operational role of the relevant Directorate or Department.

Even a small departmental scheme will be improved by a structured approach to opening the new or re-furbished department.

An appropriately sized commissioning team will be normally established to support the commissioning process and to bring the new facility into use. The commissioning team should include representatives of management and users together with appropriate support from specialist departments such as Works and Estate, Procurement, Finance, Human Resources and Specialist Support Services.

The commissioning team will normally take the lead in developing new operational processes and procedures.

7.3 Operational Policies

Achieving the objectives or targets set in a business case may require changes to clinical practice or operational procedures.

An operational policy should normally be developed prior to the design stage of the capital project process as part of the brief. This is a basic statement of how it is envisaged that the new facility will function once open. This can be revised throughout the project.

A template for Operational Policies is given in Annex 9.

An operational policy needs to closely follow the anticipated work of a new department and describe how each element interrelates to another and to other departments.

7.4 Staffing

Proposals may be required for the transfer of staff, possible redeployment of staff and a recruitment strategy. All proposals that may affect staff should be discussed with HR to ensure that all necessary consultation etc takes placed. Staff must be kept informed about and involved in the development of the new facility.

7.5 Equipping Strategy

The specification and timely procurement of equipment is critical to the successful implementation of a Capital Project. See Section 10 of this guidance.
It is essential that the Capital Equipping Officer is involved at the early stages of a capital project. Relationships with users and suppliers are critical and where a third-party procurement is involved – such as a Welsh Government initiative – this will have to be carefully managed so that information is provided to contractors when required.

7.6 Hand-over to Operational Management

The Project Manager or Commissioning Manager must work closely with the Works & Estates Department to ensure that technical and operational commissioning are undertaken in parallel to ensure a smooth transition to the operational management of the new Unit.

A Handover of Technical Information must be recorded using a Works & Estate Certificate of Technical Handover.

The post-hand-over period should be used to ensure that staff are fully conversant with the new unit or facility and that appropriate in-situ training is completed. This may be supported by the Health Board's Training & Development Department and by specialist input from equipment manufacturers etc.

7.7 De-commissioning Redundant Facilities

A plan must be in place for the re-use or de-commissioning of any vacated facilities. This should include sufficient time to ensure that any surplus properties are disposed in such a planned way that vacated premised are left secured and unused for as little time as possible.

7.8 Public Relations

The Project Director, will consider, in conjunction with the Communications Department, the mechanism to obtain appropriate publicity.

7.9 Post – contract

The Project Director shall ensure that the following tasks are carried out: -

Practical completion.
Commissioning/hand over/making good defects.
Defects liability period.
Building open.
Final certificate/account including deductions/reclaim.
Post project evaluation/review.
End of defects liability period.
Release of retention

The Project Director or his representative shall ensure that: -

- The final payment is made based on work performed and that the payment is within budget.
- Payments are only made in line with the contract price.
- Final payments are authorised by the contract manager.
- Prior to the final payment being made, the contract should be subject to an independent review whether it be internal or external with documentation available for internal audit to review.
- Retention monies are withheld from the final payment and are not paid before they are due (usually one year after the completion of the project).
- Final accounts are based on detailed measurements from the quantity surveyor/cost advisor.
- Before the payment is made a certificate of making good defects is issued.
- The actual completion date is in line with the agreed completion date.
- Works are completed satisfactorily before the final payment is made.
- A certificate of making good defects is issued.
- The project manager and the end users examine the site before final payment is made.
- The completed project is reviewed against the design to ensure that the completed project is what was required. Guidance notes on post Project Evaluation are set out in Section 8.

7.10 Liquidated damages

The Project Director or his representative shall ensure that subject to form of contract document: -

- All claims for liquidated damages are valid and are collected before the final payment is made.
- Liquidated damages are recovered as soon as possible.
- Liquidated damages are recovered at the rates specified in the contract.
- Unauthorised delays are investigated as soon as they arise, and comments sought from the contractor.
- Liquidated damages are deducted from payments to contractors for any unauthorised delay on the agreed timetable.
- Deductions are correctly calculated.

8 POST CONTRACT REVIEW AND EVALUATION

8.1 Post contract review

The Project Director or his representative shall ensure that: -

- The success of the project is considered, and performance is objectively assessed.
- The post contract review considers whether the form of contract was appropriate for the project.
- Post contract review is carried out immediately on completion of the project.
- The review considers why amendments to the design or specification were required and whether they should have been identified in advance of the project starting.
- Users are asked to comment on whether the completed project achieves their design requirements / investment objectives.
- Performance of the project team is reviewed.
- Reports are made to the Board if there is any delay in the contract.
- Final cost reports are prepared which explain any variances from budget.
- Differences between the contract price and the final cost are analysed and explained.
- The performance of the contractor is assessed in terms of: -

    - costs;
    - adequacy of supervision;
    - availability and suitability of plant and materials;
    - provision of labour;
    - relationship with employer;
    - relationship with sub-contractors;
    - industrial relations;
    - standards of work;
    - use of sub-contractors;
    - timely completion of work;
    - claims

- The report concludes with recommendations on the operation of future contracts.
- After the project has been in operation for a period the following issues are assessed:
    - the outcome compared to the plans;
    - are the revenue consequences of the project as budgeted?

- The following details of the finished asset are reported to the manager of the asset register for inclusion:
    - name;
    - place;
    - cost;
    - date first in use;
    - Asset valuation (if there is one)

8.2 Post Project Evaluation

The Project Director or his representative shall ensure that: -

- A post project evaluation is carried out six months after a project has been successfully commissioned i.e. in accordance with the guidance set out in the Capital Investment Manual. The Full Post Project Evaluation evaluates the costs and benefits criteria described in the Business Case and used throughout for evaluation purposes.
- The evaluation is carried out by an evaluation team headed by operational and project managers

not associated with the project.

- The evaluation is reported formally to the Capital Group / Strategic Capital and Estates Group.

9 MINOR WORKS

9.1 The Minor Works Service

Minor Works provide a service aimed principally at small estates schemes and similar projects that generally do not require complex design and specification.

The following principles apply for all schemes:

- Any statutory approval requirements must be addressed, (such as building control approvals).
- All schemes must be risk assessed and where applicable construction, design and management (CDM 2015) to be complied with.
- Safe systems of work must be implemented for any construction work to include notification to operational estates for safe isolation of services (electricity, fire, water, medical gases etc.) and where appropriate permit to work systems.
- Normally only Measured Term contractors from the approved list can be used for Minor Works although others may be appointed subject to the quotation levels set out in SFIs.
- Where specialist work is required of a nature that a contractor is not available off the approved list, then competency and financial viability will be assessed prior to appointment.
- Periodic tendering of service providers for Minor Works must be undertaken to comply with Health Board SFIs and contracting and tendering procedures. This will ensure that the Minor Works service provides a cost-effective service offering value for money.
- Minor Works will assess any likely non-compliance issues and co-ordinate with appropriate parties within the Health Board. This will include issues such as control of infection, fire safety compliance and health and safety.

Where it is not deemed to be the appropriate route the Director of Estates and Facilities or his representative will ensure that appropriate arrangements are in place to redirect a Minor Works request. Where the scheme is of a complex nature or complex design work is required, this will be processed via the Capital Projects route as appropriate in line with the overall Capital Procedures. Advice can be sought from the Capital Team if required and it should be noted that formal approval will be required before any internal or external planning or design resources are used on such schemes and a PPD form should be used as in Annex 5.

Mini-Competition rules are currently in place on the Measured Term Contract for the various works packages as follows: (as of 1st October 2023).

1. **Building:** <£25 direct award to any of the MTC contractors,>25k – 50k 3 quotes off any 3 MTC contractors, >£50k All MTC contractors invited to quote.
2. **Electrical:** <£25 direct award to any of the MTC contractors,>25k – 50k 3 quotes off any 3 MTC contractors, >£50k All MTC contractors invited to quote.
3. **Mechanical:** <£25 direct award to any of the MTC contractors,>25k – 50k 3 quotes off any 3 MTC contractors, >£50k All MTC contractors invited to quote.
4. **Flooring/Decoration/Ceilings**: <£25 direct award to any of the MTC contractor,>25k – 50k 3 quotes off any 3 MTC contractors, >£50k All MTC contractors invited to quote.

These limits are set out in the associated contract for each package. Some discretion however has to be exercised as levels are low and it can be cost-prohibitive for contractors and ABUHB to prepare tender packages on every occasion.
This should be approved by the Director of Estates and Facilities on a case-by-case basis.

10 EQUIPMENT

10.1 Overview

This section gives guidance on the procurement of equipment. Equipment can be clinical, non-clinical or IT related.

Bids for replacement equipment will be approved / scrutinised in line with the requirements set out in Section 2.4.

All capital equipment purchased is recorded in the Health Board's Fixed Asset Register. The Health Board also uses the Radio-Frequency Identification (RFID) Discovery system to track and verify assets that are able to be tagged with an RFID label. The Electro Biomedical Engineering Manager (EBME) and Head of Capital Finance will ensure that all capital equipment is assigned a unique RFID asset label where appropriate.

10.2 Procurement

All equipment identified and sanctioned within the Health Board or specified as part of a Capital scheme will be processed through the Procurement Department. All Capital equipment is purchased in compliance with the Health Board Standing Financial Instructions and compliance with European Union Supplies Directives. There are three distinct processes:

A. Replacement or new equipment which is below the EU regulations will be subject to local Health Board tender procedures as identified in the procurement policy. This process will be carried out to ensure that the equipment:

- is the appropriate specification for the intended purpose.
- achieves value for money.
- is subject to supplier competition on a fair and equal basis.
- meets compliance and probity requirements.
- is standardised Health Board equipment wherever possible and practical.

If a framework agreement (either a local or an all-Wales capital) is in existence for the specified equipment then the Procurement Department will ensure that the Health Board is compliant within these agreements

B. Equipment that is above the EU thresholds will be subject to a European tender to ensure compliance and probity. This process will be carried out to ensure that the equipment:

- is the appropriate specification for the intended purpose.
- achieves value for money.
- is subject to supplier competition on a fair and equal basis.
- meets compliance and probity requirements.

C New Build or Refurbishment Capital Schemes:

Once a scheme has been identified and approved, the Procurement Department will work closely with Works and Estates and the project manager to establish a plan for the scheme. Activity Data Base (ADB) or Room Loading Sheets (RLS) are produced together with, if available, floor plans. Procurement Department will then carry out the following procedures:
All ADB sheets are analysed for both clinical and non-clinical equipment requirements, this identified equipment is allocated a master inventory number (nsv code) and further identified as an individual cost.

- Group 2 (purchased by the Health Board) installed by the building contractor.
- Group 3 purchased and installed by the Health Board

- Group 4 low value items

Group 1 equipment is supplied and installed as part of the Building Contract.

The scheme is then built as a project room by room, and nsv codes are input (with quantities required). Indicative costs obtained for All Group 2, 3 & 4 items. Consolidated financial reports are produced to identify total scheme costs, which also encapsulates all identified transfer costs.
This will identify if there are any financial consequences to the scheme budget and steps can be taken to, either reduce the equipment requirement or, enable the project to obtain alternative funding at a very early stage.

Once a budget and all equipment specifications has been agreed with the Procurement Department and the project team, all equipment is then purchased in a timely manner as identified in processes one and two, ensuring compliance with all statutory internal and external legal requirements.

For all equipment that is procured the Asst. Procurement Business Officer will be responsible for briefing the Project Manager and Capital Team on progress including financial information particularly when cost variations occur post-approval or post-ordering.

10.3 The role of Procurement in CRL Management

Managing the Capital Resource Limit is a challenging process particularly when additional funds appear as a result of slippage internally and from Welsh Government. One tool used by the Health Board is to identify the highest risk equipment items in agreement with the Divisional capital links and using the Divisional Capital risk register. The aim is then to get the procurement process to a point where the order can be placed immediately when funding is identified. They are not technically "approved" but the plan is to achieve funding and approval as soon as possible.

This means that work such as specification, evaluation and selection is technically proceeding at risk until funding is confirmed. This is a low risk as any equipment dealt with in this way as if funding does not appear "in year" it will be a first call on the planned high risk equipment replacements put forward for approval at the beginning of the following financial year.

If we wait until funding is identified prior to this work being carried out the likelihood is that a successful procurement cannot be achieved within the required timescale and the funding will either be lost or used for less high risk items that can be procured quickly.

11 LAND AND PROPERTY

11.1 OVERVIEW

Specific guidance is provided in Health Board Standing Orders and Estatecode, Welsh Edition 2017 (HBN 00-08)

- This process identified in this section is to be managed by the Estates and Facilities Team.
- The Health Board Land & Property Group is responsible for the management of acquisitions, disposals, leases, and other property matters even when such transactions are part of an approved scheme.
- The Health Board Land & Property Group is chaired by the Director for Estates and Facilities and should report to the Health Board and Welsh Government on a regular basis.
- This section provides a brief summary of the requirements of Estatecode. These transactions are carried out by officers from the Works and Estate department who will appoint any outside specialists and who work closely with NWSSP - FS - Property Management.
- In addition to any guidance contained within this section it should be emphasised that all acquisitions and disposals of land/property of any limit must receive the written approval of the Welsh Government before being entered into. Therefore for acquisitions, disposals and leases, Ministers Approval must be requested by a submission to the Capital Estates and Facilities Branch including the property name, acquisition/ disposal value and estimated timescale. This should be after internal ABUHB Board level approval.

11.2 ACQUISITION OF LAND AND PROPERTY

The Acquisition of Land and Property by NHS Health Boards in Wales is governed by **Estatecode –** Health Building Note 00-08, Estatecode, Welsh Edition 2018.

- This document outlines mandatory requirements and general principles that should be followed. All the tasks identified below should be carried out by or with an Officer from the Health Board's Works and Estate Department.

The Business Case

- A business case should be prepared in accordance with Welsh Government requirements.
- Purchases of land or property for a capital scheme should not be undertaken in advance of the approval of the business case except with the consent of the Welsh Government.

Site Identification

- A site search should be carried out by appropriate estates staff or advisers and the possibility of reusing existing land and property should be explored.
- All accommodation requests are required to be submitted to the Accommodation Group for review and approval.
- NHS or civil estate land or property should always be used first unless there are very good business reasons for not doing so, which must be recorded in the Business case.

General points when acquiring land and buildings.

- Check the availability and likely price.
- Check the accessibility of the site to the public.
- Check the relative business rates potential liability for each option.
- Ensure potential sites are capable of development i.e., services available, ground conditions suitable, density adequate or buildings suitable for conversion.

- Check the planning position and checks should also be made with the highway authority and utility companies.
- A structural survey should be carried out on existing buildings intended for reuse, including mechanical & electrical installations, drainage and other services, compliance with building regulations and planning permission, fire and health & safety issues, presence of asbestos or other contamination.

Valuations and Purchase Price

- Professional advice must be sought from the Valuation Office Agency or appropriately qualified private consultants.

Planning Approval

- NHS organisations are subject to town and country planning controls, including listed building control. Planning advice should be sought early in the process. Specialist consultants may be necessary. Planning approval should ideally be secured prior to purchase and prior to submitting a planning approval it should be ensured that the vendor cannot withdraw from the transaction unilaterally. Conditional or Option contracts should be considered.

- When an agreement to purchase has been reached, it should be stipulated that the vendor withdraws the property from the market.

Section 106 Agreements

- The Local Planning Authority may wish to attach conditions to the planning consent and professional advice should be sought before accepting any liability.

Freehold Covenants

- Negotiations should uncover all positive or negative covenants attached to the site to be acquired. Responsibility for boundary structures, service diversions, shared access etc should be established.

Heads of Terms

- Following the completion of the Business Case and the selection of the site that represents best value, a "heads of terms" for agreement between the vendor and purchaser is required. This forms the basis for instructing solicitors and will include: -

    - a description of the site and a location plan.
    - the names and addresses of the parties and their solicitors.
    - the price.
    - the timescale for exchange of contracts and completion.
    - any conditions (i.e. subject to obtaining planning permission, or satisfactory ground condition survey).
    - any obligations on vendor (such as works to be carried out prior to completion or obtaining vacant possession).
    - the tenure.
    - for leases – details of the proposed terms.
    - any dilapidation requirements.

Solicitor's Role

- In the case of a major site acquisition/development a solicitor should be involved at an early stage. Any legal constraints can then be addressed, or the purchase abandoned thus avoiding high abortive costs.

- The solicitor's role is to ensure that: -

- all planning permission and building regulation consents are in place and conditions complied with.
- roads and sewers serving the site are maintained at public expense.
- there are no major redevelopment proposals in the vicinity that might affect the suitability of the site.
- there are no unforeseen third–party rights i.e. public footpaths or other covenants.
- the negotiated terms are included in the contract.
- the vendor has title to transfer the site.
- the transfer is completed on the required date.

Key Points

- Written confirmation of the terms of the transaction should not be given to the vendor without appending the words "subject to contract".
- Once a solicitor is instructed, points in dispute should not be negotiated without reference to the solicitor.
- Once contracts are exchanged both sides are committed to the terms. After exchange no attempt to vary the terms should be made, other than through the solicitor.
- From the date of exchange of contracts, the risk of holding the site passes to the purchaser. Ensure that all the usual risks are assessed, and appropriate action taken.
- It is vital to ensure that when documents are signed (Contracts and Tenancy Agreements of up to three-year terms) or sealed (Conveyances, Transfers and Leases over three years) that Standing Orders are observed. Signature by an unauthorised officer can be binding if it seems to the other party that he or she has ostensible authority to do so.

11.3 LEASING

This process identified in this section is to be managed by the Estates and Facilities Team.

Decision to Lease

- Decision to Lease
- Business case results usually show that re-use of an existing site or site purchase secures best value. However, leasing should be chosen for short-term use, or where the location, such as a business park, means a freehold acquisition is impossible.
- All accommodation requests are required to be reviewed and approved by the Accommodation Group.
- The approval procedure for new leases is set out in Section 13.

Negotiating the Lease

- Specialist advice should be sought relating to landlord and tenant relationships and when negotiating a lease the terms to be considered should include: -
- repair liability
- length of term
- rent reviews
- break clauses
- any alteration work required
- permitted use
- alienation provisions
- option to renew
- Value Added Tax liability
- contracting out of the Landlord & Tenant Act 1954
- dilapidations
- asbestos management requirements
- service charges
- statutory compliance liability

11.4 DISPOSAL OF SURPLUS NHS PROPERTY

- The Disposal of Land and Property by NHS Health Boards in Wales is governed by **Estatecode –** Health Building Note 00-08, Estatecode, Welsh Edition 2018

12. PRIMARY CARE

12.1 Introduction

The current investment programme for Primary Care premises is based on the ABUHB Primary Care Estate Strategy and Welsh Government Primary Care Pipeline.

12.2 Guidance

Primary Care Estates Developments using Third Party Developers are progressed in line with the Welsh Health Circular (2007) 064 'Primary Care Estate Development and Bid Processes'.

Please Note:
The below documents have been withdrawn , however SES advised that as an interim measure the documents should still be referenced however any reference to the former Estates Forum and approvals process should be taken internally to the health boards own governance structure .

We have issued revised IG guidance which replaces the WHC (2006) 032

There has been no other guidance issued in the meantime.

A. Interim Guidance

NWSSP-SES recommends that on an interim basis - pending the issue of the revised guidance - the existing 5 documents (listed below) are still referenced for general process but noting points numbered 1-8 below

- WHC(2007) 064 - Primary Care Estate Development and the Bid Process
- WHC (2007) 007 - Guidance for Selection of 3rd Party Developers
- WHC (2008) 009 - Additional Requirements - 3PD Selection Process
- letter 19/11/2009 – IPD process
- WHC (2006) 032 – Improvement Grants - Revised Guidance

1. All references to WG approval or the Primary Care Estate Forum are deleted.
2. For 3PD Developments it is recommended that decision processes are developed via the IPD (initial proposal document) process but adopting a 2-phase approach. An initial service brief and outline case, which is an IPD, should be adopted for Health Boards' Board approval prior to the selection of a 3PD developer. Secondly, a more detailed document with the full proposal detail (following the content of the former Bid document) should be submitted for final Health Board approval prior to confirming full commitment to the scheme.
3. Any reference to the Premises Cost Directions of 2004 should read The National Health Service (General Medical Services-Premises Costs) (Wales) Directions 2015
4. Reference to design specification should refer to WHBN 36 General Medical Practice Premises in Wales, a guide to planning and design.
5. Welsh Government will require a copy of the final Health Board approved document for information purposes only. This document should confirm the specific funding requirements of any Welsh Government offer made by letter.

6. Welsh Government may also request timeline updates to ensure schemes are delivered within required timescales.
7. Improvement Grants should still be progressed with reference to WHC (2006) 032 for general principals, but referring to the current Directions, the National Health Service (General Medical Services-Premises Costs) (Wales) Directions 2015 and noting changes to abatement periods, eligible works and fees. Proposals should be developed in detail with practices, have justified service benefits and demonstrate commitment. Practices must agree revenue figures in advance and agree to claw back provisions should GMS services cease from the premises. Welsh Government will require the submission of a prioritised pipeline of proposed schemes for consideration in advance of each financial year.
8. Please refer to NWSSP - SES with any general queries or for scheme specific guidance.

13. LEASES

13.1 Overview

An entity is required to determine whether an arrangement is, or contains, a lease. A lease is an agreement whereby the lessor conveys to the lessee, in return for a payment or series of payments, the right to use an asset for an agreed period of time.

13.2 IFRS 16 Leases

The new accounting standard, IFRS 16 Leases, applies to NHS Wales bodies from 1 April 2022 (replacing IAS 17) and introduces a singular lessee accounting approach to the measurement and classification of leases, as well as a modified classification approach for lessors.

The new Standard eliminates a lessee's classification of leases as either operating leases or finance leases. Instead, almost all leases are 'capitalised' by recognising a lease liability and right-of-use asset on the balance sheet.

There are two notable exemptions included in the standard which are for low value leases and short terms leases.

A short-term lease is any lease that has a lease term of 12 months or less. In such instances the lessee shall recognise lease payments as an expense on a straight line or other systematic basis.

For WG group bodies it has been mandated to adopt a low value lease exemption threshold of £5,000 and exercise the recognition exemption for leases in which the underlying asset is determined to be of a low value

For all other leases there is a requirement to recognise a right-of-use asset representing its right to use the underlying leased asset and a lease liability representing its obligation to make lease payments.

As a consequence, there will be depreciation of the right-of-use asset and interest on the lease liability.

The Capital Finance team shall ensure that an accurate record of all leases captured under IFRS 16 is maintained in the ProLease system and that appropriate funding is requested from Welsh Government.

13.3 Process for Entering Into a New Lease/Lease Renewal

13.3.1 Property Leases

For the Health Board to achieve best value for money, it is essential that the owned estate is fully utilised before additional leased premises are procured. The approval process below ensures that all accommodation requests are reviewed and approved by the Accommodation Group, chaired by the Director of Estates and Facilities, to confirm whether or not the service requirements can be met from within the existing estate.

13.3.2 Property Lease Approval Process

Note: All Lease agreements are to be signed off by the Chief Executive Officer

13.3.3 Equipment / Vehicle Leases

If a contract contains the right for the Health Board to use an asset, an assessment of whether the contract is deemed to contain a lease needs to be completed by the Capital Finance Team.

Equipment leases may be contained within:

- Leases previously classed as operating leases
- Managed service contracts
- Consumable contracts where equipment is provided free of charge in exchange for an agreed amount of consumable purchases.

As the majority of leases will now require capital funding, the approval route will follow the same process as set out in Section 2.4 with the requirement to submit a PPD or BJC dependant on the complexity of the scheme. Under the WG IFRS16 lease funding rules annual revenue budgets are required to be released in exchange for the capital funding. The revenue budget deduction will need to be confirmed within the approval documentation and signed off by the Division.

The only exceptions to this will be leases that meet the low value / short term criteria described in Section 13.2. Leases that meet the exception criteria will continue to be classed as revenue expenditure.

14 CONTROLS, MONITORING AND EFFECTIVENESS

14.1 Overview

This section sets out the expected controls; the information required to evidence those controls and the person(s) who will have responsibility for ensuring those controls are in place and monitored. The controls are considered to be the minimum necessary to demonstrate sound financial controls in relation to capital projects.
Managers should implement additional controls where projects are considered to involve a greater degree of risk and/or reporting than normal.

14.2 Summary of high-level controls

Phase/Area	Expected control	Evidence	Person responsible
Project planning and appraisal			
The planned project meets the requirements of the Health Board's IMTP/ Annual Plan and CF Strategy and is prioritised and evaluated on that basis.	Project Brief signed off prior to significant BJC/PPD and design development.	IMTP/ Annual Plan Capital Group Minute Executive Team Minute PIP minute/feedback Board Minute Project files Correspondence	**Action** Divisional General Manager/Project Director/ Lead User **Monitoring** Head of Capital Planning
The benefits realised from the investment are clearly explained and described in such a way that they can be monitored and evaluated	Benefits have to be clearly stated in the Capital bid (PPD/BJC/SOC) Annexes 5 and 6	The Benefits/Impacts of Proposed Solution section of the relevant case has been completed and are subsequently taken forward to the Post Project Evaluation where applicable. Project monitoring reports	**Action** Divisional General Manager/Project Director/ Lead User **Monitoring** Head of Capital Planning
All the financial implications of the project have been considered before the contract is let and are monitored	The PPD or BJC (Annexes 5 and 6) contains the following information 1. Capital budget 2. Revenue cost implications and a source of funding.	The capital costs given in the bid document are full costs including works costs, equipment (inc. furniture), ICT, fees, contingency and VAT. Compare budget against tender	**Action** Divisional General Manager/Project Director/ Lead User /Business Partner

throughout the implementation period	3. Profiled and realistic capital cash flow to be used for Project Monitoring purposes (Section 5)	Revenue section of PPD Project monitoring reports including AWCP where appropriate.	Accountant **Monitoring** Head of Capital Finance
Appropriate approvals for the scheme have been received.	Approval is required at: Project initiation Feasibility OBC FBC	Capital Group/Executive Team/Board minutes as required.	**Action** Divisional General Manager/Project Director/ Lead User **Monitoring** Head of Capital Planning
Key risks are identified and a risk management approach set out	A risk assessment has been carried out and risks are allocated to those best placed to manage them.	The Project Risk Assessment section of the PPD is completed and if appropriate a Project Risk Register (Annex 11) has been drawn up and is regularly reviewed and updated	**Action** Divisional General Manager/Project Director/ Lead User **Monitoring** Head of Capital Planning
A clearly established management team, which includes representatives of all interested departments, has been given responsibility for the project.	A project team has been set up with a named individual responsible for the successful delivery of the project and reporting requirements are clear Only one named person can instruct contractors External advisers roles clearly defined and appointed competitively	Project Board and Team Minutes Project appointment letters Project Directory	**Action** Divisional General Manager/Project Director/ Lead User **Monitoring** Head of Capital Planning
Pre Contract			
Contractors invited to tender are capable of undertaking the work - both financially and technically	Tendering for schemes is to be carried out in accordance with the ABUHB Standing Financial Instructions and the guidance set out in Annex 15. Most contractors will be pre-selected/vetted	Appropriate Frameworks etc.	**Action** Divisional Director facilities or Representative **Monitoring** Head of Procurement
The tendering process results in the most appropriate contractor being contracted to perform the contract for the best price.	Tendering for schemes is to be carried out in accordance with the ABUHB Standing Financial Instructions and the guidance set out in Section 6	Tender register and select list Tender, contract register Signed as reviewed Board minutes	**Action** Divisional Director facilities or Representative **Monitoring** Head of Procurement
The contract entered into is the most appropriate for the work in hand.	Standard terms and conditions are used. Legal confirmation is sought The suitability of guarantors is assessed. Under and poor performance is covered by liquidated damages.	Assess for suitability Correspondence Performance bond or similar Agreed by legal	**Action** Divisional Director facilities or Representative **Monitoring** Head of Procurement

	The basis of prices is specified.	Contract clauses	
Ensure best practice aimed at reducing the risk of bid rigging/ anti competitive behaviour between contractors.	Measures are in place to reduce the risk of bid rigging and anti-competitive behaviour. Annex 15 section 4.12	Tender analysis etc. Annual Tender analysis and report to Capital Group	**Action:** Divisional Director facilities /Head of Procurement **Monitoring** Audit
The design of the project meets the requirements of the Business Case.	The brief is sufficiently well developed to allow design. The design is sufficiently detailed for tender. The design is in line with the project approval. The design has been approved by the users.	Readiness to proceed to design Annex 17 Match design, specification, tender, as built Matching and signed. Check for inconsistencies. Proceed to Tender Annex 18	**Action** Directorate General Manager/Project Director/ Lead User **Monitoring** Divisional Director facilities or Representative

Finance Controls			
The project is completed to meet the specification, on time and within budget.	There is a documented budgetary procedure. Budget reports and monitoring forms are produced monthly. Each project is reported upon separately. Variations are authorised before being incurred	Obtain a dated copy. Copies and circulation list. Financial ledger and reports. Variation orders, dated and signed	**Action** Estates Officer/Lead User **Monitoring** Head of Capital Planning/ Head of Capital Finance
Conduct of the Contract			
Payment is only made for work completed to the required standard.	There is a procedure for Interim certificates. Interim valuations are regularly produced. The contract register should be checked prior to approving interim certificates and invoice calculations are checked. The contractor supplies supporting statements.	Obtain a dated copy. Certificates dated and signed. Signed and dated when received	**Action** Divisional Director facilities or Representative **Monitoring** Head of Procurement
All variations to the specification are necessary and are approved	There is a procedure for variations. Only the contract administrator should authorise. Authorisation is given before work is carried out. Variations are supported by documentation. Variations are measured before being paid.	Obtain a dated copy. Signed and dated. Signed and dated. Compare with original tender. Signed and dated, compare with records.	**Action** Divisional Director facilities or Representative **Monitoring** Head of Procurement
Any claims made are valid and counter claims are only paid	There is a procedure for claims. All claims are submitted in writing.	Obtain a dated copy. Controlled stationery.	**Action** Divisional Director facilities

if based on a reasonable claim.	All claims are acknowledged. Insurance should be checked for claims liability. Claims are validated and authorised. Notes are produced of meetings with contractors.	Response attached to controlled stationery. Signed and dated. Named officers, signed and dated. Agreed schedule of site meetings.	or Representative **Monitoring** Head of Capital Finance/ Head of Procurement
In the case of the contractor becoming bankrupt the Health Board does not lose any money and that the contract can be continued.	There is a procedure for dealing with bankruptcy Annex 15 Section 5.2	Obtain a dated copy. Letter from legal advisers Site register Compare rates with original tender. Review if any bonds have been undertaken.	**Action** Divisional Director facilities or Representative **Monitoring** Finance Director

Final Account			
The final payment is made on the basis of work performed and that the payment is within budget.	There is a procedure for making a final payment. Payments are made in accordance with the contract sum. Final payment authorised by the contract administrator. There is an independent management review. Retention is held until the due date. Final accounts are based upon detailed measurement. A certificate of making good defects is issued. The date of completion is as per the contract.	Obtain a dated copy. Named officers, contract register and tender. Signed and dated. Finance Department Finance Department Quantity surveyor, signed and dated. Finance to receive before release of retention Named officers	**Action** Divisional Director facilities or Representative **Monitoring** Capital team/Head of Procurement
Works are completed satisfactorily before the final payment is made.	A certificate of making good defects is issued. The project manager and users accept the site. The site is reviewed against the design.	Finance to receive before release of retention Project report, Board report Project Team, project report	**Action** Divisional Director facilities or Representative **Monitoring** Capital team/Head of Procurement
All claims for liquidated damages are valid and are collected before the final payment is made.	There is a procedure for liquidated damages. Liquidated damages are recovered.	Obtain a dated copy. Legal adviser.	**Action** Divisional Director facilities or Representative **Monitoring** Head of Procurement/ Finance Director
The success of the project is considered and performance is objectively assessed.	There is a procedure for post project evaluation. There is an independent check carried out. Users should comment on the scheme. A final project report should be made to the Capital Group where applicable.	Obtain a dated copy. Internal Audit as appropriate. Project report Capital Group minutes	**Action** Directorate General Manager/Project Director/ Lead User **Monitoring** Head of Capital Planning

	The performance of the contractor should be assessed.	Independent team	

Note
Where appropriate the above controls should be supported by checklists signed and dated by named officers and independently reviewed.

14.3 **Project Manager Responsibilities**
The Project Manager is required carry out the monitoring and reporting set out in Section 5

14.4 **Capital Audit**
As part of the Health Board's Internal Audit process periodic audits are carried out on both individual schemes and the overall capital programme. Periodic reports are made to the Audit Committee setting out the degree of compliance with controls. Managers will be expected to provide responses to be included in the reports and implement any identified shortfalls in controls.

14.5 **Integrated Assurance and Approval Plan**
All projects developed for AWCP funding are required to have an Integrated Assurance and Approval Plan. This is used as a tracker to track progress and monitor performance.

14.6 **Gateway Healthcheck Reviews and Risk Potential Assessments**
The Welsh Government has reinstated the requirement for periodic Gateway Health check Reviews of Major AWCP Schemes. These will be managed on an "as required" basis.

As part of this process it is mandatory for all Senior Responsible Owners (SRO) to complete an (RPA1) at the beginning of a programme/project and at key decision points in their lifecycles. This may lead to a more detail submission of an RPA 2.

The WG Risk Potential Assessment form part 1, (RPA1) is designed to provide a standard set of high-level criteria for assessing the initial risk potential of a programme/project in a strategic context.

The RPA1 has two purposes: (a) for identifying potential risk of all programmes/projects across WG for use by the Integrated Assurance Hub, and (b) for determining the most applicable assurance method for a programme/project.

The RPA enables a conversation to be had about the risks and responsibilities that the SRO has for delivery. The RPA can also help the programme/project to identify areas where specific skills sets may be required.

14.7 **WELSH GOVERNMENT and NWSSP–**Specialist Estate Services **(SES) returns**
In line with the requirements set out within the NHS Wales Infrastructure Guidance, Project Progress Reports are required bi-monthly for WG selected AWCP projects. These need to be provided to the Welsh Government Capital Team electronically by the 12th working day of every other month.

ANEURIN BEVAN UNIVERSITY HEALTH BOARD
CAPITAL PROCEDURES
Annex 1

Key Capital Governance Roles and Responsibilities

The Chief Executive

- The Chief Executive has overall responsibility for delivery of the Health Board's Capital Programme.
- The Chief Executive may act as Project Owner/ Senior Responsible Owner and has overall responsibility for the management of capital schemes at all stages of the process, from inception to post project evaluation and for ensuring the recording of assets once acquired.
- The Chief Executive must ensure that the manager appointed to manage an approved capital scheme receives notification of delegated authority to commit expenditure, to proceed to tender or to accept a successful tender as required.
- The Chief Executive may delegate capital investment management in accordance with Welsh Government guidance, Estate code guidance and the Health Board's Standing Orders.
- The Chief Executive shall have the delegated authority to approve capital investment up to a value of £100,000.

The Executive Director of Strategy, Planning and Partnerships

Capital Programme

The Director of Strategy, Planning and Partnerships will:

- Chair the Capital Group and shall have the delegated authority to approve capital investment up to a value of £75,000.
- Fulfil the role of Senior Responsible Owner for the Capital Programme.
- Lead the development of the Capital Programme for Health Board approval ensuring links to the Integrated Planning Process.
- Ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon the IMTP/ Annual Plan, Strategic Change Programmes and individual business plans.
- Lead liaison with Welsh Government with reference to Clinical Futures and the Capital Programme.
- Report as required to the Health Board on capital project progress and issues.

- Ensure that the decision to invest capital is in accordance with the Health Board's overall strategic aims.
- Agree as required the Capital Audit requirements associated with the Capital Programme.

Capital Projects

The Director of Strategy, Planning and Partnerships will:

- Lead and chair as required Project Teams and/or Project Boards delivering Major Projects
- Ensure that a Project Director and Project Manager are appointed and there are adequate project management, monitoring and control arrangements.
- Be responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost.
- Ensure that the capital investment is not undertaken without confirmation of the availability of resources to finance all relevant consequences, including capital charges.
- Seek the approval of the Board as required for the inclusion of a capital investment proposal within the Health Board's Capital Programme.

The Finance Director

The Finance Director will: -

- Issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes (Capital Assets and Charges).
- Issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.
- Authorise periodic estimates of capital charges resulting from the Health Board's Capital Programme, in accordance with Welsh Government guidelines and timescale.
- Carry out the financial vetting of contractors prior to the issue of tender documentation.
- Liaise with internal and external auditors, report auditor's recommendations to the relevant Health Board officers and Audit Committee and monitor the implementation of corrective action.
- Be responsible for all capital financial planning for the capital programme and capital finance input to all business cases.
- Maintain links with external groups or bodies who have a key role in the allocation of capital resources. This includes the Welsh Government.

Divisional Director of Facilities

The Divisional Director of Estates and Facilities or his representative shall carry out the following roles: -
Capital Programme

- Develop proposals for submission/consideration for inclusion in the Capital Programme.
- Develop a programme for Statutory Compliance, Health and Safety issues and Backlog Maintenance.
- Management of Statutory Compliance, Health and Safety and Backlog Maintenance programme element of the Health Board approved capital programme.
- Provide routine reports on progress, cost control and any changes to the Statutory Compliance, Health and Safety and Backlog Maintenance programme to Capital Group.
- Liaise with the Planning Directorate to allocate appropriate resources to support the development of capital schemes at all stages of the planning process.
- Support feasibility studies for developments of business cases for capital developments.
- Provide support and regular reporting to Capital meetings.
- Ensure all required Estate cost returns are made to Shared Services.
- Lead and Manage all areas of property acquisition, disposal and leasing.

Technical/Professional Project Management

This role is to be filled using a suitably qualified and experienced person whether employed internally or externally. This person will be accountable to the client lead for the provision of specialist technical project management and support and in conjunction with the project lead:

- Allocate design team resources.
- Support the development of user requirements.

- Provide technical advice on feasibility of user options.
- Undertake and support option appraisal for business case development.
- Provide outline costing, identifying the costing basis.
- Provide comprehensive cost information and estimates in line with the requirements of the CRL ensuring that cost variances are identified separately for the effects of programme and cost changes.
- Advice on statutory approval requirements.
- Advice on project timetable in the form of a project execution plan.
- Advising on the appointment of external project managers as appropriate.
- Support the appointment and management of external design teams.
- Compliance and Construction, Design and Management (CDM) regulation 2015.
- Provide appropriate support through membership of Capital Project teams.
- Ongoing management and control of capital schemes.
- Development of an agreed programme.
- Prioritise capital schemes.
- Advice on requirement of Capital Procedures compliance.
- Support the submission of Project start up documents with appropriate advice on status of any cost provided.
- Manage Design Teams ensuring appropriate and timely instructions/solutions are received through the Contract Administrator/Design Team

Head of Capital Planning

The Head of Capital Planning shall carry out the following roles: -

- To provide effective management, co-ordination and development of the ABUHB capital annual or three year (as required) programme including the development, maintenance and implementation at a corporate level. These plans must balance with the organisation's Capital Resource Limit (CRL).
- To provide effective management, co-ordination and development of capital investment proposals and to encourage the use of good practice in the preparation of capital business cases.
- Lead and/or assist in the production of appropriate documentation and analysis, Business cases etc. and ensure that for each approved project a business case or business justification document is produced which contains a full appraisal of options against potential benefits and known costs for each investment proposal.
- To establish, or advise on the establishment of, appropriate Project Management structures including Project Teams, user groups and purchaser liaison arrangements.
- To produce, lead or assist in the production of, appropriate documentation and analysis, Business Cases and Capital Programmes and Reports for Health Board and Capital Group.
- To maintain links with external groups or bodies who have a key role in the allocation of capital resources. This includes Welsh Government.
- To provide practical support to Project Owners, Directors and Managers including the clarification of investment objectives, provision of a quality assurance role and implementation of Prince2.
- To provide as required, Capital and Project Papers for the Executive Team and the Health Board.
- Manage the business of the Capital Group and 'Chair' this meeting when the DOP is unavailable.
- Chair Capital Monitoring and Divisional meetings as required.
- To apply NHS Wales Infrastructure Investment Guidance, Capital Investment Manual and Welsh Government 5 Case Model techniques including development of strategic and financial contexts, identification of benefits criteria, option appraisal and risk analysis to capital investment proposals.
- To support the ongoing improvement in Health Board Capital Investment protocols and practices to ensure that the maximum benefit is gained from limited capital resources.
- In co-operation with the Head of Capital Finance, develop annual or three year plans (as required) for discretionary capital expenditure and submit to the Health Board.
- To be responsible for the regular review and reporting of the Health Board Capital Programme.

- When property transactions form part of a capital project ensure that appropriate procedures are followed including Health Board Land and Property Group, Health Board scrutiny and approvals and Welsh Government approvals.
- To ensure alignment with the Welsh Government Capital Programme, the Health Board IMTP/Annual Plan and all current requirements of the strategic development of the Estate and if required provide strategic property briefings for the Health Board.
- To work with Shared Services to plan the audit programme and facilitate audit of Capital schemes.
- To review external opportunities to enhance funding through external/additional funding streams.

Head of Capital Finance
The Head of Capital Finance shall carry out the following roles: -

- Certify the capital costs and revenue consequences of any Capital scheme.
- Support the development of the Capital programme in co-operation with the designated staff from the Planning Directorate.
- Reconcile the Capital Plan to the Capital Resource Limit received from the Welsh Government.
- Produce capital monitoring information for the monthly Welsh Government financial monitoring return.
- Carry out a monthly reconciliation of capital expenditure to the General Ledger.
- Produce periodic estimates of capital charges resulting from the Health Board's Capital Programme, in accordance with Welsh Government guidelines and timescale.
- Provide expert financial support for the development, co-ordination and monitoring of capital investment proposals and to encourage the use of good practice in the preparation of business cases that identify a requirement for capital investment.
- Advise on areas of priority capital spend and will be responsible for capital accounting, including capital charges, IFRS implications and revenue implications of all capital schemes.
- Ensure that all necessary information is provided, and action initiated to successfully meet the requirements of the CRL.
- Produce, or assist in the production of, appropriate documentation and analysis, Business cases and Capital Programmes and Reports for the Health Board and other Health Board meetings.
- Ensure the upkeep and future development of the capital asset register.
- Maintain links with external groups or bodies who have a key role in the allocation of capital resources. This includes the Welsh Government.
- Apply Capital Investment Manual techniques including development of strategic and financial contexts, identification of benefits criteria, option and financial appraisals and risk analysis to capital investment proposals and overall appraisal of capital investment proposals.
- Contribute to the ongoing development of the Health Board's Capital Investment protocols and practices.
- Responsible for completion and submission of Welsh Government lease funding returns.

ANEURIN BEVAN UNIVERSITY HEALTH BOARD
CAPITAL PROCEDURES
Annex 2

Strategic Capital and Estates Programme Board

Terms of Reference

1.0 The main purpose of the Board is to:

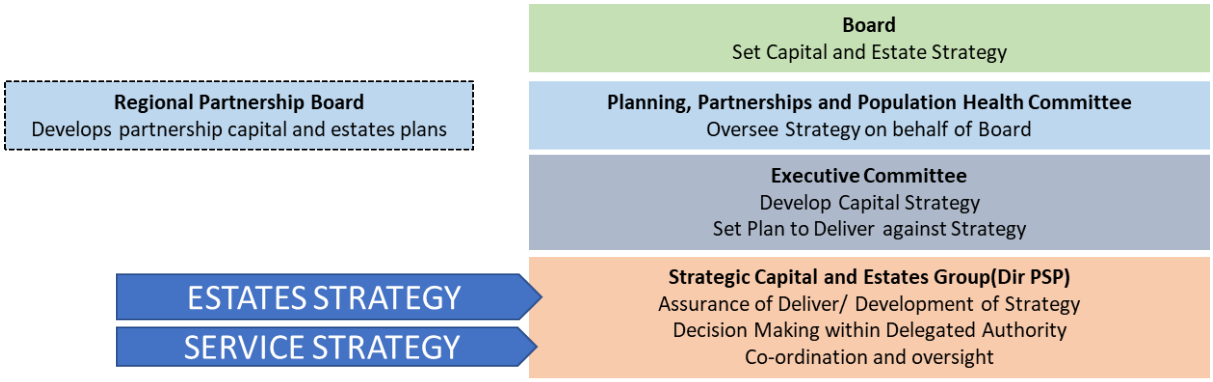
1. Oversee the implementation of the Health Board Estates Strategy and the associated updated Estate Strategy Strategic Objectives.
2. Oversee the ongoing progress and implementation of the Health Board strategic capital projects.
3. Oversee the Discretionary capital programme.

2.0 Specific Role:

- Receive and review a monthly progress report on the implementation of the Estate Strategy Strategic Objectives.
- Monitor delivery of the Strategic Objectives, acting as a point of escalation for issues and risks that cannot be resolved at Local or Divisional level.
- Receive and review a monthly progress report on the implementation of the Strategic capital projects and the associated Capital Matrix.
- Monitor delivery of the Strategic capital projects, acting as a point of escalation for issues and risks that cannot be resolved at Local or Divisional level.
- Assess wider regional and / or organisational plans and their implications for the Estate Strategy and the Strategic capital projects.
- Evaluate new proposed capital developments to consider strategic fit, implications for quality & patient safety and the best use of resources to ensure value for money.
- Receive and review a monthly update on the progress of the Discretionary capital programme.

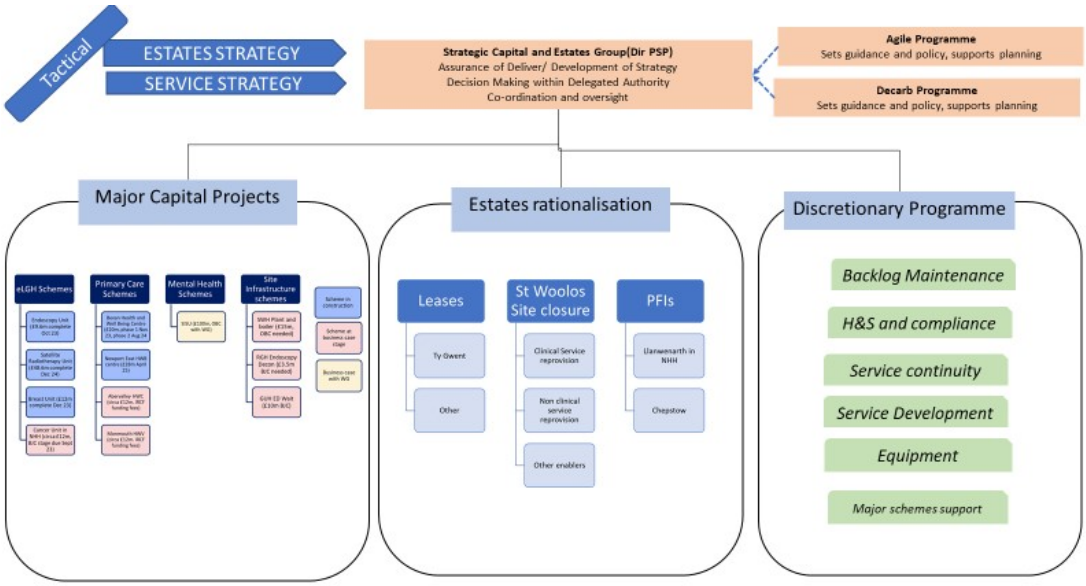
3.0 Reporting Arrangements

The Board will report directly into the Executive Committee providing assurance regarding the delivery of the key objectives and escalating key risks or issues as they become clear.



Feeding through into the Strategic Capital and Estates Group will be:

- Updates and insight from the Integrated Capital Planning Group (RPB)
- All Major Capital Projects
- Work on Estates Rationalisation
- Discretionary Programme



4.0 The Board membership will include:

Name	Title / Role
Hannah Evans	Executive Director of Strategy, Planning and Partnerships
Richard Morgan Evans	Deputy COO
Andrew Walker	Programme Director Strategic Capital and Estates
Jamie Marchant	Director of Estates and Facilities
Kelly Jones	Capital Finance
Suzanne Jones	
Tbc	Digital
Julie Chappelle	Assistant Director of Workforce
Lorraine Morgan	Programme Manager - Strategic Capital & Estates
Lowri Ashworth	Programme Support - Strategic Capital & Estates
Hannah Capel	Associate Director Capital and Estates

ANEURIN BEVAN UNIVERSITY HEALTH BOARD
CAPITAL PROCEDURES
Annex 3

CAPITAL GROUP
TERMS OF REFERENCE - CAPITAL GROUP

Accountability
The Capital Group is accountable to the Executive Committee and ABUHB Health Board.
The Capital Group is required to 'feed' into the Estates Strategic and Capital Group to ensure alignment of the Health Boards Strategic intent.

Financial Delegated Accountability
The financial delegated limits and remit of the Capital Group will include:

- Evaluation and approval of individual capital investment business cases with a cost of less than £75,000 prior to inclusion in the Health Board Capital Programme.
- Evaluation of individual capital investment business cases with a cost between £75,000 and £500,000 prior to Executive Team submission, approval by the Chair and Chief Executive and inclusion in the Health Board Capital Programme.
- Review of Project proposal documents and business cases for schemes costing from £500,000 to £1,000,000 prior to Executive Team and Health Board submission. This should include any bids for funds from external funding sources that do not require Health Board capital resource.

Frequency of Meetings
- To be held monthly
- All meetings will be agenda based
- Notes will be taken of each of meeting.

Capital Group Membership
The Capital Group will include the following membership:

Executive Director of Planning (Chair)
Assistant Director of Financial Planning and Performance
Associate Director Planning and Service Improvement
Major Projects Programme Director
Head of Capital Planning (Deputy Chair)
Head of Capital Finance
Divisional Director of Estates & Facilities
Procurement Manager
ICT Manager
Divisional representatives including General Managers
Note: Additional membership can be designated or co-opted to attend as required.

The Capital Group will: Take a strategic view of the Health Board's assets and estate to ensure that investment decisions are consistent and appropriate.

- The Capital Group will 'feed' into the Estates Strategic and Capital Group to ensure alignment of the Health Boards Strategic intent.
- Development and ratification of the Health Board Capital Programme prior to Executive Team and Health Board approval.
- Monitoring the Health Board Capital Programme and ensuring CRL compliance including proposing and implementing such measures required to achieve this.
- Escalate minor schemes that, through natural development increase by cost or technical intricacy, to the Estates Strategic and Capital Strategic Group for re-allocation to the Major Projects Team. Typical escalation value to be over £1,000.000.
- Ensuring compliance with Health Board capital protocols and procedures, Health Board standing financial instructions and standing orders, Welsh Government Five Case model requirements, the NHS Capital Investment Manual and such other guidance as issued or adopted by the Welsh Government or Health Board
- Liaising with Health Board Audit, Capital Audit, District Audit and National Audit Office and act upon their recommendations reporting within the Health Board as required.
- Support the preparation of Executive Team and Health Board submissions on both Programme and individual cases.
- Monitoring of the ABUHB Capital programme
- Contributing to the management of the CRL including in-year measures and changes to funding and approved expenditure.
- Promoting the use and development of the UHB's Capital Procedures.
- Overview of procurement including frameworks etc.
- Overview of contracting etc.
- Development of good practice/training etc.
- Receive the Annual Tender report.

Review
The Board will review this TOR annually or when the need arises.

ANEURIN BEVAN UNIVERSITY HEALTH BOARD
CAPITAL PROCEDURES
Annex 4

CAPITAL APPOINTMENT LETTERS

Dear NAME

Appointment of Capital Project Director
Scheme Title: -
PART A

1. The (DELETE AS REQUIRED) PPD/Scoping Document/Business Justification/Strategic Outline Case/Outline Business Case/Full Business Case for this Project has been authorised/approved/submitted to/by the Capital Group/Executive Team/ABUHB Board/Welsh Assembly Government.

2. You have been formally confirmed as Project Director effective from the date of this letter.

3. Please sign and return a copy of this letter.

4. Please arrange for the Project Manager letter to be signed and returned.

Signed on behalf of ABUHB

……
[Insert Name]
Chief Executive

PART B

1. I understand the requirements of the Project as set out in the Business Cases and associated documents and the duties and responsibilities of the Project Director as set out in the attachment to this letter and in the ABUHB Capital Procedures.
2. I accept the appointment of Project Director

Signed

……
[Insert Name]
Project Director

Capital Appointment Letter Annex 4 Attachment

The role and responsibilities of the Capital Project Director

The Project Director will: -

- Lead and direct (on behalf of the Project Owner) the Project Board and Project Team(s) towards the successful delivery of the project objectives as agreed with the Project Owner (Chief Executive) and Board.

The Project Director shall ensure that: -

- A Project Manager is appointed.
- A clearly established structure including a Project Team and Project Board, which include as required appropriate skills and expertise, representatives of all interested departments and stakeholders, has been given responsibility for the project and appropriate training is available.
- The appointment of project officers is recorded in the minutes of the Major Capital Group and letters of appointment have been issued to the project officers.
- There is a clear scheme of delegation that supports each individual's levels of responsibility.
- The Project Manager has a clear brief including: -
  - Terms of reference and duties including contractual.
  - Objectives/Business Needs
  - CRL requirements
  - Resources available
  - Delegated authority including chairing Capital and User groups
  - Responsibilities for H&S
  - Relationship with (Internal) specialist support,(External) Project Manager and the SCP
  - Change Management responsibilities
  - Training needs and resources
- Appropriate techniques and components from PRINCE2 are used as required to help with the delivery of the project.
- Responsibility and ownership of the project is retained by ABHB and not delegated to external contractors.
- The project team reports on a regular basis using financial and non-financial Monitoring Forms included in the ABUHB Capital Procedures.
- The role of Design Champion is identified and carried out.
- The project team has:
  - clear responsibilities and methods of working;
  - a timetable for key events;
  - co-ordinated plans;
  - guidance notes;
  - monitoring information
  - project documentation and records
- Lines of communication are clearly specified and are short and direct.
- One person has responsibility for directing the activities of consultants, advisers, contractors and third parties.
- External management team members providing professional services are appointed on a competitive basis.
- Appropriate project files and documentation are kept. These should include: -
  - PPD and Business case documentation
  - All correspondence including approvals
  - Project approach and procurement strategy
  - Output specifications
  - Project plans

- Quality Plans
- Risk Log
- Communications plan
- Records of all meetings and decisions taken
- File notes of conversations where actions are agreed, decisions taken and authorisations given.
- Details of the appointment of the Project Team and Job Descriptions
- Details of the appointment of any external experts or advisers
- Records of all reports made and approvals received
- Change controls
- Details of the appointment of the SCP
- Contract documentation
- Scheme development and design

The process should be documented in such a way that will allow auditors to examine the project.

Dear NAME

Appointment of Capital Project Manager
Scheme Title: -
PART A

1. The (DELETE AS REQUIRED)PPD/Business Justification/Strategic Outline Case/Outline Business Case/Full Business Case for this Project has been authorised/approved/submitted to/by the Capital Group/Executive Team/ABUHB Board/Welsh Assembly Government

2. You have been formally confirmed as Project Manager effective from the date of this letter.

3. Please sign and return a copy of this letter.

Signed on behalf of ABUHB;

…….
[Insert Name]
Project Director

PART B

3. I understand the requirements of the Project as set out in the Business Cases and associated documents and the duties and responsibilities of the Project Manager as set out in the attachment to this letter and in the ABUHB Capital Procedures.
4. I accept the appointment of Project Manager

Signed;

…….
[Insert Name]
Project Manager

Capital Appointment Letter Annex 4 Attachment

The Role and Responsibilities of the ABUHB Project Manager

The Project Manager is the Authorised Signatory for each capital project and will:

- Lead and direct (on behalf of the Project Director and Project Owner) the Project Team(s) towards the delivery of the project objectives as determined by the SRO, Project Board, Chief Executive and ABHB Board.
- Ensure that appropriate and adequate communication mechanisms exist between the Project Director and Project Owner, Project Manager and external organisations, and between the Project Manager, Project Director and the rest of the ABHB.
- Act as the one point of contact between the ABHB and the Contractor/SCP (via the External Project Manager who will have formal responsibility under the NEC contract). This will require ensuring that appropriate formal processes are in place for the provision of professional and technical support and guidance from the Head of Works and Estate.

In conjunction with, and as delegated by, Project Director, the Project Manager will ensure that: -

- A clearly established structure including a Project Team(s) which includes as required appropriate skills and expertise, representatives of all interested departments and stakeholders, has been given responsibility for the project.
- Capital investment manual guidance as appropriate is followed in respect of the size of project, including setting up appropriate project governance, information management, and reporting arrangements and ensure that the project complies with relevant WG and NHS Estates and Capital Guidance
- The project team has:
  - clear objectives
  - defined responsibilities and methods of working;
  - a timetable for key events;
  - co-ordinated plans;
  - guidance notes;
  - monitoring information
  - project documentation and records
- There is a clear scheme of delegation that supports each individual's levels of responsibility.
- An appropriate business case is developed and remains robust at the procurement stage
- To ensure appropriate clinical involvement and sign-off of requirements
- There is a brief and project execution plan with clearly defined outcomes and an indicative and achievable programme including cost and time.
- To submit timely monthly financial reports (on the ABUHB required forms) of actual cost and accurately forecast costs; and forecast and actual cash flows on the forms provided by finance (an appreciation of the CRL process will be required).
- Appropriate techniques and components from PRINCE2 are used as required to help with the delivery of the project.
- Ownership of the project is retained by the ABUHB and not delegated to external contractors.
- There is liaison with the project manager to direct the activities of consultants, advisers, contractors and lines of communication are clearly specified and are short and direct.
- The Design produced meets all the requirements of the project and is signed off as required.
- Ensure that adequate procedures are in place to monitor and control cost, time and quality thereby ensuring CRL compliance
- To obtain robust project costs and act in accordance with standing orders and standing financial instructions utilising appropriate delegated input such as provision of build costs.

- To take overall responsibility for the project being delivered within budget, including being informed of and agreement of works budget variations, and direct control of non-works variations (e.g. equipment & fees).
- To include reporting of pre-contract costs e.g. survey and feasibility work, including agreement of budgets.
- To ensure that all project matters and costs are appropriately authorised and notified to appropriate parties.
- To liaise effectively with the technical project manager (usually works and estates), attending project team meetings and ensuring arrangements are in place for specific queries in their absence.
- To ensure that adviser fees are appropriately related to activities when agreed, and similarly checked when incurred.
- To inform the project team of equipping requirements.
- To ensure that an equipment schedule is derived to an appropriate stage to enable both initial and final budget estimates, the latter schedule to contain identified suppliers, lead times and itemised costs.
- To agree with the works project manager and contractor, items to be supplied and fitted by the contractor as part of the build, including agreement of cost.
- To ensure that equipment transfers are appropriately identified and agreed.
- Provide a regular report to the project director identifying cost, time and quality performance.
- Ensure that procedures are in place for any changes requested by the project team or users.
- Ensure the project is completed and handed over to the ABUHB in a managed way.
- To co-ordinate the user commissioning programme, providing time allocations and responsibilities.
- A post-completion evaluation of the scheme takes place.
- Appropriate project files and documentation are produced and kept. These should include: -
  - PPD and Business Case documentation
  - All correspondence including approvals
  - Project approach and procurement strategy
  - Output specifications
  - Project plans
  - Quality Plans
  - Risk Log
  - Communications plan
  - Records of all meetings and decisions taken
  - File notes of conversations where actions are agreed, decisions taken and authorisations given.
  - Details of the appointment of the Project Team and Job Descriptions
  - Details of the appointment of any external experts or advisers
  - Records of all reports made and approvals received
  - Change controls
  - Details of the appointment of the SCP
  - Contract documentation
  - Scheme development and design

The Project Management process should be documented in such a way that will allow auditors to examine the project.

ANEURIN BEVAN UNIVERSITY HEALTH BOARD
CAPITAL PROCEDURES
ANNEX 5

PROJECT PROPOSAL DOCUMENT (PPD)

Where funding is required from the Discretionary Capital Programme, the attached Document is to be fully completed and signed off by the relevant signatures as identified in the document.

This is to be submitted to the Head of Capital Planning for scrutiny and processing to the Capital Group.

PPD%20TEMPLATE.docx

ANEURIN BEVAN UNIVERSITY HEALTH BOARD
CAPITAL PROCEDURES
Annex 6

Project Title:

Business Justification

Version no:
Issue date:

Purpose of this document

This document provides a template for business cases in support of small and medium size investments – typically those below £2 million whole life costs that are ***not*** *novel or contentious in nature.*

The SOC, OBC and FBC templates should be used to progress the business case for significant procurements, in excess of this guideline.

Please note that this template is for guidance purposes only.

VERSION HISTORY

Version	Date Issued	Brief Summary of Change	Owner's Name
Draft	00.00.00	First draft version	

Version	Date Issued	Brief Summary of Change	Owner's Name

CONTENTS – BUSINESS JUSTIFICATION TEMPLATE

TEMPLATE AND SUPPORTING GUIDANCE

1. Purpose
2. Strategic context
3. Case for change
4. Available options
5. Preferred option
6. Procurement route
7. Funding and affordability
8. Management arrangements

Appendix Investment appraisals
Cost Forms

Annex 6 Cost Forms attachment.docx

BUSINESS JUSTIFICATION TEMPLATE AND SUPPORTING GUIDANCE

1. Purpose

State clearly what the business justification is in support of: typically – 'this is to seek approval of ... for £ … on … in support of …'

2. Strategic Context

Please provide an overview of the context within which the investment will be made. In other words, the strategy, work programme, service, project or operation, which the investment supports.

3. Case for Change

A. Business needs

Please provide the compelling reasons for investment in the required services or assets, with reference to:

- the investment objectives for the procurement
- the problems with the status quo.

B. Benefits

Please provide a summary of the **main** benefits associated with the investment, distinguishing between qualitative and quantitative; cash releasing and non-cash releasing; direct and indirect to the organisation, as appropriate.

C. Risks

Please provide a summary of the **main** risks associated with the investment, distinguishing between business and service risks during the design, build and operational phases of the project, as appropriate.

4. Available Options

Please provide a description of the main options (or choices) for investment, together with their relative advantages and disadvantages (a SWOT analysis).

Please bear in mind:

- that a minimum of **four options** should be considered, including the 'do minimum' or 'do nothing' (unless there are compelling reasons to the contrary)
- that these options may differ in potential business scope, service solution, service delivery, implementation and funding, depending on the nature of the investment
- that the investment appraisal for each option should be contained as an appendix and prepared in accordance with the tools and techniques set out in the Capital Investment Manual and HM Treasury Green Book.

5. Preferred Option

On the basis of the above, please:

- state why the recommended option optimises value for money (VFM)
- describe the services and/or assets required.

6. Procurement Route

Please state how the asset or service will be procured in accordance with the Government Procurement Agreement (WTO) and the EU Consolidated Public Sector Procurement Directive (2004).

This may involve the use of an existing contract; a call-off contract or framework agreement; or the requirement for a new procurement under the above.

7. Funding and Affordability

Please indicate:

- the capital and revenue costs of the proposed investment
- how the investment will be funded
- any affordability gap (as appropriate).

8. Management Arrangements

Please indicate how the investment will be delivered successfully with particular reference to:

- project management arrangements
- business assurance arrangements (if applicable)
- benefits realisation monitoring
- risk management
- post project evaluation (if applicable)
- contingency plans (if applicable).

ANEURIN BEVAN UNIVERSITY HEALTH BOARD
CAPITAL PROCEDURES
Annex 7

INITIAL SCOPING DOCUMENT TEMPLATE

Capital Proposals - Initial Scoping Document for PIP consideration prior to formal Capital Scheme development

Title of Bid:

Project lead(s):

Brief summary of proposal including problem to be resolved and options considered:

- The problem:
  - Define it objectively and provide evidence
  - Objectives
  - Can we give measurable deliverables?
  - Is it "critical" to ABUHB services?

Strategic Context (including IMTP, Divisional priority and Clinical Futures):

- Describe where the service sits in organisational/management terms/IMTP/SCPs/Clinical Futures etc.
- Give overall activity levels so approvers can get an idea of the scale of the operation, its role in clinical services, its importance, dependencies, associated risks and why Capital Investment is being considered as a way of addressing this problem.
- If possible include the relevance to the post-SCCC model of care for your service

Main outcomes and Benefits from investment (e.g. performance, sustainability, compliance, spend to save, service development):

Scale of Capital cost (only if known – please do not approach Works or Procurement for costs at this stage):

Revenue or Workforce implications:

Co-dependencies (e.g. is this an enabler for other improvements/objectives; do other things need to happen first; is this part of a national programme or initiative)

Interfaces (Who and what does the project affect?):

Risks (What are the Risks associated with doing the project?):

Current stage of development:

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ABUHB
Project Brief Template *Example*

Background to the service
- Describe where the service sits in organisational/management terms etc.
- Give overall activity levels so approvers can get an idea of the scale of the operation, its role in clinical **services, its importance, dependencies and associated risks.**

The problem
- Define it objectively and provide evidence
- Objectives
- Can we give measurable deliverables? *"We must have 3 procedure rooms"*
- Is it "critical" to ABHB services?

Scope
- What's in (and what's not included - give **exclusions**)

Constraints e.g.
- *maintaining activity*
- *space*
- *finance*
- *time*

Interfaces
Who and what does the project affect?

Quality
- What clinical standards are relevant?
- What technical guidance applies – *HTMs/HBNs etc.*

Performance
- What performance standards are relevant?

Options
- Are there **Options** for dealing with this? <u>These do not have to be capital options</u>

Assumptions e.g.
"The unit will fail accreditation if we don't do anything"
"The service has to remain where it is"
"We can keep activity going during the work"
"We can decant activity during the scheme"
"We must do exactly what the xxxx report says"
"Units at xxx and yyy can not do any more decanted activity"

Consequences
"Impact of scheme on activity is acceptable"
"Revenue cost of using improved facilities will be met"

Project Management
- Who will be involved?

- Can we identify the scale of work required and how it will be carried out?

Risks

What are the **Risks** associated with doing the project?

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CAPITAL PROJECTS

OPERATIONAL POLICY TEMPLATE

An Operational Policy is a document that sets out all the information required about a service or department to allow the Design Team to meet those requirements in a co-ordinated way.

Name of service/department -

Introduction **– this should set out the aims and purpose of the service/department and describe the service provided**

Philosophy of Care/Operation of the service – **this should set out any relevant principles, guidance or standards**

Utilisation/Hours of operation **– this may include differential use of the department e.g. depending on whether the service is out-of hours etc. This may be best expressed as a table**

Activity descriptors and numbers **– this may include patient activity, procedures or processes carried out, products, orders, requests, etc. This may be best expressed as a table and any readily available detail should be included.**

Staffing numbers and locations **– this should give the staffing structure of the department including out of hours and on-call arrangements. Staff numbers per room may also be required. This may be best expressed as a table and must be consistent with agreed work-force assumptions**

Patient Pathway/workflows/ operational processes/FM processes - **this should define as many of the processes to be carried out as possible.**

Description of Service and component parts **– especially those that impact on design**

Room/Facility requirements **- with activity/staff numbers where possible**

Intra-departmental relationships/Internal Functional Relationships – **identifying the key physical relationships and adjacencies required to deliver the patient or workflows required. Distinguish between essential and desirable links.**

Inter-departmental relationships/External Functional Relationships/Whole Hospital relationships – **including links to whole hospital policies. Distinguish between essential and desirable links.**

Specific restrictions/exclusions **– services not provided by the department which may be expected to be provided**

Access and Exit routes Staff/Patients/Materials/Waste etc – **including any restrictions and required separations as well as holding and storage areas**

IT – **individual departmental requirements and links to whole hospital/trust systems**

Performance and Quality/Standards**– if applicable**

Consumer Standards **– if applicable**

Specific Engineering or other technical requirements and issues **– such as power supplies, drainage, maintenance, security etc.**

Relevant Design Guidance – **to include HBNs/HTMs etc. and other documents which can be used to validate the operational policy and design. It is also helpful to set out where guidance is not followed and give reasons for this.**

Service and Technical Developments – **this can include any factors which may affect <u>future</u> service delivery and facility or equipment requirements that could lead to further change after the development has been opened.**

Author, File Name, Version Number and Date

Signed off by:

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BENEFITS

Benefits

Benefits and their delivery are a major feature in the capital investment scrutiny process.

A benefit may be described as:

> "A measurable improvement resulting from an outcome which …should contribute, directly or indirectly, towards one or more of the strategic objectives of the organisation". [Managing Successful Programmes]

Welsh Government are explicit in that they require Benefits to be SMART.

Benefits management focuses on the realisation of benefits as an effect of outcomes resulting from service change.

Benefits Realisation Plan

The Benefits Realisation Plan is a stand-alone document
The process for identifying the Benefits Realisation Plan will include:

- Identifying and prioritising the benefits;
- Identifying and agreeing benefit ownership;
- Developing measures;
- Quantifying benefit opportunities;
- Developing Benefit Management Action Plans (including timelines, responsibilities, resources, and inter-dependencies);
- Implementing an on-going benefits management tracking and reporting process; and
- Agreeing how benefits information will be communicated to stakeholders and acted upon to ensure maximisation.

Benefits register

The Benefits Register is a central location for collating and monitoring the information from the benefits profile and benefits realisation plan.

The owner of the benefits register is the Senior Responsible Owner for the programme or Project Director for a Project.

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RISKS

Risk Proforma:

Annex 11 - Risk Proforma Feb 2020.x

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IMPROVING THE DELIVERY OF CAPITAL PROJECTS – this summary guidance is aimed at small to medium sized projects usually funded from the Discretionary Capital Programme.

What constitutes a successful project?

A successful project is a project:

- Which starts with a clear brief, scope and intended outcome agreed by all relevant parties that fits with the overall strategic direction of the UHB.
- With a project "lead" named from the affected service or department who will be responsible for implementation, chasing actions and will act as a single point of contact.
- The project lead needs to be allowed appropriately delegated autonomous decision making authority on a day to day basis to move the project along. This lead needs accept the formality of the role and when more formal arrangements are required to put in place a governance structure that provides leadership and facilitates clear direction and decision making.
- That delivers the agreed outcomes and benefits to an agreed cost, standard and timetable.
- Which has examined and evaluated different ways of achieving the desired outcomes and benefits.
- Which clearly identifies and manages the risks associated with the project delivery.
- That has a clear understanding of the number of key stakeholders that must be identified and involved in both bid development and implementation.
- Which has a realistic timescale and budget at the outset.
- With a governance structure that provides leadership and facilitates clear direction and decision making.
- With an appropriate level of record keeping that allows post project review and evaluation plus audit if required.
- With robust procurement arrangements demonstrating the necessary competition in the appointment of suppliers and contractors.
- Where a realistic, deliverable timetable or programme is provided including lead times and approval periods AND has measures in place to monitor the programme.
- Where the capital costs have been provided by W&E, ICT or Capital Equipping or all 3 if required and the capital costs used for approval are full costs including surveys, works costs, equipment, ICT, fees, contingency and VAT.
- Where revenue costs (including any service contracts, maintenance etc)have been identified and a source of funding agreed with Divisional Business Partners for Finance and Workforce.

What tools are available?

- All of the issues listed above should be reflected in an appropriate **Business Case** or **PPD which can be used by the Capital Team/ Capital Group to review justification.**

- If the project is likely to require significant design and construction resources **an Internal Scoping Document** should be prepared for PIP scrutiny.

- Any design work either for a building project or for equipment fitting should be based on an **Operational Policy/Service Strategy** developed with and signed off by users and a **Project Brief.**
- The design must be supported not only by an agreed operational policy but also with **Room Data Sheets,** an agreed **Schedule of Accommodation** and a **design or layout** signed off by key users.
- Any equipment should only be procured using a **Specification** prepared with Procurement.
- A **Project Execution Plan** is mandatory for projects with a value of £1m or more.
- Even if a formal **Gantt chart** is not produced using Microsoft Project a simple **Critical Path** of events and dependencies must be produced by the Project manager and used to plan and monitor the project.
- A **Risk Register** must be developed and regularly reviewed by the Project team.

What lessons have we learnt from previous projects?

- The basic tools listed above must be used appropriately and proportionately for the specific level of project risk and cost.
- Each project must have a designated lead who is responsible for owning and leading the delivery of the outcomes and benefits.
- Project leads need access to current Finance information if they are to discharge their responsibilities and control expenditure.
- Regular Project team meetings must be held, chaired effectively, and recorded.
- Each major project requires oversight from a Project Board. • All relevant technical information must be considered when developing a proposal or purchasing equipment, including engineering infrastructure generally, structural assessment as required and informatics generally.
- A dedicated Operational Procurement lead is invaluable to the success of purchasing capital items for all levels of project.
- No equipment should be ordered without the involvement of procurement and preparation of a specification.
- It always permissible to pause progress on a project if the necessary information is not ready or there are other issues – for example if there is concern about the number or quality of tender returns or unforeseen technical issues.
- Any other affected departments (e.g. facilities/estates and informatics) must be involved in the bid INCLUDING revenue implications.
- The majority of skills and knowledge required to successfully deliver a capital project are standard managerial competencies that all NHS managers should be able to deploy.
- The specialist tools and templates required are available in the Capital Procedures
- Advice is available on a day-to-day basis from the Capital Team.
- Post Project Review and Evaluation must form a part of the life cycle of capital projects.

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PROJECT INITIATION PLAN TEMPLATE

Project Initiation Document

1 Overview

1.1 Purpose

The purpose of this Project Initiation Document (PID) is to describe the proposed project to
It has been prepared based on the PID template used in the PRINCE2 project management methodology.

There are two primary uses for the document:

- It is designed to ensure that the project has a sound basis and provides a common understanding of the project at the outset for those involved in its delivery
- It will act as a base document against which the Health Board can assess progress, change management issues and ongoing viability

1.2 Key questions including

- What is the project aiming to achieve?
- Why it is important to achieve it?
- Who is going to be involved and what are their roles and responsibilities?
- How and when it is going to happen?

2 Background including Service Context

3 Project Definition/Scope

3.1 Objectives

3.2 Project scope

3.3 Project deliverables and desired outcomes

3.4 Constraints

3.5 Exclusions

3.6 Interfaces

3.7 Assumptions

4 Project Structure and Management Arrangements

Clear roles and responsibilities are vital to ensure successful delivery of agreed objectives.

5 Project Plan

6 Communication Plan

An effective and widespread communications and engagement programme is essential to ensure productive and efficient dialogue with stakeholders at key stages of the programme.

7 Quality Plan

8 Project Controls and Reporting

This section sets out the project controls including monitoring, reporting and authorisation mechanisms including exception processes.

9 Initial Risk Register

Monitoring of the risk register will be undertaken on a monthly basis by the Project Team and key risks will be reported

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PROJECT EXECUTION PLAN TEMPLATE

(Required for all projects with a value greater than £1m)

Project definition and Brief

i. With reference to (but not duplication of) the Full project definition of the Brief to include:
ii. Project Particulars
iii. Full Business Case Approval summary / OR review progression and user involvement procedures
iv. Procedure for changes to Brief
v. Priorities of Brief
vi. Healthcare Objectives
vii. Operational Constraints
viii. Construction objectives (overall budgetary and programme limits)
ix. Time / cost / quality priorities
x. Location, general arrangements, physical environment, and design constraints
xi. Design philosophy
xii. Contract procurement strategy

Roles Responsibilities and Authority

i. Details of all parties
ii. Roles and relationships
iii. Delegated responsibilities
iv. Key personnel
v. Project Directory (to define relationships and lines of communication)
vi. Project Director financial delegation limits
vii. Project Director interface with Users
viii. Project Director interface with Chief Executive
ix. Roles responsibility & authority for
- Project director
- Project manager
- Lead designer / design team
- Quantity surveyor
- Contractors
- Sub-contractors
- Contract administrator
- Clerk of Works
- Commissioning staff etc.

Project Plan and Cost Management

i. Cost Centres
ii. Cost Plan
iii. Budgets & Outturn recording
iv. Responsibility for monitoring and control
v. Change control (to include management of Variation Requests and Design queries. The Project should therefore include pro-forma documents to manage such elements)
vi. Risk management
vii. Cost reporting
viii. Contingency management
ix. Expenditure profile and annuity control

Risk and Sensitivity Analysis

Programme management

i. Milestone events

ii. definitions and meaning
iii. detail required
iv. frequency of review
v. how progress is monitored against a Critical Path network diagram showing interdependencies, Critical Path and float and any GANTT charts.

Contracting and Procurement

Administrative Systems and Procedures

i. Document and computer filing systems
ii. Project reporting
iii. Meeting frequencies, objectives, attendances etc.

Safety and environmental issues

Quality assurance

Commissioning

Post Project Evaluation and Post Contract Review

Technical standards

i. drawing formats
ii. plant and equipment numbering consistent with Asset Register
iii. maintenance requirements (generally future)

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NOTES ON DESIGN, TENDERING AND CONTRACTING - WORKS SCHEMES

1 Overview

This Annex sets out guidance on the Design, Tendering and Contracting phase of a capital project. It includes:

- The steps necessary to deliver a capital project.
- The role of Works and Estates
- The role of external professional advisers and consultants

All projects should follow the RIBA Plan of Work 2020 generally ensuring that all 7 stages are visited engaging key stakeholders accordingly.

RIBA Plan of Work 2020.pdf

2 Initiating a Scheme

2.1 Background

Schemes will differ dependent upon complexity; each scheme will consider and identify the roles and responsibilities for the service/client project manager and technical project manager (whether external appointment of internal).

2.2 Procurement Strategy

The choice of procurement route will affect the project structure and can include:

- The Welsh Government Designed for Life Construction Procurement Framework (Annex 16)
- ABHB Works and Estates Frameworks,
- Value Wales
- Competitive Tender
- Shared Services procurement led model.

Each scheme will also need to consider any requirements resulting from OJEU procurement requirements etc.

This is discussed in more detail in Section 4 of this Annex.

2.3 Accessing Works and Project Resources

With the exception of high-level feasibility work professional Estates advice and technical support is normally only available for a project that has had a case for change and brief signed off by the ABHB Capital Group as set out in Section 3.5 of this document.

This process will identify the need for a fee line to fund internal/external fees to develop the scheme further if deemed appropriate.

The Project Sponsor, Client Project Manager or Lead User may then be asked to develop the Project Brief (Annex 8). Reference should be made to:

WHBN 00-01 General Design Principles 2017

The outline brief should normally be developed in sufficient detail to comprise of a basic functional content, a basic schedule of accommodation, department operational policy, whole hospital policy (if deemed necessary).

Service users must first contact the Works & Estates help desk for a scheme to be allocated a reference number.

2.4 Feasibility Stage

To ascertain whether a scheme is technically feasible a feasibility study should be undertaken utilising a project team.

Generally, every capital project with works implications and with a value over £250k should be taken forward by a multi-disciplinary team established by the Health Board. The membership of the project team should reflect the requirements of individual projects and will vary as appropriate but will most likely include:

1. PM (service/technical/external)
2. Ops and maintenance rep
3. Facilities management
4. Multi discipline design team leads
5. Principle Designer
6. Other disciplines as deemed appropriate
7. Key user rep/clinical lead
8. Infection control
9. Fire officer
10. Procurement officers/IT

In the first instance though it may only comprise of a nominated service/client PM, Works & Estates lead/ representative/user department lead.

This team should develop the outline brief further in order to create a technical brief that can be used to further inform the internal team or external team if deemed the appropriate skills needed to be brought in. This embraced brief should enable internal or external teams to be able to draw up an outline design together with a budget cost to be used to drive the business case process be it PPD/BJC/OBC/FBC.

Issues to be taken into account at feasibility stage are:

1. Existing Site Development control plans and other proposed changes
2. Site investigation to determine:
    - Site capacities MEP/infrastructure
    - Site ground contamination issues/constraints
    - ICT constraints/capacities
    - Fire precautionary issues
    - Safety Services issues
    - Operational Works Management specifications
    - Facilities Management specifications
    - Environmental issues:
        i. Traffic impact studies
        ii. Access statements
        iii. Environmental impact studies
    - CDM 2015 implications/access and maintenance or other relevant issues required in the Pre-construction information.
    - Consultation with asbestos database

- Risk log identified/costed
- Equipment strategy to be considered
- Legionella issues
- Safety hazard notices/alerts
- Carry out a dimensional survey to confirm drawing accuracy of MICAD drawings
- Designer risk assessments
- Green issues
- Way finding issues
- Energy requirements
- Dementia Friendly Environment requirements.
- Project Manager via the Ops and Maintenance Manger to check requirements for degassing, residual oils, electric meter terminations etc.

Feasibility should ideally result in an outline design with 1:200 room relationship drawings that can be costed using DECAGS or similar approved costing methodology i.e. high level elemental cost analysis. For Discretionary Capital Projects Costings will normally be submitted on the cost forms in Annexes 5 and/or 6.

N.B. An elemental cost breakdown using a recognised format could also be referenced at this stage to further inform the business case. All costs should be adjusted for location factor current at the time and take account of current indexation levels (i.e. MIPS or equivalent).

Any abnormal costs are to be included for together with projected fee lines, building regulations, planning fees, ICT costs, contingency sum, equipment costs, art works (1% works cost) BREAM, environmental and traffic impact considerations. All costs to be subject to a VAT assessment.

If a scheme is a refurbishment of an existing premise it is usual to abate the DECAG figure by 30% and add on costs up to a maximum of 50%.

For accurate equipping costs Procurement Services, NHS Wales Shared Services Partnership (Capital Equipping) are to be involved in the process from inception of scheme. See Section 10 of the main document.

There will also be a need to consider revenue implications to feed into the business case (PPD/BJC/OBC/FBC).

A cost plan projection and a guideline high level programme also need to be considered.

A Project Execution Plan or PEP (See Annex 14) should also be developed for major schemes (subject to discussion with the Capital Team this will be for projects with a capital value of £1m and above).

If consultants are invited to carry out a feasibility study it is important to:

- Ensure that there is a clear approval for capital funding and a fee estimate is provided leading to the release of a Capital Cost Code.
- Agree a procurement strategy (If necessary with NHS Wales Shared Services Partnership - Specialist Estates Services). The value of the project will determine if an All-Wales Construction Framework will be used.
- Have a signed appointment document to reflect the services required.
- If a Consultant is acting as Principal Designer under CDM 2015 ensure that a standard letter is issued to the principal designer at the outset of the commission.
- Have a costed resource plan and programme to undertaken the feasibility as per user/ technical brief developed by the internal team.

- Consider they have adequate PI and public liability (to be ratified annually for 6/12 years dependant on contract being underhand/under seal.
- They are on a recognised framework although if required competitive tendering is permitted.
- They are informed that we require copyright of their design drawings and specification
- They deliver on time and to budget as per brief.
- N.B. Design development may occur at this stage in the design which may necessitate additional fees. Any additional fee line rights to be proposed by the Project Manager agreed with Divisional Director Estates and the Capital Team.
- Consider drawing formats PDF/DWG AutoCAD 2008 or above.
- Ensure there is a break clause in the appointment process that permits ABUHB to proceed with their design by others if deemed necessary due to escalation of costs etc.
- Take advice from any patient panels/CHC/LA/specialist groups as deemed appropriate, consult/engage as necessary.
- Prepare and consider an equipment strategy.
- Prepare and consider life-cycle costings (if required by the scheme)
- Obtain outline planning permission if deemed a requirement.
- Obtain permissions to develop from statutory under-takers gas/water/electric/BT – carry out surveys as appropriate.
- Agree a cut-off date for design data standards.
- Welsh Government consents and approvals and OJEC thresholds need to be considered at this stage.

On completion of feasibility the Certificate of Readiness to Proceed to Design should be signed by the Divisional Director Estates /Capital Project Manager (See Annex 17).

3 Design – Approved Scheme

3.1 Design Phase

On completion of the feasibility stage and successful application of the PPD/BJC/OBC the preferred option can be worked up into a detailed design proposal.
An agreed fee line to take the project through this stage needs to have been approved by the Capital Group/Director of Planning to proceed through to design and a capital job number issued if not already done at feasibility stage.

3.2 Development of the Brief

The project team/design team will further develop the outline brief in association with the ABUHB Technical PM to ensure the brief translates into the project requirements.
The external/internal multidisciplinary design team will further develop the outline brief in association with the ABUHB representatives to ensure the brief translates into the project requirements. Work on the 1:200 sketch design/room relationship layouts along with the operational policies for whole site and departmental schedule of accommodation and will be enhanced further to create a detailed design to 1:50 and 1:5 drawings with accompanying detailed room data sheets.
Data sheets will be developed further to better inform the costing process and pre-tender estimate, specification, procurement of equipment strategy to take account of any abatements or purchase of new.

3.3 Compliance/Standards/Derogations

At this stage internal/external designers will ensure full compliance with all current applicable Standards in NHS Wales and ABUHB including:

1. Firecode
2. Health Building Notes (HBNs)
3. Health Technical Memoranda (HTM's)
4. Hazard Notices and Medical Source Alerts
5. Health Facilities Guidance

6. Equipment Rates
7. Activity Database/Data Sheets
8. BREEAM Health Care
9. Detailed Building Regulations (if deemed applicable)
10. Detailed Planning Application (if deemed applicable)
11. Health and Safety at Work Act
12. Workplace Regulations
13. Secured by Design for Health Care Premises
14. One Wales: One planet
15. Capital charges
16. Capital Investment Manual (Guidance only – now archived)
17. Concode (Guidance only – now archived)
18. CDM Regulations 2015
19. EU Directives Governing Public Procurement and Welsh Government Guidance
20. ABUHB Standing Orders/Standing Financial Instructions
21. ABUHB Works & Estates Technical Brief
22. ABUHB Code of Conduct for Contractors
23. Electricity Regulations
24. Dementia Friendly Environment requirements
25. Asbestos Regulations
26. Water management and Legionellae
27. Any requirement relating to Accommodation Utilisation (ASUG)
28. Any specific departmental or clinical guidance or standards that apply.
29. NHS Wales Infrastructure Investment Guidance.

3.4 Design Sign-off

An agreed date for design data cut off must be agreed by all relevant parties under the guidance of the PM. The design and any derogation from standards must be signed off by service user and ABUHB PM/PD prior to tender.

3.5 Design Team

The design team is responsible for the technical content of the design. The service and/or technical project manager has authority over the design team in matters of design management.
The design team will operate under a principal designer if appointed. If a principal designer is not appointed this role will be discharged by the Technical PM (ABUHB Estates).

The following factors must be considered and their impact on design and cost of the project evaluated:

- Integrity of brief is maintained throughout process i.e. freeze the brief as soon as is reasonably practicable.
- Design process is held to budget and programme. Advise ABUHB lead Project Manager/Project Director of any design development issues which will attract more fees
- For all PTEs exceeding £25k each firms should be contacted via a preliminary invitation to tender letter
- Ensure a fit for purpose design – taking into account patient needs/aesthetics/DDA/ longevity of products costs in use/life cycle costings.
- Review the requirement for art works to be incorporated into the project to enhance the patient experience and healing process (1% works cost).
- Consider any landscaping issues in depth/flood consequences with Environment Agency
- Consider an in depth traffic impact and environmental study if required.
- Revisit all issues as mentioned/listed in the feasibility section and further investigate their impact on design and cost of the project.

- Carry out a destructive pre-demolition asbestos survey if the building/site permits to further advise the business case. This may not be possible and in which case a contingency/P. sum needs to be considered to inform costs. Sometimes "hybrid" surveys are required in occupied areas.
- The selected contractor is required to present the proposed construction phase programme to the Principal Designer for approval prior to the award of tenders.
- The design should sufficiently detail the requirements of the ABUHB to enable a tender to be drawn up and costs to be apportioned to the works in question.
- The design and any derogation from standards are signed off by service user and ABUHB Project Manager/Project Director prior to tender.
- Prior to the construction phase a pre-construction H & S plan needs to be drawn up if the scheme attracts CDM compliance.
- The final design is to be subject to approval/design check by the ABUHB Divisional Director of Facilities or his delegated Estate representative.
- For major projects the design team will normally present the final design to the Divisional Director Facilities and/or his representatives prior to tender.
- All consultant/internal fees are to be monitored throughout the design process by the Project Manager (external/internal).
- Procurement strategy to be revisited and changed/checked as necessary.
- Room relationships to be checked for compliance with standards.
- Consider any cooling requirements in line with HTM's and ABUHB policy.
- Consultants to ensure update of data sheets during the construction phase to enable their use in the commissioning process.
- Prepare a more detailed outline programme of works with anticipated contract period.
- Prepare a detailed cost plan and update costed risk log.
- Hold regular project team and design team meetings to establish the scheme detail and minute matters arising. Enhanced membership may be required at this stage.
- Ensure consultation with and sign off from Infection Control.
- Ensure consultation with and sign off from Safety Services if deemed appropriate.
- Designer risk assessment to be fully developed within this stage.
- Formulation of a derogation register (if required) enhanced from feasibility stage.
- Full engagement required from procurement partners .
- Re-consult with statutory undertakers i.e. Environment agency, Highways LA, Planning, Building Regulations, Carbon Trust .
- Equipment strategy to be signed up by PD/PM on behalf of users and NWSSP – Procurement Services.
- Calculate any VAT reclaims/claw backs.
- Consider capital charges with Head of Capital Finance.
- Re-consider costs in use/revenue/service/contracts.
- Sign off Certificate to Proceed to Tender Divisional Director Estates /Capital Project Manager (Annex 18).
- Cost and progress reports are issued at suitable intervals with a minimum of one at mid stage and one at stage completion preference will be monthly.
- For Welsh Government funded projects BREEAM and AEDET assessments will be required.

3.6 Traditional Approach

The design team (internal or external) is responsible for the technical content of the design.

The Project Manager has authority over the design team in matters of design management.

The cost estimate produced by the QS must be regularly updated as the design is progressed, preference monthly.

The Principal Designer (normally Project Manager/Architect/Engineering Consultant) or ABUHB Technical PM (if no PD appointed) is to ensure all service requirements for the design are

coordinated throughout the process and must ensure all large major equipment requirements are noted.

3.7 Fast Track Design Strategies i.e. Design & Build

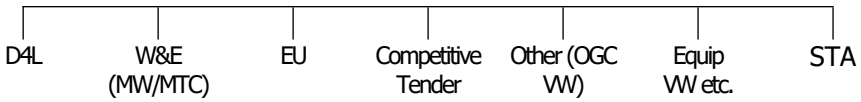
Consideration can be given to allow the contractor to design and build the whole project. The Project Manager and Project Director or professional adviser should assess the suitability of the contractor's design and scrutinise all clarifications as they are submitted.

4 Tender Stage – Katy to review whole of section 4

4.1 Tendering Capital Works Packages and Consultants

Tendering for schemes is to be carried out in accordance with the ABUHB Standing Financial Instructions and the guidance set out in Annex 16.

The procurement route will be dependent on scheme value and complexity, options as follows:



It is to be noted that some of these frameworks are not currently in place and there is an expectation that discussion will take place with the Head of Procurement/Divisional Director of Estates as required.

4.2 Designed for Life (D4L) (see Annex 16)

National Frameworks are currently being updated and current advice should be followed at the project initiation.

4.3 Works & Estates Local Framework for Contractors (Minor/Major Works)

This covers the appointment of Contractors (Local specialist framework)

A new Framework is to be advertised via the Buy4Wales website via NWSSP–Procurement Services.

Contractors invited to tender shall be vetted financially and in relation to professional competence by Procurement via Buy4Wales.

Contractors not registered on Sell for Wales will not be considered for any invites to tender for Capital works under this procurement route.

Contract will operate for three years with Annual Evaluation to ensure Value for Money and Quality of Performance.

Individual Maximum Order Values to be a maximum of:

5. **Building:** <£25 direct award to any of the MTC contractors,>25k – 50k 3 quotes off any 3 MTC contractors, >£50k All MTC contractors invited to quote.
6. **Electrical:** <£25 direct award to any of the MTC contractors,>25k – 50k 3 quotes off any 3 MTC contractors, >£50k All MTC contractors invited to quote.
7. **Mechanical:** <£25 direct award to any of the MTC contractors,>25k – 50k 3 quotes off any 3 MTC contractors, >£50k All MTC contractors invited to quote.
8. **Flooring/Decoration/Ceilings**: <£25 direct award to any of the MTC contractor,>25k – 50k 3 quotes off any 3 MTC contractors, >£50k All MTC contractors invited to quote.

Running Schedule of MTC Schemes each financial year to be maintained for Building, Mechanical, Electrical, Decorating, Floor Coverings and Suspended Ceilings to ensure individual packages fall within financial limits and aggregated sum does not exceed the agreed threshold

MTC Quantity Surveyor to be appointed for the duration of the framework to monitor value for money and manage the MTC contracts. Monitoring of the contract and selection of the QS will be via Value Wales.

4.4 EU

This is covered by Designed for Life (D4L).

4.5 Traditional Competitive Tendering

4.5.1 Traditional Route via Approved Contractor List

Traditional tendering process remains an option for procurement of Works & Estates Capital Works, this to include a select list of contractors that have been previously vetted for competence and capability. Every effort will be made to maintain and update the approved list on a yearly basis.

Rotation of the list to be monitored by Divisional Director Estates or delegated representative. Head of Works & Estates to select 50% of tender invites remaining 50% to be selected by Project Manager/Technical Project Manager.

Note values contained in this section as follows:

- < £5,000 (Excluding VAT) - 1 **Written Quotation**
- £5,000-£25,000 (Excluding VAT) - Minimum 3 **Written Quotations** to be returned to the Corporate Service manager
- £25K to £1M Minimum - **4 Competitive Tenders** returned to the Chief Executive
- £1M to £4M Minimum - **6 Competitive Tenders** returned to the Chief Executive

Note 1
Consent for contracts exceeding £1 million is exercised directly by the Director General. However, contracts entered into under the All Wales Capital Programme are not covered by this requirement. The application and approval procedures for All Wales Capital Programme activity already embed arrangements for Welsh Ministers consent into the overall project approval process.
Additional monitoring arrangements are in place for contracts that fall below £1million. The following process and information requirement is as follows:
(I) For individual contracts with a value exceeding £500,000 and up to £1,000,000, a contract summary form should be provided for review prior to entering into the contract. It is not necessary to obtain consent to enter into such contracts, however adequate information and time should be given for the Director General to review the contract particulars.
(ii) For individual contracts with a value exceeding £250,000 and up to £500,000 a list of contracts let in the preceding 6 months is to be provided.

Note 2 Competitive Tendering Procedures will not be required when the Health Board has legitimate access to Framework Agreements. Mini Competition may still be required for any framework contractor appointment.

Note 3 For all contracts > £25000 The Health Board should take account of social, economic and environmental issues when making procurement decisions. (Local Labour)

4.5.2 Value Wales Competitive Route

The requirements to follow under this particular procurement route will be to advertise the project on Buy4Wales via Service Contract Manager Works & Estates. Invitations will then in turn be advertised for people on Sell4Wales. A prequalification questionnaire will then be sent out to the applicants requested to carry out the works, this questionnaire will then be used to select 4/6 for competitive tender via traditional specification and drawings.

4.5.3 Others (OGC Buying Agency Etc.)

Use of Pre-Tendered Contracts for the purchase of:

- Equipment
- Services
- Consultancies
- Legal Services
- Utilities
- Other Government Frameworks for Public Bodies applicable for works in question.

4.6 Equipment (See in addition Main Document Section 9)

European Public Contracts Directive 2004 to apply. Consult Head of Procurement/Capital Equipping.

4.7 All Wales Framework - Specialist Service Contracts

To be the responsibility of the Service User Department or Works & Estates Service Contract lead dependent on who holds the budget. Monitoring of service contracts to be done via Procurement/ Shared Services.

4.8 Single Tender Action

Single Tender action should be the exception and should only be called for when a single firm or contractor or proprietary item or service of a special character is required and set out in law. Single tender action should only be employed following Procurement Guidance on Single Tender and Quotation Approval Process.

Where an end user identifies a need for a Single Tender action, or single quotation action, the following process should be undertaken. This process ensures compliance with the following Policies, which are available on the Intranet: ***Organisation Policies: Standing Orders/Standing Financial Instructions***

End user identifies need for a Single tender/quotation action, in line with tender/quotation limits set out in above Organisation Policies

↓

End user prepares business case for goods/services in normal manner

↓

End user seeks approval for finances in normal manner, via Directorate Management or Finance Management Group (FMG)

↓

End user writes to Head of Procurement requesting formal approval to carry out a single tender/quotation action, in line with above Organisation Policies (draft example attached). This memo must state the reasons justifying need to go to one supplier only. A copy of the original business case and a copy of formal approval of finances should be attached

↓

Head of Procurement will forward to Chief Executive advising of Procurement issues, procurement law and Procurement rules and regulations surround the request

↓

Chief Executive will write back to end user authorising, or not authorising, a single tender/quotation action

↓

End user provides copy of final Chief Executive approval to Head of Procurement, who will arrange for single tender/quotation to be issued by relevant section with Procurement Services Department, if action has been agreed

4.9 Key considerations at tender stage:

Carry out a final review of Pre Tender Estimate (PTE), and update Proforma' Annex 17 & 18.

Drawings and specifications as appropriate should be prepared by the design team under direction of the Project Manager/Principal Designer

Concode should be used as a guide. The Project Manager/ Principal Designer to advise the Project Director of the contract type best suited to the works in question.

For traditional contracts the drawings and spec must be complete and comprehensive enough to reflect requirements.

For design and build, performance specifications can be prepared, where performance criteria, standards and quality issues and basic layout/room relationships/data sheets/ schedule of accommodation are included as basic criteria for issue to the contractor for tendering against.

Specification should ask for samples and maybe mock ups to ensure compliance with specification and workmanship requirements.

The Project Manager to ensure propriety is maintained at all stages and all contracts must comply with all Welsh Government Policies relating to the NHS.

A bona fide form/certificate of non-collusion is to be prepared at tender stage and sent out with the contract documents (see Annex 17)

ABUHB Code of Conduct for Contractors to be included with the document.

ABUHB technical design brief to be included in the specification build up for the scheme if deemed appropriate.

Day work sheets proforma to be included with the document.

Ensure a subcontractor selection proforma sheet is also included within the specification although it is recognised that this can be varied by the contractor.

If possible ensure that the pre-construction Destructive Asbestos Survey is included as part of the package if the main contractor is to be responsible for this aspect of the work. This is sometimes carried out by others prior to the contractor engagement.

Ensure there is a priced Summary Sheet attached to the specification to be completed by the contractor.

Ensure there is a Collection Sheet included in the documentation to be completed by the contractor.

Ensure the proforma for compliance issues are included within the document for:

- Water Management Issues
- Electrical Certificates
- Equipment Schedules
- Medical Gas Schedules
- Fire Strategy Updates
- Air Conditioning Schedules

Ensure a unique reference number is created for the scheme and is logged in a register for quotations or tender.

Ensure all return documentation is in return envelopes provided with the scheme appropriately reference by number and pre-addressed to:

- Corporate Service manager for quotations £5k - £25k +VAT
- Chief Executive for tenders above £25k +VAT
- Mini-comp to be returned to the Cost Consultant or PM engaged at the time of the commission for measured term

Designer risk assessments are produced for all aspects of the works.

A pre-construction phase H & S plan is prepared for inclusion with the package by the Project Manager/Principal Designer.

Ensure the Project Execution plan is updated in a timely manner if required.

Ensure all ICT issues are covered off and included with the package either as a Provisional Sum if tendered separately by ICT or as a complete package with a specification written by ABUHB ICT department.

Ensure selection of tenderers from ABUHB Approved Lists, appropriate frameworks, advertise on Value Wales Site etc. This may involve inviting firms to pre-qualify and draw up a tender list of these firms able to meet requirements of the Health Board. Equifax or equivalent checks on all contractors and consultants to be carried out prior to any appointment.

Should the requisite number of tenderers not be available due to market conditions or professional constraints the Chief Executive or designated deputy shall be authorised to accept a lower number of tenderers. Where the number of tenders received is insufficient to demonstrate adequate competition, a tender evaluation report will be prepared:

- Assessing the reasons why the full number of tenders were not received;
- Assessing the impact on project costs, compared with any pre-tender estimate (i.e. does the returned tender provide adequate value for money in line with prior expectations); and
- Requesting approval to accept the tender from the Chief Executive or designated deputy. In accordance with Capital Procedures.

Tenderers to be advised that costs are not recoverable from the Health Board unless substantial costs are incurred on some large design and build contracts. This would be by prior arrangement with the contractors.

Companies to be invited by letter to tender for works as per Health Board standard letter of invite for work costing £25k and above. (This excludes Measured Term Contractors)

Tender periods to be sufficient to enable contractors to tender the works, all dependent on type of contract and programme to complete the works. Design and build to be given an extended tender period to be confirmed by Project Manager. The normal tender period shall be 4 weeks.

Tender documents should specify criteria to be used in the assessment. If lowest tender is not recommended the reasons must be justified and carefully recorded.

See notes in Section 4.5.1 for contract approval requirements.

Notify Chief Executive of tender returns or EMT Admin Manager of quotation returns. Complete with reference number, date of return and pre-tender estimate of the works. (Annex 20)

The Tender Register is maintained by the ABUHB Board Secretary.

4.11 Return of Tenders

This does not include Mini-Comp or Measure Term Contracts.

Return of tenders/quotes to be logged in tender/quotation register with time deposited and amount.
Retain all return envelopes on file with tender/quotation returns.

Advise contractors that payment will be withheld if Health and Safety Files and O&M's are not supplied at handover. Contractors will be advised that the H & S Executive will be advised of any misdemeanours relating to the non-production of these documents.

All tenders must be returned in document envelope provided for on invite of the works.

Extensions of time are not normally granted but may be in exceptional circumstances and where the number of returned tenders may be reduced if not granted. All tenderers to be advised in writing if this is the case.

All tenders to be stored in safe custody prior to opening.

Carry out a tender evaluation exercise on return of tenders
Award of tender can be based on Evaluation Criteria rather than lowest price. This is to be supported by a 'Tender Report and Recommendation' by the Project Manager (PM) setting out the decision-making process and conclusion of the evaluation process.
Tender assessment should be sent to the Project Director to include issues of compliance technical content programme, prices and resources.

For complex projects tenderers can be asked to complete a method statement for the intended works.

The selected contractor is required to present the proposed construction phase programme to the Principal Designer for approval prior to the award of tenders.

Tender documents should specify criteria to be used in the assessment. If lowest tender is not recommended the reasons must be justified and carefully recorded in the form of a Tender Report and Recommendation.

'Results of tenders' and/or where appropriate, 'Tender Report and Recommendation' to be submitted to the Project Director whom will review and instruct to proceed to award contract

Post tender negotiations are permissible (usually with the two lowest tenderers)

Valve Engineering (VE) may be required at this stage to enable the scheme to proceed.

Ensure the construction phase plan is embraced by contractor at this stage. Assuming funding is in place and matched against the business case the Project Director will give an instruction to award the contract.
When all complete award contract and execute the contract.

- Under hand is less than £500k
- Under seal over £500k.

If smaller forms of contract are used the Project Director or Project Manager may sign on behalf of the Health Board i.e. JAC 90's JCT Minor Works forms of contract.

All unsuccessful and successful contractors are to be notified of contract award and sent the results of the tender in alphabetical and numerical order. This included Mini-comps.

Update the PEP – if required (Annex14) at this stage. (Projects over £1m)

Ensure contract/specification and drawings are stored in the Health Boards safe for safe keeping and for latent defect period usually 12 months unless the contract is executed as a deed.

Normally contracts above £25k should attract the need for a pre-contract meeting to be held.

Membership of the Pre-contract meeting should include:

- Principal Designer
- Project Manager
- Clerk of Works/Site Engineer
- Ops and Maintenance Representative
- User Department Representative
- Facilities Manager
- Principal Contractor and sub-contractors as required.
- Design Team
- Fire Officer - part only
- Infection Control - part only
- Health and Safety.

Pre-Contract Agenda – Notwithstanding the below requirements the contract agenda ANNEX 24 should be adopted.

Ensure a project directory is produced at this stage by Project Manager. Other relevant documentation at this stage to be completed/received:

1. Any parent/company guarantees (where appropriate)
2. Contractors current insurance details (to remain on agenda as standard item for duration of contract)
3. F10 notice issued (where appropriate to HSE)
4. Contractors H & S policy
5. Inland Revenue tax deduction certificate

6. Any risk assessments and method statements specific to the works

Nomination of contractors is not normally permitted under any contract. Naming is however permissible under the JCT Intermediate Form of Contract. An official order must be placed on the contractor for completion of the intended works via an Oracle order.
Normally no work is to be started until the order is set up and approved.

4.12 Tender analysis

A number of measures are in place to reduce the risk of bid rigging and anti-competitive behaviour. Following the OFT report into Collusion and Cover pricing Capital Audit reviewed the existing procedural framework against the best practice guidance issued as consequence of the report, aimed at reducing the risk of bid rigging/ anti-competitive behaviour between contractors.

The audit acknowledged the existing good practice in that the Health Board's procedures were generally in accordance with the best practice but recommended a number of specific actions. This table provides background information and sets out the actions required

Recommendation	Action required	Responsibility
Formal instructions on how to proceed if an insufficient number of tenders are returned within a tender exercise.	Section 4.11 of this annex	Responsible Estates Officer to submit request to Project Director/Chief Executive
Procedure for obtaining feedback from non-bidders and implement a log of feedback to inform future tender exercises.	The Divisional Director Estates or his representative will write to all – non-bidders to establish their reasons for not bidding	HWE Responsible Estates Officer/PM
Database of past and current bid results. Mechanism to analyse tender returns and identify any patterns or unusual behaviour that could show collusion.	Start data collection Agree analysis process and provide periodic reports.	Business Partner Accountant/Capital Finance BPA/Head of Capital Finance
Formal contractor rotation	To be implemented within the limits of existing frameworks with advice from Head of Procurement Annual Tender report	Divisional Director Estates Head of Capital Planning
Certificate on Non-Collusion for external consultants.	Annex 19	Divisional Director Estates
Guidance and Training in identification of bid-rigging.	Design and implement Request Audit assistance	Head of Capital Planning

Pre-Tender Estimate - V - Actual Tender Return Review:
Pre-Tender Estimates should be within 10% of the tender return. Any variance to this should be justified with narrative. This can be through the Tender Report and recommendation, or for minor schemes by means of a simple narrative beneath the tender/quotation Proforma.

5 Construction Phase

5.1 Contract Period

A capital cost code is to be issued by Head of Capital Finance to endorse the expenditure against the scheme.

The Project Manager to advise the Project Director of all issues as the contract proceeds.
Any material change to the intended works is to be advised to the Project Director by the Project Manager in accordance to the change control procedure (see Appendix 22). The proforma to indicate the reason for design change, cost implications and programme implications.

The Project Manager (with appropriate support from the Technical PM etc.) is responsible for contract cost control and is responsible to the Project Director.

The Project Manager must:

- Ensure regular monthly site meetings to take place chaired by Project Manager (meeting to have minutes taken). For complex projects a weekly meeting should be considered with mandatory attendance by contractor and design team.
- Ensure regular internal Project Team meetings are held monthly or fortnightly (subject to the complexity of the project) to inform the user department of any issues/ progress etc.
- Ensure works are executed within the approved contract sum.
- Ensure that the risk log is reviewed at each internal project team meeting.
- Report on a monthly basis of cost profile for the project
- Monitor programme and any delays to be reported through to the Project Director. (This needs to be escalated to the Capital Planning Team.)
- Ensure the liquidated damages amount is entered onto the contract documents prior to signature. This is to be calculated as to the expected loss incurred income for the Health Board for non-completion of the works.
- Issue Architects instructions/variations as appropriate to cover off:
    - Contingency variations (unforeseen)
    - Service side variations (charge control process)
    - Design variations (expenditure of any PS.Sums and PC.Sums etc.)
    - Contractor variations (cost saving proposals)

All variations must always be priced where possible. Approximate costs can be included and adjusted at a later date i.e. at final account. All variation orders to be retained on file for audit.

During the construction period the contractor is to advise on progress regarding the programme of works and must send valuation of works complete monthly to QS/Technical Project Manager. Monthly certificates for works completed and valued for all capital projects are to be prepared either by the consultant QS or the Project Manager (tech) for the scheme. Invoices are required to be paid in line with the contract provisions. All invoices to be sent to accounts payable. Monthly valuations/invoices to be recorded by the Project Manager and Technical Project Manager and receipted to work certified on the monthly payment certificate certified by the external QS or Project Manager.

Where the individual order value is exceeded there will be a need to raise a new Oracle order/ submit a further requisition for approval to increase the original order.

Consultant fees are generally VAT reclaimable and payable on design work completed.

A schedule of payments made to each consultant and contractor shall be recorded and maintained by the PM within the project file.

Contractor and consultant performance to be monitored through using a KPI Proforma.

5.2 Insolvency

On hearing of impending insolvency, the Technical Project Manager should contact the Director of Finance or a designated deputy. The Director of Finance may elect to carry out a financial check or call in the Directors of the company concerned to explain their position. The issue must be kept confidential.

When it is evident that there is an issue the Architect and QS must be notified by Project Manager/Project Director. Sites should be secured so items on site can be valued by a third party.

Any payments due should be cancelled. The Technical Project Manager must ask the QS for a financial statement of works complete and materials stored on site in the ownership of the Health Board identified. The Project Manager to inform the liquidator/receiver that he will be filing a claim as an unsecured creditor of the company (in liquidation).

Replacement contractors shall be appointed as soon as possible to avoid unnecessary disruption and delay. Compensation from performance bonds is sought and the receivers are informed of any claim outstanding again the contractor.

5.3 Claims and Counter Claims

Working with the External Project Manager/Technical Project Manager/Project Manager will ensure:

- Any claims made are valid.
- All claims are in writing referencing the relevant contract clause.
- Claims are investigated to ensure that they are not covered by an insurance provision.
- Claims to be numbered in sequence for record keeping.
- The QS and Project Manager (external/tech) to examine the claims and make a judgement whether they are deemed valid or not.

5.4 Liquidated and Ascertained Damages (LAD)

It is important that the Technical Project Manager adheres to the relevant contractual requirements when considering whether or not to invoke LAD's against a contractor. In many cases it is questionable whether the UHB can demonstrate financial loss as a result of delay to a contract and this needs to be carefully considered when any action is proposed.

If applicable LADs will be recoverable from a contractor if that contractor fails to complete the contract works, or a section of the work, by the date set out in the contract (as amended by any extension of time awarded by the Project Manager) and the Project Manager certifies that completion has not been achieved by the due date. The Technical Project Manager must ensure that LAD calculations are calculated using the recommended formula within the contract or calculated on actual demonstrable proven loss.

This is outlined in the JCT Standard Form of Building Contract as an example. This may vary with other Forms of Contract as selected.

The procedure for recovery of LAD is at the discretion of the Health Board and damages should be recovered following receipt of a certificate issued by the Project Manager/Architect unless otherwise agreed. Once the decision to apply the LAD clause has been taken, the following points must be complied with before the Project Manager/Architect can legitimately seek recovery:

- A Certificate of Non-Completion has been issued stating that completion has not been achieved by the contract date.

- The Technical Project Manager /Architect has written to the contractor stating that LAD is payable under the terms of the contract. This notice should also inform the contractor of the date from which LAD will be recovered and the amount due at the date of notice. Before any subsequent recovery of LAD can be recovered under the contract, a new notice will need to be issued to the contractor.

The Technical Project Manager should carefully consider the effect of any revision to the completion date of the works following the recovery of LAD as this may require the Health Board to refund part or whole of the amount to the contractor.

5.6 Extension 0f Time

Most forms of contract selected will set out the detailed procedures for the claiming and granting of an extension of time for completion of the works and lists the grounds on which an extension of time may be granted.

The Technical Project Manager will be the responsible person for ensuring that all delays whether they are due to inclement weather or delays occasioned by the contractor, subcontractors or the Health Board are formally recorded. Such delays must have fully documented reasons for their occurrence before a decision can be taken whether or not to grant an extension of time. Cardiff Regional Weather Centre to be referenced as a baseline for weather related issues. This needs to be stated within the contract.

The Technical Project Manager shall seek the agreement of the Project Director before any extension of time is granted to the contractor. This shall be embodied in a Notification of Revision to Completion Date being issued to the contractor.

5.7 Practical Completion Handover Meeting

The Technical Project Manager should arrange handover meetings for individual capital projects to take place. The composition of the meetings will vary according to the size and complexity of the project.

At handover meetings inspections shall be made of the facilities and the Project Manager shall be responsible for ensuring that the project has been completed satisfactorily and in accordance with the design intent. The Technical Project Manager, on behalf of the Health Board, formally accepts the project as being practically complete.

Operation and Maintenance Manuals (O & M Manuals):
For larger and/or complex projects, a full and comprehensive O&M Manual is to be completed by the contractor.
Notwithstanding the requirements below, the contractor will supply 2 electronic and 1 hard copy document to the Health Board. This document is to be delivered as an integral part of the Handover meeting/process, subject to agreement of the Project Manager certain elements can be deferred to an agreed date. Failure of receipt of these documents may delay 'handover acceptance'. The (external when commissioned) Technical Project Manager will ensure that the contractor will include the following (albeit not exhaustive and subject to scheme specific requirements) in the O & M Manuals:

- final "as built" record drawings are provided as two "hard" copies, and two copies on disc, compatible with AutoCAD 2008 (later updates accepted subject to Project Manager agreement). One set of the documentation are to be deposited with the Estate Management Department. The second set of manuals deposited with the Technical Project Manager. The relevant commissioning certificates are to include at handover:

- Electrical Certificates inc. Emergency lighting and Fire alarms
- Lift Commissioning

- Water Chlorination Certificates
- Asbestos Clearance Certificates
- Air Conditioning Certificates
- Medical Gas Certificates
- Building Regulations Completion Certificate
- Nurse Call systems certificates
- Fire Door Certificates
- 3rd party Fire compartmentation accreditation Certificates

For New Builds include all of the above plus if applicable:

- Air tightness certificate
- Energy performance certificates
- Planning/Building Control certificate
- BREEAM
- AEDET
- Secure by Design

These must all be witnessed by an ABUHB representative and must be available at handover. The Contractor must also prepare a Health and Safety file for handing over to the Technical Project Manager.

The Technical Project Manager will then advise the Project Director and issue the contractor with a Certificate of Practical Completion (subject to any defects/incomplete items being corrected within a specified period of time - see Annex 21).

A copy of the Certificate of Practical Completion shall be retained with the contract documents in the project folder for audit purposes.

The penultimate interim Certificate shall be issued by the Technical Project Manager authorising payment to the contractor once the Certificate of Practical Completion is issued (less 50% retention sums held).

Defects/snagging: A schedule of defects is to be developed for snagging/defect items. This schedule should identify:

- Date of defect identification
- Date sent to Contractor
- Date contractor advised to complete
- Date of completion.

This schedule is to be integrated within the practical completion certificate.

5.8 Final Accounts

It is important that final accounts are agreed with the contractor and paid promptly within any time limit set by the particular conditions of contract.

Once the Certificate of Practical Completion has been issued there is no reason why the QS/ Technical Project Manager should not draw up and agree the content of the final account with the contractor. The Technical Project Manager will consult with the Head of Capital Finance on the timing of final accounts but will be bound by the terms of the contract.

As soon as the final account has been agreed and verified the documentation should be forwarded to the Project Director for action/sanctioning.

5.9 Defects Period

Any defects raised within the building with regards to plant, equipment or the building infrastructure from practical completion shall be reported through the Works & Estates Helpdesk for the attention of the relevant Technical Project Manager for the scheme.

A defects schedule shall be maintained for all schemes.

A Making Good of Defects Certificate to be completed at the end of 12 months with an accompanying list of outstanding defects to be issued two weeks prior to the defects period end date.

The Technical Project Manager shall call an end of defects period meeting no later than 12 months after the Certificate of Practical Completion has been issued.

It is the responsibility of the Technical Project Manager to co-ordinate any legitimate defects of workmanship for passing onto the contractor for correction under the terms of the contract.

Once the Technical Project Manager is satisfied that all the defects have been corrected he will advise the Project Director and issue the contractor with the End of Defects Certificate.

The Technical Project Manager will then issue the final valuation releasing any outstanding retention money.

A copy of the end of Defects Certificate shall be retained with the project/contract file.

5.10 Post Contract Review and Evaluation

This is covered in detail in section 8.2 of the main Procedure document.

5.10.1 Post Contract Contractor Evaluation

An evaluation of the Contractor's performance shall be undertaken on those projects over £500k and used to inform the future selection process.

A "Reporting of Contractor's Performance" form should be completed and submitted for examination by the Divisional Director Estates or his representative.

5.10.2 Post Contract Consultant Evaluation

The evaluation of consultant's performance shall be undertaken on all projects and used to inform the future selection process and the Divisional Director Estates informed.

For such projects the Technical Project Manager shall undertake the evaluation to establish how well the consultant performed against clinical and financial objectives.

5.10.3 Lessons Learnt

The UHB may require an informal Lessons learnt exercise examining elements of the whole project from the initial mandate to the delivery of Benefits. This would normally be facilitated by a third party not previously involved in the project.

5.10.4 Post Project Evaluation

The evaluation should include:

i. The extent to which the original objectives have been met and benefits delivered.
ii. The cost of the project and the extent to which it can demonstrate value for money.

iii. The Project outcome compared with the 'do nothing' or 'do minimum' scenarios.
iv. The economic viability of the project in comparison with the do-nothing option
v. Risk Allocation
vi. Timetable
vii. Functional suitability
viii. Functional relationships
ix. Recommended changes to the project and business case functions
x. User satisfaction
xi. Procurement route

ANEURIN BEVAN UNIVERSITY HEALTH BOARD
CAPITAL PROCEDURES
Annex 16

DESIGNED FOR LIFE 3

At present the 3rd generation NHS frameworks have been extended to run until April 2024 when the new Framework is expected to be introduced.
The New Framework will have 2 lots and thresholds have been revised as follows:

- Lot 1 Projects £20 million plus
- Lot 2 Projects between £7million – £10 million

Should you require to progress a project prior to April 2024, NWSSP-SES advise to use the current Framework below until notified.

Specialist Estates Services Notification 17/07 09 November 2017

For action by:
Chief Executives, NHS Health Boards and Trusts
Directors of Planning, NHS Health Boards and Trusts
For information only:
Copy to: Head of Capital, Estates and Facilities,

Dear Colleague
Please note that the Designed for Life Building for Wales construction and consultant frameworks for major capital projects in excess of £4 million ceased at the start of October 2017. The replacement for these frameworks is now programmed to be operational at the start of February 2018.
Should Health Boards/Trusts need to progress capital projects utilising construction and consultant frameworks until such time as the new frameworks are available, I would be grateful if you could contact Andrew Waddington, Head of Designed for Life Building for Wales onAndrew.Waddington@wales.nhs.uk.
It has been established that alternative frameworks may be utilised by Health Boards and Trusts , dependent upon the requirements, may include the National Procurement Service (Property) frameworks, SEWSCAP2 framework, SCAPE framework or Pagabo framework.
Yours sincerely,
NH Davies BSc (Hons), Dip Proj Man (RICS), MBA, MCIOB, FIHEEM
Director Specialist Estates Services
NWSSP Specialist Estates Services, 3rd Floor, Companies House, Crown Way, C

Framework Email Contacts:

- Andrew Waddington - *(Andrew.Waddington@wales.nhs.uk)*
- Jonathan Simcock - *(Jonathon.Symcock@wales.nhs.uk)*
- Jonathan Jones - *(Jonathon.Jones5@wales.nhs.uk)*
- Thomas Kuehn - *(Thomas.Kuehn @wales.nhs.uk)*

ANEURIN BEVAN UNIVERSITY HEALTH BOARD
CAPITAL PROCEDURES
WORKS AND ESTATE
ANNEX 17

CERTIFICATE OF DESIGN SIGN OFF AND READINESS TO PROCEED TO TENDER

SCHEME: _____

Aneurin Bevan Health Board is satisfied that this scheme has been prepared in accordance with the Health Boards capital schemes procedures and that all reasonable steps have been taken to ensure that once the contract is let the scheme should be able to proceed to completion without delay. In particular, the Health Board is satisfied that:

- The Design Brief was frozen at the appropriate stage and will not be altered during the course of the contract other than in exceptional circumstances.
- The design reflects fully the aspirations of the Head of Dept/PM and meets user briefing all aspects.
- The scheme has been designed within budget.
- There are no causes of delay currently foreseeable.
- Tender documentation etc. is consistent with and fully reflects the general production information to be provided to the Contractor. There is a feasible programme for the supply of any production material not available at tender stage and the Health Board has taken account of these factors in its assessment of the degree of readiness for the scheme.
- The Health Board has been assured by the Design Team and is satisfied that to the best of its knowledge and belief the design complies generally with the Building Regulations and with Codes of Practice including Health Service Standards and British Standards Specifications and where appropriate Design Certificates have been obtained.
- Capital Resources will be available to build and commission the scheme according to programme and to operate the planned services.

- Pre-tender Estimate: £ …….. Inclusive of VAT

  Allocate to proceed to tender ☐

Signed for and on behalf of the Health Board

Lead Designer
Signature: _____ Name: _____

Designation: _____ Date: _____

Project Manager
Signature: _____ Name: _____

Designation: _____ Date: _____

Project Director
Signature: _____ Name: _____

Designation: _____ Date: _____

ANEURIN BEVAN UNIVERSITY HEALTH BOARD
CAPITAL PROCEDURES
WORKS AND ESTATE
ANNEX 18

CERTIFICATE OF READINESS TO PROCEED TO TENDER

SCHEME: _____

Aneurin Bevan Health Board is satisfied that this scheme has been prepared in accordance with the Health Boards capital schemes procedures and that all reasonable steps have been taken to ensure that once the contract is let the scheme should be able to proceed to completion without delay. In particular, the Health Board is satisfied that:

- The Design Brief was frozen at the appropriate stage and will not be altered during the course of the contract other than in exceptional circumstances.

- The scheme has been designed within budget
  AND
  There are no causes of delay currently foreseeable

- Tender documentation etc. is consistent with and fully reflects the general production information to be provided to the Contractor. There is a feasible programme for the supply of any production material not available at tender stage and the Health Board has taken account of these factors in its assessment of the degree of readiness for the scheme.

- The Health Board has been assured by the Design Team and is satisfied that to the best
  of its knowledge and belief the design complies generally with the Building Regulations and with Codes of Practice including Health Service Standards and British Standards Specifications and where appropriate Design Certificates have been obtained.

- Capital Resources will be available to build and commission the scheme according to programme and to operate the planned services.

- Pre-tender Estimate: £ ……..inclusive of VAT

Signed for and on behalf of the Health Board
Lead Designer
Signature: _____ Name: _____

Designation: _____ Date: _____

Project Manager
Signature: _____ Name: _____

Designation: _____ Date: _____

Project Director
Signature: _____ Name: _____

Designation: _____ Date: _____

ANEURIN BEVAN UNIVERSITY HEALTH BOARD
CAPITAL PROCEDURES
WORKS AND ESTATE
ANNEX 19

CERTIFICATE OF NON-COLLUSION

PREMISES:

SCHEME:

TENDER RETURNABLE:

The essence of selective tendering is that the Employer shall receive bona fide competitive tenders from all those tendering. In recognition of this principle we certify that this is a bona fide tender, intended to be competitive, and that we have not fixed or adjusted the amount the amount of the tender by or under or in accordance with any agreement or arrangement with any other person. We also certify that we have not done and we undertake that we will not do at any time before the hour and date specified for the return of this tender any of the following acts:

A. communicating to a person other than the person calling for these tenders the amount or approximate amount of the proposed tender, except where the disclosure, in confidence, of the approximate amount of the tender was necessary to obtain insurance premium quotations required for the preparation of the tender;

B. entering into any agreement or arrangement with any other person that he shall refrain from tendering or as to the amount of any tender to be submitted;

C. offering or paying or giving or agreeing to pay or give any sum of money or valuable consideration directly or indirectly to any person for doing or having done or causing or having caused to be done in relation to other tender or proposed tender for the said work any act or thing of the sort described above.

In this certificate the word "person" includes any persons and anybody or association, corporate or unincorporated; and "any agreement or arrangement" includes any such transaction, formal or informal, and whether legally binding or not.

Signed: _____

On behalf of: _____

Date: _____

THIS FORM MUST BE SIGNED AND RETURNED WITH THE TENDER
ANEURIN BEVAN UNIVERSITY HEALTH BOARD
CAPITAL PROCEDURES
WORKS AND ESTATE
ANNEX 20

AUTHORISATION AND NOTIFICATION OF TENDER

TO: The Chief Executive **REF:**
CAPITAL JOB: **DATE:**

I have today forwarded to the under mentioned list of contractors, invitations to provide tenders for:

Authorisation to proceed to tender stage was approved on ……..
The pre-tender sum for the works is £ ……. Plus VAT.

Signed: _____ Divisional Director Estates or EMT member

Completed tenders are due to be returned to you by NOON ……

Please open these, in accordance to Standing Financial Instructions.

Name of Contractor	Contract Sum	Opened By

Tenders Opened By: _____ Signature _____

Tenders Opened In The Presence Of:

(1) _____ Date of Opening Tender _____

_____ Time of Opening Tender _____

(2) _____ Details of Late Tenders _____

_____

Signature and Designation

ANEURIN BEVAN UNIVERSITY HEALTH BOARD
CAPITAL PROCEDURES
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ANNEX 21

CERTIFICATE OF PRACTICAL COMPLETION OF WORKS

Issued By: Issue Date:

Divisional Director of Estates & Facilities
Management Centre Job Ref:
St. Cadoc's Hospital
Caerleon
NP18 3XQ

Contractor:

Address:

Works:

Situated at:

Contract Dated:

Under the terms of the above mentioned contract, I/we certify that Practical Completion of the Works was achieved on:

Signature: _____

Name (print): _____

Designation: _____ Date: _____

(To be signed by or for the issuer named above)

The Defects Liability Period will therefore end on: ……..

ANEURIN BEVAN UNIVERSITY HEALTH BOARD
CAPITAL PROCEDURES
WORKS AND ESTATE
ANNEX 22

VARIATION CHANGE CONTROL

Change Management Procedure

1.0 Purpose

1.1 This Change Management Procedure establishes how 'Changes' and "Compensation Events" will be proposed, accepted, monitored and controlled by Aneurin Bevan University Health Board (ABUHB). The Change Management Procedure will govern Changes to the Final Project Brief after Client Approval at Full Business Case through to Completion – i.e., Changes to Project Scope, Programme and Cost.

2.0 Procedures for Change Identification

2.1 The Works Information contained in the Stage 4 Contract sets the Client Approved 'baseline'. The Works Information is based on the design submitted as part of the approved Full Business Case or Business Justification Case.

2.2 When a ***Client (Client is identified as an official of the Health Board Trust)*** initiated change to the Client Approved 'baseline' is identified, the Change will be clearly defined using the attached Change Request Form.

2.3 The Requester completes Section 1 of the Change Request Form and submits it to the Project Director / Capital Team for review.

3.0 Procedures for Change Analysis

3.1 The Project Director will need to identify in the Change Request Form if the proposed Change has a time and / or cost impact. The cost impact will need to differentiate between the following:

- Works costs
- Non-works costs
- Equipment
- IT

3.2 At this stage, it is not always possible to quantify the time and / or cost impact. A RAG rating will be applied to identify the potential level of impact for both time and cost.

3.3 On the basis of the Change Analysis, the Project Director will determine if the request is reasonable / viable and decide whether the Change Request merits further consideration by the Project Manager, Cost Advisor, Project Team and /or the Project Board.

4.0 Change Request Approval Procedure

4.1 If the Change Request is considered to be reasonable / potentially viable and if the Change will impact upon the Contract between ABUHB and the Supply Chain Partner, the Project Director will instruct the External Project Manager to raise a Request for Quotation for the Change from the Supply Chain Partner to provide a formal quotation for the time and cost impact of the Change in line with the NEC3 Contract procedures.

4.2 If the Change has no impact on the Contract but does have a potential cost impact, the Change Requestor will need to identify the potential cost consequences.

4.3 Upon receipt of the cost impact the Project Director will assess what level of authority is required to approve the change request in the context of the likelihood that the Change will have to be funded from the approved Project Contingency. The following limits, as set out in ABUHB SFIs, will apply:

- Associate Capital Project Director 25k
- Project Director £50k
- Exec Director / SRO £75k
- CEO / Deputy CEO £100k
- CEO & Chair £500k

4.4 In all instances the Project Team and / or Project Board will be kept informed of the emergence of changes and changes that have been agreed. All changes between £5k and below £25k will be discussed at the Project Team prior to sign off. All changes above £25k will be discussed at the Project Board prior to sign off.

4.5 If the Change is approved, the Project Director, in conjunction with the Project Manager will put measures in place for the appropriate project documentation to be updated and issued.

4.6 The effect on the project contingency will be noted and recorded on the attached Project Control Form and the Change Control Register will be updated.

It should be noted that the above process also needs to be followed for changes that reduce cost and /or propose moving costs from one cost header to another.

5.0 Approval of Compensation Events initiated by the Supply Chain Partner

5.1 This will follow the process as set out in the contract with the SCP and will be managed by the Project Manager in conjunction with the Cost Advisor and Project Director.

5.2 If and when both the Project Manager and the Cost Advisor agree that a Compensation Event is warranted and if and when the cost impact has been agreed with the SCP the Project Director will be required to sign off the attached Project Control Form.

5.3 The Project Director has delegated authority for sign off up to £50,000. For values above that the Health Board Scheme of Delegation, as outlined above, will need to be followed.

5.4 In this context the Project Team and Project Board will need to be kept informed of the approved Compensation Events and the effect on the project contingency.

It should be noted that the above process also needs to be followed for CEs that reduce cost and /or propose moving costs from one cost header to another.

6.0 Change and Compensation Event Tracking

6.1 The Project Manager will maintain a Change Control Register of all Change Requests , Compensation Events and the resolution of each. This will be appended to the monthly PM reports and shared with the Project Team and Project Board at monthly meetings.

Change Control Forms:

Change%20Control %20Form%20v3.doc

Change%20Control %20PCF.xlsx

ANEURIN BEVAN UNIVERSITY HEALTH BOARD
CAPITAL PROCEDURES
WORKS AND ESTATE
ANNEX 23

POST TENDER REVIEW:

SCHEME Title: ……

……

SCHEME REFERENCE: PPD [……] Financial Code: [……]

TENDER RETURN DATE: ……..

PRE-TENDER ESTIMATE: £ …… Inclusive of VAT

Tender Returns:

Name of Contractor	**Contract Sum** (including VAT)	**Comments**

Is the Tender Estimate within **10%** of the Tender return?
If, No, Provide narrative to reasons why this has exceeded the 10% margin.

Narrative:

Narrative Reviewed by:

……
Signature (Responsible Design Officer)

……
Signature (Responsible Lead Design Officer)

AGENDA FOR PRE-CONTRACT MEETING

ANNEX 24

DATE	
TIME	
SCHEME	
VENUE	

1.0 INTRODUCTION

The Chairman will arrange introduction of all present.

2.0 SCOPE OF WORK – to be outlined by Contract Administrator

3.0 CONTRACT

3.1 Outstanding production information.
3.2 Insurances and tax certificates
3.3 Bond

4.0 CONTRACT MATTERS

4.1 Start date
4.2 Contract period
4.3 Programme of works
4.4 Health and safety (see Appendix A) / Asbestos survey

5.0 SITE WORKING ARRANGEMENTS

5.1 F 10/Construction phase plan/method statements/risk assessments
5.2 Traffic management plan/access to site/deliveries/car parking for contractors
5.3 Site security/Arrangements for keys/Protection of the public/ storage/identity badges/contractor checklists, if applicable (Appendix. A)
5.4 Waste – transit routes, positioning and protection of skips
5.5 Welfare facilities – Canteen, Toilets etc.
5.6 Noise/dust control – advise local departments & wards in advance of any work likely to cause undue noise or dust and programme accordingly.
5.7 Infection Control – report to ward/department manager before proceeding and **wash** hands on every occasion
5.8 Local liaison – arrangements to minimise disruption or inconvenience
5.9 Service Arrangements – Water/Gas/Electricity/Telephone
5.10 Disruption to essential services (normally 7 days' notice in writing to W & E), P-T-W
5.11 Fire precautions/Visit from Health Board fire officer/Emergency arrangements/First Aid

6.0 SUPERVISING OFFICER/COMMUNICATIONS (SEE APPENDIX B)

7.0 SPECIFICATIONS AND DRAWINGS INCLUDING WORKING DRAWINGS

8.0 VARIATIONS – VALUATIONS/INTERIM CERTIFICATES – (SEE APPENDIX C)

9.0 COMMISSIONING OF PROJECT (Contractor and User commissioning)

10.0 AS BUILT DRAWINGS/INFORMATION FOR THE HEALTH AND SAFETY FILE OR TO UPDATE HEALTH BOARD RECORDS, SUCH AS THE ASBESTOS REGISTER

11.0 FUTURE MEETINGS – (SEE APPENDIX D)

12.0 DISTRIBUTION OF MINUTES

13.0 ANY OTHER BUSINESS

ANEURIN BEVAN UNIVERSITY HEALTH BOARD
APPENDIX 'A'

1. HEALTH AND SAFETY

The Construction, Design and Management Regulations (CDM) 2015 (or current updated) apply to all construction projects. If part 3 of CDM applies (notifiable projects), the organisation and arrangements for managing health, safety and environmental issues on the site must be detailed in the construction phase health and safety plan and is the responsibility of the Principal Contractor. **Work must not begin until this plan has been scrutinised and you have been notified, in writing that work can commence.**

The following items should be included in the site health and safety management system, whether as part of the "plan" (in the case of notifiable projects), as a stand-alone system, or incorporated into method statements.

This will include but not be limited to:

- A clear organisational structure detailing responsibility for health, safety and environment.
- Adequate arrangements for the following aspects:
- Secure site boundaries.
- Controlling access and egress to and from site.
- Site rules and the provision of induction training for anyone attending site.
- A site traffic management plan, including effecting segregation of vehicles and pedestrians.
- Adequate emergency arrangements, particularly for the effects of fire and spills that could impact on the environment.
- Adequate arrangements for the provision of first aid.
- A procedure for reporting and investigating incidents (including reporting to the H.S.E. when required by RIDDOR).
- Adequate and suitable welfare facilities.
- An inspection regime to monitor health, safety and environmental performance.
- A framework to ensure consultation and communication with everyone involved with or affected by the work, with regard to health, safety and the environment.
- A system to ensure that any sub-contractors have adequate arrangements for health, safety and environmental management and are subjected to the same site rules and regimes as directly employed staff, including the vetting and testing of risk assessments.

The Contractor must also ensure that risk assessments are in place for the tasks to be undertaken on site and that they are effectively communicated to all appropriate personnel. Risk Assessments and where appropriate Permits to Work (P-T-W), should include but not be limited to:

Exposure to:

- Noise, vibration and dust
- Hazardous substances
- Manual handling
- Working at height
- Excavations (P-T-W)
- Hot Work (P-T-W)
- Work in confined spaces (P-T-W)
- Slip and trip hazards

The Contractor must ensure that the impact the work has on the day to day function of the area, adjoining or neighbouring areas, has been considered in the risk assessment process and that effective channels of communication are established and maintained with these areas and other appropriate Health Board staff groups, such as:
Works and Estates, Fire Safety, Safety, Health and Environment, Clinical Risk Management, Infection Control, Hotel Services etc.

In summary, ensure: Operatives are competent, Materials are safe to use, Equipment is fit for purpose and properly maintained, the working Environment is kept clean, ventilated, well-lit and free from clutter, and effective communication and consultation is established and maintained.

Upon completion of the project, a Health and Safety file (in the case of notifiable projects) or in all other cases, any information that will be necessary to update Health Board plans, drawings or records; or necessary to allow any future maintenance, alterations or demolition to be done safely, must be submitted to the Health Board.

SAMPLE CONTRACTOR CHECKLIST (Not applicable to Capital projects where site access will be controlled by the Principal Contractor

Appendix 4 - Gwent Healthcare NHS Trust, Estates Department
CONTRACTORS CHECKLIST No.....

Contractor Name		W & E Officer	
Scope And Location Of Work			
Start date/time		Finish date/time	

EMPLOYEE NAME	CSCS Card or affiliated equivalent, e.g JIB, ECS ,CCDO, SKILL, CISRS,CPCS	CRB Checked	INDUCTION DELIVERED AND UNDERSTOOD including site rules, emergency procedures, waste, parking, welfare and first aid Employees signature	Risk assessment & Method statement approved	Comments	Badge Issued	Badge returned

CONTRACTORS SIGNATURE		PRINT NAME		JOB TITLE	
Permit to work issued (Yes, No, N/A)		DATE		JOB COMPLETE – Signed off and dated by Supervising Officer	

CSCS Affiliated Cards: CCDO (demolition), CISRS (scaffolders), ECS/JIB/PMES (electricians, plumbers), CPCS (plant operators), SKILL (refrigeration, ventilation, air conditioning, heating)

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

APPENDIX 'B'

COMMUNICATIONS (Agenda Item 6.0)

The communications between all parties concerned with this Project must follow the normal pattern of the Health Board Works Projects, as follows:

1. All instructions to the Contractor will be given in writing by the Contract Administrator. No instructions are to be accepted by the Contractor from any other source. Site Works Orders are expected to be confirmed by formal instructions within 72hours.

2. Instructions to Sub-Contractors will be given only by the Main Contractor on receipt of directions from the Contract Administrator, bearing in mind that all instructions intended for Sub-Contractors must be issued by the Contract Administrator through the Main Contractor.

3. A copy of all correspondence relevant to the Contract, between the Contract Administrator and the Main Contractor.

4. A copy of all relevant correspondence emanating from the above should be sent to the Health Boards Project Manager.

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

APPENDIX 'C'

CERTIFICATE PROCEDURE – (Agenda Item 8.0)

Interim Certificates will be issued in accordance with the period specified in the Articles of Agreement to take account of works executed and goods on site etc. The term 'month' shall be deemed to mean calendar month, and all valuations made will be calculated on this basis.

Certificates for payment should be forwarded direct to the Contract Administrator, to ensure prompt payment of the Certificate.

Mechanical and Electrical valuation to be with the Project Engineer for presentation with the Main Contractor's valuation by the end of the third week in each month.

Where a Quantity Surveyor is employed he shall provide a Financial Statement monthly to the Project Manager.

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

APPENDIX 'D'

FUTURE MEETINGS – (Agenda Item 11.0)

Future meetings will be in two different categories - these are:

1. Contractors Site Meetings

   Site meetings are the responsibility of the Main Contractor and will be called and chaired by him. It is suggested that these should be at monthly intervals. It is also suggested that the Main Contractor should invite representatives of the Contract Administrator and Project Manager to these meetings. Minutes of these meetings will be issued by the Contractor.

2. Routine Agenda Items

   To include ongoing development of the Health and Safety File and the Ops and Maintenance manual, including familiarisation for Operational staff.

3. Contractor Manager meeting (Site Meetings)

   These meetings may be called and chaired by the Project Manager at intervals to discuss the progress of the development with the Main Contractor. The following persons or their representatives would normally be present at these meetings.

   The Project Manager – in the Chair
   The Contract Administrator – in the Chair
   The Project Engineers
   Representatives of the Main Contractor

   And as considered necessary - by representatives of:

   The Health Board Estates Officer
   Clerk of Works
   Engineering Clerk of Works
   Health & Safety Advisors

Minutes of the meetings will be issued by the Contract Administrator.

ANEURIN BEVAN UNIVERSITY HEALTH BOARD
CAPITAL PROCEDURES
PPD SCRUTINY DOCUMENT
ANNEX 23

ALL SUBMITTED PPD Documents will be scrutinised using the embedded document below:

Scrutiny%20Form%20(003).docx

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	28 November 2023
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	**Update on Losses and Special payments –1st April 2023 – 30th September 2023**
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	**Director of Finance, Procurement and Value Based HealthCare**
SWYDDOG ADRODD: **REPORTING OFFICER:**	**Mark Ross, Assistant Director of Finance (Financial Systems & Services)**

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

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report provides the Audit, Finance & Risk Committee with information in relation to financial losses and special payments made by the Health Board between 1st April 2023 and 30th September 2023.

Cefndir / Background

Losses and Special payments are reported in the financial position monthly and reported to the Audit, Finance & Risk Committee in line with the Committee's terms of reference.

The main content of the report is in the Losses and Special Payments table and sets out the recorded "loss" for the year to date alongside where this category of expense is considered and scrutinised within the Health Board.

The report also provides details of the provision held by the Health Board in relation to all outstanding Medical Negligence, Personal injury and redress claims which are currently under review.

Asesiad / Assessment

The losses and special payments recorded during the period 1st April 2023 to 30th September 2023 totalled £10.8m of which £9.6m is recoverable from the Welsh Risk Pool (WRP), this means the actual loss to the Health Board is £1.2m.

The losses & special payments for which the Health Board are accountable for including movements in provision are recorded as expenditure and are reflected in the reported and forecasted expenditure.

In addition to the cost recorded above, a provision for clinical negligence and personal injury cases is recorded on the balance sheet and is based on the estimated potential liability as advised by Welsh Health Legal Services of the maximum possible future cost for all known cases. It has increased by £46.5m since 31st March 2023 to an overall provision of £208.6m of which it is expected that £203.3m is recoverable from WRP leaving potential future losses to the Health Board of £5.3m.

1 Financial Analysis of Losses

LOSSES AND SPECIAL PAYMENTS

01.04.23-30.09.23

	No. of Cases	Amount of Loss or Payment			Type of loss/ payment	Where reported/reviewed	Notes
		ABUHB £'000	Welsh Risk Pool £'000	TOTAL £'000			
LOSSES:							
Bad Debts	0	0	0	0	Various	Authorised by Division and notified/approved by Audit Risk and Assurance Committee	
SPECIAL PAYMENTS:							
Loss of personal effects	7	2	0	2	Minor Losses	Losses form completed - Authorised by Division and Putting Things Right team	Lost dentures, glasses etc.

Clinical negligence with advice	177	859	9,117	9,975	Clinical Negligence	Clinical negligence and personal injury - payment verified and lessons learnt addressed by the litigation committee for claims over £25K. Feedback into the quality and patient safety committee re Lessons Learnt. Reimbursement of payment made not processed by WRP until satisfied that lessons learnt have been clearly documented and implemented. Annual Report to Quality & Patient Safety Committee by the Litigation Department. Includes case type, numbers, financial information, and historic comparisons.	Completed cases
Personal injury with advice (includes Permanent Injury Benefit)	90	313	353	66	Personal Injury	As above	Completed cases
Other clinical negligence and personal injury	26	17	127	144	Clinical Negligence and Personal Injury - claims under £25K	Redress committee for payments under £25K. Lessons learnt fed back to division	Completed cases
Other	25	30	0	30	Various	Ombudsman cases - confirmed by putting things right team, other losses reports completed as appropriate	
TOTAL LOSSES AND SPECIAL PAYMENTS	**325**	**1,221**	**9,597**	**10,818**			
Of which, cases of £250,000 or more:							
Clinical negligence with advice	5	0	6,046	6,046			
Personal Injury with advice	0	0	0	0			

2 Clinical Negligence and Personal Injury Provisions

The table below shows the analysis of the estimated liability for losses as at 30th September 2023 compared to the position reported at 31st March 2023. It reflects the estimated liability in relation to cases advised by Welsh Health Legal Services for both clinical negligence, personal injury and redress with the provision updated to reflect new or changed cases.

After the expected recoveries from the Welsh Risk Pool are taken in to account the estimated liability to the Health Board at the end of September 2023 is £5.3m.

Losses & Special Payments Provisions	31-Mar-23		30-Sep-23	
	No. of Cases	£'000	No. of Cases	£'000
Clinical Negligence	248	158,192	272	204,167
Personal Injury	59	843	54	1,278
Permanent Injury Benefit	21	2,770	22	2,977
Redress	50	340	40	217
Sub Total	**378**	**162,145**	**388**	**208,639**
Less WRP Recoverable: Clinical Negligence	-147	-156,109	-163	-201,994
Less WRP Recoverable: Personal Injury	-7	-617	-3	-1,128
Less WRP Recoverable: Redress	-49	-319	-38	-202
Net Liability	**175**	**5,100**	**184**	**5,315**

The percentage of recovery for Personal Injury cases is much lower than Medical Negligence cases as most Personal Injury cases are under £25K. Up to the end of September only 3 Personal Injury cases out of the 54 cases are over £25K whereas 163 of the 272 Medical Negligence cases are over £25K.

Argymhelliad / Recommendation

The Audit, Risk and Assurance Committee is asked to note the content of this report for assurance.

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

Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment: • **Workforce** • **Service Activity & Performance** • **Financial**	**Is EIA Required and included with this paper** A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following: Not Applicable Yes, outlined within the paper Yes, outlined within the paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	Choose an item. An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change.

	If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. Choose an item.

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	28 November 2023
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Counter Fraud Progress Quarter 2 Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Robert Holcombe, Director of Finance, Procurement and Value Based Healthcare
SWYDDOG ADRODD: **REPORTING OFFICER:**	Michelle Morris – Head of Counter Fraud

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

Er Gwybodaeth/For Information

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

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

Cefndir / Background

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

Asesiad / Assessment

1 Counter Fraud Staffing

In relation to staffing the department has been fully staffed since 1st August 2023. As previously stated, the new appointee Nicola Tillings was already an accredited LCFS. Sara Morris the other trainee LCFS achieved her full accreditation on the 6th of September 2023 and as a result has now been given access to the NHS Counter Fraud Authority's case management system Clue.

2 Staff awareness

During Q2 the Counter Fraud Department has completed a further lunch and learn session via Teams in relation to Hospital Pharmacy that specifically covered Management of Controlled Drugs and WP10 (Hospital Prescriptions). On this occasion 39 of Aneurin Bevan University Health Board's Pharmacy Staff attended and the feedback from the requestor was very positive following this engagement.

Counter Fraud awareness input at Corporate Induction remains a mandatory requirement. This financial year to date, 668 members of staff have completed the Corporate Induction which includes the fraud awareness input. The new Counter Fraud E-Learning programme via ESR that went live on the 20th of April 2023 has seen 44 staff members completing it by the end of Q2. As previously discussed, in relation to the Counter Fraud E-Learning programme being mandated the formal application was completed and presented to the Core Learning Committee on the 21st of October. This process is currently ongoing and hopefully the final decision from the Core Learning Committee should be available soon.

It appears that the fraud awareness programme undertaken by the LCFS is reaching its target audience. During Q2 a record number (25) of referrals were made to Counter Fraud. A number of these referrals again have come anonymously via the Fraud and Corruption Reporting Line, but most have come directly to the LCFS via all mediums of staff reporting.

3 Proactive Work

Again, Q2 has seen a significant increase in the number of reactive fraud referrals that have required investigating. These high numbers of referrals have had an impact on the LCFS undertaking any specific Fraud Risk Assessment (FRA) work, but this will hopefully be rectified in Q3/Q4.

Fraud prevention activity/Local Proactive Exercises (LPE)

The Head of Counter Fraud together with Jan Robinson Resource Bank Manager have been running a proactive exercise since Q1. This came about as a result of an investigation whereby a member of staff managed to allocate herself shifts and finalise those shifts for payment. This highlighted a potential fraud risk, so Resource Bank Staffing have started running a monthly audit. The monthly audits highlighted self-authorised, self-worked and self-finalised shifts. These results were then sent to the respective managers notifying them of the breach of the process. Counter Fraud followed this email notification

with an email requesting discrete enquires to be made by the managers to make sure that shifts had been worked. As a result of monitoring this for several months it was clear that the E-System needed to be changed. This is currently being looked at and will hopefully be reported on in Q3.

National Fraud Initiative

As previously mentioned, the NFI has been underway since October 2022. Over the past few months those tasked with dealing with the matches have covered the majority of the work. So far it has not resulted in any investigations required by the Health Board, but information we have provided to another Health Board from a cross match has resulted in a positive hit, which has resulted in an investigation into one of their staff members.

4 Reactive Work

There were 28 open cases at the end of Q1 and 7 cases have been closed during Q2. With the 25 new cases that arose during Q2 there were 45 open cases as at its close (one case has been passed to the NHS Counter Fraud Service Wales Team to investigate). Two of the suspects investigated during Q1 have received Police Cautions for Fraud and Misuse of Computers Act offences but are still subject to the internal disciplinary process. A further 5 interviews under caution took place in Q2, these investigations are still ongoing. This past quarter has seen a financial recovery of £56,987.86 as a result of Counter Fraud's investigation/intervention. This recovery is mainly made up of overpayments of salary cases. A list of current investigations is as detailed in **Appendix 1.**

Overpayments Platform

The new NWSSP Overpayments Platform which is shared by Payroll, Counter Fraud and Accounts Receivable went live in Q2. There have been some teething issues, but the new system appears to have made a positive difference. Cases are placed onto the platform and those that meet the Counter Fraud criteria are immediately flagged to the Counter Fraud area. Counter Fraud then have the option of excepting or rejecting the case which then alerts Payroll. This means that referrals to Counter Fraud can now be done expeditiously and are now held on one system. Also, if there are any queries there is a means of communication via a comments section, which are then actioned directly by the Payroll Overpayments Team. All the information that Counter Fraud requires to carry out its investigation is now held within the case and any further information requested from Payroll is uploaded to the case.

Argymhelliad / Recommendation

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

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

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

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb **Equality Impact Assessment** (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change.

	If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives Choose an item.

APPENDIX 1

LCFS Summary of Open Cases on 30th September 2023

No.	Case No	Date Opened	Subject	Offence	Case Summary
1	INV/23/02114	27/09/2023	Non-NHS	Patient prescription fraud	Adding items to prescriptions - investigation ongoing
2	INV/23/02088	25/09/2023	NHS Staff (Facilities)	Fail to Disclose & Theft	Failed to disclose previous conviction for theft/theft of NHS supplies. Investigation ongoing. Subject suspended pending HR disciplinary.
3	INV/23/02042	20/09/2023	NHS Staff (Facilities)	Fail to Disclose	Allegation that subject failed to disclose conviction for assault.
4	INV/23/02015	18/09/2023	NHS Staff (District Nurse)	Working while sick	Investigation ongoing
5	INV/23/01980	18/09/2023	NHS Staff (Nurse)	Theft	Theft of PPE and equipment, investigation ongoing
6	INV/23/01919	12/09/2023	Non-NHS	Patient prescription fraud	Allegation that prescribed medication is being sold, investigation ongoing
7	INV/23/01885	06/09/2023	NHS Staff (Medical Secretary)	Timesheet fraud	Allegation that subject is not completing contracted hours, investigation ongoing
8	INV/23/01845	31/08/2023	NHS Staff (Specialty Doctor)	Salary Overpayment	Supplementary banding allowance overpayment, investigation ongoing
9	INV/23/01741	18/08/2023	NHS Staff (Nurse)	Salary Overpayment	Investigation ongoing
10	INV/23/01740	18/08/2023	NHS Staff (Consultant)	Salary Overpayment	Investigation ongoing
11	INV/23/01669	09/08/2023	NHS Staff x 5	Salary Sacrifice/non-payment	Investigation ongoing
12	INV/23/01632	07/08/2023	NHS Staff (Facilities)	Timesheet Fraud	Investigation ongoing
13	INV/23/01587	01/08/2023	NHS Staff (Nurse)	Working while sick	Investigation ongoing
14	INV/23/01532	31/07/2023	NHS Staff (Hospital Doctor)	Salary Overpayment	Investigation ongoing
15	INV/23/01521	28/07/2023	NHS Staff	Timesheet Fraud	Failure to work contracted hours
16	INV/23/01520	28/07/2023	NHS Staff (Nurse)	Salary Sacrifice/non-payment	Lease vehicle, investigation ongoing
17	INV/23/01424	20/07/2023	Non-NHS	Patient prescription fraud	Altered prescription, investigation ongoing
18	INV/23/01396	17/07/2023	NHS Staff (Nurse)	Salary Sacrifice/non-payment	Lease vehicle, investigation ongoing
19	INV/23/01340	14/07/2023	NHS Staff (Nurse)	Timesheet Fraud / False Representation	Investigation ongoing
20	INV/23/01338	14/07/2023	NHS Staff	False Representation / Sickness	Investigation ongoing
21	INV/23/01331	06/07/2023	NHS Staff	Salary Overpayment	Investigation ongoing
22	INV/23/01330	06/07/2023	NHS Staff (Nurse)	Salary Overpayment	Investigation ongoing
23	INV/23/01329	06/07/2023	NHS Staff (Nurse)	Timesheet Fraud	Failure to complete contracted hours, Investigation ongoing
24	INV/23/01308	05/07/2023	NHS Staff (Nurse)	Timesheet Fraud	Claiming bank shifts while working in substantive role, investigation ongoing
25	INV/23/01141	15/06/2023	Non-NHS	False details to GP to obtain medication	Investigation ongoing.
26	INV/23/01142	15/06/2023	Non-NHS	Patient prescription fraud	Investigation ongoing.
27	INV/23/01054	02/06/2023	NHS Staff	Salary Overpayment	Investigation ongoing.
28	INV/23/01050	01/06/2023	NHS Staff	Timesheet fraud	NFA fraud - awaiting HR disciplinary outcome
29	INV/23/01051	01/06/2023	NHS Staff x4	Timesheet fraud/ Misuse of computers.	Investigation ongoing
30	INV/23/01053	01/06/2023	NHS Staff	Salary Overpayment	Investigation ongoing.
31	INV/23/00970	22/05/2023	Non-NHS	False personal details to GP	Investigation ongoing.

32	INV/23/00761	20/04/2023	NHS Staff	Working while sick	Investigation ongoing.
33	INV/23/00920	19/04/2023	NHS Staff	Timesheet / Annual Leave fraud	Investigation ongoing.
34	INV/23/00921	18/04/2023	NHS Staff	Salary Overpayment	Investigation ongoing.
35	INV/23/00674	06/04/2023	NHS Staff	Timesheet fraud.	Investigation ongoing.
36	INV/23/00922	04/04/2023	NHS Staff	Working while sick	Investigation ongoing.
37	INV/23/00258	06/02/2023	NHS Staff	Timesheet fraud.	Investigation ongoing
38	INV/22/01414	04/10/2022	NHS Staff	Salary Overpayment	Investigation ongoing.
39	INV/22/01391	03/10/2022	NHS Staff	Salary Overpayment	NFA on criminal & disciplinary aspect. Recovery of £24,000.00 in progress
40	INV/22/01201	31/08/2022	NHS Staff	Timesheet fraud	Investigation ongoing.
41	INV/22/01195	30/08/2022	NHS Staff	Theft of hospital prescription medication	Police caution on 14/01/2023 - criminal sanction. Awaiting disciplinary outcome - subject not engaging, will be held in their absence.
42	INV/22/01184	26/08/2022	NHS Staff	Timesheet fraud	NFA criminal - disciplinary ongoing.
43	INV/22/00899	15/07/2022	NHS Staff	Working while sick	Investigation concluded NFA on criminal aspect – awaiting HR disciplinary outcome
44	INV/21/00276	11/10/2021	NHS Staff	Salary Overpayment	Criminal conviction September 2022, £21,389.69 repaid. Dismissed from CTMUHB September 2022, NMC suspension - case to be closed Q3.
45	WARO/19/00145	17/12/2019	NHS Staff	False WLI payment claims	CPS declined charging decision, No Further Action (NFA) criminal aspect. Civil recovery and GMC action pending.

Agenda Item:3.3

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	28 November 2023
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Post Payment Verification Progress Report – 1st April 2023 to 30th September 2023
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Director of Finance
SWYDDOG ADRODD: **REPORTING OFFICER:**	All Wales Post Payment Verification Manager - Amanda Legge

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

Er Sicrwydd/For Assurance

This paper highlights the narrative on how practices have been performing over the current Post Payment Verification (PPV) cycle.

PPV of claims from General Medical Services (GMS), General Ophthalmic Services (GOS) and General Pharmaceutical Services (GPS) are undertaken as a part of an annual plan by NHS Wales Shared Services Partnership (NWSSP).

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

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

The paper is being produced for the Committee to review and seek assurance that the Post Payment Verification cycle is being managed appropriately. PPV provides assurance in all contractor disciplines, except for General Dental Services.

Cefndir / Background

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

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

The past year in 2022-2023, PPV faced challenges associated with the ability to perform 'Business as Usual' due to different factors.

To effectively respond to challenges identified within Primary Care further avenues were investigated to enhance the PPV services which has maintained an excellent level of PPV. This provides the Health Board with reasonable assurance that public monies are being appropriately claimed.

Asesiad / Assessment

The following key points should be noted:

General Medical Services (GMS): Following communications that went out on 20th December, regarding the inability to undertake the entirety of the visits on the visit plan for 2022/2023, we are planning to condense all remaining visits from the 3-year visit plan into 2-year period of 2023/24 and 2024/25. We also experienced some transitional points with the introduction of the new payment system, so a separate assurance exercise is being undertaken by our payment colleagues in SSP for the data range January 2022 to September 2022. As a result, we began by checking the data submitted from practices from October 2022. The length and period of data will extend as time moves forward as it has done historically as part of the PPV assurance.

Regarding the revisits that were raised because of routine visits in the last financial year, and any outstanding visits, we will be utilising the same data, however if a revisit is due at the same time as the routine, we will do an 'extended visit' which means 10% of the claims for the routine and 100% check on the services that were triggered in the initial routine.

General Ophthalmic Services (GOS): The visit plan for GOS 2022-2023 was agreed by Health Boards after explaining that these visits were subject to change due to beginning a new way of working. PPV began remote access options having full support from Optometry Wales and begun to carry out virtual visits via Microsoft TEAMS which proved successful. Future visits will now be included in the 2023-2024 visit plan, and although we are hoping to increase the number of remote visits, we are also incorporating physical visits to carry us through this transition period of electronic claiming which is being encouraged by Welsh Government. We also continue to undertake the GOS patient letter programme across Wales to provide additional elements of assurance to our Health Boards.

Pharmacy Services (GPS): Due to COVID-19, the Medicines Use Review (MUR) service was stopped in March 2020. In 2022/23 NWSSP introduced a pilot for two new service checks by PPV, which are the Quality and Safety Scheme and

the Collaborative Working Scheme. In April 2023 we went 'Live' with the Quality and Safety scheme and will begin the Collaborative Working Scheme in April 2024.
Additional Services: As requested by Welsh Government in 2022/2023 we verified the PPV declaration for additional community pharmacy payments that were paid in 2022/2023 which has now been completed.
We are providing a new service check for incorrect dispensing data and after a successful pilot we rolled this out nationally in August 2022 using the quarterly data from April-June 2022. This is continued as a quarterly service for all Health boards across Wales.

Clinical Waste Self Assessments have been piloted for GMS and are now being rolled out to ensure compliance with legislation. We are planning to conduct a pilot with the Self Assessments for Pharmacies in the next few months.

Quarterly meetings are scheduled with the Head of Primary Care, Primary Care Managers, Finance Lead, PPV Team and local Counter Fraud team to regularly review the progress report and to discuss themes, recommendations, and any risks.
There is a bi-monthly National GMS Working Group with Primary Care Managers and PPV to discuss and agree any issues regarding the National application of the programme. PPV are planning to commence a National GPS and GOS Working Group to align with the above which has proved successful.

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

Argymhelliad / Recommendation
It is recommended that the Audit & Risk Assurance Committee Members note the contents of this report. There are no options included in this report. The report is for Assurance and details specific risks as outliers in a traffic light system, but provides the narrative for what PPV, Primary Care, Finance and Counter Fraud consider the be the best approach to support practices in improving.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Not Applicable Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Not Applicable Choose an item.

Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item. Not Applicable
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• **Workforce**	Not Applicable
• **Service Activity & Performance**	Not Applicable
• **Financial**	Not Applicable
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	Choose an item. An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk

Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Not Applicable Choose an item.

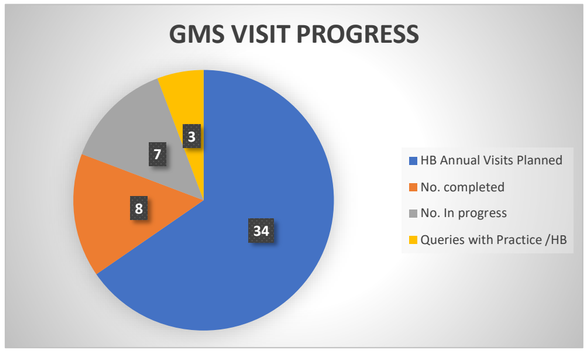
ABUHB Audit Report - 1st April 2023 to 30th September 2023

To Notes

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

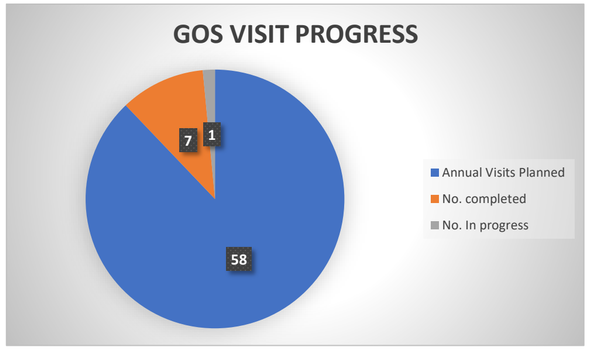
GMS	Visit Type	HB Annual Visits Planned	No. completed	No. In progress	Queries with Practice /HB	No. Recoveries	Value of recoveries	All Wales Completed	All Wales No. in progress	All Wales Planned	All Wales Value of Recoveries
	Routine	34	8	7	3	138	£6,591.66	40	48	166	£23,187.18
	Revisit	21	3	0	0	186	£11,820.06	3	1	131	£11,820.06
	Total	55									

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



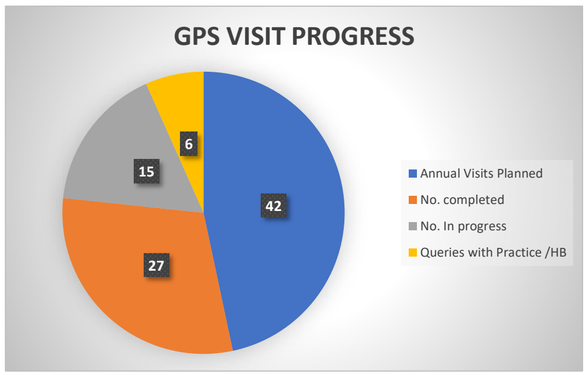
GOS	Visit Type	Annual Visits Planned	No. completed	No. In progress	Queries with Practice /HB	No. Recoveries	Value of recoveries	All Wales Completed	All Wales No. in progress	All Wales Planned	All Wales Value of Recoveries
	Routine	58	7	1	1	7	£274.64	25	1	301	£2,217.05
	Revisit	0	0	0	0	0	0	0	0	6	£0.00
	Total	58									

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



GPS	Visit Type	Annual Visits Planned	No. completed	No. In progress	Queries with Practice /HB	No. Recoveries	Value of recoveries	All Wales Completed	All Wales No. in progress	All Wales Planned	All Wales Value of Recoveries
Q&S Scheme	Routine	42	27	15	6	0	£0.00	62	167	229	£0.00
	Total	42									

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



Agenda Item: 3.4

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	28 November 2023
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Consultant Job Planning - Interim Update
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	James Calvert Executive Medical Director
SWYDDOG ADRODD: **REPORTING OFFICER:**	Kathryn Bourne Strategic Lead Medical & Dental Workforce

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

Er Sicrwydd/For Assurance

This paper provides an interim update on achievement of actions to address the 2020 Audit recommendations on Consultant Job Planning. This interim report is designed to provide **assurance** that work is progressing.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

A revised approach to Job Planning has been developed to address historic poor compliance with job planning and the low quality of job plans set out in the 2020 audit action plan. Actions include:

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

An update on the action plan to address the 2020 audit recommendations is provided in appendix 1.

Achievement of a number of these actions is dependent on the roll out and realisation of the benefits of the new E-Job Planning system. The perceived benefits of E-Systems are detailed in Appendix 2.

Procurement of an E-job planning system
The original procurement process was anticipated to conclude by 12th May 2023. However, delays in the procurement process have been experienced due to:

- A failed (first) procurement exercise with no bidders
- Significant site pressures and availability of Clinicians to complete the evaluation element of the second procurement process.
- Procurement delays due to staffing deficits.
- Supplier challenge and the requirement for additional legal advice following completion of the second (successful) procurement exercise.

Due to these unforeseen delays the contract was finally awarded on 4th September 2023.

The E-Systems Programme Manager is engaging with the successful suppliers to agree the implementation timescale. Once this concludes the implementation plan will be updated.

Overall, Job Planning Compliance was 29% for September 2023, although this is an increase of 2% since July 2023, it demonstrates little improvement since September 2022 when overall compliance was 25%. This is in part a consequence of Divisional and Clinical Directors supporting the procurement of E-systems as a priority which resulted in SPA time being directed to this.

The committee has previously been informed that significant improvements in job plan compliance would not be realised until June 2024 as this is dependent on full roll out of the E-system.

Cefndir / Background

Aneurin Bevan University Health Board's use of job planning and benefits realisation from the Consultant Contract were the subject of an internal Audit (follow up) undertaken in late 2019.

Progress in relation to addressing the 2020 audit recommendation has been the subject of previous reports to the Audit, Risk and Assurance Committee; People and Culture Committee and the Remuneration and Terms of Service Committee.

These papers: -

- outlined the work that had been undertaken prior to the 2020 Covid 19 pandemic (appendix 1)
- acknowledged the impact of the pandemic on progress.
- identified a revised approach to job planning.
- provided updates on the approved action plan to address the audit recommendations which included the procurement of an Electronic Job Planning System.

Asesiad / Assessment

E- Job Planning system

L2P has been identified as the Job Planning System provider. The Medical Workforce eSystems team is currently working with the successful suppliers to develop and configure the software to conform to the Health Board's organisational structure and our specific requirements aligned with the new Job planning Procedure.

By the time, the initial phase is complete the implementation team will have completed training to enable roll out across Clinical Divisions.

Detailed plans are in development, however following data gathering and configuration it is anticipated that the following actions will take place on the dates indicated:

- User acceptance Stage - Pilot in Family & Therapies Divisions commences 12th December 2023, with training commencing 20th November 2023.
- Divisional Training on the system from 11th December 2023.
- Go Live across the organisation following completion of divisional training and review of implementation pilot in Family & Therapies Division.

A draft proposed implementation plan is provided in Appendix 3.

Following discussion with medical leaders the implementation plan will be approved formally by the Medical E-Systems Programme Board.

The implementation of the job planning eSystem will be supported by a dedicated medical eSystem implementation team and the supplier's system support team. Both teams are in place and are being trained.

Job Planning Procedure and associated policies/guidance

The Job Planning procedure is designed to ensure consistency in job planning across the organisation in line with the Amendment to the Consultant Contract (Wales (2003)) to ensure an engaged and valued workforce. It: -

- provides a structure for effective job planning.
- Provides a clear interpretation of the Consultant Contract 2003 T&C
- supports divisional management teams in ensuring consistency and equity of approach.
- provides detail on how SPA time will be recognised in job planning to ensure that divisional investment in SPA time is matched by clear expectations with regard to outputs required for that investment.
- assists in achieving the recommendations of the audit report as highlighted in appendix 2.

Appendices include guidance and information on:

- SPA allocation and outcomes
- Developing a Team Job Plan
- Undertaking a Diary Exercise & Diary exercise tool
- Travel and parking times between sites

In order to develop the procedure, the Health Board has undertaken considerable engagement with the LNC and Medical Leaders. Engagement with BMA/LNC has been positive and helpful. There are still some aspects which the BMA/LNC are seeking clarification on, but the Health Board did not believe the areas of disagreement were significant enough to delay implementation. Further engagement is ongoing.

The Health Board continues to work through issues as they arise with the LNC and have committed to formally review the procedure in 12 months.

The new job planning procedure was launched by the Medical Director on 18th August 2023. A link to the associated and newly developed Job Planning Distance Learning Pack was circulated, and all consultants were asked by the Medical Director to utilise one of their SPA sessions to review the pack prior to 15th September 2023. Completion of the training is recorded in ESR to enable reporting.

A job planning procedure page is live on the intranet with useful resources available on-line. These have been positively received. In addition to the training pack and on-line documents, the Deputy Medical Director and Strategic Lead for Medical Workforce have conducted Question and Answer sessions on the procedure via MS Teams.

A Job Planning Consistency Group has been established to allow issues with implementation to be quickly resolved. The first meeting took place on 9th November.

All questions raised are being captured and shared by means of FAQs on the job planning intranet page.

Argymhelliad / Recommendation

The committee is asked to:

- note the progress made.
- agree to receive a further report in May 2024. At present a further report is due in February 2024. A delay until May should allow greater progress to be made and assurance provided.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	Not applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	7. Staff and Resources 7.1 Workforce Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Not Applicable Choose an item.

Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Workforce and Culture
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
• **Workforce**	Not Applicable
• **Service Activity & Performance**	Not Applicable
• **Financial**	Not Applicable
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements**
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. Choose an item.

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

ACTION PLAN FOR JOB PLANNING – Updated October 2023

The 2021-2022 plan for job planning aims to: -

- Support the effective delivery of annual job planning.
- Improve compliance.
- Ensure job planning is aligned to service delivery and outcomes.
- Ensure consistency of application of T&Cs.
- Meet internal audit requirements.

		OBJECTIVES	ACTION REQUIRED BY	RESPONSIBLE DIRECTOR	LOCAL LEAD	STATUS AND MILESTONES
REF IA/19	**1. JOB PLANNING PROCEDURES & POLICIES**					
R1 R2 R3 R4	1.1	Development of a detailed Health Board Procedure for job planning which will provide consistent interpretation of the T&Cs and align with all Wales guide "effective job planning for Medical and Dental Staff"	First Draft June 2021	Medical Director	Stephen Edwards/Kathryn Bourne	The new procedure and associated policies and guidance were launched on 8th August 2023.

Update

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

ACTION PLAN FOR JOB PLANNING – Updated October 2023

	OBJECTIVES		ACTION REQUIRED BY	RESPONSIBLE DIRECTOR	LOCAL LEAD	STATUS AND MILESTONES
	2. SUPPORTING PROCESSES & SYSTEMS					
R1	2.1	Review existing processes and systems to align with the new Health Board procedure e.g., escalation process, payment of commitment awards	Review – January 2023	Medical Director/Director of Workforce & OD	Stephen Edwards/Kathryn Bourne	Existing processes including Escalation and Commitment awards have been reviewed and aligned to the new procedure these are referenced in the procedure and supporting documents e.g., template letters are included in the appendices. Where possible, aspects of these will be automated in the e-Job Planning system. Should further processes require review these will be addressed as identified.
R1	2.2	Develop processes and systems to support implementation of the new Procedure	Review – January 2023	Medical Director/Director of Workforce & OD	Stephen Edwards/Kathryn Bourne	A Job Planning consistency group has been established chaired by the Deputy Medical Director specifically to advice on and agree consistent approach to SPA.

Updated 10

Appendix 1 – Job Planning Action Plan

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

ACTION PLAN FOR JOB PLANNING – Updated October 2023

	OBJECTIVES		ACTION REQUIRED BY	RESPONSIBLE DIRECTOR	LOCAL LEAD	STATUS AND MILESTONES
	3. REPORTING & MONITORING OF THE JOB PLANNING PROCESS					
R1	3.1	Agree with Divisional and Clinical Directors an over-arching plan to identify the job planning cycle within each Directorate/Division	June 2021	Director(s) of Operations/Deputy Medical Director	Divisional management teams	The Medical Director wrote to Divisional Directors in 2021 emphasising the need for CDs to undertake job plan review meetings. He has also asked that a named member of the divisional management team is given responsibility for supporting CDs in doing this and that the Deputy Medical Director is made aware of who is identified. The new Job Planning procedure makes explicit the role of the CD in agreeing a proposal for how the job planning process will be applied in the specialty and also identifies the stages of the planning process. The specifications within the procedure supersede the action within this plan. The roll out of the e-job planning system may influence the plan for some specialities in 23/24.
R1	3.2	Monitoring of the plan and job planning compliance via the Divisional management teams and assurance meetings	Monthly and on going	Director(s) of Operations	Divisional management teams	Agreed by Executive team on 1st June 2021 that monitoring of the plan and job planning compliance would be undertaken at the Divisional management teams and assurance meetings.
R1	3.3	Exception reporting to the Executive team on delivery of the plan and compliance	As required	Director(s) of Operations	Divisional management teams	Agreed by Executive team on 1st June 2021 that they will receive exception reports on delivery of job planning and compliance as necessary from the Directors of Operation.

Updated 10

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

ACTION PLAN FOR JOB PLANNING – Updated October 2023

R1	3.4	Maintenance of the ABUHB's job planning compliance database and issuing of monthly compliance reports to management teams, WFBPs, DOO, MD & WOD,	Monthly	Director of Workforce	E-Job Planning Project Manager	The compliance database continues to be maintained. Compliance reports are produced monthly. Divisional reports are provided to the DDs; GMs; DMs; CDs and WBPs monthly or on request. Compliance reporting will be enhanced with implementation of the new E-Systems. Divisional management teams will be able to access detailed reports from the systems themselves as required. Corporate reporting from the system will continue.

Updated 10

	OBJECTIVES		ACTION REQUIRED BY	RESPONSIBLE DIRECTOR	LOCAL LEAD	STATUS AND MILESTONES
REF IA/19	**4.E-SYSTEMS**					
R2 R4 R5	4.1	Identify system requirement to • improve link between job planning and the rota, • improve compliance and transparency around job planning, • support delivery of contracted session across the year, • improve link between rostering and locum bank for locum shift cover, • Improve the link between Locum shift cover and the need to go to agency (third party systems), • Improve and streamline the end to process for workforce planning and management across all functions, • maximise reporting and performance.	Review March 2023	Medical Director/Director of Workforce & OD/ Director(s) of Operations	Julie Chappelle/ Stephen Edwards	An e -Job planning system has been procured with an e-rostering and e- Bank system. Although these systems stand alone interoperability between the systems was a requirement of the tender process. This ensures the three eSystems work together to provide an effective single solution to medical workforce planning and management. The roll out plan for all three systems is in draft and will be agreed by the E-systems programme Board.
R2 R4 R5	4.2	Procurement and implementation of appropriate system(s).	Review March 2023	Director of Workforce/ Director(s) of Operations	Ann Bentley (Programme Manager)	See above - System has been procured and we are now in implementation phase.

Updated 10.2

		OBJECTIVES	ACTION REQUIRED BY	RESPONSIBLE DIRECTOR	LOCAL LEAD	STATUS AND MILESTONES
	5. TRAINING/ SUPPORT & RESOURCES					
R3 R4	5.1	Review the E-training package to align with new Health Board procedure.	Review – January 2023	Medical Director/Director of Workforce & OD	Stephen Edwards/Kathryn Bourne	A new E-distance Learning Pack has been developed to align with the Job Planning procedure. The electronic link to this was sent in the launch letter from the Medical Director and all Consultants asked to use an SPA session to undertake the training and submit any questions to the ABBjob planning email address for response.
R3 R4	5.2	Review training requirements and means of upskilling staff to undertake job planning.	January 2023	Medical Director/Director of Workforce & OD	Workforce Business Partners and DDs	In addition to the new e-learning package the Deputy Medical Director and Strategic Lead for Medical workforce have conducted Q&A session which have been advertised for all involved in Job planning via the intranet. A series of FAQs available on the intranet has been updated as further questions are received. Support and advice are available as required. Where there are specific speciality issues the Workforce Business partners are working through these with the support and advice of the Deputy Medical Director and Strategic Lead for Medical workforce as required. Job planning continues to form part of the Senior Clinician CPD programme. An implementation team has been appointed to support operational divisions.

Updated 10.2

		OBJECTIVES	ACTION REQUIRED BY	RESPONSIBLE DIRECTOR	LOCAL LEAD	STATUS AND MILESTONES
	5. TRAINING/ SUPPORT & RESOURCES					
R4	5.3	Work with divisional teams to identify support required to enable Medical managers to fulfil their job roles in respect of delivery of annual job planning aligned to service requirements.	June 2021	Medical Director/Director of Workforce & OD	Workforce Business Partners and DDs	See 5.1 & 5.2 Job planning clinics and webinars have previously been offered. The Medical Director has previously written to Divisional Directors asking that a named member of the divisional management team is given responsibility for supporting CDs in doing this and that the Deputy Medical Director is made aware of who is identified. Training on the new e-system is being incorporated into the roll out plan. An implementation team has been appointed to support operational divisions
R1	5.4	Review time required to undertake effective job planning annually and ensure this is provided for with Clinical Director and Directorate Managers job roles/plans and objectives.	July 2021	Director(s) of Operations/Medical Director	Divisional Directors /General Managers	A survey of CDs has been undertaken (N=27). They fed back unanimously that time and training for their roles is insufficient for them to discharge their duties. A review of time job planned for the CD role is being discussed by DOO and MD. The triumvirate development program started in September 2022. The launch of the new procedure and associated resources, support and training should resolve the lack of knowledge previously identified if accessed. A framework for the appointment and remuneration for medical Leadership posts including CDs is in development and a paper will be taken to the People & Culture Committee.

Updated 10.

Updated 10.23

Job Planning Benefits Realisation Log

Reference	Benefit	Benefit Description	Measurable Benefit?	Status	Background	Updates	Expected Realisation Date	Target Outcome	Impact Score	Realisation Probability	Item Type	Path
JP - 001	Improved capacity and demand planning	Job planning linking capacity to demand and development of annualised team job planning	Yes	On track			Project End				Item	sites/ABBJobPlanningE-SystemProject/Lists/Benefits Realisation
JP - 002	Central Job Planning repository	Job plans will be stored electronically on the new system. This will allow the information collected to be sorted in a logical, organised and accessibility.	Yes	On track			Project End				Item	sites/ABBJobPlanningE-SystemProject/Lists/Benefits Realisation
JP - 003	Improved accuracy in information	Current word document results in inconsistency of data, control and governance of information collected. New system will have agreed fields and terminology.	Yes	On track			Project End				Item	sites/ABBJobPlanningE-SystemProject/Lists/Benefits Realisation
JP - 004	Improved reporting	The new system will have a variety of pre determined reports and have the tools to create bespoke reports when required, which can then be exported in different formats as required. This will help reduce manual input and make it easier to create bespoke reports. Reports will also be in real time.	Yes	On track			Project End				Item	sites/ABBJobPlanningE-SystemProject/Lists/Benefits Realisation
JP - 005	Consistency across the Health Board	All job plans will have to be completed on the new system in line with the job planning policy and procedure . This will help maintain a consistent approach with job plan completion.	Yes	On track			Project End				Item	sites/ABBJobPlanningE-SystemProject/Lists/Benefits Realisation
JP - 006	Automatic Reminders	Reminders will be sent to the relevant individuals when a job plan is close to expiry or when job plans are awaiting sign off.	No	On track			Project End				Item	sites/ABBJobPlanningE-SystemProject/Lists/Benefits Realisation
JP - 007	Time Saving	The new system will enable more efficient processing of information, and will help users to complete job plans quicker and result in a simplified process.	No	On track			Project End				Item	sites/ABBJobPlanningE-SystemProject/Lists/Benefits Realisation
JP - 008	Standardised Language	Helps maintain consistency and clarity of job plan completion across the Health Board.	No	On track			Project End				Item	sites/ABBJobPlanningE-SystemProject/Lists/Benefits Realisation
JP - 009	Increase Job Plan compliance	The publication of the new job planning procedure sets the foundation for implementing the new electronic software solution. The aim is to increase the Job Planning compliance levels across the Health Board to optimise patient care and safety and to support staff wellbeing.	Yes	On track							Item	sites/ABBJobPlanningE-SystemProject/Lists/Benefits Realisation
JP - 010	Intergration with eRostering	Job plan details to be sent to rostering system	Yes	On track							Item	sites/ABBJobPlanningE-SystemProject/Lists/Benefits Realisation

MWES Draft Implementation Plans V3.0

Job Planning

Task Name	Duration	Start	Finish
Announcement of Suppliers	10.5 days	05/09/2023	19/09/2023
Communication with Suppliers	5 days	14/09/2023	21/09/2023
Data Collection Workshops	25 days	14/09/2023	19/10/2023
Provide current job planning policy	1 day	05/09/2023	05/09/2023
Job Planning Approval Structure (standard levels of approval	55 days	05/09/2023	27/11/2023
Job Plan Sign Off Protocol	55 days	05/09/2023	27/11/2023
Job Planning Medic Import Template Completion	55 days	05/09/2023	27/11/2023
Provide Communication Plan	55 days	05/09/2023	27/11/2023
Collate Existing Historical Job Plans	55 days	05/09/2023	27/11/2023
Agree schedule of Project Meetings for Programme Board	55 days	05/09/2023	27/11/2023
Agree Final data sign off date (20 days before go live)	1 day	27/11/2023	27/11/2023
Administrator Training (90 mins per session)	5 Sessions	11/12/2023	12/02/2023
Pilot F&T Division (User Acceptance Phase)	10 days	12/12/2023	23/12/2023
Participant/Managerial/CD Training (60 mins per session)	16 Sessions	13/12/2023	27/03/2023
Go Live Date	1 day	10/01/2024	10/01/2024
Implementation of Job Planning			
Task Name	**Duration**	**Start**	**Finish**
Family & Therapies (Pilot)	65 days	12/12/2023	10/03/2024
Divisional Review & Support Period	30 days	22/05/2024	30/06/2024
Finish F & T Implementation - Move to BaU	30 days	22/05/2024	30/06/2024
Task Name	**Duration**	**Start**	**Finish**
Mental Health and LD	65 days	10/01/2024	10/04/2024
Divisional Review & Support Period	30 days	22/05/2024	30/06/2024
Finish MH & LD Implementation - Move to BaU	30 days	22/05/2024	30/06/2024
Task Name	**Duration**	**Start**	**Finish**
Primary Care and Community	65 days	10/01/2024	10/04/2024
Divisional Review & Support Period	30 days	22/05/2024	30/06/2024
Finish PC&C Implementation - Move to BaU	30 days	22/05/2024	30/06/2024
Task Name	**Duration**	**Start**	**Finish**
Clinical Support Services	65 days	10/01/2024	10/04/2024
Divisional Review & Support Period	30 days	22/05/2024	30/06/2024
Finish CSS Implementation - Move to BaU	30 days	22/05/2024	30/06/2024
Task Name	**Duration**	**Start**	**Finish**
Medicine	65 days	10/01/2024	10/04/2024
Divisional Review & Support Period	30 days	22/05/2024	30/06/2024
Finish Medicine Implementation - Move to BaU	30 days	22/05/2024	30/06/2024
Task Name	**Duration**	**Start**	**Finish**
Scheduled Care	65 days	10/01/2024	10/04/2024
Divisional Review & Support Period	30 days	22/05/2024	30/06/2024
Finish SC Implementation - Move to BaU	30 days	22/05/2024	30/06/2024
Task Name	**Duration**	**Start**	**Finish**
Urgent Care	65 days	10/01/2024	10/04/2024
Divisional Review & Support Period	30 days	22/05/2024	30/06/2024
Finish UC Implementation - Move to BaU	30 days	22/05/2024	30/06/2024

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	28 November 2023
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Audit Risk and Assurance Committee Work Plan 2023/24
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Head of Corporate Risk and Assurance

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

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

- Fulfil its Terms of Reference as agreed by the Board (March 2023);
- seek assurance and provide scrutiny on behalf of the Board, in relation to the delivery of the key elements of the Health Boards internal and external audit, counter fraud and PPV arrangements (second and third lines of defence);
- seek assurance that governance, risk, and assurance arrangements are in place and working well;
- seek assurance in relation to the preparation and audit of the Annual Accounts; and
- ensure compliance with key statutory, national, and best practice audit and assurance requirements and reporting arrangements.

Cefndir / Background

The purpose of the Audit, Risk and Assurance Committee is to support the Board and Accountable Officer by reviewing the comprehensiveness and reliability of

assurances on governance, risk management, the control environment and the integrity of financial statements and the annual report.

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

Asesiad / Assessment

The Committee work plan is outlined in **Appendix A** and is presented at each Committee meeting for oversight and noting.

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

Argymhelliad / Recommendation

The Committee is asked to:

- **RECIEVE** the Audit Risk and Assurance Committee work plan for oversight.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	The monitoring and reporting of committee business is a key element of the Health Boards assurance framework
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Choose an item. Th workplan supports delivery of the IMTP.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol:

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

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

AUDIT, RISK & ASSURANCE COMMITTEE
PROGRAMME OF BUSINESS 2023/24

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

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

- fulfil its Terms of Reference as agreed by the Board (March 2023);
- seek assurance and provide scrutiny on behalf of the Board, in relation to the delivery of the key elements of the health boards internal and external audit, counter fraud and PPV arrangements (second and third lines of defence);
- seek assurance that governance, risk and assurance arrangements are in place and working well;
- seek assurance in relation to the preparation and audit of the Annual Accounts; and
- ensure compliance with key statutory, national, and best practice audit and assurance requirements and reporting arrangements.

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2023/24					
			18th April 2023	May 23rd *Draft Accounts*	July 18th *Final Accounts*	12th Sept	28th Nov	8th Feb 2024
Preliminary Matters								
Attendance and Apologies	Standing Item	Chair	√	√	√	√	√	√
Declarations of Interest		All Members	√	√	√	√	√	√
Minutes of the Previous Meeting		Chair	√	√	√	√	√	√
Action Log and Matters Arising		Chair	√	√	√	√	√	√
Committee Requirements as set out in Standing Orders								
Development of Committee Annual Programme of Business 2023/24	Annually	Chair & Director of CG	√					
Review of Committee Programme of Business	Standing Item	Chair	√			√	√	√
Annual Review of Committee Terms of Reference 2023/24	Annually **(April)**	Chair & Director of CG	√					
Annual Review of Committee Effectiveness 2022/23	Annually **(September)**	Chair & Director of CG				√		
Committee Annual Report 2022/23	Annually **(April)**	Chair & Director of CG	√					
Corporate Governance, Risk & Assurance								
Receive assurance on implementation of the Governance Priorities set out within the IMTP 2022-25	Quarterly	Director of CG					√	
Review and report upon the adequacy of arrangements for declaring, registering and handling interests	Annually	Director of CG			√			√
Receive full report of all offers of gifts and hospitality as declared	Annually	Director of CG			√			√
Compliance with Ministerial Directions	Bi-Annually	Director of CG			√		√	
Compliance with Welsh Health Circulars (WHCs)	Bi-Annually	Director of CG			√		√	√
Review of Standing Orders, Standing Financial Instructions and Scheme of Delegation	Annually	Director of CG						√

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2023/24					
			18th April 2023	May 23rd *Draft Accounts*	July 18th *Final Accounts*	12th Sept	28th Nov	8th Feb 2024
Audit Recommendations Tracking Report	Standing Item	Director of CG	√	√	√	√	√	√
Annual Review of Risk Management Strategy	Annually	Director of CG						√
Report on the Implementation of the Risk Management Strategy Realisation Plan	Bi-Annually	Director of CG	√				√	
Annual Review of the Board Assurance Framework Process	Annually	Director of CG	√					√
Committee Risk & Assurance Report	Standing Item	Director of CG	√	√	√	√	√	√
Financial Governance and Control								
Report of the use of Single Tender Action	Standing Item	Director of FPV	√			√	√	√
Report of Losses and Special Payments *(May report will be included in the Accounts)*	Bi-Annually	Director of FPV		√			√	
Reviewed and Updated Financial Control Procedures	As Required	Director of FPV				√		
Annual Report and Accounts								
To consider the approach and timelines for the Annual Report and Accounts	Annually	Director of FPV & Director of CG	√					
Review the Health Board's Annual Report (Overview & Performance Section) (Part 1)	Annually	Director of CG		√	√			
Review Draft/Final Accountability Report, including Annual Governance Statement (Part 2)	Annually	Director of CG		√	√			
Review Draft/Final Annual Accounts and Financial Statements (Part 3)	Annually	Director of FPV		√	√			
Audit Enquiries to those charged with Governance and Management	Annually	Director of FPV		√				
Audit Wales, Audit of Accounts (ISA 260) including Letter of Representation	Annually	External Audit			√			
Final Annual Accounts Memorandum	Annually	External Audit					√	
Receive the Annual Head of Internal Audit Opinion (including Specialised)	Annually	Internal Audit			√			
Agree a recommendation to the Board in respect of the audited annual report and accounts	Annually	Chair			√			
Anti-Fraud								
Review of the Counter Fraud, Bribery and Corruption Policy	3-Yearly (Feb 2026)	Director of FPV	-	-	-	-	-	-

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2023/24					
			18th April 2023	May 23rd *Draft Accounts*	July 18th *Final Accounts*	12th Sept	28th Nov	8th Feb 2024
Receive the Counter Fraud Annual Report	Annually	Head of CF	√					√
Agree the Counter Fraud Annual Workplan	Annually	Head of CF	√					
Receive a Quarterly Report on Counter Fraud Activity	Quarterly	Head of CF			√		√	√
Agree the Counter Fraud Functional Standard Return Declaration	Annually	Head of CF			√			
Receive the Post Payment Verification Annual Report	Annually	PPV Manager (Amanda Legge)				√		
Agree the Post Payment Verification Annual Workplan	Annually	PPV Manager		√				
Receive a Mid-Year update in respect of Post-Payment Verification Activity	Annually	PPV Manager					√	
Clinical Audit								
Ratify the Clinical Audit Plan 2023 – 2024 to be overseen by the PQSO Committee	Annually	Medical Director			√			
Receive an Annual Report 2023 – 2024 on Clinical Audit Activity	Annually	Medical Director						√
Internal Audit (Including Specialised Audit) – NWSSP Audit & Assurance Services								
Agree the Internal Audit Annual Workplan	Annually	Head of Internal Audit		√				
Receive Internal Audit Progress Reports	Standing Item	Head of Internal Audit	√	√	√	√	√	√
Receive Internal Audit Review Reports, reviewing the adequacy of executive & management responses to any issues identified, ensuring that they are acted upon	As Scheduled within Annual Work plan	Head of Internal Audit Plan						
Review and approve Internal Audit terms of reference (charter) and the effectiveness of internal audit	Annually	Head of Internal Audit with Chair			√			
External Audit – Audit Wales								
Receive the External Audit Annual Audit Report	Annually	Audit Wales						√
Agree the External Audit Annual Plan	Annually	Audit Wales		√				
Receive the 2023 Structured Assessment	Annually	Audit Wales						√

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2023/24					
			18th April 2023	May 23rd *Draft Accounts*	July 18th *Final Accounts*	12th Sept	28th Nov	8th Feb 2024
Receive External Audit Progress Report 2023-24	Standing Item	Audit Wales	√	√	√	√	√	√
Review of External Audit Reports including results & the adequacy of executive & management responses to any issues identified, ensuring that they are acted upon	As Scheduled within Annual Work plan	Audit Wales						
Consider any Audit Wales National Value for Money Examinations & Performance Reports	Ad-hoc	Audit Wales						
Audit, Risk and Assurance Committee Members to meet Independently with:								
External Audit Team	Bi-Annually	Chair	√					√
Internal Audit Team	Bi-Annually	Chair					√	
Local Counter Fraud Team	Bi-Annually	Chair				√		

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

KEY	
√	Received at the scheduled meeting
X	Not received / Deferred to future meeting
Received √	Received deferred Item
	Draft & Final Accounts

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	28 November 2023
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Committee Self-Assessment 2023
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Head of Board Business

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to discuss the findings from the annual self-assessment process in respect of the Audit, Risk and Assurance Committee.

Cefndir / Background

As set out in the Health Board's Standing Orders (Section 10.2) the Board is required to undertake regular and rigorous self–assessment of its own operations and that of its Committees and Advisory groups. All Board Members are required to complete a self-assessment for each Committee on which they are a member, to determine its effectiveness and ability to carry out its responsibilities.

The findings of the Audit, Risk, and Assurance Committee's self-assessment will inform areas for development and focus for the coming year, as well as the development of a comprehensive board business improvement plan.

Asesiad / Assessment

The self-assessment for the Audit, Risk and Assurance Committee was completed throughout October 2023 by both Committee members and those individuals who

regularly support the work of the Committee. The self-assessment template is included in Appendix A, and the completed responses are included in Appendix B.

Following receipt of the completed self-assessments, the sections were analysed to provide an overall summary of the responses as well as recommendations for improvement for each section. Some suggestions are not specific to the Committee, but rather general observations that will help to shape the development of a comprehensive Board Business Improvement Plan, also informed by the annual Structured Assessment, relevant Internal Audit reviews, and Best Practice.

Summary of Individual Sections

Section 1 - Committee processes: Composition, Establishment and Ways of Working

There was general agreement that committee processes are well executed, and that the overall coordination and management of the meeting is consistent and well managed to allow the Committee to discharge its responsibilities.

There was broad agreement that information is provided to the Committee in sufficient time to allow for constructive debate and feedback for improvement.

There were some opportunities for strengthening in particular:

- Review Committee membership to ensure that there is enough resilience to ensure that the meeting is quorate.
- Induction and annual training to ensure members understand their role and the role of the Committee within the organisation.
- Review the report templates to include best practice, standards e.g., number of pages, language, flow etc.
- Attendance by the Lead Executive for all Audit reports presented to the Committee to provide enhanced assurance that management responses are appropriate and achievable.

Section 2 - Internal Control and Risk Management

The majority agreed that internal control and risk management are well implemented, but comments indicated that the work being undertaken to develop an effective Board Assurance Framework would be aided by the new approach to risk management and assurance reporting. The triangulation of assurance mechanisms would ensure effectiveness of the Board Assurance Framework.

The analysis also suggested that there was a good breadth of experience and knowledge to challenge the adequacy and effectiveness of control processes in responding to risks, as well as a good understanding of how the organisation develops, operates, and monitors the internal control system.

There were some opportunities for strengthening in particular:

- Internal and external audit should flag any significant findings or recommendations for all audits performed for separate discussion in the Committee meeting.
- Receive an annual compliance report demonstrating compliance with regulatory requirements set by Health Inspectorate Wales, Audit Wales, the Health and Safety Executive, and other regulators.

Section 3 - Annual Report and Accounts and Disclosure Statements
This section received a 100% response rate, with all ten questions answered positively, stating that full disclosure was evident at both the draft and final accounts meetings, enabling transparency and providing the opportunity to scrutinise the accounts at key points prior to submission to Welsh Government.

There were no comments or suggestions for improving or strengthening this area.

Section 4 - Internal Audit
Most respondents agreed that the Health Board's relationship with Internal Audit was positive, and that the Internal Audit Charter was followed. The meeting allows for constructive mutual scrutiny and debate of the results of the audits as well as the performance of the audited areas.

There were no comments or suggestions for strengthening or improving this area.

Section 5 - External Audit
Most respondents agreed that the Health Board's relationship with External Audit was positive, and that the External Audit Charter was followed. The meeting allows for constructive mutual scrutiny and debate of the results of the audits as well as the performance of the audited areas.

There were some opportunities for strengthening in particular:
- For the Committee to review the draft External Audits' Opinion on the Quality Account before receiving the final report for acceptance of the findings / recommendations.

Section 6 - Clinical Audit
Feedback in this section suggested the need to clarify the responsibilities relating to Clinical Audit between the Audit, Risk and Assurance Committee's role in ensuring that a Clinical Audit Plan is in place; with performance and delivery of the plan under the purview of the Patient Quality, Safety, and Outcomes Committee (PQSOC).

There were some opportunities for strengthening in particular:
- Patient Quality, Safety and Outcomes Committee to provide regular assurance reports to the Committee that the plan is on track and delivering improvements.

Section 7 - Counter Fraud
This section received a 100% response rate, with all ten questions answered positively, stating that the Committee received comprehensive updates and facilitated rich discussions over the management output from reports, as well as the conclusions / actions raised.

There were no comments or suggestions for improving or strengthening this area.

<u>Specific Responses for Audit Risk and Assurance Committee Improvement</u>

The table below details the specific areas where suggestions for improving the Audit, Risk, and Assurance Committee's effectiveness were made.

Specific Actions to deliver improvements in the Committee's effectiveness			
Section	**Area of Focus requiring attention**	**By When**	**Action Holder**
2 Internal Control and Risk Management	Committee Programme of Business – Consider inclusion of an annual assurance report to ARAC on compliance with regulatory requirements.	Q1 meeting of the new financial year.	Head of Board Business
2 Internal Control and Risk Management **4** Internal Audit	Internal and external audit reviews - Executive leads should be invited to ARAC whenever an audit in their portfolio is scheduled for discussion to provide assurance of the action plans in place to deliver improvements.	**Complete** This has been implemented for the November meeting and will be implemented for all future meetings.	Committee Secretariat
5 External Audit	Consider when there is a need for a policy to govern the value and nature of non-audit work carried out by the external auditors	If required, this will be actioned.	Head of Corporate Governance
5 External Audit	Explore the possibility of building into the Forward Work Programme the draft external auditor's opinion on the quality account for review.	31 March 2024	Head of Board Business

Overall Assessment of Effectiveness

To determine the overall effectiveness of the Committee, a standardised scoring matrix has been used to assess each Committee; this is in accordance with the Well-Led Framework for Leadership and Governance Developmental Reviews and is shown below.

Overall Assessment		
Score	**Definition**	**Description**
1	**Room for improvement**	The Committee is falling short of requirements and should consider how it can work towards becoming more effective in this area
2	**Meeting standards**	The Committee is performing to the required standard in this area. There may be room for improvement, but the Committee can be seen to be discharging its responsibilities effectively.
3	**Excelling**	This is an area where the Committee is performing beyond the standard expectations and is a real area of strength when it comes to exercising its responsibilities.

Five of the seven respondents provided an overall assessment of the Committee's effectiveness, shown below.

Return ID	Assurance Rating	Comments
1	Meeting standards	Areas for improvement, particularly in the implementation of audit actions - significant progress has been made in monitoring and reporting, allowing for a closer examination of outcomes.
2	Meeting standards	The Committee is discharging its responsibilities effectively. Reports are appropriate and provide the necessary detail for assurance, though this assurance can be reinforced through appropriate questioning.
3	Meeting standards	The Committee is effective in discharging its responsibility. All key avenues provide appropriate challenge, reporting, and assurance. The Work Plan and Terms of Reference are appropriate (though the copy on the Health Board's website needs to be reviewed). There is extensive tracking of audit recommendations, though the original implementation dates are sometimes overly ambitious, as they lapse on occasion. The Committee's pace and timing are good, but there is ample opportunity to discuss agenda items or bring them back for further discussion. While keeping in mind how full the agenda can be at times, I believe there is value in discussing key recommendations raised by "reasonable assurance reports.".
4	Meeting standards	The Committee is very thorough and focused on key issues and areas for improvement.
5	Meeting standards	The Committee has an annual plan and an activity schedule, and things are progressing well. The Committee is well-chaired and supported by the CEO, the Executive Team, and the Governance Team. Papers are always distributed on time, and I have no reservations about the Committee, its plans, or its work. I am confident that once systems and processes are in place, they will provide examples of good practice. Monitoring the budget reductions expected by the Welsh Government for ABUHB in the future will be difficult, and a robust monitoring system will be in place to demonstrate that the budget is being reduced as expected. My opinion is that the overall rating is a 2, with a future trajectory towards a 3 (Excelling).

Overall Assurance Rating

The table below provides a breakdown of the responses to each section, as well as an overall assurance rating against the committee's effectiveness.

Section	No of Questions	Number of Possible Responses	Number of responses 'Yes'	Number of responses 'No'	Number that 'Didn't Answer'	Overall Assurance Rating
1	27	189	170	10	9	
2	8	56	50	1	5	
3	9	63	63	-	-	
4	10	70	62	1	7	
5	7	49	35	1	13	
6	5	35	6	-	29	
7	8	56	55	-	1	
Total	**74**	**518**	**441**	**13**	**64**	

In conclusion, the results of the individual self-assessment, combined with the analysis of the seven self-assessments with an 85% response rate of 'Yes,' determined that the Committee is effective and meeting the standards.

Rating	Definition	Evidence
2	**Meeting standards**	The Committee is performing to the required standard in this area. There may be room for improvement, but the Committee can be seen to be discharging its responsibilities effectively.

These findings will be used to inform a comprehensive annual assessment of the Board's effectiveness. The effectiveness of the Board's Business function is reported through the Annual Governance Statement, enabling a focus on the work undertaken with the Board's Committees, interconnectedness of the committees and escalation to the Board, as well as the culture between the Health Board and its auditors, regulators and partners.

Argymhelliad / Recommendation

The Committee is asked to:

- **NOTE** the performance information contained within the report,
- **CONSIDER** the proposed actions to address those areas as requiring further improvement, and;
- **AGREE** to include any proposed improvement actions within the Committee Forward Plan for 2024/25 or the wider Board Business Improvement Plan.

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

Strategic Equality Objectives 2020-24	

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	N/A
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	None

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

Audit, Risk and Assurance Committee Self-Assessment Checklist

Introduction

The self-assessment tool is a way for our Audit, Risk and Assurance Committee (ARAC) to develop its effectiveness. The Board and its sub-Committees should aim to assess their effectiveness against these questions on an annual basis.

To gain an overall view of ARAC effectiveness, it is important that the individual views of all members are considered as a whole, therefore, each area of the effectiveness tool allows space for comments. This provides an important opportunity to expand on any considerations relating to that section of the effectiveness tool and to highlight any concerns about the Committee's performance.

At the end of the self-assessment there is an opportunity for you to provide an overall score on the Committee's effectiveness using the scoring scale below.

Score	Measure	Description
1	**Room for improvement**	The ARAC is falling short of requirements and should consider how it can work towards becoming more effective in this area
2	**Meeting standards**	The ARAC is performing to the required standard in this area. There may be room for improvement, but the ARAC can be seen to be discharging its responsibilities effectively.
3	**Excelling**	This is an area where the ARAC is performing beyond the standard expectations and is a real area of strength when it comes to exercising its responsibilities.

The completed self-assessments will enable the Corporate Governance Team to: -

1. generate an overall view of ARAC effectiveness; and
2. drill down and analyse specific areas of strength or improvement on a section, sub-section, and individual question level.

The results of which will be reported to the Committee in November and used to inform the Committee Annual Report, Annual Accountability Report and Governance Statement.

Section 1 - Committee Processes: Composition, Establishment, and Ways of Working				
	Question	**Response Yes / No**	**Comments**	**Suggested Improvement Actions**
1	Does the Committee have written terms of reference, and have they been approved by the Board?			
2	Are the terms of reference reviewed annually?			
3	The number of meetings held during the year is sufficient to allow the Committee to perform as effectively as possible?			
4	Has the Committee been quorate for each meeting this year?			
5	In terms of numbers, membership of the Committee is sufficient to discharge its responsibilities?			
6	Members who have recently joined the ARAC have been provided with induction training to help them understand their role and the organisation?			
7	The Committee is clear about its role in relationship to other Committees that play a role in relations to clinical governance quality and risk management?			
8	Committee members understand their responsibilities regarding identifying, declaring, and resolving conflicts of interest?			
9	The Committee uses assurance mapping to identify where assurance is required and identify any key gaps where no assurance is provided, or where the quality of the assurance is poor?			
10	The Committee has an established a plan of matters to be dealt with across the year?			
11	Does the Committee consider issues at the right time and in the right level of detail?			
12	The Committee ensure that the relevant executive director attends meetings to enable it to understand the reports and information it receives?			
13	Are the Committee's papers distributed in sufficient time for members to give them due consideration?			
14	The quality of the Committee's papers received allows Committee members to perform their roles effectively?			

15	Committee meetings are chaired effectively?			
16	The Committee chair allows debate to flow freely and does not assert his/her own view too strongly?			
17	The Committee environment enables people to express their views, doubts, and opinions?			
18	The Committee challenges management and other assurance providers to gain a clear understanding of their findings?			
19	Members hold their assurance providers (management) to account for late or missing assurance?			
20	Internal and External Audit contributes to the debate across the range of the agenda?			
21	Each agenda item is 'closed off' appropriately so that the Committee is clear on the conclusion; who is doing what, when and how and how it is being monitored?			
22	At the end of each meeting the Committee discuss the outcomes and reflect on decisions made and what worked well, not so well etc?			
23	Decisions and actions are implemented in line with the timescale set down?			
24	Are the outcomes of each meeting and any internal control issues reported to the next Board meeting?			
25	Does the Committee prepare an annual report on its work and performance for the Board?			
26	The results of the annual self-assessment are used to inform and influence succession planning and improve effectiveness.			
27	The self-assessment is objective and rigorous enough for meaningful conclusions to be drawn?			

Section 2 - Internal Control and Risk Management				
Question		**Response Yes/No**	**Comments**	**Suggested Improvement Actions**
28	Has the Committee reviewed the effectiveness of the organisation's assurance framework?			
29	The Committee has an effective system for monitoring management's progress with recommendations from internal and external sources?			
30	Does the Committee receive and review the evidence required to demonstrate compliance with regulatory requirements – for example, as set by the Health Inspectorate Wales, Audit Wales, HSE etc?			
31	The Committee challenges management on whether there is a comprehensive process for identifying and evaluating risk, and for deciding what levels of risk are tolerable?			
32	The Committee critically challenges and reviews the adequacy and effectiveness of control processes in responding to risks?			
33	The Committee has a good understanding of how the organisation develops, operates, and monitors the system of internal control.			
34	When any significant failings or weaknesses in internal control arise, the Committee reviews management's analysis of the root cause and subsequent action plan.			
35	Has the Committee reviewed the accuracy of the draft annual governance statement?			

Section 3 - Annual Report and Accounts and Disclosure Statements				
	Question	**Response Yes / No**	**Comments**	**Suggested Improvement Actions**
36	Does the Committee receive and review a draft of the organisation's annual report and accounts?			
37	**Does the Committee specifically review?**			
	a. Changes in accounting policies?			
	b. Changes in accounting practice due to changes in accounting standards?			
	c. Changes in estimation techniques?			
	d. Significant judgements made in preparing the accounts?			
	e. Significant adjustments resulting from the audit?			
	f. Explanations of any significant variances?			
38	Is a meeting of the Committee scheduled to discuss any proposed adjustments to the accounts and audit issues?			
39	Does the Committee ensure it receives explanations for any unadjusted errors in the accounts found by the external auditors?			

Section 4 - Internal Audit				
Question		**Response Yes / No**	**Comments**	**Suggested Improvement Actions**
40	Is there a formal 'internal audit charter' which includes terms of reference, defining internal audit's objectives and responsibilities?			
41	Does the Committee review and approve the internal audit plan and any changes to the plan?			
42	Is the Committee confident that the audit plan is derived from a clear risk assessment process?			
43	Does the Committee receive periodic progress reports from the Head of Internal Audit?			
44	Does the Committee effectively monitor the implementation of management actions arising from internal audit reports?			
45	Does the Head of Internal Audit have a right of access to the Committee and its chair at any time?			
46	Is the Committee confident that Internal Audit is free of any scope restrictions, or operational responsibilities?			
47	Has the Committee evaluated whether Internal Audit complies with the Public Sector Internal Audit Standards?			
48	Does the Committee receive and review the Head of Internal Audit's Annual Opinion Report?			
49	Does the Committee hold periodic private discussions with external auditors?			

Section 5 - External Audit				
Question		**Response Yes / No**	**Comments**	**Suggested Improvement Actions**
50	Do the external auditor's present their audit plan to the Committee for agreement and approval?			
51	Does the Committee review the external auditor's ISA 260 report (the report to those charged with governance)?			
52	Does the Committee review the external auditor's value for money conclusion?			
53	Does the Committee review the external auditor's opinion on the quality account when necessary?			
54	Does the Committee hold periodic private discussions with external auditors?			
55	Does the Committee require assurance from External Audit about its policies for ensuring independence?			
56	Has the Committee approved a policy to govern the value and nature of non-audit work carried out by the external auditors?			

Section 6 - Clinical Audit				
	Question	**Response Yes / No**	**Comments**	**Suggested Improvement Actions**
57	If the Committee is NOT responsible for monitoring clinical audit, does it receive appropriate assurance from the relevant Committee?			
58	**If the Committee is responsible for monitoring clinical audit, has it:**			
	a. Reviewed an annual clinical audit plan?			
	b. Received regular progress reports?			
	c. Monitored the implementation of management of actions?			
	d. Received a report over the quality assurance processes covered by clinical audit activity?			

Section 7 - Counter Fraud				
Question		**Response** Yes / No	**Comments**	**Suggested Improvement Actions**
59	Does the Committee review and approve the counter fraud work plans, and any changes to the plans?			
60	Is the Committee satisfied that the work plan is derived from an appropriate risk assessment and that coverage is adequate?			
61	Does the audit Committee receive periodic reports about counter fraud activity?			
62	Does the Committee effectively monitor the implementation of management actions arising from counter fraud reports?			
63	Do those working on counter fraud activity have a right of direct access to the Committee and its chair?			
64	Does the Committee receive and review an annual report on counter fraud activity?			
65	Does the Committee receive and discuss reports arising from quality inspections by NHSCFA?			
66	Does the Committee hold periodic private discussions with external auditors?			

Overall Assessment		
Score	**Measure**	**Description**
1	**Room for improvement**	The ARAC is falling short of requirements and should consider how it can work towards becoming more effective in this area
2	**Meeting standards**	The ARAC is performing to the required standard in this area. There may be room for improvement, but the ARAC can be seen to be discharging its responsibilities effectively.
3	**Excelling**	This is an area where the ARAC is performing beyond the standard expectations and is a real area of strength when it comes to exercising its responsibilities.

Comments:

	1. Does the Committee have written terms of reference, and have they been approved by the Board?	1a. Comments	1b. Suggested Improvement Actions	2. Are the terms of reference reviewed annually?	2a. Comments	2b. Suggested Improvement Actions	3. The number of meetings held during the year is sufficient to allow the Committee to perform as effectively as possible?	3a. Comments	3b. Suggested Improvement Actions	4. Has the Committee been quorate for each meeting this year?
	Yes			Yes			Yes			Yes
	Yes			Yes			Yes			Yes
	Yes			Yes			Yes	Now that we have two distinct committees audit and finance there seems to be enough time to perform effectively		Yes
	Yes			Yes	The copy of the terms of reference on the Health Board's internet page appear to be due for review.		Yes			Yes
	Yes			Yes			Yes			Yes
	Yes			Yes			Yes			Yes
	Yes			Yes			Yes			Yes
YES	**7**			**7**			**7**			**0**
NO										
Didn't Answer										

4a. Comments	4b. Suggested Improvement Actions	5. In terms of numbers, membership of the Committee is sufficient to discharge its responsibilities?	5a. Comments	5b. Suggested Improvement Actions	6. Members who have recently joined the ARAC have been provided with induction training to help them understand their role and the organisation?	6a. Comments	6b. Suggested Improvement Actions	7. The Committee is clear about its role in relationship to other Committees that play a role in relations to clinical governance quality and risk management?
		Yes	•Currently running at minimum membership – would not be quorate if 1 member unable to attend	Increase membership	Yes			Yes
		Yes	It's always good to have more members on any committee but especially in the Audit areas, so if additional member/s could be on this committee I think this would be positive. A stronger link between the QPSOC may strengthen the work of the committee.	Maybe increase numbers on the committee.		Not Sure		Yes
		Yes	Given the nature of the pervious question and the reliance of a small core of members if the membership were to be widened then the quorum could be always met	Increase Core Number		Not Known - I do not recall this when I joined pre merging with finance and certainly have not post stand alone	Refresher training for members	Yes
		Yes			Yes	I have not been a part of this, but I suspect this does happen within the induction process.		Yes
I think so		Yes				Don't know		Yes
		Yes				Did not answer n/a	Did not answer n/a	Yes
		Yes			Yes			Yes
		7			**3**	**3/7 Did not know if training was provided to members.**	**Refresher training for members**	**7**
					4			

7a. Comments	7b. Suggested Improvement Actions	8. Committee members understand their responsibilities regarding identifying, declaring, and resolving conflicts of interest?	8a. Comments	8b. Suggested Improvement Actions	9. The Committee uses assurance mapping to identify where assurance is required and identify any key gaps where no assurance is provided, or where the quality of the assurance is poor?	9a. Comments	9b. Suggested Improvement Actions	10. The Committee has an established a plan of matters to be dealt with across the year?	10a. Comments
		Yes			Yes			Yes	
See comments above		Yes			Yes	Assume this relates to the BAF, so needs more work.		Yes	
There is some blurring around the edges but the advice of the corporate governance team “keeps us in line”		Yes	I can only speak for myself but it would appear that members do		Yes	This is evidenced in reports and effected by questioning		Yes	There is a work plan and when new items or updates occur these are advised
Appropriate matters are often reported / escalated into other committees / Board.		Yes	There is also a declaration at the start of each meeting.		Yes	This is also achieved through the BAF.		Yes	
		Yes				?		Yes	
		Yes			Yes			Yes	
		Yes			No			Yes	
Corporate Governance team keeps the committee in line, Appropriate matters are escalated to other relevant committees/board.		**7**	**There is a declaration at the start of each meeting.**		**5**	**Acheived/supported via BAF.**		**7**	
					2				

10b. Suggested Improvement Actions	11. Does the Committee consider issues at the right time and in the right level of detail?	11a. Comments	11b. Suggested Improvement Actions	12. The Committee ensure that the relevant executive director attends meetings to enable it to understand the reports and information it receives?	12a. Comments	12b. Suggested Improvement Actions	13. Are the Committee's papers distributed in sufficient time for members to give them due consideration?
	Yes			Yes			Yes
	Yes	Mostly this is true, sometimes the committee has requested additional clarity due to the ambitious wording in some reports……		Yes			Yes
	Yes	The timings seem right for the discussion		Yes	However the reality it can be the relevant officer in addition to or in place of		Yes
	Yes	If further discussion is required, additional items are tabled at future committees. However, there is a challenge that this may be too far in advance. However, I have observed evidence of these matters being discussed.		Yes	However, this is only for 'limited assurance reports', but I have seen it extended to other matters e.g. clinical audit.	There may be value in tabling specific recommendations / matters arising from 'reasonable assurance audit reports'.	Yes
	Yes			Yes			Yes
	Yes			Yes			Yes
	Yes			Yes			Yes
	7	**All members are satisfied with avaliable time.**		**7**	**Only for limited assurance reports**		**7**

13a. Comments	13b. Suggested Improvement Actions	14. The quality of the Committee's papers received allows Committee members to perform their roles effectively?	14a. Comments	14b. Suggested Improvement Actions	15. Committee meetings are chaired effectively?	15a. Comments	15b. Suggested Improvement Actions
		Yes				•Probably one for others to comment on but no feedback to the contrary received.	
		Yes	Mostly this is true, sometimes the committee has requested additional clarity due to the ambitious wording in some reports		Yes		
They are dispatched with time. It is then not always convenient to properly consider the papers in time for the committee. This is my personal time management rather than dispatch		Yes	By enlarge the papers give us the information to consider reassurance. Sometimes can be repetitive and often unnecessarily long		Yes		
At times a higher volume of audit reports may align to a particular Committee date, there may be value in receiving finalised audit reports (just ones that have insignificant matters arising) inbetween meetings to ease the burden of reading papers. They would still be presented at the next committee date, but provide more advance opportunity to review report content.		Yes			Yes	The agenda timing is good, but with still enough time to	
		Yes	Variable quality in some cases but improved		Yes		
		Yes			Yes		
		Yes			Yes	Should be in person now	Move ARAC to in person
Papers are always delivered on time		**7**	**Ambitious wording sometimes used. Can be unnecessarily long at times.**		**6**	**Enough time provided to discuss. Meetings could be in person now.**	
					1		

16. The Committee chair allows debate to flow freely and does not assert his/her own view too strongly?	16a. Comments	16b. Suggested Improvement Actions	17. The Committee environment enables people to express their views, doubts, and opinions?	17a. Comments	18. The Committee challenges management and other assurance providers to gain a clear understanding of their findings?	18a. Comments	18b. Suggested Improvement Actions	19. Members hold their assurance providers (management) to account for late or missing assurance?	19a. Comments
	•Probably one for others to comment on but no feedback to the contrary received.		Yes		Yes			Yes	
Yes			Yes		Yes			Yes	
Yes	Chair allows and encourages debate		Yes	I do not get the impression that people are reluctant to express their opinion or appropriately challenge	Yes	Appropriate challenge is provided but not challenge for challenge sake		Yes	Challenge is made to late items in tracker and from previous reports
Yes	There are numerous opportunities for members to contribute.		Yes	Views are shared equally between members.	Yes	There is often detailed interviewing / questioning at Committee.		Yes	
Yes			Yes		Yes			Yes	
Yes			Yes		Yes			Yes	
Yes			Yes		Yes			Yes	
6	**Encouragement to debate.**		**7**	**People are not reluctant to share their views.**	**7**	**Appropriate challenge takes place.**		**7**	**Late/overdue are challenged**
1									

19b. Suggested Improvement Actions	20. Internal and External Audit contributes to the debate across the range of the agenda?	20a. Comments	20b. Suggested Improvement Actions	21. Each agenda item is 'closed off' appropriately so that the Committee is clear on the conclusion; who is doing what, when and how and how it is being monitored?	21a. Comments	21b. Suggested Improvement Actions	22. At the end of each meeting the Committee discuss the outcomes and reflect on decisions made and what worked well, not so well etc?	22a. Comments	22b. Suggested Improvement Actions
	Yes			Yes			No	• Should we have a five-minute postmortem at the end of each meeting – members only?	
	Yes			Yes			Yes	Although this is not a formal committee agenda item, so maybe dependent of the chair. Maybe this could be formalised as an item on the agenda	See Comment
	Yes			Yes	Item closed off or further work requested or updated and brought back at a time 6 months year etc		No	Not to my knowledge either formally or informally	
	Yes			Yes			Yes	Matters are summed up with consideration to reporting to other committees taken too.	
	Yes			Yes			No	Not aware that this happens	
	Yes			Yes			Yes		
	Yes			Yes			Yes		
	7			**7**			**4**	**Could formalise a five minute round up at the end of the meeting.**	
							3		

23. Decisions and actions are implemented in line with the timescale set down?	23a. Comments	23b. Suggested Improvement Actions	24. Are the outcomes of each meeting and any internal control issues reported to the next Board meeting?
	Yes/No •Actions arising from the committee captured in the log are generally managed well and reported within the appropriate timescales and/or updates given. •Significant volume of audit actions overdue		
Yes			Yes
No	Often delays or slippage in implementation		Yes
Yes	Occasionally Management actions for the recommendations can take longer to implement.		Yes
Yes			
Yes			Yes
Yes	Audit actions are sometimes slow to be completed (not by committee)	Action leads need to ensure Audit recommendations are agreed actions are completed within timescales.	Yes
5	**Audit actions are sometimes slow to be implemented**		**5**
1			
1			2

24a. Comments	24b. Suggested Improvement Actions	25. Does the Committee prepare an annual report on its work and performance for the Board?	25a. Comments	25b. Suggested Improvement Actions	26. The results of the annual self-assessment are used to inform and influence succession planning and improve effectiveness.	26a. Comments	26b. Suggested Improvement Actions	27. The self-assessment is objective and rigorous enough for meaningful conclusions to be drawn?	27a. Comments
Y/N •Due to timescales, it may be the board meeting after next at times.		Yes				Y/N •Used to improve effectiveness – not sure about succession planning?		Yes	
		Yes			Yes			Yes	
I have said yes as the committee have the option what to take to board. Not every decision is reported back its more by exception and concern		Yes			Yes			Yes	In addition to the questions we can free script any items issues which concern us
Items for escalation are identified.		Yes			Yes			Yes	
? Don't know			Not sure I've seen one			Don't know			Don't know
		Yes			Yes			Yes	
		Yes			Yes			Yes	
Unsure if this happens		**6**			**5**	**Not sure**		**6**	**Not sure**
		1			2			1	

27b. Suggested Improvement Actions	28. Has the Committee reviewed the effectiveness of the organisation's assurance framework?	28a. Comments	28b. Suggested Improvement Actions	29. The Committee has an effective system for monitoring management's progress with recommendations from internal and external sources?	29a. Comments	29b. Suggested Improvement Actions	30. Does the Committee receive and review the evidence required to demonstrate compliance with regulatory requirements – for example, as set by the Health Inspectorate Wales, Audit Wales, HSE etc?
	Yes			Yes			Yes
	Yes	As this is under review at the moment there will no doubt be more work to do on this.		Yes	Still work in progress, but has improved over the last year		Yes
	Yes			Yes			
	Yes			Yes	Reviewed each year as part of the annual Internal Audit Plan.		Yes
		Don't know		Yes			Yes
	Yes			Yes			Yes
	Yes			Yes			No
	6			**7**			**5**
							1
	1						1

30a. Comments	30b. Suggested Improvement Actions	31. The Committee challenges management on whether there is a comprehensive process for identifying and evaluating risk, and for deciding what levels of risk are tolerable?	31a. Comments	31b. Suggested Improvement Actions	32. The Committee critically challenges and reviews the adequacy and effectiveness of control processes in responding to risks?	32a. Comments	32b. Suggested Improvement Actions
		Yes			Yes		
As it relates to the TOR of the committee eg Audit Wales, not HSE etc		Yes	Work in progress with Risk ongoing			Yes/No We do ask questions, but it is difficult to challenge some of the controls in place as they are not always clear. Hopefully the new format for report will assist in this	
No known - Without tracking back I can not say this across all regulatory requirements. I recall reports coming before us but not if this is complete		Yes	This has been a long journey but does show improvement and possibly nearly where members would like to see it. The committee feels its views have been listened to		Yes	When it is presented to us	
Possibly To a degree, but only at a high level, instead they I would expect them to receive assurance from providers that requirements are being met.		Yes	Risk management process.		Yes	CRR is presented to Committee, along with review of risk management process.	
		Yes			Yes		
		Yes			Yes		
Not all regulatory requirements are reported to ARAC, these are split to other committees.	ARAC should receive compliance reports	Yes			Yes		
Not all regulatory requirements are reported to ARAC, these are split to other committees.	**ARAC should receive compliance reports**	**7**	**Ongoing work**		**6**	**Only when presented to the committee, Can be diffucukt to challenge.**	
					1		

33. The Committee has a good understanding of how the organisation develops, operates, and monitors the system of internal control.	33a. Comments	33b. Suggested Improvement Actions	34. When any significant failings or weaknesses in internal control arise, the Committee reviews management's analysis of the root cause and subsequent action plan.	34a. Comments	34b. Suggested Improvement Actions
Yes			Yes		
Yes				Yes/No While the committee reviews the failings, the detailed analysis will go back to the relevant subject committee	
Yes			Yes	And follows up to ensure the plan is developed	
Yes	There is good membership of experience and knowledge on the Committee.		Yes	To a degree With audit reports, details of a control failure is described, together with action. However, only significant failings (i.e. limited assurance reports) are discussed at a Committee level.	There is scope for significant findings / recommendations on advisory, reasonable / substantial reviews to be considered within Committee. Whilst there is an opportunity to raise this from members, they are not routinely discussed. It might beneficial for key findings to be flagged up by Internal Audit and External Audit etc. for separate discussion.
Yes				?	
Yes			Yes		
Yes			Yes		
7			**5**	**2 - Not sure**	**There is scope for significant findings / recommendations on advisory, reasonable / substantial reviews to be considered within Committee. Whilst there is an opportunity to raise this from members, they are not routinely discussed. It might beneficial for key findings to be flagged up by Internal Audit and External Audit etc. for separate discussion.**
			2		

35. Has the Committee reviewed the accuracy of the draft annual governance statement?	35a. Comments	35b. Suggested Improvement Actions	36. Does the Committee receive and review a draft of the organisation's annual report and accounts?	36a. Comments	36b. Suggested Improvement Actions	37. Does the Committee specifically review?	37a. Comments	37b. Suggested Improvement Actions	38. Is a meeting of the Committee scheduled to discuss any proposed adjustments to the accounts and audit issues?
Yes			Yes			Yes			Yes
Yes			Yes			Yes			Yes
Yes			Yes	There is a special audit committee to do this specifically and afford it the time it deserves		Yes			Yes
Yes			Yes			Yes	Overview presented by AFD - Financial Accounting / DoF		Yes
Yes			Yes			Yes	Covered in the paper to the committee on the accounts and any significant changes are updated throughout the year		Yes
Yes			Yes			Yes			Yes
Yes			Yes			Yes	For accounts analysis		Yes
7			**7**	**There is a special audit committee to do this specifically and afford it the time it deserves**		**42**			**7**

38a. Comments	38b. Suggested Improvement Actions	39. Does the Committee ensure it receives explanations for any unadjusted errors in the accounts found by the external auditors?	39a. Comments	39b. Suggested Improvement Actions	40. Is there a formal 'internal audit charter' which includes terms of reference, defining internal audit's objectives and responsibilities?	40a. Comments	40b. Suggested Improvement Actions	41. Does the Committee review and approve the internal audit plan and any changes to the plan?	41a. Comments
		Yes			Yes			Yes	
		Yes			Yes			Yes	
I believe this is covered by the committee referred to in 36 abov		Yes			Yes			Yes	
		Yes	In addition, there are separate opportunities to scrutinise the accounts.		Yes			Yes	This is raised as part of the agenda, as and when required. A justification is also provided as to why this is required.
2 meetings used – draft accounts and final accounts – full disclosure in both		Yes	Audit report – but all errors are adjusted in any event			? Don't know		Yes	
		Yes			Yes	Not sure if it is referenced as the Internal Audit Charter		Yes	
		Yes			Yes			Yes	
2 meetings used – draft accounts and final accounts – full disclosure in both		**7**	**separate opportunities to scrutinise the accounts.**		**6**	**Not sure**		**7**	**This is raised as part of the agenda, as and when required. A justification is also provided as to why this is required.**
					1				

41b. Suggested Improvement Actions	42. Is the Committee confident that the audit plan is derived from a clear risk assessment process?	42a. Comments	42b. Suggested Improvement Actions	43. Does the Committee receive periodic progress reports from the Head of Internal Audit?	43a. Comments	43b. Suggested Improvement Actions	44. Does the Committee effectively monitor the implementation of management actions arising from internal audit reports?	45. Does the Head of Internal Audit have a right of access to the Committee and its chair at any time?	45a. Comments
	Yes			Yes				Yes	
	Yes			Yes			Yes	Yes	
	Yes			Yes			Yes		I would hope so but can not answer yes or no and not been part of any out of committee meeting with HIA
	Yes	We utilise PowerBI to draw comparisons, highlight themes and risks, alongside an audit universe.		Yes	Each Committee		Yes	Yes	We meet frequently.
	Yes	Assume so - they approve it		Yes			Yes	Yes	Assume so
	Yes			Yes			Yes	Yes	
	No	Not sure a risk based assessment has been performed.		Yes			Yes	Yes	
	6	**Not sure a risk based assessment has been performed.**		**7**	**Each Committee**		**6**	**6**	
	1								
							1	1	

45b. Suggested Improvement Actions	46. Is the Committee confident that Internal Audit is free of any scope restrictions, or operational responsibilities?	46a. Comments	46b. Suggested Improvement Actions	47. Has the Committee evaluated whether Internal Audit complies with the Public Sector Internal Audit Standards?	47a. Comments	47b. Suggested Improvement Actions	48. Does the Committee receive and review the Head of Internal Audit's Annual Opinion Report?
	Yes			Yes			Yes
	Yes			Yes			Yes
	Yes	Their reports would imply this as would any recommendations		Yes	This is a lack in my memory		Yes
	Yes	As part of each review we are required to respond to a series of Code of Ethics questions, including objectivity and independence.		Yes	This is completed as part of our Head of Internal Audit Opinion and Annual Report, which provides a confirmation of adherence to the PSIAS. Each audit is also completed in accordance with the PSIAS. Furthermore, Audit and Assurance was externally assessed to confirm that the PSIAS were agreed to.		Yes
		Not aware this has come up as an issue			Part of audit brief		Yes
	Yes			Yes			Yes
	Yes			Yes			Yes
	6			**6**	**This is completed as part of our Head of Internal Audit Opinion and Annual Report, which provides a confirmation of adherence to the PSIAS. Each audit is also completed in accordance with the PSIAS. Furthermore, Audit and Assurance was externally assessed to confirm that the PSIAS were agreed to.**		**7**
	1			1			

48a. Comments	48b. Suggested Improvement Actions	49. Does the Committee hold periodic private discussions with external auditors?	49a. Comments	49b. Suggested Improvement Actions	50. Do the external auditor's present their audit plan to the Committee for agreement and approval?	50a. Comments	50b. Suggested Improvement Actions	51. Does the Committee review the external auditor's ISA 260 report (the report to those charged with governance)?	51a. Comments	51b. Suggested Improvement Actions
		Yes			Yes			Yes		
		Yes			Yes			Yes		
			I would hope so but can not answer yes or no and not been part of any private meeting		Yes	Think it is for agreement rather than approval but that could just be me			Without referring back to committee papers I can neither confirm or otherwise	
		Yes			Yes			Yes		
			Not sure		Yes	Albeit very late	Could be provided to the committee earlier in the cycle	Yes		
		Yes			Yes			Yes		
		Yes			Yes			Yes		
		5			**7**			**6**		
		2						1		

52. Does the Committee review the external auditor's value for money conclusion?	52a. Comments	52b. Suggested Improvement Actions	53. Does the Committee review the external auditor's opinion on the quality account when necessary?	53a. Comments	53b. Suggested Improvement Actions	54. Does the Committee hold periodic private discussions with external auditors?	54a. Comments	54b. Suggested Improvement Actions	55. Does the Committee require assurance from External Audit about its policies for ensuring independence?	55a. Comments
Yes			Yes			Yes			Yes	
Yes			Yes			Yes			Yes	
	Without referring back to committee papers I can neither confirm or otherwise			Without referring back to committee papers I can neither confirm or otherwise			Without referring back to committee papers I can neither confirm or otherwise			Probably should by cannot recall it doing so
Yes	There is challenge from the Committee members over this.		Yes			Yes			Yes	
Yes				Exists?			Not sure			Not sure
Yes			Yes			Yes			Yes	
Yes				This is new. This is not a WG requirement for 23/24	Include for 24/25	Yes			Yes	
6			**4**	**Not cuurently a requirement 23/24**	**Include for 24/25**	**5**			**5**	
1			3			2			2	

55b. Suggested Improvement Actions	56. Has the Committee approved a policy to govern the value and nature of non-audit work carried out by the external auditors?	56a. Comments	56b. Suggested Improvement Actions	57. If the Committee is NOT responsible for monitoring clinical audit, does it receive appropriate assurance from the relevant Committee?	57a. Comments	57b. Suggested Improvement Actions	58. If the Committee is responsible for monitoring clinical audit, has it:
		•Can't remember seeing this but may well have?			Y/N •In general, yes, but issues raised 22/23 with clinical audit		
		Not sure		Yes			
		Probably should by cannot recall it doing so					
	Yes			Yes	It does receive the Clinical Audit Plan and there is extensive challenge over this.		a.Reviewed an annual clinical audit plan?
	No	Not needed for Audit Wales?					
		Unsure		Yes			
	Yes	This is generally not open to discussion with A.W it is usually dictated by AGW	This should be implemented to assess VFM of proposed study work.	No	This needs improvement - clarity us not provided	Regular summary reports to ARAC	
	2	**Unsure if this is a requirement?**	**This should be implemented to assess VFM of proposed study work.**	**3**	**Improvement required**	**Regular summary reports to ARAC**	**1**
	1			1			
	4			3			6

58a. Comments	58b. Suggested Improvement Actions	59. Does the Committee revi approve the counter fraud wo and any changes to the pla
		Yes
		Yes
		Yes
b. Received regular progress reports? - No It has only recently approved the Clinical Audit approach, so this is not necessarily fully up to speed. c. Monitored the implementation of management of actions? - Unsure This may be captured by the Audit Recommendation Tracker, but I am not sure what clinical audits have been completed. I know that local audits will probably capture actions differently. d. Received a report over the quality assurance processes covered by clinical audit activity? - Unsure	b. I would probably be conscious of overloading the agenda, so I think the frequency of updates would need to be considered carefully, but equally regular reports would highlight any concerns earlier. c. If it is not captured, I would suggest utilising the same methodology as other actions – with the Audit Recommendation Tracker	Yes
		Yes
a, b, c and d		Yes
		Yes
		7

59a. Comments	59b. Suggested Improvement Actions	60. Is the Committee satisfied that the work plan is derived from an appropriate risk assessment and that coverage is adequate?	60a. Comments	60b. Suggested Improvement Actions	61. Does the audit Committee receive periodic reports about counter fraud activity?	61a. Comments	61b. Suggested Improvement Actions	62. Does the Committee effectively monitor the implementation of management actions arising from counter fraud reports?	62a. Comments
		Yes			Yes			Yes	
		Yes			Yes			Yes	
		Yes			Yes			Yes	
		Yes			Yes	There are comprehensive updates.		Yes	There is a lot of discussion over the management output from reports, together with the conclusions / actions raised.
		Yes			Yes			Yes	
		Yes			Yes			Yes	
		Yes			Yes			Yes	
		7			**7**	**There are comprehensive updates.**		**7**	**There is a lot of discussion over the management output from reports, together with the conclusions / actions raised.**

62b. Suggested Improvement Actions	63. Do those working on counter fraud activity have a right of direct access to the Committee and its chair?	63a. Comments	63b. Suggested Improvement Actions	64. Does the Committee receive and review an annual report on counter fraud activity?	64a. Comments	64b. Suggested Improvement Actions	65. Does the Committee receive and discuss reports arising from quality inspections by NHSCFA?	65a. Comments	65b. Suggested Improvement Actions	66. Does the Committee hold periodic private discussions with external auditors?
	Yes			Yes			Yes			Yes
	Yes			Yes			Yes			Yes
	Yes	In so far as we meet pre meeting not been in any other private meetings		Yes			Yes			
	Yes			Yes			Yes			Yes
	Yes			Yes			Yes			Yes
	Yes			Yes			Yes			Yes
	Yes			Yes			Yes			Yes
	7			**7**			**7**			**6**
										1

66a. Comments	66b. Suggested Improvement Actions	Score	Comments
		Meeting standards - The ARAC is performing to the required standard in this area. There may be room for improvement, but the ARAC can be seen to be discharging its responsibilities effectively.	Overall Score 2. Areas for improvement specifically around implementation of audit actions – considerable improvement made in monitoring and reporting which enables closer scrutiny of outcomes
		Meeting standards - The ARAC is performing to the required standard in this area. There may be room for improvement, but the ARAC can be seen to be discharging its responsibilities effectively.	
I refer to my answer in 49		Meeting standards - The ARAC is performing to the required standard in this area. There may be room for improvement, but the ARAC can be seen to be discharging its responsibilities effectively.	I feel the Committee is discharging its responsibilities effectively. Reports are appropriate and provide with the detail required for assurance though this assurance may be reinforced by appropriate questioning. Personal reflection I should reflect on those areas I could not provide a definitive answer
			I believe the ARAC is effective within discharging its responsibility. There is appropriate challenge, reporting and assurance provided from all key avenues. The Work Plan and the terms of reference are appropriate (although the copy hosted on the Health Board's website is due for review). There is comprehensive tracking of audit recommendations, although sometimes the original implementation dates are too ambitious, as they on occasion lapse. The pace and timing of the Committee is good, but at the same time there is good opportunity to discuss agenda items or bring them back for further discussion. Whilst being mindful of how packed the agenda can be at times, I think there is benefit to discussing key recommendations raised from 'reasonable assurance reports'. We often raise significant matters from
			The committee is very thorough and focussed on key issues and where it seeks improvement.
		Meeting standards - The ARAC is performing to the required standard in this area. There may be room for improvement, but the ARAC can be seen to be discharging its responsibilities effectively.	The ARAC has ab annual plan and a programme of activity and things are progressing well. The ARAC is well chaired and supported by the Chief Executive and the Executive team and the Governance Team. Papers are always on time, and I have no worries or concerns about the committee, plans or its work. I am sure that now that systems and processes are once they are embedded, will ensure examples of good practice. For the future, the monitoring of the reductions in the budget expected by the welsh government for ABUHB will be a challenge, and there will be a robust monitoring system in place to evidence that the budget is being reduced as expected. My own thoughts are that the assessment is an overall 2, with direction of travel being towards a 3 in the future.
		Meeting standards - The ARAC is performing to the required standard in this area. There may be room for improvement, but the ARAC can be seen to be discharging its responsibilities effectively.	
		100% of committee members beleive the committee is meeting the required standards.	

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	28 November 2023
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Implementation of the Governance Priorities set out within the Integrated Medium-Term Plan 2023-26
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Head of Corporate Governance

Pwrpas yr Adroddiad
Purpose of the Report

Er Sicrwydd/For Assurance

The purpose of this paper is to provide the Audit, Risk & Assurance Committee with an update in respect of implementing the governance priorities set out within the Integrated Medium-Term Plan 2023-26.

ADRODDIAD SCAA
SBAR REPORT

Cefndir / Background

Aneurin Bevan University Health Board (ABUHB) recognises the importance of governance in ensuring that the organisation fulfils its overall purpose, achieves its intended aims and outcomes for our population, and operates in an effective, efficient, and ethical manner. The effectiveness of our governance arrangements will therefore have a significant impact on how well we deliver our vision, aims and objectives.

Within our Integrated Medium-Term Plan 2023-26, we set out our commitment to continually reflect upon, developing and maturing our governance systems to ensure that the organisation has a strong focus on integrated governance and leadership across quality, finance and operations as well as an emphasis on organisational culture, improvement and system working. In doing so, we aim to continuously ensure that the Health Board is a well-led organisation with effective, agile and proportionate structures, processes and systems of accountability, including the governance and management of partnerships, joint working arrangements and shared services, which are clearly set out and understood.

The Integrated Medium-Term Plan sets out our governance improvement priorities, focussed on further strengthening the Health Board's governance arrangements, ensuring they are robust and fit for purpose, responding to areas identified for improvement, informed by sources including Internal and External Audit and the Board's reflections on its own effectiveness (reported to Board in September 2023). These governance improvement priorities are intended to:

- Ensure clarity of purpose, roles, responsibilities and systems of accountability;
- Ensure Board effectiveness; and
- Embedding an effective system of risk management and assurance.

Asesiad / Assessment

An update in respect of implementing the governance priorities set out within the Integrated Medium-Term Plan 2023-26, at the end of Quarter 2 2023/24, is provided below.

1. Ensuring Clarity of Purpose, Roles, Responsibilities and Systems of Accountability:

Action	Update	RAG Rating
a) Establishing a Decision-Making Framework and an Accountability Framework to enable appropriate integrated-decision making at all levels of the organisation, along with strengthened internal control	The Health Board's arrangements align to Standing Orders and Standing Financial Instructions (reviewed and approved September 2023). The Board's Scheme of Delegation, including delegated limits, is subject to review in Q3, 2023/24. The Executive Team has been working with the organisation's senior leadership team to further embed a culture of empowerment, autonomy, authority and accountability, building on existing arrangements in place. A Governance and Delivery Framework for Financial Recovery has been prepared for Q3&4 2023/24 and will be presented to the Board in November 2023. In addition to these specific arrangements to oversee delivery of financial recovery and sustainability, the Board approved a Performance and Accountability Framework in September 2023.	
b) Developing a Partnership Governance Framework to support achievement of the Board's objectives, where the involvement of our key partners is critical	Strengthened oversight of the Board's statutory committees and joint committees has been established, with reporting to each meeting of the Board. A Governance Review of the Regional Partnership Board (RPB) has been undertaken to review its governance	

	model and understand the interface with the Health Board's internal governance framework, to ensure clarity on decision making delegations and accountability. The review has concluded and reported to the RPB in September 2023. An action plan will now be developed to respond to the findings of the review. The action to develop a comprehensive Partnership Governance Framework, spanning all statutory partnerships, will be continued in 2023/24.	
c) Further strengthening mechanisms for recording and reporting declarations of interest, gifts, hospitality and sponsorship.	The Health Board continues to operate under its approved policies to support Standards of Behaviour. A review of these policies is scheduled to take place be the end of Q4. This will include consideration of more effective ways of receiving and recording declarations for disclosure, based on national discussions.	
2. Ensuring Board Effectiveness		
Action	**Update**	**RAG Rating**
a) Reviewing and strengthening the Board's Committee Structure, aligning the Board's needs with its assurance and advisory infrastructure	The Board established a revised committee structure in March 2022. The purpose of which was to better balance the focus between strategy, delivery, performance, and culture. The Board undertook a self assessment against the NHS England Well-led Framework for Leadership and Governance Departmental Reviews in June 2023. This identified areas for improvement to be taken forward during 2023/24. This includes the introduction of mid-year self assessments by Committees to inform the year end Board Self Assessment.	
b) Re-establishing the Board's Advisory Structure, i.e. the Healthcare Professionals' Forum and the Stakeholder Reference Group	The Board's Advisory infrastructure still requires the establishment of the Stakeholder Reference Group and Healthcare Professions' Forum. A Clinical Advisory Forum (which will be the Health Board's Healthcare Professions' Forum) is currently being established. The ToR were approved by the Board in September 2023. Membership will be submitted to the	

	Board for approval in November 2023. The Health Board's Local Partnership Forum (Trade Unions) continues to operate effectively.	
c) Ensuring openness and transparency in the conduct of board and committee business	The Health Board has introduced hybrid meeting arrangements for Board meetings, accommodating both in-person and virtual attendance. Recordings of meetings are also published to the website for viewing after the meeting. These arrangements now need to extend to meetings of the Board's committees, which will be established by the end of Q3, 2023/24.	
d) Further improving the quality of reports and information to the Board and its Committees	Revised report templates have been developed and will be developed and rolled-out with supporting guidance. The provision of report writing training is also being explored.	
e) Implementing an annual development programme for Board members, focussing on awareness sessions as well as training and learning to support the development of individual roles and the Board as a cohesive team	The Board undertook a self assessment against the NHS England Well-led Framework for Leadership and Governance Departmental Reviews in June 2023. This identified areas for improvement to be taken forward during 2023/24. A structured development programme will be established for 2023/24 onwards, ensuring the Board receives training on its core statutory responsibilities, as well as focussing on maturing its effectiveness and ways of working.	
f) Ensuring a programme of comprehensive recruitment and induction for Board Member appointments	During 2022/23, the Health Board introduced new induction arrangements for Executive Directors and Independent Members. This process remains under review to ensure its effectiveness, seeking feedback for new Board Members. The Health Board has appointed to the roles of Vice Chair and Independent Member (Third Sector) during 2023/24. Recruitment is currently underway for an Independent Member (Community).	
g) Promoting Board Member visibility, openness and engagement	Executive Directors of the Board continue to undertake visits across Health Board sites, promoting visibility and strengthening staff engagement. The Chief Executive Officer continues to	

	deliver a comprehensive programme of CEO visits and engagement events to meet with staff across the organisation. Patient Safety visits by Independent Members of the Board, have also recommenced, in line with the Quality Strategy, approved by the Board in May 2023.	
h) Reviewing and implementing arrangements for the development, review, approval and publication of policies delegated by the Board	An Internal Audit review of the Health Board's policy management framework, undertaken in January 2023, concluded that the Health Board could take limited assurance that there are effective processes in place to manage policies and other relevant documentation. Overall, Internal Audit found that an appropriate and up-to-date framework and guidance document for the management of policies is in place. However, there are a significant number of policies and other documentation overdue for review. A Policy Management Improvement Plan has been established and has started to deliver improvements in compliance. However, the Framework and process for policy management is being reviewed and the implementation plan refreshed during Q3 2023/24 to ensure clear processes for the development, approval and review of policies.	
i) Reviewing Board Champion Roles, ensuring clarity on purpose and responsibility	Board Champion roles were reviewed and re-affirmed by the Board in March 2022. National guidance on role profiles is awaited. Work will be undertaken on Q3/4 to establish clear reporting from Champions into the Board's governance structure.	
3. Embedding an Effective System of Risk and Assurance		
Action	**Update**	**RAG Rating**
a) Further implementation of the Risk Management Strategy, ensuring it continues to be fit for purpose and supports the organisation to navigate risk management processes in a simplified manner	The Risk Management Benefits Realisation Plan, approved by the Audit, Risk & Assurance Committee, continues to be implemented. An updated Risk Management Framework, including the Board Assurance Framework, is due to the Board for consideration in November 2023. It is proposed that the revised Framework will go out for consultation for two weeks beginning of	

	November. Once approved by the Board, it will be communicated throughout the organisation via our communication channel and the hierarchy structure. A programme of implementation and training will be planned to embed the Framework, building on the existing Risk Management Benefits Realisation Plan. Risk Management Sessions continued to be held with divisions. Once the revised Framework has been approved, training will be delivered, centred on the framework and how the framework will assist the organisation in embedding risk management into its operations.	
b) Review the Board's Risk Appetite Statement, ensuring it is reflective of the organisation's capacity and capability to manage risks	The Board, with the assistance of NHS Providers, developed its Risk Appetite Statement, which has been included in the revised Risk Management Framework for Board approval. This is expected to be approved at the Board meeting in November.	
c) Prepare for implementation of a revised risk register reporting system to ensure it is comprehensive and aligned to the Corporate Risk Register (via Once for Wales Complaints Management System [DATIX])	Due to functional issues with the demo model, the revised system's implementation has been pushed back to summer 2024. Powys Teaching Health Board is currently testing the most recent version, with a performance update due at the end of October. As per the previous update, work continues to prepare for implementation, ensuring organisational readiness if the module is approved on a national level. Discussions have commenced regarding continuity plans should the risk module not be approved and access to the legacy Datix system is removed in November 2024, as advised by Datix.	
d) Further Embedding of the Board's Assurance Framework, aligned to the Corporate Risk Register	The Corporate Risks were reviewed and refreshed in June 2023 and a new set of Strategic risks were developed (10 overarching risks with 18 sub risks). As a result of the refresh some risks were de-escalated to the Corporate or	

	Divisional Risk Register(s) for management and monitoring. The strategic risks (previously corporate risks) are owned by the Board and the corporate risks now sit with the Executive Team, unless escalation to the Strategic Risk Register is required. The revised Risk Management and Assurance Framework explains how the Corporate and Strategic Risk Registers are integrated into the concept of a Board Assurance Framework. There are plans to develop a Board Assurance Dashboard as part of the Risk Benefits Realisation Plan, which will show the strategic objectives, strategic risks, and performance metrics so that the Board can obtain assurance from multiple sources in an integrated visual way.	
e) Introducing a system of Organisational Assurance Mapping at a divisional and directorate level to inform internal control arrangements	Organisational mapping of internal controls and assurance arrangements has not yet commenced. The process for this work will be set out within the integrated Risk Management and Assurance Framework, which will include the Board Assurance Framework and supporting processes.	

Whilst progress has been made in delivering the required actions to achieve these objectives between February and September 2023, there remains considerable work to be delivered within the organisation. It is recognised that the necessary capacity and expertise to support this work is deemed imperative. To support this, a revised Director of Corporate Governance Structure, covering the breadth of corporate governance and corporate business elements and aligned to the governance priorities has been developed and, following a period of consultation, approved. Recruitment has now been completed and all staff will be in post by the end of November 2023. This will provide the capacity and expertise within the team to drive forward the required changes, working with the wider orgasniation on key aspects.

Argymhelliad / Recommendation

The Audit, Risk & Assurance Committee is asked to receive this update for information, noting progress achieved to-date and those objectives which require further action.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	This paper outlines actions taken to strengthen organisational risk management arrangements.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. This paper reflects on the Governance Priorities set out within the Integrated Medium-Term Plan 2023-26.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item. Choose an item. Choose an item. Choose an item.
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

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

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb **Equality Impact Assessment** (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change.

	If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs Choose an item.

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	28 November 2023
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Welsh Health Circular and Ministerial Directions Tracking
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Rani Dash, Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Bryony Codd, Head of Corporate Governance

Pwrpas yr Adroddiad
Purpose of the Report

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The paper presents the Audit, Risk and Assurance Committee with an overview of the current position relating to the implementation of Welsh Health Circulars (WHC) and Ministerial Directions (MDs) within Aneurin Bevan University Health Board.

Cefndir / Background

Welsh Health Circulars
A Welsh Health Circular (WHC) is health guidance, issued by Welsh Government to NHS Wales health bodies and professionals as a circular. Whilst issued as guidance, WHCs will often include expected actions to be implemented by respective organisations and individuals. The publication of WHCs can be seen at Health circulars | GOV.WALES.

For Aneurin Bevan University Health Board, WHCs are received from Welsh Government and issued via the Corporate Governance Team for action to the respective director leads/professional groups.

Ministerial Directions
Acts of Parliament, Assembly Measures and Assembly Acts enable Welsh Ministers to develop more detailed legislation, known as secondary or subordinate legislation, usually by means of Statutory Instruments (SI). Non-Statutory Instruments (NSI), otherwise known as Ministerial Directions (MD) are legislative in character; they alter legal rights and duties, however they are not SIs. NSIs, which are issued by Welsh Ministers, include codes of practice and guidance. The publication of WHCs can be seen at Publications | GOV.WALES.

For Aneurin Bevan University Health Board, the website is regularly reviewed, by the Corporate Governance Team, for new Ministerial Directions and added to the tracker for review by the respective executive lead.

Asesiad / Assessment

Progress against implementation of WHCs and MDs was previously published in the Annual Governance Statement. However, to ensure a more robust process to monitor the status of WHCs throughout the year, a WHC and MD Tracker has been established, with progress against the tracker reported to the Audit, Risk and Assurance Committee twice a year.

The Annual Governance Statement 2021/22 confirmed that those WHCs and MDs issued during 2021/22 had been implemented. The Tracker therefore captures WHCs, and MDs issued since 1st January 2022.

An overview of progress, as at the end of October 2023, is provided below:

	Welsh Health Circulars	
	2022	**2023**
No Progress	0	0
In Progress	1	6
Complete	28	27
Withdrawn	1	0
Total Number issued	**30**	**33**

	Ministerial Directions	
	2022	**2023**
No Progress	0	0
In Progress	0	4
Complete	13	9
Withdrawn	0	0
Total Number issued	**13**	**13**

The full tracker is provided as Appendix One, however, those WHCs and MDs not yet complete are highlighted below:

WHC No	Name of WHC
WHC/2022/022	**The role of the Community Dental Service**
WHC/2023/001	**Eliminating hepatitis (B and C) as a public health threat: actions for 2022 to 2023 and 2023 to 2024**
WHC/2023/04	**COVID-19 spring booster 2023**
WHC/2023/009	**COVID-19 vaccination of children aged 6 months to 4 years in a clinical risk group**
WHC/2023/11	**Guidance on Self-harm: assessment, management and preventing recurrence**
WHC/2023/019	**In support of prevention of suicide and self harm: GMC and NICE Guidance on Information disclosure for the protection of patients and others**
WHC/2023/008	**SaBTO FAIR III recommendations to tissue and cell donation process**

Issue Date	**Ministerial Directions**
01/04/2023	**The Duty of Candour statutory guidance 2023**
11/05/2023	**The NHS (General Medical Services Contracts) (Wales) Regulations 2023: integrated impact assessment**
01/06/2023	**The Primary Care (E-Prescribing pilot scheme) Directions 2023**
17/07/2023	**NHS (General Medical Services contracts) (Wales) Regulations 2023**

Following a review of the database, the Executive Committee has requested that deadlines be added to the database. A review of WHCs issued in 2023 has been undertaken and it has been determined that deadlines are not often provided in WHCs, however the information, where available, will be provided for future updates. If a deadline for action is not provided in the WHC, Executive leads will be requested to determine an appropriate timescale for completion, and this will be included in the database going forward.

Argymhelliad / Recommendation

The Audit, Risk and Assurance Committee is asked to discuss the current position, taking assurance that the Health Board has a system in place to receive, manage and report against Welsh Health Circulars and Ministerial Directions.

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

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

Effaith: (rhaid cwblhau) **Impact: (must be completed)**

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

WHC No	Date Issued	Review Date	Name of WHC	Summary	Status	Lead Executive (issued to)	Progress	Rating	Link
WHC/2023/001	16/01/2023		**Eliminating hepatitis (B and C) as a public health threat: actions for 2022 to 2023 and 2023 to 2024**	Letter to health boards on the actions they need to take to make progress on hepatitis B and C elimination	Action	Director of Public Health	Multi-agency steering group established, baseline position in place, and reviewing priorities to inform joint recovery plan. JRP submission date extended by WG to mid-July.	**In progress**	Eliminating hepatitis (B and C) as a public health threat: actions for 2022 to 2023 and 2023 to 2024 (WHC/2023/001) | GOV.WALES
WHC/2023/002	31/01/2023	N/A	**Faecal immunochemical testing (FIT) in symptomatic colorectal cancer referral**	Letter to health boards on faecal immunochemical testing (FIT) for suspected bowel cancer (new guidance/thresholds)	Action	Medical Director	This was actioned within AB before the WHC circulation and discussed at cancer Board on the 18th January	**complete**	https://www.gov.wales/sites/default/files/publications/2023-01/new-lower-gastrointestinal-fit-national-optimal-pathway.pdf
WHC/2023/04	08/03/2023	N/A	**COVID-19 spring booster 2023**	Provision of additional spring COVID-19 booster dose for our most vulnerable citizens.	Action	Director of Public Health	Implemented as required and on target for delivery as and uptake as planned	**In progress**	https://www.gov.wales/sites/default/files/publications/2023-03/whc202304-covid-19-spring-booster-2023-english_0.pdf
WHC/2023/007	31/03/2023	01/06/2023	**Patient testing framework, updated guidance**	Updated guidance April to September 2023	Action	Director of Public Health	Implemented and interpreted locally. On-going discussions in place with PHW regarding support from AWARe in relation to care home testing.	**complete**	https://www.gov.wales/sites/default/files/publications/2023-03/patient-testing-framework-updated-guidance.pdf
WHC/2023/006	31/03/2023	01/04/2024	**Commencement of the Health and Social Care (Quality and Engagement) (Wales) Act 2020**	guidance on the commencement of the Health and Social Care (Quality and Engagement) (Wales) Act 2020 on 1 April 2023.	Action	Director of Nursing Medical Director Director of Therapies and Health Science	Quality Strategy and Patient Experience and Involvement Strategy approved and implementation underway. Training session held for Board members. Also issued to Director of Nursing & Director of Therapies and Health Science	**Complete**	https://www.gov.wales/sites/default/files/publications/2023-04/commencement-of-the-health-and-social-care-quality-and-engagement-wales-act-2020_0.pdf
WHC/2023/003	04/04/2023	01/05/2025	**Guideline for the Investigation of Moderate or Severe early developmental impairment or intellectual disability (EDI/ID)**	clinical guideline for the investigation of moderate or severe early developmental impairment or intellectual disability (EDI/ID) in children. It is provided to support clinical decision making for paediatricians who assess children and young people referred because of early developmental concerns. It establishes a baseline for Wales-wide practice to ensure equitable access to timely diagnosis wherever a child lives in Wales.	Action	Medical Director	Completed This has been disseminated to all Paediatric medical staff (community and general, consultants, trainees, ANPs and Specialty Doctors) Also on Healthier Together website.	**Complete**	https://www.gov.wales/sites/default/files/pdf-versions/2023/4/3/1681288392/early-developmental-impairment-or-intellectual-disability-whc202303.pdf
WHC/2023/009	06/04/2023	N/A	**COVID-19 vaccination of children aged 6 months to 4 years in a clinical risk group**	The Welsh Government has accepted the latest advice from the Joint Committee on Vaccination and Immunisation (JCVI), which recommended the vaccination for COVID 19 of children aged 6 months to 4 years in a clinical risk group. Health Boards will start to invite eligible children for vaccination in May 2023	Action	Director of Public Health	Implemented as required locally - Currently a national issue with DHCW who are yet to identify eligible patients	**in progress**	https://www.gov.wales/sites/default/files/publications/2023-04/covid-19-vaccination-of-children-aged-6-months-to-4-years-in-a-clinical-risk-group-whc202309.pdf
WHC/2023/017	12/05/2023	31/03/2024	**NHS Wales Executive National Policy on Patient Safety Incident Reporting and Management**	A policy for the NHS in Wales to report, manage and learn from patient safety incidents.	Action	Director of Nursing	12/4/23: The publication of the RDAP has been highlighted and shared with clinical leads across several specialities. Work is ongoing to ensure ABUHB adheres to the four key priorities outlined in the plan.	Complete	https://www.gov.wales/sites/default/files/publications/2023-05/policy-on-patient-safety-incident-reporting-and-management.pdf
WHC/2023/015	09/05/2023	N/A	**COVID-19 Vaccination observation periods**	A letter to health workers regarding COVID-19 vaccinations	Action	Director of Public Health	Information cascaded and SOPs updated	**Complete**	https://www.gov.wales/sites/default/files/publications/2023-05/covid-19-vaccination-observation-periods-vaccination-following-recovery-from-covid-19.pdf

WHC/2023/016	12/05/2023	N/A	**Implementing the move to one dose of the HPV vaccine in Wales**	Letter to health professionals confirming changes to the HPV vaccination programme	Action	Director of Public Health	School based Programme: ABUHB School Nursing Service acyioned the requirements of WHC/2023/016 'Implementing the move to one dose of the HPV vaccine in Wales', the changes are included in our HPV Comms & Engagement plans 23/24. Professionals: ABUHB School Nursing staff updates provided through our training events/updates through school our learning zone/emails/borough meetings. Schools have been updated through our communication when planning the schools sessions. Public: ABUHB School Nursing service prepared parents/carers of the pending changes in our literarture sent for HPV in 22/23. We will be utilising the PHW updated literature for our HPV programme and updating our consent forms. We are launching HPV in the spring term and have prepared social media and comms messaging to share on all our social media platforms. We have developed new training / education resources for school assemblies.	**Complete**	https://www.gov.wales/sites/default/files/publications/2023-05/hpv-immunisation-programme-update.pdf
WHC/2023/025			**Cancer Waiting Times Rules for SCP**				13/4/23: LT Message sent to all practices on 6/5/22 . This theme is also included in the work programme for the medicines management team for this coming year.	**Complete**	Suspected cancer pathway: guidelines (WHC/2023/025) | GOV.WALES
WHC/2023/028			**Withdrawal of WHC 2019/042 re Annual Quality Statements**	Removing the requirement to prepare Annual Quality Statements as a result of the revised reporting arrangements introduced under the Duty of Quality.	Action	Director of Nursing	Noted	**Complete**	Withdrawal of WHC/2019/042 regarding annual quality statements | GOV.WALES
WHC/2023/026			**NHS FRAMEWORK FOR RESEARCH AND DEVELOPMENT – Research Matters – What excellence looks like in NHS Wales**	Introduction of the new Research and Development (R&D) Framework, in a drive to embed and integrate research into all aspects of health and care services in NHS Wales	Action	Medical Director	Complete: The ABUHB R&D strategy was developed in consultation with HCRW and fully supported and approved by the Board in November 2022 which shows that research is not seen as an additional activity but is a core function. Developing an implementation plan as included a series of stakeholder events including patients and public, the purpose being to map and explore our stake holders expectations. This has helped define clear focus areas and timelines for implementation and adds value to the service we provide. Collaboration with our partners and stakeholders is key to its success and we are committed to ensuring that we nurture those who display early talent to become strong research leaders. The first year has included engagement within the wider organisation to raise awareness of the strategy and our vision, as well as putting foundations in place to support implementation. The next steps are to defining work streams, delegating leads for projects and ensuring we can measure progress. Progress and performance monitoring will ensure we can regularly update, review and revise our implementation plan.	**Complete**	NHS framework for research and development (WHC/2023/026) | GOV.WALES
WHC/2023/031		31/03/2024	**AMR & HCAI Improvement Goals for 2023-24**	Continuing to work towards the goals of the current 5 eyar National Action Plan.	Action	Director of Nursing		**Complete**	Consultation Template (gov.wales)
WHC/2023/033			**Vaccine Products to be used in the Autumn 2023 covid-19 Vaccination Programme**	Further COVID-19 vaccine information following WHC/2023/029	Compliance/ Action	Director of Public Health	Information cascaded SOP's & delivery plans updated	**Complete**	WN (Year) Number (gov.wales)
WHC/2023/036	20/09/2023		**Speaking up Safely Framework - NHS Wales**	Publication of the Framework for Speaking up Safely in NHS Wales	Action	Director of Workforce & OD	Published on the Health Board's Intranet Site	**Complete**	NHS Wales speaking up safely framework (WHC/2023/036) | GOV.WALES

WHC/2023/034	25/09/2023		**NHS Welsh Sustainability Awards**	Information regarding NHS Welsh Sustainability Conference and awards	Action	Director of Finance		**complete**	NHS Welsh Sustainability Conference and Awards (WHC/2023/034) | GOV.WALES
WHC/2023/037	26/09/2023	31/12/2023	**Patient Testing Framework for Autumn/Winter 23**	Update to WHC issued in March 2023	Action	Director of Public Health	The Patient Testing Framework for Autumn/Winter 2023 was received and discussed within the appropriate Leadership meeting. This concluded that no further action was required within the existing sampling provision (ABUHB Health Protection Service) or within pathology. The updated framework was cascaded to the wider Health Board the senior Leadership Team via emails and the use of the staff Intranet, in conjunction with IPAC's updated staff risk assessment. Additionally, a local collaborative Winter Pressures plan has been developed to ensure that a robust approach is available should demand increase over the winter period. Samples Undertaken: Sept - 18, October - 40 Nov up to 7/11/2023- 9	**Complete**	Patient testing framework for autumn/winter 2023 (WHC/2023/037) | GOV.WALES
WHC/2023/10	07/07/2023		**Certification of vision impairment**	Guidance on the process for certifying patients as partially sighted or blind	Compliance/Action	Chief Operating Officer	**Current progress:** - The WHC was issued to optom practices via SSP and forms part of WGOS 3 – this is the continuation of the Low Vision service, with the addition of Certification of Vision Impairment. This came into force from 20th October, with legislative change and can be performed by Optometrists who are listed to provide WGOS 1, 2 and 3 inclusive and comply with the eligibility requirements under WGOS 3: Low Vision - WGOS 3 – Low Vision Assessment - NHS Wales ABUHB current position: •35 practices •48 practitioners	complete	Certification of vision impairment (WHC/2023/010) | GOV.WALES
WHC/2023/11	27/04/2023	Apr-28	**Guidance on Self-harm: assessment, management and preventing recurrence**	NICE guidance	Information	Chief Operating Officer	Further update awaited	in progress	Guidance on Self-harm (WHC/2023/11) | GOV.WALES
WHC/2023/012	02/05/2023	Apr-24	**NHS Wales financial monitoring returns, 2023 to 2024**	Monthly financial monitoring return guidance and associated templates	Action	Director of Finance and Procurement		Complete	NHS Wales financial monitoring returns, 2023 to 2024 (WHC/2023/012) | GOV.WALES
WHC/2023/013	17/05/2023	2028	**Health and Care Quality Standards 2**	Replacing Health and Care Standards - WHC/2015/015	Action	Director of Nursing		Complete	Health and Care Quality Standards 2023 (WHC/2023/013) | GOV.WALES
WHC/2023/018	14/06/2023	Jun-26	**Introduction of HL7 FHIR as a foundational standard in all NHS Wales Bodies**	Mandating FHIR as a foundational interoperability standard for all IT and all digital systems/services	Action	Director of Digital	Confirmed we have adopted HL7 / FHIR as a foundational standard and are working closely with the National Data Resource Programme on development of our local capabilities.	Complete	Introduction of HL7 FHIR as a foundational standard in all NHS Wales Bodies (WHC/2023/018) | GOV.WALES
WHC/2023/019	09/06/2023		**In support of prevention of suicide and self harm: GMC and NICE Guidance on Information disclosure for the protection of patients and others**	GMC and NICE Guidance on information disclosure for the protection of patients and others	Information	Medical Director	Further update awaited	In Progress	In support of prevention of suicide and self-harm (WHC/2023/019) | GOV.WALES

WHC/2023/021	08/08/2023	08/08/2028	**Consent to Examination or Treatment - Update**	Replaces WHC/2017/036 - retired with immediate effect	Action	Medical Director	Completed: WHC and relevant information to consent is available on HB intranet / SharePoint. The Consent Policy being updated to reflect up to date information. Newsletter issued bringing together up to date information on consent in one place. Poster also created and distributed. Audits being undertaken to provide assurance e-learning module on Decision Making and Consent in Wales.	Complete	Consent for examination or treatment: update (WHC/2023/021) | GOV.WALES
WHC/2023/022	22/06/2023	30/06/2026	**Armed Forces Covenant - Healthcare Priority/Special Consideration for Veterans/ Ex Armed Forces Personnel**	Update and clarify guidance on Armed Forces Covenant - Healthcare Priority for Veterans (WHC (2017) 41	Action	Director of Workforce & OD	Action plan in place to implement the requirements of the WHC	complete	Armed Forces Covenant healthcare priorities (WHC/2023/022) | GOV.WALES
WHC/2023/023	22/06/2023		**The National Influenza Immunisation Programme 2023-24**	Detailed guidance for the flu vaccination programme 2023-24	Action/Information	Director of Public Health	Information cascaded and delivery plans adjusted accordingly. GPs advised through local and national communication lines	complete	The National Influenza Immunisation Programme 2023 to 24 (WHC/2023/023) | GOV.WALES
WHC/2023/024	28/06/2023		**Change of vaccine and cohort expansion for shingles vaccination programme (From September 2023)**	Information about forthcoming changes to the NHS Wales shingles vaccine programme	Compliance/Action/Information	Director of Public Health	Proposed changes to the shingles programme included in our annual update training since June 23. This is delivered to Practice Nurses, HCSW and District Nurses. Cascaded all correspondence from PHW to practices, including training resources, PGD's etc. Scoped all GP practices for their implementation plans. Encouraged practices to prioritise the 50+ years, immunocompromised. Discussions held re the possibility of running shingles clinic in covid-19 vaccine centres (resource permitting)	Complete	Changes to shingles vaccinations (from September 2023) (WHC/2023/024) | GOV.WALES
WHC/2023/029	21/08/2023		**Winter Respiratory Vaccination Programme: Autumn and Winter 2023 to 2024**	Details of the next winter vaccination programme for COVID-19 and flu	Action	Director of Public Health	Information cascaded and delivery plans adjusted accordingly. GPs advised through local and national communication lines	Complete	Winter respiratory vaccination programme 2023 to 2024 (WHC/2023/029) | GOV.WALES
WHC/2023/30	22/08/2023		**New 2023 National Safety Standards for Invasive Procedures (NatSSIPS2) by the Centre for Perioperative Care (CPOC) and Patient Safety Notice PSN 034**	The Centre for Perioperative Care's new safety standards with a recording and resources from a meeting around the topic.	Action	Medical Director	Complete: Responsibility lies with the Division and Directorate leads from a governance perspective. The recent paper provides an update on the wider improvement work of which NarSSIPS2 will be included. The Divisions have assigned posts dedicated to this work and report through their normal accountability processes to the Theatre and Anaesthetics lead and Lead nurse.	Complete	New 2023 National Safety Standards for Invasive Procedures (NatSSIPS2) (WHC/2023/30) | GOV.WALES
WHC/2023/008	25/09/2023	18/09/2023	**SaBTO FAIR III recommendations to tissue and cell donation process**	Implementation of the recommendations outlined in the FAIR III report for any living or deceased tissue or cell donations	Action/Information	Medical Director	emailed MC (currently on a/l 13/10)	In Progress	Advice on tissue and cell donation (WHC/2023/008) | GOV.WALES

WHC/2023/032	09/10/2023	Mar-24	**Amendments to Model Standing Orders and Model Standing Financial Instructions**	Supercedes WHC/2020/011 & WHC/2021/010	Compliance/Action	Director of Corporate Governance	12/4/23: The following is taken from discussion at the Chief Pharmacists meeting of 3/4/23 with representatives of AWTTC. Plan to discuss at MMPB 13/4/23. "Following the WG mandate to implement Blueteq within all HBs/Trusts a number of questions have been raised. Implementation will be through a staged approach and the aim is to start off with Rheumatology and then Haematology. BCUHB is to undertake a pilot in rheumatology and HBs will be able to learn from this and share how they have approached it e.g. training etc. Templates have been produced and the plan is to have a generic template that can be used across Wales so individual HBs/Trust don't need to develop their own. BCUHB is in the process of working through the IG and DPIA issues and hope to start the pilot in May. For Haematology it is planned to look at all drugs that have commercial access agreements linked to them and develop templates. It is intended to use some of the NHS England templates and adapt for Wales but as we progress ahead of England we will need to develop our own. CPG requested that as more detail is available this is shared with it so CPG can assess the increased workload for staff and start putting the relevant processes in place."	Complete	

WHC No	Date Issued	Review Date	Name of WHC	Summary	Status	Lead Executive (issued to)	Progress	Rating	Link
WHC/2022/007	15/02/2022	31/03/2023	**Recording of Dementia Read Codes**	Sets out the Read codes which should be captured by memory assessment and GP/ primary care services and recorded on all information shared between services, to the person living with dementia and their carer (if they wish to receive this information), and within the Memory Assessment Service, Learning Disability Memory Assessment Service and primary care data bases. It also sets out guidance for Welsh Health Boards to assist with the recoding of a diagnosis of dementia using the Read codes.	Action	Director Primary Care, Community and Mental Health Services	Issued and Implemented	**complete**	recording-of-dementia-read-codes-whc-2022-007.pdf (gov.wales)
WHC/2022/014	01/03/2022	31/03/2023	**Healthcare associated infections and antimicrobial resistance improvement goals**	Extension of WHC to 31 March 2023	Action / Information	Director of Nursing	The HCAI Welsh Government expectations against the nationally reportable infections are reported at every PQSO Committee, with performance oversight via RNTG.	**complete**	amr-hcai-improvement-goals-for-2021-2023.pdf (gov.wales)
WHC/2022/011	24/03/2022	01/06/2022.. Update issued September 2022	**COVID-19 patient testing framework**	Updated guidance based on the need to introduce proportionate and effective changes which balance the risks from SARS-CoV-2 against the need to deliver routine and emergency healthcare safely, and the impact that testing regimes have on patients.	Action	Director of Public Health	Issued and Implemented	**complete**	https://gov.wales/sites/default/files/publications/2022-05/patient-testing-framework-updated-guidance%20%282%29.pdf
WHC/2022/010	29/03/2022	N/A	**Reimbursable vaccines and eligible cohorts for the 2022 to 2023 NHS seasonal influenza (flu) vaccination programme**	General practices, community pharmacies and health boards/trusts should plan to order their influenza vaccine to match the high levels of uptake achieved in 2021-22	Action	Director of Public Health	Issued and Implemented	**complete**	https://gov.wales/sites/default/files/publications/2022-03/reimbursable-vaccines-and-eligible-cohorts-for-the-202223-nhs-seasonal-influenza-flu-vaccination-programme.pdf
WHC/2022/005	24/03/2022	31/03/2025	**Welsh Value in Health Centre: data requirements**	Health Boards and Trusts are required to supply the clinical audit/registry data to DHCW to support the work of the Welsh Value in Health Centre and in particular to: Continue to submit data to UK-wide clinical audit and outcome reviews and national PROMs platforms; Provide audit and PROMs data to DHCW for the purposes of creating visualisations and dashboards for Value Based Health Care approaches.	Action	Director of Digital	Issued and Implemented	**complete**	welsh-value-in-health-centre-data-requirements.pdf (gov.wales)
WHC/2022/09	04/04/2022	28/02/2023	**Prioritisation of COVID-19 patient episodes by NHS Wales clinical coding departments**	Following review, the decision has been made that there is no longer a requirement to prioritise the assignment of classifications codes to inpatient episodes of care involving COVID-19 ahead of other types of inpatient activity. This decision supports the transition from COVID-19 as a pandemic to being an endemic condition. Therefore WHC/2022/009 has been **withdrawn.**	Withdrawn	Director of Planning and Performance	continue to prioritise the coding of COVID-19 patients as per the WG directive.	**complete**	https://gov.wales/sites/default/files/publications/2022-04/prioritisation-of-covid-19-patient-episodes-by-nhs-wales-clinical-coding-departments_0.pdf
WHC/2022/006	21/04/2022	30/04/2026	**Direct paramedic referral to same day emergency care: All Wales policy**	Publication of an all-Wales policy to support the Welsh Ambulance Services NHS Trust (WAST) and health boards in implementing direct paramedic referrals into Same Day Emergency Care (SDEC).	Action	Director of Operations	**Current Position:** Paramedics can via the flow centre refer Medical and Surgical patients to SDEC GUH and Medical to SDEC YYF. WAST referrals are triaged on arrival at the GUH and will be considered for SDEC under the ED-to-SDEC Pathway. We have introduced an SDEC advice line week commencing 6th November accesible to paramedics and primary Care	**complete**	https://gov.wales/sites/default/files/publications/2022-04/direct-paramedic-referral-to-same-day-emergency-care-all-wales-policy.pdf
WHC/2022/13	27/04/2022	01/04/2023	**Health boards, special health authorities and trusts financial monitoring guidance 2022 to 2023**	2022/23 LHB, SHA and Trust monthly financial monitoring return guidance and associated submission templates.	Compliance	Director of Finance	Issued and Implemented	**complete**	202223-lhb-sha--trust-monthly-financial-monitoring-return-guidance.pdf (gov.wales)

WHC/2022/015	01/06/2022	N/A	**Changes to the vaccine for the HPV immunisation programme**	Information on the forthcoming changes to the human papillomavirus (HPV) immunisation programme. Aimed at health professionals who are responsible for delivering the programme. Share guidance with all those who are involved in delivering the national HPV vaccination programme in your area.	Action	Director of Public Health	Information on changes to schedules is cascaded centrally from PHW and WG	**complete**	changes-to-the-vaccine-for-the-hpv-immunisation-programme_0.pdf (gov.wales)
WHC/2022/16	01/06/2022	N/A	**The national influenza immunisation programme 2022 to 2023**	Increase in influenza vaccination coverage in all groups that are eligible for the vaccine, to best protect the Welsh public.	Action	Director of Public Health	Dual offer made alongisde covid in mass vaccination centres.	**complete**	https://gov.wales/sites/default/files/publications/2022-06/the-national-influenza-immunisation-programme-2022-23_1.pdf
WHC/2022/002	14/06/2022	01/04/2023	**NHS Wales national clinical audit and outcome review plan annual rolling programme for 2022 to 2023**	Full participation in all national clinical audits and outcome reviews listed in the annual National Clinical Audit & Outcome Review Annual Plan.	Information/ Action	Medical Director	The new clinical audit plan (soon to be published) has a full list all national clinical audits and outcome reviews listed in the annual National Clinical Audit & Outcome Review Annual Plan. Participation is mandatory and the list has been shared with all Divisions. The list is published with a nine month rolling programme	**Complete**	https://gov.wales/sites/default/files/publications/2022-06/nhs-wales-national-clinical-audit-and-outcome-review-plan-annual-rolling-programme-for-202223.pdf
WHC/2022/12	16/06/2022	31/12/2026	**Donation and transplantation plan 2022 to 2026**	Health boards and NHS trusts, where appropriate, are expected to work with the Welsh Health Specialised Services Committee (WHSSC), Welsh Renal Clinical Network (WRCN), NHS Blood and Transplant (NHSBT), Welsh Transplantation Advisory Group (WTAG), third sector and other relevant organisations towards implementing the priorities and actions in the Donation and Transplantation Plan for Wales. Health boards should take account of the priorities for donation and transplantation when planning their services and developing their IMTPs.	Action	Director of Planning and Performance	Plan is accounted for as part of IMTP planning processes.	**complete**	https://gov.wales/sites/default/files/publications/2022-06/donation-and-transplantation-plan-for-wales-2022-2026.pdf
WHC/2022/17	16/06/2022	31/12/2026	**Wales rare diseases action plan 2022 to 2026**	Highlight the publication of the Wales Rare Disease Action Plan (2022-2026).	Action / Information	Medical Director	The publication of the RDAP has been highlighted and shared with clinical leads across several specialities. Work is ongoing to ensure ABUHB adheres to the four key priorities outlined in the plan.	**complete**	https://gov.wales/sites/default/files/publications/2022-06/wales-rare-diseases-action-plan-2022%E2%80%932026-whc-2022-017_3.pdf
WHC/2022/019	21/06/2022	01/04/2025	**NHS Wales non specialised paediatric orthopaedic services**	To ensure that this service specification is used to inform the delivery and commissioning of Non Specialised Paediatric Orthopaedic Services for children (aged up to 16 years) resident in Wales	Action	Director of Operations	Stakeholder response Proforma submitted in March 2022 outlining service provision of level 1 and level 2 services. Both services are able to be maintained in ABUHB with the current level of paediatric anaesthetic, radiology and general medical cover. Inter-organisational discussions between Consultants ongoing to agree on levels of transfer according to available capacity.	**complete**	https://gov.wales/sites/default/files/publications/2022-07/non-specialised-paediatric-orthopaedic-services.pdf
WHC/2022/18	30/06/2022	N/A	**Suspected cancer pathway: guidelines**	Guidelines for Managing Patients on the Suspected Cancer Pathway	Compliance	Director of Operations	Fully compliant	**complete**	https://gov.wales/sites/default/files/publications/2022-07/guidelines-for-managing-patients-on-the-suspected-cancer-pathway_2.pdf
WHC/2022/20	22/07/2022	Continuous review	**Never events: policy and incident list July 2022**	Updated list of Never Events (remove wrong tooth extraction)	Compliance / Action / Information	Director of Nursing	SI team shared the WHC with the divisions and also published on the intranet	**complete**	https://gov.wales/sites/default/files/publications/2022-07/whc-2022-020-never-events-policy-july-2022.pdf
WHC/2022/21	28/07/2022	30/09/2022	**National optimal pathways for cancer**	The Quality Statement for Cancer requires that the nationally optimised pathways are fully embedded in local service delivery.	Action	Medical Director	Issued and Implemented	**complete**	https://gov.wales/sites/default/files/publications/2022-08/national-optimal-pathways-for-cancer-2022-update.pdf
WHC/2022/008	29/07/2022	01/05/2023	**New records management code of practice for health and care 2022**	Notification of the publication of the new Records Management Code of Practice for Health and Care 2022 and to advise Chief Executives, Directors of Social Care, Health and Care Records Managers and all line managers and supervisors within the relevant organisations that they should use it from May 2022.	Compliance / Action	Director of Digital	Issued and Implemented	**complete**	https://gov.wales/sites/default/files/publications/2022-07/new-records-management-code-of-practice-for-health-and-care-2022.pdf

WHC/2022/022	22/08/2022	01/08/2024	**The role of the Community Dental Service**	Updated guidance on the role of the community dental service, including the expansion of salaried dental officer posts, to support local communities who have limited or no access to general dental services normally provided by the independent contractor model. Ensure that arrangements are in place to implement this guidance.	Action	Director of Primary, Community and Mental Health Services	Discussed at Primary Care Senior Leadership Team and satisfied that progress is being made in line with the WHC	**In progress**	https://gov.wales/sites/default/files/publications/2022-08/the-role-of-the-community-dental-service.pdf
WHC/2022/023	09/09/2022	N/A	**Changes to the vaccine for the HPV immunisation programme**	Information on the recently announced changes to the human papillomavirus (HPV) immunisation programme. Aimed at health professionals who are responsible for delivering the programme. Share the information with all those who are involved in delivering the national HPV vaccination programme in your area.	Information		Information on changes to schedules is cascaded centrally from PHW and WG	**complete**	changes-to-the-vaccine-for-the-hpv-immunisation-programme-whc2022023.pdf (gov.wales)
WHC/2022/026	11/10/2022	01/10/2023	**Approach for Respiratory Viruses – Technical Guidance for Healthcare Planning**	Letter to health professionals about the approach for responding to respiratory viruses over autumn and winter.	Action	Director of Public Health	Forwarded to relevant parts of the organisation.	**complete**	approach-for-respiratory-viruses-technical-guidance-for-healthcare-planning.pdf (gov.wales)
WHC/2022/027	24/10/2022	N/A	**Urgent polio catch-up programme for children under 5 years old**	Health Board's to carry out a 'targeted' immunisation catch-up programme across Wales. Targeting children under 5 with partial or no vaccination against Polio without delay. This is a priority project which will need to commence as soon as possible and be completed by 31 January 2023 at the latest, after which time the NES will no longer apply…."	Action	Director of Public Health / Interim Director Primary, Community and MH Services	Implemented - gone beyond requirements: MVCs offered scheduled imms. to children in 17 GP practices that opted out of enhanced service inc. domiciliary vaccination visits.	**complete**	urgent-polio-catch-up-programme-for-children-under-5-years-old.pdf (gov.wales)
WHC/2022/003	31/10/2022	01/10/2025	**Guidance for the provision of continence containment products for Adults in Wales 2022**	Consensus document regarding the provision of continence containment products for adults, to ensure all adults who suffer with urinary or faecal incontinence, undergo a comprehensive assessment and have access to an equitable service	Compliance/ Action/Information	Director of Nursing	Issued and Implemented	**complete**	https://www.gov.wales/adult-continence-products-whc2022003
WHC/2022/004	31/10/2022	01/08/2025	**Guidance for the care of children and young people with continence problems**	Consensus guidance document regarding the provision of continence containment products to children and young people, to ensure all children and young people who have not toilet trained, or have urinary or faecal incontinence, undergo a comprehensive assessment and have access to an equitable service	Action	Director of Nursing	Issued and Implemented	**complete**	https://www.gov.wales/paediatric-continence-containment-products-whc2022004
WHC/2022/029	22/11/2022	N/A	**Follow-up advice on the polio catch-up programme for children under 5 years old**	extension to deadline in WHC/2022/027 to 31st March 2023	Action	Director of Public Health / Interim Director Primary, Community and MH Services	As above: since April we have sought self-reported uptake from GPs delivering enhanced service. MVCs currently evaluating uptake within 17 opt out practices.	**complete**	https://www.gov.wales/follow-advice-polio-catch-programme-children-under-5-years-old-whc2022029
WHC/2022/031	08/12/2022	N/A	**Reimbursable vaccines and eligible cohorts for the 2023 to 2024 NHS seasonal influenza (flu) vaccination programme**	Letter to health professionals about the 2023 to 2024 NHS seasonal influenza vaccination programme.	Action	Director of Public Health	Issued and Implemented: position endorsed by Gwent LMC.	**complete**	https://www.gov.wales/reimbursable-vaccines-and-eligible-cohorts-2023-2024-nhs-seasonal-influenza-flu-vaccination
WHC/2022/025	16/12/2022	02/12/2025	**All Wales guidance for prescribing intervals**	Health boards should notify general practitioners of the change and work with them to encourage the use of longer prescribing intervals where appropriate. Doing so will have benefits for general practice, community pharmacy, and patients and their carers.	Action	Medical Director	essage sent to all practices on 6/5/22 . This theme is also included in the work programme for the medicines management team for this coming year.	**complete**	https://www.gov.wales/sites/default/files/publications/2023-03/all-wales-guidance-for-prescribing-intervals.pdf
WHC/2022/035	22/12/2022	N/A	**Influenza (flu) vaccination programme deployment 'mop up' 2022 to 2023**	Letter to health professionals on mop-up activity for the seasonal influenza vaccination programme 2022 to 2023	Action	Director of Public Health	Issued and Implemented: MVCs offered walk-in service from end of Dec '22 and by the end of the season administered over 7,000 additional vaccines.	**complete**	https://www.gov.wales/influenza-flu-vaccination-programme-deployment-mop-2022-2023-whc2022035
WHC/2022/034	15/02/2023	N/A	**Health board allocations for 2023 to 2024**	This letter notes health boards' funding arrangements for the coming financial year.	Action	Director of Finance	Complete and has informed the IMTP and budget setting / delegation approvals	**complete**	https://www.gov.wales/sites/default/files/publications/2023-03/health-board-revenue-allocations-2023-to-2024.pdf

WHC/2022/032	24/03/2023	01/04/2024	**Further extending the use of Blueteq in secondary care**	Following successful implementation of the system by WHSSC, the Minister for Health and Social Care has agreed that Blueteq use should now be extended to a wider range of medicines to support improved financial governance and collecting information about the use of medicines in priority areas for the NHS.	Action	Medical Director	The following is taken from discussion at the Chief Pharmacists meeting of 3/4/23 with representatives of AWTTC. Plan to discuss at MMPB 13/4/23. "Following the WG mandate to implement Blueteq within all HBs/Trusts a number of questions have been raised. Implementation will be through a staged approach and the aim is to start off with Rheumatology and then Haematology. BCUHB is to undertake a pilot in rheumatology and HBs will be able to learn from this and share how they have approached it e.g. training etc. Templates have been produced and the plan is to have a generic template that can be used across Wales so individual HBs/Trust don't need to develop their own. BCUHB is in the process of working through the IG and DPIA issues and hope to start the pilot in May. For Haematology it is planned to look at all drugs that have commercial access agreements linked to them and develop templates. It is intended to use some of the NHS England templates and adapt for Wales but as we progress ahead of England we will need to develop our own. CPG requested that as more detail is available this is shared with it so CPG can assess the increased workload for staff and start putting the relevant processes in place."	**complete**	Further extending the use of Blueteq in secondary care (gov.wales)

Ministerial Directive	Date Issued	Summary	Lead Executive	Action to demonstrate implementation/response	Rating	Link
The Directions to Local Health Boards as to the Personal Dental Services Statement of Financial Entitlements (Amendment) Directions 2022	07/04/2022	Amendments to Directions to reflect new activity measures for contract reform practices.	Interim Director Primary, Community and Mental Health Services	Implemented	**Complete**	https://www.gov.wales/sites/default/files/publications/2022-04/the-directions-to-local-health-boards-as-to-the-personal-dental-services-statement-of-financial-entitlements-amendment-directions-2022_0.pdf
The Directions to Local Health Boards as to the General Dental Services Statement of Financial Entitlements (Amendment) Directions 2022	07/04/2022	Amendments to Directions to reflect new activity measures for contract reform practices.	Interim Director Primary, Community and Mental Health Services	Implemented	**Complete**	https://www.gov.wales/sites/default/files/publications/2022-04/the-directions-to-local-health-boards-as-to-the-general-dental-services-statement-of-financial-entitlements-amendment-directions-2022_0.pdf
Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 2) Directions 2022	09/06/2022	Directions to local health boards on amendments to the general medical services contract	Interim Director Primary, Community and Mental Health Services	Implemented	**Complete**	https://www.gov.wales/sites/default/files/publications/2022-06/directions-to-local-health-boards-as-to-the-statement-of-financial-entitlements-amendment-no-2-directions-2022.pdf
The National Health Service (Charges to Overseas Visitors) (Amendment) (No. 3) (Wales) Regulations 2022	29/06/2022	These Regulations amend the National Health Service (Charges to Overseas Visitors) Regulations 1989 (S.I. 1989/306).	Director of Finance and Procurement	Regulation has been implemented. Monkeypox has been added to the 'non chargeable' category of diseases.	**complete**	https://www.gov.wales/sites/default/files/publications/2023-01/the-national-health-service-charges-to-overseas-visitors-amendment-no-3-wales-regulations-2022.pdf
The Pharmaceutical Services (Advanced Services) (Appliances) (Wales) (Amendment) Directions 2022	29/07/2022	The Directions set out amendments to the requirements for the provision of appliance services in Wales	Medical Director	The amendments are published in the drug tariff and are publicly available. In this instance the directions aren't tasking the HB to action anything as it's an update of existing arrangements, so there's nothing to disseminate. Additionally, although we maintain provision for pharmacies or appliance contractors to commission stoma appliance customisation and Appliance Use Reviews (covered in our PNA) the HB doesn't have any pharmacies providing the service or any appliance contractors on our list.	**complete**	https://www.gov.wales/sites/default/files/publications/2022-07/the-pharmaceutical-services-advanced-services-appliances-wales-amendment-directions.pdf
The Primary Medical Services (Influenza and Pneumococcal Immunisation Scheme) (Directed Enhanced Service) (Wales) (No. 2)	08/08/2022	The amendment Directions update the clinically at risk groups eligible for the influenza vaccination	Interim Director Primary, Community and Mental Health Services	Implemented	**Complete**	https://www.gov.wales/sites/default/files/publications/2022-08/the-primary-medical-services-influenza-and-pneumococcal-immunisation-scheme-directed-enhanced-service-wales-no.-2-amendment-directions-2022.pdf
The Primary Care (Contracted Services: Outpatient Waiting List Scheme) Directions 2022	12/08/2022	Directions and guidance for Local Health Boards on reviewing outpatient waiting lists.	Interim Director Primary, Community and Mental Health Services	Lead with Planned Care Board. Practices asked if they wish to particpate - no further action taken at this time	**Complete**	https://www.gov.wales/sites/default/files/publications/2022-08/the-primary-care-contracted-services-outpatient-waiting-list-scheme-directions-2022.pdf
Primary Care Contracted Services: Immunisations (PCCS:I) Amending Directions August 2022	25/08/2022	How health boards can engage primary care contractors to administer the COVID-19 vaccine.	Interim Director Primary, Community and Mental Health Services	Implemented	**Complete**	https://www.gov.wales/sites/default/files/publications/2022-08/primary-care-contracted-services-immunisations-2-directions-20-22.pdf
The Abortion Act 1967 – Revocation of the Approval of a Class of Place for Treatment for the Termination of Pregnancy (Wales) 2022	26/08/2022	Provisions within the Health and Care Act 2022 come into force on 30 August 2022. Therefore, the Approval of a Class of Place for Treatment for the Termination of Pregnancy (Wales) 2022 is revoked to ensure there is no overlap in legislation.	Medical Director	The HB already allow patients to administer medications to induce a legal abortion in their own home. The medications will have been prescribed by a hospital based doctor after completing the appropriate `blue form`	**complete**	https://www.gov.wales/sites/default/files/publications/2022-08/the-abortion-act-1967--revocation-of-the-approval-of-a-class-of-place-for-treatment-for-the-termination-of-pregnancy-wales-2022.pdf
The National Health Service (Charges to Overseas Visitors) (Amendment) (No. 4) (Wales) Regulations 2022	22/11/2022	The Regulations add Malta and the Bailiwick of Guernsey to the list of countries with which the UK has a reciprocal healthcare agreement.	Director of Finance and Procurement	Regulation has been implemented. Guernsey and Malta have been added to the list of countries where the Health Board has reciprocal arrangements.	**complete**	https://www.gov.wales/sites/default/files/publications/2023-01/the-national-health-service-charges-to-overseas-visitors-amendment-no-4-wales-regulations-2022.pdf

The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 4) Directions 2022	30/11/2022	Fee scales for dispensing doctors from 1 October 2022 to 31 March 2023 and from 1 April 2023	Director of Finance and Procurement	This regulation has been implemented as required - by NWSSP.	**complete**	https://www.gov.wales/sites/default/files/publications/2022-11/directions-to-local-health-boards-as-to-the-statement-of-financial-entitlements-amendment-no-4-directions-2022.pdf
The Wales Infected Blood Support Scheme (Amendment) (No. 2) Directions 2022	08/12/2022	Wales Infected Blood Support Scheme introduction of child payments.	Director of Finance and Procurement	Ministerial Direction implemented by NWSSP on behalf of Wales Infected Blood Support Scheme (WIBSS) - WIBSS has written to all current beneficiaries of WIBSS to bring this to their attention and also included a reference in the December 2022 Newsletter. As at 31 March 2023 18 applications had been processed in respect of 31 children; amounting to a commitment of £69,600	**Complete**	https://www.gov.wales/sites/default/files/publications/2022-12/the-wales-infected-blood-support-scheme-amendment-no-2-directions-2022.pdf
The Local Health Boards (Directed Functions) (Wales) Directions 2022	15/12/2022	Directions to local health boards relating to prisoner healthcare in 'His Majesty's Prison and Young Offender Institute Parc'.	Interim Director Primary, Community and Mental Health Services	Implemented	**Complete**	https://www.gov.wales/sites/default/files/publications/2022-12/the-local-health-boards-directed-functions-wales-directions-2022.pdf
The Directions to Local Health Boards as to the General Dental Services Statement of Financial Entitlements (Amendment) Directions 2023	13/01/2023	These Directions uplift NHS dental contract payments for 2022 to 2023.	Interim Director Primary, Community and Mental Health Services	Implemented	**Complete**	https://www.gov.wales/sites/default/files/publications/2023-01/the-directions-to-local-health-boards-as-to-the-general-dental-services-statement-of-financial-entitlements-amendment-directions-2023.pdf
The Directions to Local Health Boards as to the Personal Dental Services Statement of Financial Entitlements (Amendment) Directions 2023	13/01/2023	These Directions uplift NHS dental contract payments for 2022 to 2023.	Interim Director Primary, Community and Mental Health Services	Implemented	**Complete**	https://www.gov.wales/sites/default/files/publications/2023-01/the-directions-to-local-health-boards-as-to-the-personal-dental-services-statement-of-financial-entitlements-amendment-directions-2023.pdf
Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2023	21/02/2023	Directions to local health boards on amendments to the general medical services contract.	Interim Director Primary, Community and Mental Health Services	Implemented	**Complete**	https://www.gov.wales/sites/default/files/publications/2023-02/directions-to-local-health-boards-as-to-the-statement-of-financial-entitlements-amendment-directions-2023.pdf
Local health boards and NHS Trusts reporting on the introduction of new medicines into the National Health Service in Wales Directions 2023	24/03/2023	Directions regarding the Implementation of the high-cost drugs reporting system	Director of Finance and Procurement / Medical Director	Implemented	**Complete**	https://www.gov.wales/sites/default/files/publications/2023-03/local-health-boards-and-nhs-trusts-reporting-on-the-introduction-of-new-medicines-into-the-national-health-service-in-wales-directions-2023.pdf
The Duty of Candour statutory guidance 2023	01/04/2023	Statutory guidance regarding the purpose and application of duty of candour	Director of Nursing	Currently implementing this guidance as part of the delivery of the Health Board Strategy	**In Progress**	The Duty of Candour statutory guidance 2023 | GOV.WALES
The NHS (General Medical Services Contracts) (Wales) Regulations 2023: integrated impact assessment	11/05/2023	WG plans to maintain and improve effective delivery of General Medical Services	Chief Operating Officer	The Unified Contract came into effect on 1st October 2023. Health Boards are currently awaiting WG to issue a template variation notice and GMS regulations template: •template variation notice containing the changes needed for a GMS contract that was based on the 2006 template GMS contract to comply with the new regulations, and •template document from which Health Boards will prepare a "conformed copy" showing, for ease of reference, what your contract looks like after the variations. Once received, these will be personalised and sent to each GP practice. Further details are also expected in relation to the Unified Contract Assurance Framework.	**In Progress**	The NHS (General Medical Services Contracts) (Wales) Regulations 2023: integrated impact assessment | GOV.WALES

The Primary Care (E-Prescribing pilot scheme) Directions 2023	01/06/2023	Arrangements and provisions for E-Prescribing pilot scheme	Director of Digital	The first use of the Electronic Prescription Service (EPS) in Wales is on track to take place this autumn in Rhyl, North Wales. There will be several weeks of testing in Rhyl before EPS is rolled out across Wales in a phased approach in 2024. ABHB will support this as required alongside the Digital Medicines Transformation Portfolio.	**In Progress**	The Primary Care (E-Prescribing Pilot Scheme) Directions 2023 | GOV.WALES
NHS (General Medical Services contracts) (Wales) Regulations 2023	17/07/2023	Summary report to the informal consultation on th NHS (General Medical Services Contract)(Wales) Regulations 2023	Medical Director	19/10/23: The Unified Contract came into effect on 1st October 2023. Health Boards are currently awaiting WG to issue a template variation notice and GMS regulations templates: • a template variation notice containing the changes needed for a GMS contract that was based on the 2006 template GMS contract to comply with the new regulations, and • a template document from which Health Boards will prepare a "conformed copy" showing, for ease of reference, what your contract looks like after the variations. Waiting 3rd Party	**In Progress**	NHS (General Medical Services contracts) (Wales) Regulations 2023 | GOV.WALES
The Primary Medical Services (Influenza and Pneumococcal Immunisation Scheme)(Directed Enhanced Service)(Wales)(No. 2)(Amendment) Directions 2023	28/07/2023	The amendment Directions update the clinically at risk groups eligible for the influenza vaccination	Director of Public Health	This amendment was cascaded and delivery plans adjusted accordingly. GPs advised of change in policy through local and national communication lines	**Complete**	The Primary Medical Services (Influenza and Pneumococcal Immunisation Scheme) (Directed Enhanced Service) Wales) (No. 2) (Amendment) Directions 2023 | GOV.WALES
The Nursery Milk Scheme (Wales)(Amendment) Directions 2023	31/07/2023	Amendment	Director of Nursing	This is an extension entitlement of the distribution of milk to nurseries for a further 2 years. This offer will be reviewed in two years	**Complete**	The Nursery Milk Scheme (Wales) (Amendment) Directions 2023 | GOV.WALES
The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 3) Directions 2023	07/08/2023	Directions to local health boards on amendments to the general medical services contract.	Director of Finance and Procurement	Enacted by Shared Services automatically	**Complete**	The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 3) Directions 2023 | GOV.WALES
Primary Care Contracted Services: Immunisations (PCCS:I) Amending Directions	24/08/2023	How health boards can engage primary care contractors to administer the COVID-19 vaccine.	Chief Operating Officer	The Primary Care (Contracted Services: Immunisations) scheme has been offered to all GP practices - 33/68 are participating and 1 pharmacy	**Complete**	Primary Care Contracted Services: Immunisations (PCCS:I) Amending Directions | GOV.WALES
Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment)(No.2) Directions 2023	30/08/2023	Directions to local health boards on amendments to the general medical services contract.	Director of Finance and Procurement	Enacted by Shared Services automatically	**Complete**	Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 2) Directions 2023 | GOV.WALES

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	28 November 2023
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Internal and External Audit Recommendation Tracker
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Head of Corporate Risk and Assurance

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The paper presents the Audit, Risk, and Assurance Committee (referred to as the Committee throughout the report) with an overview of all identified internal and external audit recommendations and current implementation status as at 30th September 2023.

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

The Committee is asked to:

- **NOTE** the position in respect of overdue audit recommendations;
- **NOTE** the position in respect of completed audit recommendations;
- **NOTE** the progress against the number of outstanding long-standing (2017-2021) recommendations remaining, and;
- **APPROVE** the revised timescales for the **30** Internal and **2** External Audit Recommendations.
- **APPROVE** the completed audit recommendations.

Cefndir / Background

Since the implementation of the revised reporting arrangements, the Committee has been able to focus its attention on recommendations that have passed their original and revised completion dates but remain outstanding. As a result, the Committee has been able to apply focused scrutiny to obtain assurance of the implementation and progress of internal and external recommendations resulting from audit findings. This has also facilitated greater accountability and transparency in terms of the status of recommendations.

Since the last Committee meeting in September 2023, work has continued to reduce the number of legacy recommendations that remain outstanding, as well as to provide revised completion dates for recommendations that have passed their original completion date.

The Dashboard in **Appendix 1** provides an overview of all residual live recommendations, both 'Overdue' and 'Not Yet Due,' separated out by 'Year,' 'Executive Lead,' and 'Priority Rating' should the Committee accept the recommendations to approve the completed recommendations and revised deadlines as set out in the report.

The information supplied in Table 1 provides a high-level summary of the number of overdue recommendations from audits conducted between 2017 and 2021 that were sent to Executive Leads to review and update. More detailed information is contained within **Appendix 2**.

Table 1

All Longstanding (pre-2022) Overdue Audit Recommendations as at 30 September 2023					
Year	**Priority Rating of Recommendation**				**Total**
	Low	Medium	High	N/A	
2017	0	0	2	0	**2**
2018	0	0	1	0	**1**
2019	0	0	0	0	**0**
2020	0	0	0	19	**19**
2021	6	23	2	4	**35**
Total	**6**	**23**	**5**	**23**	**57**

The information supplied in Table 2 provides a high-level summary of the number of overdue recommendations from audits conducted in 2022/2023 that were sent to Executive Leads to review and update. More detailed information is contained within **Appendix 3.**

Table 2

All Overdue Audit Recommendations from 2022/23 as at 30 September 2023					
Year	**Priority Rating of Recommendation**				**Total**
	Low	Medium	High	N/A	
2022	18	41	8	2	69
2023	1	2	0	2	5
Total	**19**	**43**	**8**	**4**	**74**

The combined data in Tables 1 and 2 represent the **131** recommendations that needed to be updated as at the end of 30 September 2023 (Q2).

Asesiad / Assessment

Internal and External Audit Recommendation Tracking, 30 September 2023

Since the previous reporting period, 30 June 2023, work has been completed to update the master tracker to include all internal and external audit recommendations up until the last Committee meeting on 12 September 2023.

Following the previous reporting period which ended on 30 June 2023, several revised timeframes were agreed upon, leaving a residual position of **75** overdue internal and external recommendations. A further **56** recommendations were triggered as overdue in Quarter 2 (June – September). In total **131** updates against overdue recommendations were requested.

The position reported in Table 3 reflects the updates received against all 131 overdue recommendations by Lead Executive.

Table 3

Overview of Recommendation Returns for Quarter 2 Reporting Period												
Lead Executive	**Chief Executive**	**Chief Operating Officer**	**Director of Corporate Governance**	**Director of Digital**	**Director of Finance and Procurement**	**Director of Nursing**	**Director of Public Health**	**Director of Strategy, Planning, and partnerships**	**Director of Workforce and OD**	**Medical Director**	**Director of Therapies and Health Science.**	**Total**
IA Overdue	-	19	7	31	-	6	-	3	-	-	1	67
EA Overdue	-	-	1	2	-	2	-	-	1	-	-	6
Revised Deadline	-	-	*8	*18	-	*8	-	*1	*1	-	*1	*37
Completed	3	15	1	10	9	5	1	7	3	2	2	58

NB: *x denotes the revised number of deadline(s) requested; these are still included in the overdue figures because they have not yet been approved by the Committee**.**

Of the 131 recommendations that were overdue as at 30 September 2023**, 37** have been returned with revised deadlines, as shown below, and **58** have been completed for Committee approval.

- 33 revised deadlines for Internal Audit
- 4 revised deadlines for External Audit

If the committee approves the **37** revised deadlines the residual overdue position will be as follows:

- 34 Internal recommendations overdue
- 2 External recommendations overdue

Summary tables, four to seven, provide a breakdown of overdue and completed internal and external recommendations by auditor and audit year.

INTERNAL AUDIT

Table 4 below summarises the position as at 30th September 2023 by audit year, in relation to the **67** (**33** of the **67** have revised deadlines) **overdue** (past the original agreed-upon implementation date) internal audit recommendations. Further details can be found at ***Appendix 4***

Table 4

Internal Audit Overdue Recommendations					
Year	**Priority Rating of Recommendation**				**Total**
	Low	Medium	High	N/A	
2017	**-**	**-**	**1** (***1**)	**-**	**1** (***1**)
2018	**-**	**-**	**-**	**-**	**-**
2019	**-**	**-**	**-**	**-**	**-**
2020	**-**	**-**	**-**	**8** (*5)	**8** (***5**)
2021	**4** (*1)	**14** (*3)	**-**	-	**18** (***4**)
2022	**11** (*8)	**25** (*13)	**4** (*2)	**-**	**40** (***23**)
2023	**-**	**-**	**-**	**-**	**-**
Total	**15** (*6)	**39** (*15)	**5** (*3)	**9** (*6)	**67** (*33)

*(x) Revised number of deadline requests

The **33** internal audit recommendations with proposed revised timescales for implementation can be found at ***Appendix 5***

On the basis that the Committee endorses the **33** revised timeframes, **34** internal audit recommendations will remain **overdue** as at 30th September 2023.

Table 5 below summarises the position reported as at 30th September 2023 by the Year of audit in respect of **completed** recommendations. **45** internal overdue recommendations have been completed in this reporting period. Further detail can be found at **Appendix 6.**

Table 5

Internal Audit Completed Recommendations					
Year	**Priority Rating of Recommendation**				**Total**
	Low	**Medium**	**High**	**N/A**	
2017	**-**	**-**	**-**	**-**	**-**
2018	**-**	**-**	**-**	**-**	**-**
2019	**-**	**-**	**-**	**-**	**-**
2020	-	-	-	2	**2**
2021	2	8	1	-	**11**
2022	7	16	4	2	**29**
2023	1	2	0	0	**3**

Total	10	26	5	4	45

EXTERNAL AUDIT

Table 6 below summarises the position as at 30th September 2023, in relation to the **6** (**4** of the **6** have revised deadlines) **overdue** (past the original agreed-upon implementation date) external audit recommendations. Further detail can be found at **Appendix 7.**

Table 6

External Audit Overdue Recommendations					
Year	Priority Rating of Recommendation				Total
	Low	Medium	High	N/A	
2017	-	-	-	-	-
2018	-	-	1	-	1
2019	-	-	-	-	-
2020	-	-	-	-	-
2021	-	1	1 (*1)	2	4 (*1)
2022	-	-	-	1(*1)	1 (*1)
2023	-	-	-	-	-
Total	-	1	1(*1)	4 (*1)	6 (*4)

*(x) Revised number of deadline requests

The **4 External audit** recommendations with proposed revised timescales for implementation can be found in **Appendix 8.**

On the basis that the Committee agrees to the **4** revised timeframe, **2** external audit recommendations will remain **overdue** as at 30th June 2023.

Table 7 below summarises the position reported as at 30th September 2023 by the Year of Audit, in respect of **completed** recommendations. **13** External overdue recommendations have been completed in this reporting period. Further details can be found at **Appendix 9.**

Table 7

External Audit Completed Recommendations					
Year	Priority Rating of Recommendation				Total
	Low	Medium	High	N/A	
2017	-	-	1	-	1
2018	-	-	-	-	-
2019	-	-	-	-	-
2020	-	-	-	9	9
2021	-	-	-	2	2
2022	-	-	-	1	1
2023	-	-	-	-	-

Total	-	-	**1**	**12**	**13**

At the next reporting cycle recommendations with deadlines in quarter 3 (October - December) of the financial year 2023/24 would have become overdue. In preparation for the next reporting cycle, updates on these, as well as the 36 residual recommendations with no revised timeframes, will be requested.

For information, all recommendations marked 'Not Yet Due' as at 30 September 2023 are attached as Appendix 10.

Argymhelliad / Recommendation

The Audit, Risk & Assurance Committee is asked to:

- **NOTE** the position in respect of overdue audit recommendations;
- **NOTE** the position in respect of completed audit recommendations;
- **NOTE** the progress against the number of outstanding long-standing (2017-2021) recommendations remaining, and;
- **APPROVE** the revised timescales for the 33 Internal and 4 External Audit Recommendations

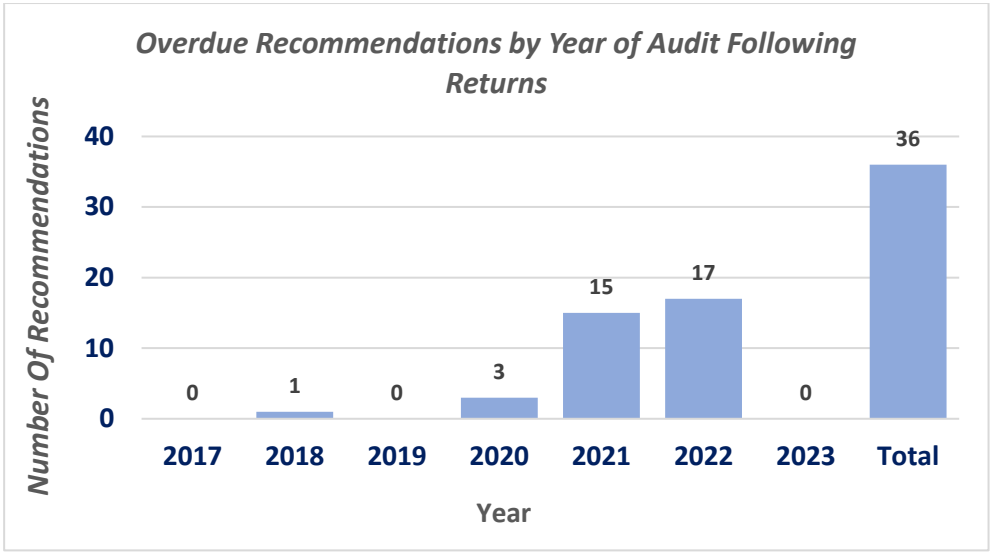
Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	Risks associated with overdue recommendations will be captured locally and escalated to the strategic risk register if necessary.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2.1 Managing Risk and Promoting Health and Safety Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Choose an item. Integral to the delivery of the IMTP
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

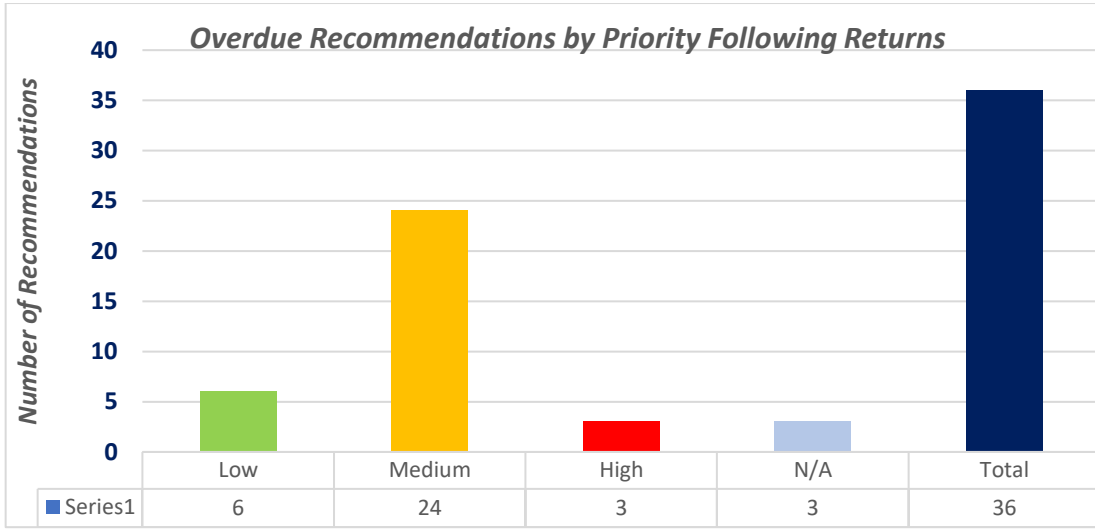
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A

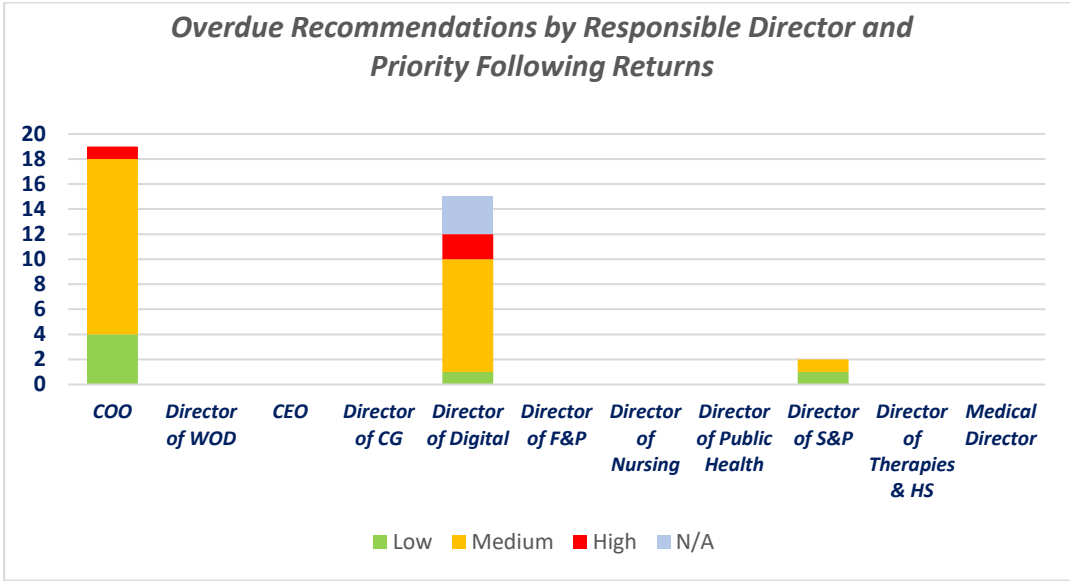
Rhestr Termau: Glossary of Terms:	All terms are explained within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	N/A

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

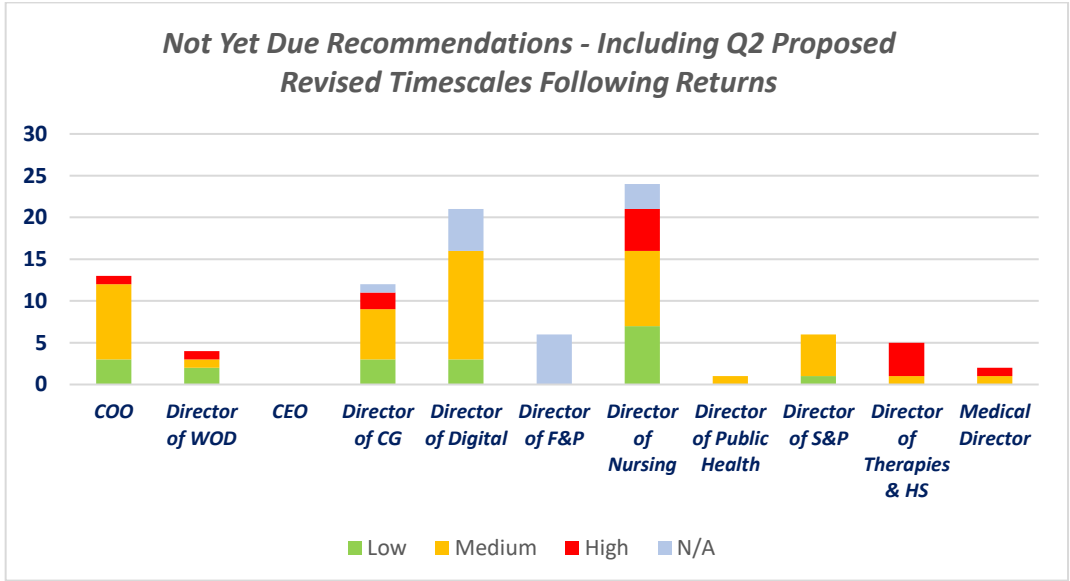
Audit Recommendation Dashboard - Position Following Update for Quater 2 2023-24 (June-September)







Overdue Recommendations by Priority	Low	Medium	High	N/A	Total
	6	24	3	3	36



Not Yet Due Recommendations by Priority	Low	Medium	High	N/A	Total
	19	46	14	15	94

Appendix 2) 2017-2021 57 Overdue Recommendations Sent to Executive Leads For Updates

Audit Type	ABUHB Ref No:	Report Title	Assurance Rating	Director	Responsible Officer	Priority	Recommen-dation No.	Recommendation	Management Response	Deadline Agreed in Final Report	Months passed Agreed Deadline	Proposed Revised Deadline	Months passed Revised Deadline	Date Revised Deadline was approved by ARAC Comittee	Final Report Deadline Status	Revised Deadline Status	If closed and not complete please provide justification and ensure evidence is available	Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	What evidence is available to close down the recommendation?	Reporting Date
Internal	2017.00	Medical Equipment and Devices (2017/18)	Limited	Director of Therapies and Health Science	N/A	High	R1	R1 Registers should be maintained for operational management of medical devices and equipmenton each ward and department, which should record relevant equipment details.The register format should be consistent and overseen centrally, with periodic reviews / scrutiny completed.Each areashould ascertain the total number of devices held, by reviewing each and every item (including non-electrical equipment) physically and record itupon theirregister. Discrepancies that are identified can be updated / amended on the register, so all items are correctly recorded. Going forward, relocation of equipment, disposals, additions etc. should be updated promptly to ensure an accurate record continues.	The Health Board to consider investing in an overarching equipment database register with staff resources to ensure regular updating and management.	31/03/2018	-65.87	31/08/2023	-0.98	06/10/2022	Overdue	Overdue		**November 2022** - This recomendation is monitored regularly via the Medical Devices Committee. The deadline is proposed to be extended due to Health Board ability to get around all of the equipment. We would suggest that the system is in place to track the assests however, further work is required to phyiscally tag the equipment and ensure compliance and tracibility.	The software development between the 3 systems (Softpro Medusa, Ram Asset 4000 and Paragon RFID) is now operational. The unrelenting service pressures however means that there is still an extensive amount of work to visit every site and tag locations and equipment. This is still an ongoing project and work in progress. Assets are being tagged as and when we see them , however the process to blitz equipment tagging is restricted by the ongoing service pressures. There is also the ongoing restructuring of services/departments throughout our LGH's.	Medical Electronics (EBME) & Capital Finance still record all of the equipment details on their independent systems. Medical Electronics (EBME) update the latest location on their database as equipment passes through the department. Capital Finance undertake walk about audits to tag and update locations of assets. All new assets are RFID tagged as part of our EBME commissioning checks.	Whilst the aim is to tag all medical Equipment & devices throughout the HB hospitals we are focused on completing one major site. This being the GUH and to date out of 3242 assets listed on our database 1341 devices have been tagged, which represents 41.3% of assets on site at the GUH. In total we have RFID tagged over 4100 medical devices to date across our HB sites. Its difficult to commit to a completion date giving the ongoing service pressures, but this work is a daily ongoing process and when time allows we will undertake a blitz approach to RFID tagging the remaining devices, starting at the	30/09/2023
External	2017.01EA	Structured Assessment 2017	Not Rated	Chief Executive	Assistant Director of Comms and Engagement	High	R7	R7 The Health Board should review, refresh and update the Engagement Strategy – 'Hearing and acting upon the voice of our staff and citizens'.	The Health Board will undertake a review and refresh its Citizen Engagement Strategy in line with the Clinical Futures Programme and IMTP. The Health Board will also continue to take forward its programme of staff engagement in line with the Clinical Futures Programme.	31/07/2018	-61.87	29/09/2023	-0.03	06/10/2022	Overdue	Overdue		**May 2023** - The Communication and Engagement Strategy will be presented to Board in September for approval.		Low risks determined as work is ongoing with the public, however staff enagement sits within Workforce and OD.		30/09/2023
External	2018.01EA	Structured Assessment 2018	Not Rated	Director of Digital	Head of Information Governance	High	R3	R3 The Health Board should improve its information governance arrangements by: improving compliance with the information governance training programme to reach the national rate of 95%.	Information Governance training reviewed to include the legislation changes as a result of GDPR. An additional module was developed and launched for Cyber Security which is mandatory for all staff to complete. The Information Governance Unit has set up Information Governance Delivery Groups (IGDG) for each of the Divisions in the organisation. The meetings are held bi monthly and training is included on the agenda for every meeting. Discussions are held specifically around compliance and Managers are tasked with improving their compliance rates. Reports are assessed at Transformation to Digital (T2D) Delivery Board.	01/03/2020	-42.89				Overdue			**August 2023**: Training compliancis currently 84%. ABUHB now using new all Wales training package for DHCW which includes cyber security. Paul to pick up with Jon. May 2023 - The current training compliance is 79%. The new training package from DHCW has still not been launched. Annual reports are being written for each of the Divisions highlighting areas where improvements to their training compliance is required. March 2023 _ The current training compliance is 78% for the organisation. there will be a major communication exercise undertaken by IG commencing in April with the focus on getting an improvement in the compliance rate. Hopefully by then the new national training package will be made available by DHCW. **January 2023** - First Governance and Assurance Board held and will be reporting into the Office of the SIRO. The Health Records module has been provided to the All Wales e-learning for incorporation into the new elearning launch. Final review is expected at the end of November. Monitoring will be improved as this will go into ESR and is now part of a national programme of work **August 2022** - The Information Governance Unit have been engaged with national IG leads to create a new IG training programme into which ABUHB training has been amalgamated and can now be	Identified as outstanding in Structured Assessment 2022 - The pandemic has hindered progress	Non compliance reports are being sent to senior managers within Divisions to ensure that compliance is monitored and actioned in these areas. Where non-compliance persists targeted escalation routes have been established and the appropriate corrective action will be taken. Promotion of the audio learning tool for staff groups that have dificulty in leaving the workplace or access to computer systems and e-learning will be facilitated by the IG team and attendance recorded.		30/09/2023
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	N/A	R1	R1 The governance framework for IM&T / digital should be clarified and where control over aspects of IM&T has devolved to departments, there should be a process for these to feed into the relevant Committee to ensure oversight. Underneath the Committee the steering group remit and membership should be defined.	Agreed. The Health Board is establishing a new governance framework. Currently Informatics is reporting to the Audit Committee, the first report is scheduled for 8thApril. A Health Board governance framework is in development for informatics including exec oversight, investment and delivery. The management of the global pandemic has disrupted the planning work by 12 months but this is now re initiated. Recommendations arescheduled to be presented to Exec TeamQ1 , and Board in Q2;	30/06/2021	-26.95				Overdue			**August 2023**: First HBOTs meeting was held in June 2023 chaired by Rani Dash, Director of Corporate Services. Work ongoing around the Governance Structure. May 2023 - The Governance Structure will be discussed at the SIRO meeting. The meeting will be attended by the new Digital Director who will finalise these arrangements when he takes up post. **March 2023** - The inaugural meeting for the Office of the SIRO is in May. It will be attended by a representative from Templar to explain to the membership of the group the purpose and aims of the group. The TOR was given approval from the SIRO. **January 2023** - - Training for office of the SIRO completed and update to be provided to Exec Team Dec 22. GAB will report and make escalations through this new office. GAB Board e3stablished with ToR drafted.providing GAGS with reporting mechanism and KPIs which will be escalated to the OSIRO where required. SIRO training has been completed and Rani Mallison to undertake this role. August 2022 - First meeting of Governance and Assurance Board held 27/7/2022 and will report into HBOTS and DDOB. SIRO identified and training dates being organised. June 2022 -: ToR revised for the Governance and Assurance Board				30/09/2023
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	N/A	R4	R4 The risk identification process should be formally linked to the issue / event / problem management process in order to ensure that underlying risks are identified.	A review of risk management processes has commenced. The Health Board has appointed a Chief Nursing Information Officer/Clinical Safety Officer who will lead the project to align risk management processes from Programmes, design, Service Delivery, Health Records and Information Governance and Cyber Security to inform the new governance structure.	31/12/2021	-20.92				Overdue			**August 2023:** Risk management framework currently being reviewed by the new Director of Digital. May 2023 - Department risk management approaches are developing aligned to the corporate framework. A single risk register has been developed and is being rolled out, supported by internal risk management training/handholding. Once approaches are signed off, an informatics wide framework will be developed with new Digital Director. March 2023 - Clinical Assurance Process and Strategy is now approved and in place; Informatics Risk Management Approach under development **January 2023** - Domains aligning risk registers with the Corporate template and to publish so that there is visibility of the entire Informatics Risk to be held by the PMO. The first domain is completed (Programmes) SPD, Service Delivery, ICT Health Records and IG to follow. **September 2022** - Awaiting the Octboer DDOB for formal sign off. August 2022 - ADI's have signed off the Clinical Assurance process however the DDOB meeting to approve was cancelled therefore moved to next meeting 18/10/2022 June 2022 - Final Sign off requested from ADI's to present via CCIO				30/09/2023
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	N/A	R5	R5 The Health Board should ensure greater links with divisions and the Informatics Directorate. The Informatics Directorate should be involved in the decision making process for all IM&T items.	Accepted. The CDO will present the recommended Target Operating Model to the HB which will include governance over Informatics as a Division and also departmental systems. Part of the framework will include decisions to procure and assurance processes not only for informatics division but informatics services owned outside. Part of adoption will help appraise strategic options in how the HB wishes to take this forward. Part of the SIRO objectives will set out the responsibilities for devolved asset owners and a performance management framework to identify risk and provide oversight. There is likely to be a resource impact in achieving this which will be subject to a business case.	31/03/2021	-29.93				Overdue			**August 2023:** New governance group is under development to provide strategic oversight of digital initiatives, New Digital Service Request process is currently being finalised alongside a new Financial Control Procedure to provide governance and assurance over digital spend and initiatives. Business Partnership arrangements between Digital and the Divisions / Corporate Services is being planned. May 2023 - No additional TOF posts to be created pending new Director of Digital review **March 2023** -Director of Digital will be reviewing the Target Operating Model once in post **January 2023** - Paper has been submitted to CEO and is under consideration. September 2022 - The proposal for TOF structures will be submitted October 22 with note at DDOB. August 2022 - Governance and Assurance Groups have commenced and include governance around procurement of departmental systems June 2022 - financial planning has been completed, CDO to meet with Executive Director NP on next steps July 22 March 2022 - Resource requirements have been identified as part of				30/09/2023
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	N/A	R6	R6 Consideration should be given to the placement of all informatics provision and support across the Health Board. As part of this the current partially decentralised model should be re-assessed in terms of its suitability for the modern use of technology.	Accepted. Following the exec review of the Target Operating Framework and overarching governance will appraise the hybrid environment of departmental asset ownership, responsibility, risk management. As the report sets out this is a largely historical and organic model which will be complex to resolve in itself. A risk based approach will be adopted andan options paper will be developed forconsideration by the Board.	31/12/2022	-8.95				Overdue			**August 2023**: The new Director of Digital is currently reviewing the TOF and will present findings and an action plan for the consideration by the Executive Committee in October 2023 November 2021 - This is pending the TOF being funded and requires a full risk assessment to be conducted once the business analysis has been completed				30/09/2023

Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	N/A	R7	R7 A review of the current strategic position of the Health Board in relation to its digital provision and maturity across all domains should be undertaken.	Partially accepted. The Health Board commissioned a review of the Health Boards capacity and capability to deliver the strategy with recommendations for the Board to consider. This was scheduled for Q1 2020/21 but supporting the Health Board through the pandemic became the priority. Whilst this was not a self assessment against a maturity model as in NHS England or HIMMS it provides a comprehensive framework. The report also makes recommendations about the principle of "Once for ABUHB" which if accepted will lead to a baselining of assets, processes and convention outside of the current Informatics Directorate footprint. The recommendations from the planning of the new operating framework are planned to be delivered to Exec Team Q1 and Board Q2 2021.	30/09/2021	-23.93				Overdue			**August 2023**: HIMSS report has been discussed at Directors of Digital and the learning is forming part of further planning and strategic discussions at a national level. May 2023 - HIMSS gap assessment site visit completed 4/5/23. Local report due 11/5/23. National report to be shared and discussed with Digital Directors in due course March 2023 - HIMSS Online survey complete and arrangements for on site visit underway January 2023 - Currently undertaking a HIMSS assessment as part of a national benchmarking exercise. September 2022 - Next steps have been agreed and a paper is drafted to be submitted in Oct 22. August 2022 - An update on progress aginst the Digital Strategy was presented to the Health Board Chair and Exec Team in July 2022. A Digital Delivery Oversight Board (DDOB) has been established to review progress, support prioritisation and give executive oversight and direction to the informatics teams. JunE 2022 - financial planning has been completed, CDO to meet with Executive Director NP on next steps July 22 November 2021:- A paper is being drafted for Digital Delivery Oversight Board scheduled in Jan 22 to meet the recommendations				30/09/2023
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	CDO	N/A	R8	R8 An assessment of the changes needed to implement the Digital Strategy should be undertaken, and the benefits of the changes articulated, along with the consequences of no change. The Health Board should develop a single roadmap to help deliver the Digital Strategy.	As part of the review Informatics has accepted the need for P3O Portfolio management. This work is ongoing and with an initial focus to core Informatics Division activity but provides a framework for Health Board oversight and transparency. The portfolio approach will extend subject to Board approval to all information assets in a planned programme of work. This forms part of the recommendations to Execs in Q1 2021.	30/06/2021	-26.95				Overdue			Aug-23: Progress being made on the portfolio register to surface all digital work including new service requests and ICT projects. Resource & capacity modelling being developed along with business change tools to support service readiness for change. May 2023 - Benefits audit carried out and substantial assurance awarded. Funding to fully establish the PMO not yet secured however a portfolio view of all digital service requests and trnasofmration programmes has been developed along with a prioritisation and optimisation framework. DDOB has been stood down temporarily so prioritisation is done on an ad hoc basis with members of the exec team. Mar 23: Funding required for Head of PMO however, digital Portfolio manager recruitment underway in Programmes and benefits audit completed with substantial assurance. January 2023 - Awaiting funding for Head of PMO. Benefits management audit underway in programmes. September 2022 This is part of the TOF paper submission Oct 22. August 2022 - Funding requested to progress Head of PMO to further support the portfolio development and implementation of the Digital Strategy. Report on the progress against the strategy shared with Board in July. Further update on benefits required for				30/09/2023
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	CDO	N/A	R9	R9 A network of champions across the organisation should be established. The Digital Strategy should be re-issued alongside the roadmap. This should form the basis for engaging the network of champions to drive the Strategy forward.	Accepted-The Channel 3 report also identified a need for more emphasis on Clinical Leadership, Design and Business Partnering. This is subject to additional investment although recently the appointment of a full time CNIO/CSO has been a significant step forward. Outwith the Directorate recommendations will be presented to Execs on overarching exec level oversight which is intended to both strengthen accountability but also to ensure Informatics capacity is used to best effect. Benefits realisation training has commenced in Informatics and will form part of reporting. It is in principle agreed that the Health Board adopts a single methodology and framework that should be co produced to manage all priority investments.	30/09/2021	-23.93				Overdue			Aug-23: New Digital Service Request process, business partnering and new governance group is under development May 2023 - A divisional engagement model has been agreed for managing new service request and work in progress activities. A CSS meeting has been established. Urgent care to be established next and roll out to follow as resources allow. March 2023 - Director of Digital has been appointed and a review of the Digital Delivery Oversight Board will take place once they are in post January 2023 - Funded CNIO and Nursing Informatics lead. First Divisional meeting scheduled for December and await the outcome of the financial bid for the TOF September 2022 - Informatics have fully funded the Nursing Informatics Post and an increase in allocation for clinical leadership. The TOF paper being submitted in October 22 addresses the immidiate priorities for more effective engagement with informatics in the HB. August 2022 - WNCR rollout plans include a nurse on each ward being champions for digital systems and GAG's promoting the need for diivisional champions to be identified by the SIAO's. June 2022 - agreement of co-funding Informatics and Nursing				30/09/2023
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	CDO	N/A	R13	R13 Critical assets should be identified within the asset and configuration management systems.	Agreed. This in part is due to the devolved nature of informatics.The first step will be presenting the new operating framework's overarching governance recommendations will provide oversight. A strategy, policy and resultant business case will be developed following the Health Board adoption of the reviews recommendations.	31/12/2021	-20.92				Overdue			Aug 2023: Awaiting next HBOTS meeting. May 2023 - work to commence shortly under SIRO March 2023 - Part of work programme that will be commencing from May under Rani January 2023 - Part of the HBOTS work programme to be established wiith SIAOs September 2022 - Paper is drafted and will be submitted October 22. August 2022 - Pending financial strategy andTOF implementation June 2022 - subject to financial strategy for TOF implementation November 2021 - This is dependent on the TOF being implemented and the business analysis to be conducted to provide this input into an asset management system				30/09/2023
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	CDO	N/A	R14	R14 The asset and configuration management processes developed within the Informatics Directorate should be adopted as Health Board wide documents and departments with devolved control required to comply with the requirements.	Accepted. The HB governance, policy and processes will be reviewed as part of the SIROs objectives with resultant recommendations to Board. Informatics will need to review internal processes and capacity to ensure it can scale to meet the challenge.	31/12/2021	-20.92				Overdue			Aug 2023: Awaiting next HBOTS meeting. May 2023 - work to commence shortly under SIRO March 2023 - Part of work programme that will be commencing from May under Rani January 2023 - Part of Cyber Resilience Programme- SIAOs in the process of being identified by new SIRO supported by Informatics- SIAOs will be trained and each will be accountable to identify assets within each division and directorate. September 2022 - SIRO training completed and new plan to be agreed in first Office of SIRO meeting. August 2022 - SIRO training scheduled in September and letters of delegatioN to be issued thereafter to the identified Senior Information Asset Owners June 2022 - Cyber Resilience programme commenced May 2022 - contract awarded to consultancy Mar 2022 to implement recommendations - Office of the SIRO / delegated letters of authority to all information asset owners November 2021 - A report commissioned by the Health Board has been presented at the Digital Delivery Oversight Board and accepted. A proposal on next steps will be presented with				30/09/2023
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	CDO	N/A	R14	R11 The Informatics Directorate should develop an overarching workforce plan that sets out the resource gaps together with the skills gaps and how they are to be resolved. The plan should consider apprenticeships, coordinated departmental development and partnerships in order to maximise the use of limited financial resource.	Planning despite COVID continued on the Operating Framework based on existing mandate and footprint of Informatics portfolio. This addresses key areas of competencies and capacity. This has been supported activity with HR & OD and Finance. The new structure proposal reflects the Digital Strategy and Operating Framework but will require scrutiny challenge and approval.	30/09/2021	-23.93				Overdue			Aug-23: ABUHB now represented at Digital Workforce Capability meeting. Work to align JD's with skills and competencies is progressing well and we have a comprehensive register of training opportunities and requests. January 2023 - Working through SOP for training and prioritisation of requests to be agreed. Skills profiles being matched with JD's and engage on national task and fiish group to provide benchmarking September 2022 - The Directorate now has a small but dedicated budget for training and development to support the PADR and workforce planning agenda. August 2022 - Register of training opportunities, expressions of interest forms to be completed and assessed by senior manager with identification of funding available if applicable. June 2022 - Limited training budget identified and PMO have list of training opportunities available to staff. Agreement on Process and prioritisation of training to be undertaken in the next quarter March 2022 - prioritised and phased cost model submitted November 2021 - The Informatics service is engaging iwith Health Education and Improvement Wales to further develop Health Informatics apprenticeship pathways from entry level. The service is actively engaged with HR &OD, Finance colleages to ensure the best			Systems established - Propose to close reccomendation	30/09/2023

Internal	2021.00	Clinical Futures - Transport, March 2021	Reasonable	Chief Operating Officer	Service Improvement Manager	Low	R3	R3 We recommend that the Health Board ensure that for each of the MHLD projects that benefit realisation planning is extended to cover:•the collection of baseline data;•targets or success measures with which to compare what is actually achieved;•the measurement and recording of the benefit metrics;•responsible managers; and•the oversight body of the benefits, to ensure these are achieved.	Agreed. We acknowledge that a robust benefits realisation plan needs to be developed and we are looking to commission external support to assist with this process for the SISU Programme. A tender is currently developing a tender to progress this element of the project. This is part of the OBC development and will be completed before submitted to the Board for approval.WPWS –to review benefits realisation plans for supporting projects	30/09/2021	-23.93				Overdue			Aug 2023: New phone systems to be implemented to enable capturing KPIs. Nov 2022: There has been a delay to gaining external support for the benefits realisation plan due to Omicron variant service impact. However Internal benefits work has been undertaken and measurable benefits developed for each service area within SISU. The OBC including benefits realisation is planned to be completed and submitted to the September Board. Benefits realisation plans and measures are being built in to all workstreams of WPWS work. Sanctuary project is being formally evaluated externally. Other alternative to admission workstreams now collecting triangulated service user experience measuresas well as baseline measures. Nov 2022 - commissioned an external organisation (arcus) to undertake the benefits realisation work on HB behalf in relation to the OBC.	a/w new phone system			30/09/2023
Internal	2021.00	Clinical Futures - Transport, March 2021	Reasonable	Chief Operating officer	Service Improvement Manager	Medium	R2	R2 The Flow Centre Team should:•review the current completion of the screening / transfer process documentation and establish a standard expectation of completeness;•provide refresher training to the team members, if required;•undertake periodic checks of all staff members, to ensure consistency and feedback any positive performances and improvements to individuals. This should also link into the PADR process;remind staff that the WAST incident number should be recorded to provide traceability; and•all screening questions shouldbe uploaded to CWS, where required.	Agreed. We will do this by:•implementing a staff review process, including an audit of referral information (this aspect is already implemented);•monitoringstaff performancee.g. logging in times and periodically listening to callsand to feedback onperformance;•addressing any training needs that ariseand link this to one-to-ones and the PADR process;•continuingto emphasise the importance of accurately recordinginformation e.g. WAST incident numbers, GP surgery etc.;•providingregular refresher training;and•hosting team meetings to share case studies / best practiceand address any issues / concerns that arise.	30/09/2021	-23.93				Overdue			Aug 2023: Band 6 nurse compentency booklet has been implemented and Call audits template has been created. Due to LTS the regular auditing has bee delayed. The band 3 auditing is ongoing but due to the roll out of training of the new cohorts has meant the 10% auditing of all band 3 calls target has not always been achived. Plan to roll this out to all band 6's to cover June 2023 - work has commenced on QPS and call audit	LTS flow centre review			30/09/2023
Internal	2021.00	Mental Health & Learning Disabilities Divisional Review, June 2021	Reasonable	Chief Operating officer	SISU - Strategic Capital and Estates Programme Director and WPWS Programme	Low	R3	R3 We recommend that the Flow Centre Team produce and monitor regular performance information over key risks within the process. For example, call waiting times.As this process is already underway, the Team should continue to identify other key performance indicators.This information should also link into individual performance within the Team, for training and improvement.	Agreed. We will:•clarify the audience and reporting requirements;•monitor performance information / KPIs on a regular basis;•identify the top five indicators;•develop a reporting dashboard;and•further refine performance reporting.	30/09/2021	-23.93				Overdue			June 2023 - Remodelling of service and introduction of APP to FC so KPI to develop in line with new modelling				30/09/2023
External	2021.01EA	Audit of Accounts Report, 2020-21 – Addendum issued December 2021	Not Rated	Director of Workforce & OD	N/A	High	R1	The Health Board should review the arrangements in place toensure that annual leave for all staff is accurately recorded and held centrally	The introduction of Medical E-Systems will ensure that all leave is recorded. The Health Board have agreed to procure a suite of Medical E-Systems with roll out in April 2022. However, departments have started recording leave in Electronic Staff Record (ESR). Communications will be sent to Medical Leaders in December 2021 to ensure that leave is recorded onto ESR pending the introduction of full Medical E-Systems.	30/04/2022	-16.98				Overdue			Aug 2023: The roll out the newly procured workforce medical e-system will resolve the logging of annual leave centrally. Incremental implementation will progress once purchased. Current technical issues with procurement. If resolved implementation will commence October 23. Nov 2022 the roll out the newly procured workforce medical e-system will resolve the logging of annual leave centrally. Incremental implementation will progress over the next 9 months.	Aug 2023: Given current pressures on staff it is not felt that a interim system change of 12 months would be beneficial Cultural issue anticipated that it will take longer than June 2023 to realise in full. Given current pressures on staff it is not felt that a interim system change of 12 months would be beneficial Cultural issue anticipated that it will take longer than June 2023 to realise in full.	Aug 2023: Executive Team. Legal and Procurement advice	September/October 2023 for full implementation following procurement and implementation of the new data base.Ongoing evaluation of OT provision. Request extension to September/October 23.	30/09/2023
External	2021.01EA	Audit of Accounts Report, 2020-21 – Addendum issued December 2021	Not Rated	Director of Digital	N/A	Medium	R3	The HealthBoard should consider strengtheningtheirIT Controlsas follows:i.All of the Windows server 2008 operating system should be replaced with either or Windows 2012 or higher where possible (this is almost completed with only twenty three servers left). ii.W7 and W8.1 desktop devices should be replaced as these are now de-supported. iii.Ensure that the change management procedure is finalised.iv.The IT Data Recovery Plan and Backup Policy should be updated and clearly defined.v.With regards to the Wellsky system, leavers and accesses changes should beformally recorded, and the Health Board shoulddevelop a suite of audit and security reports to run and monitor to ensure user access is appropriate.	i.With regards to our Windows Server 2008 environment, we have an active programme of work to either upgrade or decommission these servers. It is envisaged that by the end of the current quarter only a few servers may remain, although weare currently investigating options for these.ii.ABUHB have made significant progress in removing Win7/8.1 from our estate and currently have 0.4% to complete.There is an active programme of work to remove these devices from the network or upgrade them toa supported version of Win10.iii.We have an established and robust Change Management Process in place with regularly scheduled and structured Change Advisory Board meetings to manage operational change.The process has been widely socialised with all of Informatics and other Key Stake Holders, and also engages effectively with other ITIL practices such as Incident Management and Asset/Configuration Management.Critical Success Factors and Key Performance Indicators are agreed and monitored to measure effectiveness.iv.The IT Data Recovery Plan and Backup Policy is still in the process of being reviewed and updated.A draft version has been shared within the team and the finalised version will be released within the coming weeks.v.All user accounts are processedin line with NHS Wales standards.There is a current risk that unless a service request had been raised to the ICT Service Desk, staff who leave Pharmacy but remain within the organisation may still have access to WellSky. Further review of the staff leavers/policy may need to be undertaken.	31/12/2021	-20.92				Overdue			Aug-23: No update - older servers are being replaced via critical server refresh project, updated figures to be provided by SC May 23: No further update Mar-23: Discussion with 3rd party is still ongoing Jan-23 i. Currently there are 2 remaining servers left on 2008. These rely on upgrades to the software applications to enable the move to a supported Windows Server version. The team will continue to liaise with the services to remove the last 2 remaining. ii. Currently we have 3 devices remaining. The team will continue to liaise with the services to remove the last remaining. iii. Confirmed this was completed. iv. Confirmed this was completed.				30/09/2023
External	2021.04EA	Agile Delivery	Not Rated	Director of Workforce & OD	N/A	N/A	R6	R6 NHS bodies should seek to build on existing local and national workforce engagement arrangements to ensure staff have continued opportunities to highlight their needs and share their views, particularly on issues relating to recovering, restarting, and resetting services. NHS bodies should ensure these arrangements support meaningful engagement with underrepresented staff groups, such as ethnic minority staff.	The Health Board has initiated an innovative 12-month engagement programme called "#PeopleFirst, #CynnalCynefin, reconnecting our workforce". The origins are within the values of the Health Board and is a collaborative programme delivered by Wellbeing, OD and the Executive Board. The programme aims to re-connect staff to each other, to managers and senior leaders to empower them to raise and solve local problems locally, raise concerns to a higher level and offer the experience of feeling heard. As of December 2021, the project team have run 6 hospital site-based events, interacted with over 50 staff who have raised over 90 issues which we are working on. The project continues into the new year with cross-execution support.	31/12/2022	-8.95				Overdue			June 2023: 1) As a quality assurance measure, an EQIA Group has been established to monitor EQIAs. 2) Screening tool has been developed and is being implemented	Resources and capacity	New EQIA template and evidence from working group		30/09/2023
Internal	2021.05	Pathology	Reasonable	Chief Operating Officer	Assistant Directorate Manager	Low	R8	R8 The Health Board should complete a refresh of the latest workforce planning exercise(including associated laboratory space and equipment), to ensure the service requirements can still be met over the next five years and beyond.Where additional resourcing / facilities arerequired, theseshould be factored into the IMTP process.	To review and updateworkforce plans as appropriate. Workforce is factored into the IMTP	24/02/2022	-19.11	01/09/2023	-0.95		Overdue	Overdue		All managers were asked to review their workforce plans following the audit. The Cellular Pathology workforce plan is included in sustainability paper, JH has confirmed the paper will need to be re-reviewed if 7 day working is planned. Mortuary workforce plan in progress with follow up meeting 6 weeks from 27/9/22. Microbiology workforce plan in progress to be completed by 5/10/22. Blood Sciences workforce plan in progress to be reviewed 5/10/22 prior to completion. All additional workforce requirements are already factored into annual plan/IMTP.	Time constraints: Accurate workforce planning takes a considerable time to complete. Managers need to manage staff and departments while ensuring other strategic and operational tasks are undertaken on a daily basis to ensure continuation of safe service delivery.	Agency staff being utilised at a cost. Overtime being utilised at a cost. Scrutiny forms and SBARS submitted to request additional staff that are urgently required prior to implementation of revised workforce plans.	Workforce plans to be completed as soon as is possible Following completion, business cases may need to be produced and submitted for approval to recruit the additional staff required which will ensure Pathollogy service requirements will be met over the next five years and beyond.	30/09/2023
External	2021.06EA	Quality Governance Review	Not Rated	Director of Therapies and Health Science	N/A	N/A	R1	R1 Divisional risks are presented to Quality and Patient Safety Operational Group, but there was limited evidence of in-depth analysis and discussion. There is also limited evidence that the General Surgery directorate maintain risk registers that adequately identify quality and safety risks and mitigating actions. The Health Board should:•ensure there is appropriatescrutiny, challenge, cross divisional discussion and sharing of good practice around divisional risks at the Quality and Patient Safety Operational Group. •ensure that risk registers arecompleted and maintainedacross all directorates thatidentify quality and safety risksand mitigating actions andthere are appropriate riskescalation arrangements.	The form and functionof Quality Patient Safety Operational Group is currently being reviewed, with the aim of strengthening oversight of Risk. ABUHB are in the process of introducing the OFWCMS with the Risk module part of a future phase of roll-out. This will be a driver for improving Divisional ownership of risk management and mitigation. A programme of Divisional awareness raising will be introduced across ABUHB to strengthen risk management processes.The responsibillity of Divisional Directors will be reinforced in terms of maintaining registers and ensuring appropriate mitigation.	31/10/2022	-10.95	28/09/2023	-0.07	18/04/2023	Overdue	Overdue		This action is currently marked as overdue on the tracker, and I propose a revised deadline of end of September 2023. The justification for this revised deadline is related to the implementation of the HB's new Quality Strategy that was only agreed by the Board in March 2023, and because this Internal Audit recommendation has now been superseded by the development of the Quality Strategy. This action needs to align to the implementation of the Quality Strategy, which requires a full review of the QPS governance framework and the related committee / meeting structure and function, including the QPSOG. The role of the QPSOG in providing oversight and scrutiny of QPS related risk will be considered in that review, alongside other HB arrangements, such as Divisional Assurance meetings and Divisional level QPS Fora. It should not be assumed that the QPSOG will continue to fulfil this function as other arrangements may be more appropriate. To further support the implementation of the Quality Strategy, specifically strengthening oversight and scrutiny of risk, the application of risk modules within DATIX will be employed and this work is progressing well but is just an enabler to the process.				30/09/2023
External	2021.06EA	Quality Governance Review	Not Rated	Director of Nursing	with Clinical Executives	N/A	R6	R6 The Health Boards quality assurance framework includes a range of committees and groups aligned to Health and Care Standards. The framework is assisting the Health Board in identifying areas which previously had not provided assurance. However, there are still gaps in the flows of assurance from some sub-groups and in relation to elements of the Health and Care Standards. Whilst the framework is reasonably comprehensive at a corporate level, it doesn't fully articulate the operational structure and processes for quality and safety. The Health Board should:•complete its review of thequality and safety framework toensure that flows of assuranceare appropriate, and that the •framework functions asintended.•articulate the operationalstructures and processes forquality and safety within thequality assurance frameworkand how they align with thecorporate structure to provide a'floor to board' assurance.	The Quality Assurance Framework will be reviewed to assess fitness for purpose and alignment to the BAF. The revised Quality Assurance Framework will include the operational structures and processes.	31/10/2022	-10.95	31/07/2023	-2.00	18/04/2023	Overdue	Overdue		**June 23**: Due to be presented to Executive Committee and PQSOC in July 2023				30/09/2023
External	2021.06EA	Quality Governance Review	Not Rated	Director of Nursing	with Clinical Executives	N/A	R8	R8 The General Surgery directorate has recently established its own patient safety and quality group. However, the group does not have a terms of reference, standardised agenda, or report templates and minutes of meetings are not taken. Whilst quality and safety did feature in bi-annual reviews with the Executive Team and monthly assurance meetings with the Director of Operations. We note the monthly assurance meetings stopped in March 2021. We found limited focus on quality and safety at Scheduled Care Divisional Management Team meetings. The Health Board should:•review the operational patientsafety and quality groups toensure they are effectivelysupporting the Health Boardsquality governancearrangements.•ensure that other operationalmeetings / forums providesufficient focus on quality andsafety alongside finance performance and 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.	31/10/2022	-10.95	31/07/2023	-2.00	18/04/2023	Overdue	Overdue		**June 23:** Quality Assurance Framework due to be presented to Executive Committee and PQSOC in July 2023				30/09/2023

Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	PACS & RADIS Manager	Medium	R2	R2 The Health Board should seek clarity over why the requests made to DHCW and the SMBfor an integrated electronic process cannot be delivered.The Health Boardshouldcarryout an analysis to fully identifyits needsfor a Radiology system and seek to include these within WRIS or any future system.	We have tried to seek clarity and not had a full response.Arequest for CWS to include WCP for radiology reporting in the platformhas been formally raised. We haveraised the need for end to end requesting as a health board to the collaborativeboard for RISP project.	31/03/2022	-17.97	30/09/2023		12/09/2023	Overdue	Overdue		Aug 2023: The UAT has been passed and is with clincial apps and is being trialled in Primary Care on the 11/09/2023. There are discussion amonst informatics about integrating the WCP requesting within CWS and we have done early scoping exercises with a bussiness analysist revewing this currently. May 23: The UAT has been passed and is with clincial apps and Mr Rice to look at	Aug 2023: Required scoping, testing and development and planned for software development Needs to be agreed locally and product developed to suit ABUHB			30/09/2023
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	PACS & RADIS Manager	Medium	R2	R2.1 The Health Board should: • Consider undertaking risk management training for key areas, whilst awaiting the implementation of the risk management module within DatixCloudIQ, • Develop a plan to deploy risk management training, to commence once the full implementation of DatixCloudIQ has been completed.	As part of the strategy realisation plan, the Health Board will develop an in-house training package aimed at the three levels outlined within the Strategy (operational, management and Board level). This will be made available to relevant staff during May/June 2022. Further National development work will resume once the RLDatix risk management module has been finalised and bespoke training programmes can then be developed.	30/06/2022	-14.98				Overdue			Aug 2023: The RadIS team have been working closely with ABUHB in order to upgrade teh at risk server and we have currently got a pencilled in date of the 16/09/2023 if this slips it will likely be November time.		Targetted training is provided to teams in the meantime.		30/09/2023
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	PACS & RADIS Manager	Medium	R6	R6 a.Radiology have requested CWS to work with WCP for fully electronic requesting. b.Staff have SOP's and checks when putting forms on however human errors do occur without fully electronic requesting.	Since this audit,this has now been altered and note it wasonlyone user with this many attempts all Administrators now have 5 attempts.	01/03/2022	-18.95				Overdue							30/09/2023
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	PACS & RADIS Manager	High	R3	R3 Whilst we understand the Health Board isin the process of planning to upgrade to the 2016 version we highly recommend that the Health Board expeditesthe upgrade.	This upgrade took place on 14thNovember however only application server was upgraded. DHCW and ABUHB are working closely to plan the rest of the upgrade. However DHCW will not touch the RadIS local database which stores all of our crystal reports and letters. This is a risk and we havegone to our server team internally to plan anhourly update of the RadIS local database	30/04/2022	-16.98				Overdue			OFWCMS risk management model delayed nationally. Expected April 2023 for implementation and training/awareness to commence.		Targetted training is provided to teams in the meantime.		30/09/2023
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	PACS & RADIS Manager	Medium	R8	R8 The Health Boardshould request that this logging function be developed.The Health Board shouldconsider feeding WRIS events into the SIEM.	The health board have raised this at DHCW CAB along with other health boards. This is with DHCW to develop it is not in any Live RadIS version currently.	31/03/2022	-17.97				Overdue			Currently with DHCW to develop,	Time and resource in RadIS. As well as pending RISP program may not help development.			30/09/2023
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	PACS & RADIS Manager	Medium	R9	R9 A formal disaster recovery plan for WRIS should be developed.	The Disaster recovery plan is to fail over to a mirrored system however, since the upgrade this needs to be re-visited and formally set out. ABUHB have a VMware environment where this is hosted.The Radiology departments have disaster recovery by using emergency packs in each department and a policy that explains how to use these emergency packs in a Radis downtime scenario	30/04/2022	-16.98				Overdue			Aug 2023: The BC plans in radiology are quite extensive and well practiced	Aug 2023: Time and resource in RadIS. As well as pending RISP program may not help development.			30/09/2023
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	PACS & RADIS Manager	Medium	R10	R10 The WRIS backups should be subject to regular testing / restore to ensurevalidity.	A request to ensure that a process for regular testing of the back up to ensure their validity will be made.	30/04/2022	-16.98				Overdue							30/09/2023
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	PACS & RADIS Manager	Medium	R1	R1 The Health Board should: • Provide guidance detailing how risks should be recorded and monitored at different levels within the organisation. • Ensure each risk entry is fully recorded in a standard format.	3.1 This recommendation forms part of the Risk Management Strategy realisation plan. The Health Board training programme will provide material and literature to help support staff to populate Datix and risk registers appropriately and consistently ensuring alignment with best practice. The provision of in-house training will be made available to staff by May/June 2022.	01/03/2022	-18.95				Overdue					Targetted training is provided to teams in the meantime.		30/09/2023
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	PACS/Radis Manager	Medium	R4	R4 The Health Board should seek clarity over what maintenance tasks are expected and establish a process to ensure that these are completed.	There is a backupregimen in place, and DHCW has been notified of how this works.The point will be raised and the next WRIS SMB, and a request made for clarity over the expected database maintenance tasks and the freqeuncy of these.	31/03/2022	-17.97				Overdue			A database that the alerts and notifications is on is not supported by RadIS.	RadIS will not support this with the alerts and notifications query on the server still.	The database has been backed up by the server team		30/09/2023
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	PACS & RADIS Manager	Medium	R5	R5 a.The Board should investigate an electronic solution to uploading requestsinto WRIS.b.The Board should introduce a completeness check to ensure that all requestsreceived have been entered into WRIS.	a.Radiology have requested CWS to work with WCP for fully electronic requesting. b.Staff have SOP's and checks when putting forms on however human errors do occur without fully electronic requesting.	31/03/2022	-17.97				Overdue			Aug 2023: The UAT has been passed and this is currently being looked at by informatics	Aug 2023: Required scoping, testing and development and planned for software development Needs to be agreed locally and product developed to suit ABUHB			30/09/2023
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	PACS & RADIS Manager	Medium	R7	R7 The success of the use of the leavers list should be monitored to ensure that it works as anticipated and that all leaver accounts are removed on a timely basis.	We monitor this as much possible in Radiology. We have recently started receiving consultant leaver'slists from the Health Board and action these also.The success of the process will be tracked and evaluated to ensure it is working.	30/04/2022	-16.98				Overdue			Aug 2023: Any leavers we will make inactive unless access is required for global imaging within PACS or cross boundry electronic requesting if they are still working within the Welsh NHS. We are still dependant on this list being provided.				30/09/2023
Internal	2021.15	Falls Managment	Reasonable	Director of Therapies and Health Science	AD of Therapies & Health Sciences	Medium	R2	R2. The falls investigation and Datix recording process should reference the MFRA and confirm its completion in relation to the fall event. A fall should not be identified as 'unexpected' if a MFRA had not been completed, when it should have been (e.g. over the age of 65 years).	An ongoing audit process will be established aligned to evaluating the completion of DATIX incidents and the associated completion of the MFRA and will be included as an element of an audit cycle Due consideration will need to be given to the format of the incident reporting criteria within the new system.	30/09/2022	-11.97				Overdue			Nov 2022 Work has been undertaken to look at the opportunities to use the falls focus review held within the DATIX system . This would further support the incident reporting process.	Mar 23 suggest that this remains open as we are in the process of implementing the falls focus review held within the system as a phased approach and looking to establish the data parameters that provide the requirements of the recommendation through a digital process. outstanding – revised accountability framework still in draft status (March Board 23) – however existing Budgetary control FCP still relevant as a financial accountability mechanism as part of core governance.			30/09/2023
Internal	2021.20	Medicines Managment	Reasonable	Medical Director	Head of Pharmacy - Operational Services/Principal Technician, Pharmacy Technical Services	Medium	R2	R2.2 Once the Policy for the Management of Controlled Drugs is updated, the Health Board should undertake periodic reviews to ensure wards are adhering to the updated Policyand confirm the areas of non-compliance identified as part of this review have been rectified.	The stand operating procedure for pharmacy 6 month stock check on the wards is being updated by a Principal Pharmacy Technician. This will include updating the way reconciliation checks confirmation are documented to ensure compliance.The policy can include the need for periodic audits to review use of the policy and confirm areas of non compliance have been rectified.	31/03/2023	-6.00				Overdue			Update Aug 2023: The Pharmacy SOP for 6-monthly stock checks has been updated and is in place. A schedule of the checks is in place for all Acute Pharmacy sites. The new SOP is being used to undertake audits at RGH and NHH and these are due to be completed in September 2023. The checks will highlight to ward staff and the responsible Pharmacist where ward non-compliance is evident and needs to be addressed. The requirement forms part of the revised Management of Controlled Drugs Policy.			SOP 100 Controlled Drugs Stock Check on war	30/09/2023
Internal	2021.22	NIS Directive (Cyber Security)	Reasonable	Director of Digital	Chief Digital Officer	Medium	R3	R3 Management should ensure that an Improvement Action Plan is developed promptly in order to avoid delays in implementation.	NIS Improvement Plan is already being developed by the Cyber Team. Thecompleted plan willbe presented for management review and sign off. Currently ABUHB are still awaiting the publication ofCAF Based Cyber Risk Register for the Health Board these risks identified by CRU following the CAF assessment may include remediations that will be incorporated into the Improvement Plan currently being developed.	31/07/2022	-13.97				Overdue			Aug 2023: Awaiting next HBOTS meeting. May 23: work to commence shortly under SIRO Mar 23: Cyber continues to maintain the NIS Risk Register and Action plan against operational risks. Corporate level Cyber risks will transfer to HBOTS once this is fully established Jan 23: Cyber continues to maintain the NIS Risk Register and Action plan. CRU are currently reviewing all risk registers submitted with a view to finding and reporting common risks to Welsh Government . This may result in a common approach for remediation being adpoted for all Boards.Cyber will await results and support any required actions to be taken as directed by CRU Sept 22: The completed and updated register is submitted. Aug 22: The ABUHB NIS remedial Action Plan has been used to support a CRU led workshop and support the remediation of risk identified on the CRU created ABUHB NIS Risk Register. Work is ongoing with internal stakeholders to complete a review of the ABUHB NIS Risk Register The completed register will be submitted to CRU during September 2022"				30/09/2023
Internal	2021.22	NIS Directive (Cyber Security)	Reasonable	Director of Digital	Chief Digital Officer	Low	R1	R1 For future iterations of the CAF there should be greater involvement of the system owners in the review of the responses.	ABUHB will ensure that in future iterations of the CAF there is greater involvement of System Owners	31/12/2022	-8.95				Overdue							30/09/2023
Internal	2021.22	NIS Directive (Cyber Security)	Reasonable	Director of Digital	Chief Digital Officer	Medium	R2	R2 Management should ensure that records of discussions and information provided to and from the CRU are captured for future annual self-assessments.	Management will ensure that during any future self-assessments records of discussions and informationsupplied to the CRU will be captured and available for internal or external review.	31/12/2022	-8.95				Overdue							30/09/2023
Internal	2021.22	NIS Directive (Cyber Security)	Reasonable	Director of Digital	N/A	Medium	R4	R4 The costs associated with the improvement actions should be assessed and reported to a relevant committee to enable awareness of the full picture and prioritisation of actions and funding.	The NIS Improvement Plan will be submitted through the relevant governance committee for senior Management review and sign off. Prioritisation of remedial actions and related costs will be assessed through ABUHB formal risk governance structureand relevant committees. Note ABUHB are currently implementing the recommendations of the Templar consultancy report which will create the Office of the SIRO and create a new governance frameworkto support Risk Management within the Health Board.	30/09/2022	-11.97				Overdue			AUG 2023: Awaiting next HBOTS meeting. May 23: work to commence shortly under SIRO Mar 23: Part of work programme that will be commencing from May under Rani Jan 23: Office of he SIRO has been established, implementation of supporting governance and structures are in progress allowing costs to be fully assessed and actions prioritised. Aug 22: The creation of the TOM and creation of the HBOTS is ongoing This will provide the risk management framework to allow costs associated to improvements to be managed and prioritised."				30/09/2023
Internal	2021.24	Flow Centre	Reasonable	Chief Operating Officer	Service Manager (USC)	Medium	R1	R1.1 The Flow Centre Team should ensure that the reason for an aborted transfers should be adequately recorded.	The Flow Centre Team have performed regular audits throughout the year and learning outcomes identified. This recommendation features on our regular 1:1s with individuals, staff weekly updates and will be a focus over the next fewmonths in line with this audits recommendation.Assurance is given via the Operations Structure and Urgent Care Divisional meetings with a monthly frequency and contain a feedback loop to ensure learning is disseminated to the teams.Flow Navigator audit tool to be created. Key area of focus for our Flow Navigator Auditor over the next 2 months	31/07/2022	-13.97				Overdue			Mar 23 •We have seen a marked improvement with regards to documentation – noted through auding. •We have a full time Senior Flow Navigator who is responsible for auditing to help with this aim •A Flow Navigator & Flow Nurse Audit Tool has been created, in regular use and had provided key themes for service improvement.				30/09/2023
Internal	2021.24	Flow Centre	Reasonable	Chief Operating Officer	Flow Centre Nurse	Medium	R1	R1.2 The Flow Centre Team should ensure that the reason for an aborted transfers should be adequately recorded.	This audit has highlighted a key learning outcome regarding the process followed when closing calls on the system and the loophole associated with the system used for recording the referral (Nugensis).Learning identified and training provided to staff Key area of focus for our Flow Navigator Auditor over the next 3 months	31/07/2022	-13.97				Overdue			Mar 23•A reduction has been noted •This remains a key area of audit				30/09/2023
Internal	2021.24	Flow Centre	Reasonable	Chief Operating Officer	Flow Centre Nurse	Low	R2	R2 The Flow Centre Team should establish the required level of information to be documented on the Transfer Form for each patient screenedand all forms should be uploaded onto CWS.	In the past 3 months an internal audit performed by the department highlighted further evidence of this practice and an action plan has been implemented to improve this area of practice.Clinical audit tool to be created. Initial audit to be completed –5% of Flow Nurse workload. Learning identified and training provided to staff	30/09/2022	-11.97				Overdue			Mar 23 A Flow Navigator & Flow Nurse Audit Tool has been created, in regular use and had provided key themes for service improvement.				30/09/2023

Internal	2021.22	NIS Directive (Cyber Security)	Reasonable	Director of Digital	Chief Digital Officer	Medium	R5	R5 A formal reporting route for cyber security should be established to ensure that senior staff are aware of the position relating to cyber security.5.2The risk description should be reviewed, with inclusion of the potential financial penalties relating to noncompliancewith NIS.	ABUHB are adopting recommendations of the Templar Report that will establish a formal risk governance and committee structure within the Health Board which will support Cyber Security Risk Reporting.5.2As part of the improvements suggested by Templar a new Cyber Risk Register will be developed. As part of development process account will be taken to include the financial penalties associated with noncompliance to NIS regulatory requirements into the assessment methodology and reporting.	30/09/2022	-11.97				Overdue			Aug 2023: Awaiting next HBOTS meeting. May 23: work to commence shortly under SIRO Mar 23: Part of work programme that will be commencing from May under Rani Jan 23: Regular cyber reporting is in place, currently this runs through Digital Delivery Oversight Board and to execs. This will change to HBOTS/SIRO once fully established Sept 22. The reporting route is being established following the appointment of the new SIRO. Aug 22: Work is ongoing to implement the TOM and supporting Risk management framework, A governance and Assurance Committee has been established this will report IG and Cyber risks identified at the GAGS through to the HBOTS . This will be supported by a corporate risk management methodology. The assessment methodology and risk scoring will capture the costs of non compliance to NIS and subsequent financial penalties that				30/09/2023
Internal	2021.26	Facilities - Care After Death	Reasonable	Chief Operating Officer	Care After Death Manager	Medium	R3	R3 The Care after Death Team should determine if the software delivers sufficient benefits in excess of the potential risks. If not, then alternative software / system should be procured, to include some / all of the following features:•remotelyaccessible acrossall sites, at all times;•update immediatelyfollowing any change inputted;•link to keysoftwarewithin the Health Board,to minimise manual data entry;•produce management information / a dashboardand other relevant information (e.g. patient location);•raise warnings where breaches to the SOPs are imminent, e.g. capacity, temperature (if recommendation three is adopted) warnings;•a full audit trail including access information and data changes;•support profile levelsto facilitateaccess control; and•be fully compliant with the Health Board and DHCWshared service software requirements.	It is acknowledged that the current system does present the Health Board with a risk due to the issues as identified within the audit. The issue of the current & inherited database being unfit for purpose is acknowledged; the Estates & Facilities Divisionwill now engage with suppliers to identify a suitable replacement software system. A three-month window to identify supplier, design a system and implement is believed to be a significant challenge. It is expected that this work may take up to a six-month period.	30/09/2022	-11.97	30/04/2023	-5.02	12/09/2023	Overdue	Overdue		Update August 2023 - np new software procured by W&E. A meeting with informatics took place on 18/08 to discuss current database. Agreed Informatics do not have the expertise to make any significant changes to the system but have committed to maintain the system by best endeavours. Agreed that Qlik will be used to produce reports. Nov 2022 Alternative software solution has been procured via Synbiotix. Ongoing liaison between Synbiotix, IG & IT infrastructure teams to ensure all relevant safety aspects are mapped out. Further development work alongside Information Governance team to understand the barriers to uploading patient information is being	IT Infrastructure Team resouce capacity may delay the implementation.	Mar 23 Ongoiong liaision with Associate Director of Informatics Strategy & Planning	Q4 of 2022/23	30/09/2023
Internal	2021.27	Waste Management	Reasonable	Chief Operating Officer	Environmental Manager	Medium	R1	1.1 Ensure that the Waste Management Policy has been reviewed/updated and reflective of the above findings. That the updated Policy is underpinned by formal Board Level approval with all key elements of WHTM 07-01 guidance incorporated.	1.1 The Waste Management Policy will be reviewed/updated and formally approved by the Board.	31/10/2022	-10.95	30/07/2023	-2.03	12/09/2023	Overdue	Overdue		Policy is currently being reviewed/updated with new Director prior to engagement with wider stakeholders.	This is not a major update and will not require formal Board approval		Q3 2022/23	30/09/2023
Internal	2021.27	Waste Management	Reasonable	Chief Operating Officer	Environmental Manager	Medium	R1	1.3 Out-of-date policy / procedural documents published online should be updated.	1.3 All online policies and procedures will be reviewed and updated where necessary.	31/10/2022	-10.95	31/08/2023	-0.98	12/09/2023	Overdue	Overdue		Aug 2023: Waste Policy to be uploaded to Sharepoint once signed off. Date for publication will be subject to Divisional sign off. Waste Policy to be uploaded to Sharepoint once signed off. Date for publication will be subject to formal sign off internally				30/09/2023
Internal	2021.26	Facilities - Care After Death	Reasonable	Chief Operating Officer	Care After Death Manager	Low	R4	R4 The Care after Death Team should:•develop call cascade lists to identify staff contact details in advance;•identify additional scenarios that may arise and detail action plans to overcome them;•test a range of continuity events regularly (at least once a year); and•identify fridge / freezer capacity plans that could be utilised in across different sites, in the event of unavailability.	The CaD Team accept this recommendation in full.	30/09/2022	-11.97				Overdue			Update August 2023 - fridge/freezer capactiy available on the database and space can be identified in the event of unavailabiliy. Mar 23 Being developed by CAD Manager. 24/03/2023 CAD Team have been sited within CSS Division since November 2022. Due to temporarily return to E&F in April; Facilities Manager to work with team to completion during Q1 of 2023/24.	28/07/23 Environment Act (Wales) increased recycling regulations to be enforced from Apr 24 (non-inpatient premises) and Oct 25 (inpatient premises). Requirements may change in the lead up to implementation of the Act		Q3 2022/23	30/09/2023
External	2020.01EA	Efficiency Savings Arrangements	Not Rated	Director of Finance and Procurement	N/A	N/A	R1	Re-visit efficiency plans to reassess their realistic cash releasing potential as soon as practically possible. Plans should be re-prioritised according to the cash releasing potential.	The Board has established additional Board and executive level financial recovery arrangements including a continuous focus on the identification of areas that can reduce costs.This will be invigorated through theIMTPprocess to further progress general efficiency, cost avoidance and cost reduction opportunities to support an improvement to the recurrent financial position of the Health Board.The Board will consider how focus is given to higher benefit schemes going forward.	31/03/2023	-6.00				Overdue							30/09/2023
External	2020.01EA	Efficiency Savings Arrangements	Not Rated	Director of Finance and Procurement	N/A	N/A	R2	By the end of January 2023, the Health Board shold esnure earlier preperation of deployment/sevice level savings to deliver IMTPs key efficiency programmes. Ideally the savings planning approach should be continuous going forward to prevent any hiatus at the eginning of the financial year.	To provide durther detail to the response to R1 above. The Executive team hold a monthly dinincial recovery board to identify and monitor saving delivery and includes a continuious focus on the ientification of areas that an reduce costs. The continuious identification of savings schemes are part of the action plan of BUHB finiacial recovery plan, engaging divisional teams and workforce throughout ABUHB as well as executive leads.	31/03/2023	-6.00				Overdue							30/09/2023
External	2020.01EA	Efficiency Savings Arrangements	Not Rated	Director of Finance and Procurement	N/A	N/A	R3	By the end of January 2023, ensure comprehensive and effectie operational service engagement with the team preparing the compendium so that the opportunities identified within the compendium can be deliverable saving schemes.	The finance team has engaged with the Board, Sub-committees, Executive team, transformation programmes, divisional teams and corporate teams as part of its usual workplan to spread the opportunities for efficiency improvement throughout the organisation.The expected delivery of savings through the transformation programmes & divisions has not been achieved during 2022/23 due to operational pressures.As a result, it is accepted that more engagement work is required to gain service ownership to progress the opportunities for efficiency improvement and savings delivery.	31/03/2023	-6.00				Overdue							30/09/2023
External	2020.01EA	Efficiency Savings Arrangements	Not Rated	Director of Strategy, Planning & Partnersh	N/A	N/A	R4	By February 2023, align the efficiencies and savings expected in the IMTP improvement programmes with a more coordinated work programme utilising the key enablers including the Programme Management Office, the Value Based Healthcare Team, the Clinical Futures team and wider research and development.	The plan for 2022/23 aimed to progress service and financial sustainability & deliver efficiency through transformation. This would be enabled by the PMO structure with multi professional teams working with service teams across pathways to deliver improvement, this is more inclusive than the teams quoted.Due to operational pressures the progress has not delivered the expected results during 2022/23 but will be revisited to consider application for 23/24 as part of the IMTP review.	31/03/2023	-6.00				Overdue							30/09/2023
External	2020.01EA	Efficiency Savings Arrangements	Not Rated	Director of Finance and Procurement	N/A	N/A	R5	By February 2023, strengthen scrutiny of savings plans which are risk assessed as amber or (in future) red risk rated plans. In addition:Ensure that financial savings targets and timescales are agreed and regularly updated. strengthen the effectiveness of management intervention where efficiency plans are off trac	Savings plans are developed with scrutiny through the Executive team, they are risk assessed, updated regularly,and reported formally on a monthly basis to the Exec team, WG and Board.Chief executive OfficerIt is recognised there is a need to reconsider & develop a new approach to Savings agreement and ownership and management intervention, this will be developed as part of the revised governance approach for ABUHB, through the financial recovery plan actions.	31/03/2023	-6.00				Overdue							30/09/2023
External	2020.01EA	Efficiency Savings Arrangements	Not Rated	Director of Finance and Procurement	N/A	N/A	R6	Update the year-end financial forecast position more regularly based on the changing level of risk to the finances, as well as the year to-date financial position.	Financial forecasts and risks are identified, reviewed, updated on an ongoing basis with formal reporting on an established monthly cycle.2022/23 remains a very volatile and uncertain year and while the forecast did not formally change until mid-year, the risk analysis was updated monthly & reflected the risk appetite of the Board.This process will continue as good practice going forward.	31/03/2023	-6.00				Overdue							30/09/2023
External	2020.01EA	Efficiency Savings Arrangements	Not Rated	Chief Executive	Director of Finance and Procurement	N/A	R7	By March 2023, ensure there is clarity of operational financial risk sharing (for example where operational directorate responsibilities for delivering savings and IMTP programme responsibilities for delivery of efficiencies overlap).	The approach to savings responsibility and accountability will be revisited and established as part of the financial recovery process and IMTP development.	31/03/2023	-6.00				Overdue							30/09/2023
External	2020.01EA	Efficiency Savings Arrangements	Not Rated	Director of Finance and Procurement	N/A	N/A	R8	By March 2023, strengthen the use of visual management tools including service transformation trackers, saving trackers and linked risk trackers for all programmes. This performance information needs to be communicated to relevant service management for increased responsiveness.	The approach to more visual savings reporting will be alignedwith the response to R7 above and established as part of the financial recovery process and IMTP development.	31/03/2023	-6.00				Overdue							30/09/2023
External	2020.01EA	Efficiency Savings Arrangements	Not Rated	Chief Executive	Director of Finance and Procurement	N/A	R9	By the end of January 2023, implement stronger approaches for monitoring the deployment/delivery of savings to better understand where service improvements are and aren't delivering the necessary efficiency and financial improvement. As part of this ensure there is timely and effective corrective action.	It is recognised there is a need to reconsider & develop a new approach to Savings agreement and ownership and management intervention, this will be developed as part of the revised governance approach for ABUHB, through the financial recovery plan actions.	31/03/2023	-6.00				Overdue							30/09/2023

Appendix 3) 2022-2023 74 Overdue Recommendations Sent To Executive Leads For Updates

Audit Type	ABUHB Ref No:	Report Title	Assurance Rating	Director	Responsible Officer	Priority	Recommen-dation No.	Recommendation	Management Response	Deadline Agreed in Final Report	Months passed Agreed Deadline	Proposed Revised Deadline	Months passed Revised Deadline	Date Revised Deadline was approved by ARAC Comittee	Final Report Deadline Status	Revised Deadline Status	If closed and not complete please provide justification and ensure evidence is available	Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	What evidence is available to close down the recommendation?	Reporting Date
Internal	2022.01	CYP Continuing Care	Reasonable	Chief Operating Officer	Assistant Service Manager	Medium	R2	Incorporate the use ofthe recently developed All Wales CCN Senior Nurse forum KPIs for CCNS within the performance monitoring process.Regular monitoring of the performance report within the CCNS with annual (minimum) reporting to the Division.	Medium1)RL Datix to be utilised further to capture compliments as an initial step to provide more balance. 2)Key Performance Indicators for the Children's Community Nursing Service is being looked at within the All Wales Forum. Once finalised, these will be implemented locally and reported to Division two-monthlyin line with QPS frameworkwith appropriately agreed action plans supported3)CIVICA has recently been commissioned by the UHB and will support	31/12/2022	-8.95				Overdue			Partial Completion 1) COMPLETED compliments being recorded on datix if receieved 2) All Wales KPI's not yet agreed to incorportae in our performance monitoring locally 3) CIVICA feedback implemented for Care Closer to Home and awaiting first report, wider implementation anticipated in the next 6 months	28/07/2023 As above plus staffing levels in Environment Team			30/09/2023
Internal	2022.01	CYP Continuing Care	Reasonable	Chief Operating Officer	Assistant Divisional Nurse/ Division Lead for QPS	Low	R5	Implement robust communication mechanisms between the various partnership working forums (e.g., CC Development Group, Regional Integrated Complex Needs Panel, etc).Monitor the effectiveness of these forums and any new joint processes implemented.	Assistant Divisional Nurse / Division Lead QPS	30/11/2022	-9.97				Overdue			Ongoing - Development of Complex Needs Pathway underway, Interagency collaborative meetings commenced, joint processes in draft form, Consultant Nurse JD in draft, expected to be advertised shortly	some concerns regarding differeing interpretations of the national framework and organisational responsibility between health and local authority	Vanguard training proposed by Welsh Government for Autumn 2023		30/09/2023
Internal	2022.05	Digital Benefits Realisation	Reasonable	Director of Digital	Chief Digital Officer	Low	R2	R2 The Health Board should continue with an annual reporting cycle that summarises the benefits position for the Audit, Risk and Assurance Committee. Work on the benefits dashboard should be completed and incorporated into future reporting.	Benefits updates are provided at monthly programme boards and quarterly to Programme Delivery Board (PDB). Work is ongoing with the PMO using the informatics portfolio register to develop oversight of portfolio level benefits. A local dashboard is under development for summary reporting to DDOB	01/09/2023	-0.95				Overdue							30/09/2023
Internal	2022.05	Digital Benefits Realisation	Reasonable	Director of Digital	Chief Digital Officer	Medium	R1	R1 - The Health Board should finalise the "front of house" process and enable a process for a holistic prioritisation of programmes.	A draft New Digital Service Request (NDSR) process has been designed to provide transparent onboarding of new work for the informatics directorate. The process sets out how Informatics undertakes and supervises a workflow using agreed standard tools and documentation from triage, through evaluation, discovery & definition to transition to	01/06/2023	-3.97				Overdue			Aug-23: The Director of Digital has completed the review of the Front of House process and this is being finalised prior to approval by the Executive Committee in October which will include strengthening the financial and governance controls				30/09/2023
Internal	2022.06	Decarbonisation - Advisory	Not Rated	Director of Finance and Procurement	AFD	N/A	R2	DAPs should be fully costed to fully determine the total funding required.	Subgroups of the main DPB have been tasked with developing action plans relating to their delegated national initiatives. This work will include costing projects and is currently in progress. Programme/project costs to meetthe interim CO2 reduction targets are currently being analysed.	31/03/2023	-6.00				Overdue							30/09/2023
Internal	2022.06	Decarbonisation - Advisory	Not Rated	Director of Finance and Procurement	Energy & Carbon Manager DPB Workstream	N/A	R4	NHS Wales Organisation's baselines should be adequately scrutinised and challenged, as errors and overreporting has been identified in a few examples to date.	Agree. Net Zero Report data sources, analysis and report generation will be subject to an internal review. The HB have now set up a Decarbonisation Programme Board which incorporates the existing metrics along with additional scrutiny of new projects coming on line within the working groups.	01/05/2023	-4.98				Overdue							30/09/2023
Internal	2022.07	Clinical Audit	Limited	Medical Director	Assistant Director QPS	Medium	R2	R 2.3 The local clinical audits should be recorded onto AMaT, as is currently being done with national clinical audits.	It is acknowledged that the current process in ABUHB for local audit has lacked structure and formal documentation. AMaT will be utilised for local audit and will enable the development of a formally recognised process for reviewing the organisations performance when reports are published. The AMaT report will include consideration of improvements (planned and delivered) and an escalation process to ensure the executive board is made aware when issues around	01/03/2023	-6.98				Overdue			Update Aug 2023: It has been acknowledged that the historical process in ABUHB for local audit has lacked structure and formal documentation. This has been updated with the implementation of the web-based audit management and tracking system (AMaT), which is being utilised for local audit.	Currently the resource is a 0.8WTE Clinical Audit Lead who delivers both the National Clinical Audit and Local Audit Plans. All work is falling to one key person in the team who works part time.	ADQPS supporting and enlisting help from Clinical Audit team.	List of dates for attendance at Divisional meetings to present the Clinical Audit Strategy and discuss use of AMaT. AMaT training for staff. Ongoing training. Number of local audits on AMaT.	30/09/2023
Internal	2022.10	Newport HWB Centre	Reasonable	Chief Operating Officer	Capital Planning Team	Low	R15	R15 The Project Bank Account should be implemented as soon as possible.	Agreed. The UHB is awaiting a list of sub-contractors from the SCP who wish to join the PBA.	01/02/2023	-7.90	30/09/2023		12/09/2023	Overdue	Overdue		Aug 2023: The PBA will go live in September 2023 Remit of the Capital Planning Team	None	N/A	Revised valuation process	30/09/2023
Internal	2022.11	Policies	Limited	Director of Corporate Governance	Director of Corporate Governance	Low	R2	R2 The Health Board should not embed documents / files / forms etc. within a policy document hosted on the intranet. If a form is applicable, it should form part of the appendices or be referenced separately.	As part of a review of the Policy for the Management of Policies and Written Control Documents (WCDs), the Quality Assurance process will be strengthened and implemented.	29/09/2023	-0.03				Overdue							30/09/2023
Internal	2022.11	Policies	Limited	Director of Corporate Governance	Director of Corporate Governance	Low	R3	R3 The Health Board should consider the relevant Health and Care Standards when reviewing / updating a policy or other relevant documentation. An acknowledgement of this process should be included, together with the titles of the relevant Standards included.	The introduction of the Duty of Quality, under the Health and Social Care (Quality and Engagement) (Wales) Act 2020, will see the Health and Care Standards (April 2015) removed and replaced with Quality Standards 2023. As part of a review of the Policy for the Management of Policies and Written Control Documents (WCDs), the introduction of the Quality Standards 2023 will be considered, and policy templates updated as they are reviewed/developed.	29/09/2023	-0.03				Overdue							30/09/2023
Internal	2022.11	Policies	Limited	Director of Corporate Governance	Director of Corporate Governance	Medium	R4	R4 The Health Board, alongside recommendation 3.1 should consider automating the submission of a policy from the responsible owner, to ensure that a consistent submission format is adhered to.	An integrated electronic policy management system will be explored, learning from other health bodies, with an implementation plan developed to support the most appropriate system.	29/09/2023	-0.03				Overdue							30/09/2023
Internal	2022.11	Policies	Limited	Director of Corporate Governance	Director of Corporate Governance	High	R5	R5 The Health Board should consider fully automating the reminder / management process of all relevant policies / documentation hosted on the intranet. This could be achieved through the use of Power Automate, Lists and other apps within Office 365. An automated work flow would undertake a periodic (e.g. weekly) check of all policies listed on the central spreadsheet that are overdue for review and issue automatic emails	An integrated electronic policy management system will be explored, learning from other health bodies, with an implementation plan developed to support the most appropriate system.	29/09/2023	-0.03				Overdue							30/09/2023
Internal	2022.11	Policies	Limited	Director of Corporate Governance	Director of Corporate Governance	High	R6	R6 Once the Health Board has completed a review of all existing policy documentation, document reviews should be undertaken prior to the dates stated for review. Where exceptions remain, there should be an escalation process introduced to include the responsible Executive Director and potentially the Chief Executive Officer / Audit, Risk and Assurance Committee.	As part of a review of the Policy for the Management of Policies and Written Control Documents (WCDs), the review and escalation process will be strengthened and implemented.	29/09/2023	-0.03				Overdue							30/09/2023
Internal	2022.11	Policies	Limited	Director of Corporate Governance	Director of Corporate Governance	Medium	R7	R7 The Health Board should complete a data accuracy review exercise of the policies and documents, alongside recommendation 2.1. Where data discrepancies exist these should be updated immediately to the correct value.	A review of the central base (881 documents) is underway, working with divisions, to review the status of each document and respective owners.	29/09/2023	-0.03				Overdue							30/09/2023
Internal	2022.11	Policies	Limited	Director of Corporate Governance	Director of Corporate Governance	Medium	R1	R1 The Health Board should review the types of policy documents retained and hosted, to determine if each of them should adhere to the Policy, for example, departmental standard operating procedures to be managed entirely within the respective division. Alongside this review, the document owner should be determined to ensure the responsibility remains with the most appropriate individual.	As part of a review of the Policy for the Management of Policies and Written Control Documents (WCDs), clarity will be provided on which WCDs are to be held centrally and which are to be managed within services and teams. A review of the central base (881 documents) is underway, working with divisions, to review the status of each document and respective owners.	31/03/2023	-6.00	30/09/2023		12/09/2023	Overdue	Overdue		Jun 23 - The Policy on Policies is currently being reviewed and as part of the review the scope of WCDs to be held centrally. The proposed scope is that only organisational WCDs will be held and managed centrally; all local polices and procedures will be managed within respective Divisions/Departments. This will be shared with key				30/09/2023
Internal	2022.12	Records Managment	Limited	Director of Digital	DPO and Head of IG	Medium	R1	R1 Consideration should be given to making the supplementary courses mandatory and monitoring related training attendance	a.) The service is currently working with the national team on having a new online learning offering across Wales which includes a fully updated records management module which will be mandatory. b.) We will request, via the clinical information and professional leads, that attendance at the Health Records awareness sessions is compulsory for all ward based staff.At these sessions we	01/03/2023	-6.98				Overdue			Aug-23: The National online training incl: Cyber Security & Health Records modules has gone live. IG offer a blended approach to their training and supplementary courses provided are now included in the compliance rates if requested instead of the online version.				30/09/2023
Internal	2022.12	Records Managment	Limited	Director of Digital	Interim ADI – Governance & Assurance	High	R2	R2 The importance of maintaining record management quality should be re-iterated to clinical staff, using communications from senior clinical staff and clinical information leads	As per 1.1 above, we will seek to enforce attendance at Health Records awareness Sessions and further re-iterate the professional standards required.	31/03/2023	-6.00				Overdue							30/09/2023
Internal	2022.12	Records Managment	Limited	Director of Digital	Head of Workforce and OD	Medium	R4	R4 The management of ward clerks should be centralised, and consideration should be given to manage shortages through "bank arrangements".	a.) Local ward clerk shortages will be escalated to the Assistant Directors of Nursingand subsequently escalated to the Executive Director of Nursing. Action plan will be agreed how to solve them. b.) The clerical bank is undertaking a rolling programme of recruitment which will benefit the short notice requirements for ward clerks and this information will be disseminated by the	31/07/2023	-2.00				Overdue							30/09/2023
Internal	2022.12	Records Managment	Limited	Director of Digital	Chief Nursing Information Officer (CNIO)	Medium	R3	R3 Records quality checks should be regularly carried out and formally evidenced. Consideration should be given to involve senior nursing staff in these checks.	The CNIO will monitor compliance with base line records management.	31/03/2023	-6.00				Overdue							30/09/2023
Internal	2022.12	Records Managment	Limited	Director of Digital	Interim ADI - Governance & Assurance	Medium	R6	R6 It should be ensured that storage conditions for records meet basic standards.	Information on unsuitable storage areas will be presented to the Medical Director every three months by the Data Protection Officer with appropriate risk assessments. Action plan with the Medical Director will be agreed.	31/03/2023	-6.00				Overdue			Aug-23: Storage aresa review undertaken and areas of mental health identified as requiring improvement previously identified as part of the Mental Health Business Case. Services have engaged with the proposed digitisation of mental health, child health and therapy records and work is underway to begin a programme of work to digitise these	Progression to digitisation of the remaining mental health, child health, therapy and other records will require resource or the service is limited as to how much can be achieved in the short term.	RPA is being used to good effect to release hours within the service that can be directed to do some of this wrok		30/09/2023
Internal	2022.12	Records Managment	Limited	Director of Digital	DPO & Head of IG	High	R7	R7 Patient records security should be ensured at all times.	IG will conduct security audits in remote areas to ensure compliance. The Governance Assurance Group agenda will be widened to include focused audits. The Health records service will work in partnership with this group and there will be a health records representative at Divisional GAG meetings from january 2023. Records management issues to be discussed in the divisional group meetings to create local action plans. Minutes are taken in these forums and	30/06/2023	-3.02				Overdue			Aug-23: An audit programme is under development in the IG team. The programme of work will commence in early October. Health Records are present in Divisional GAG meetings. Records management issues are discussed and a portfolio register is retained by IG and minutes are taken of the meetings.				30/09/2023
Internal	2022.12	Records Managment	Limited	Director of Digital	Interim ADI - Governance & Assurance	Low	R8	R8 Conditions of boxes used for records management should be regularly checked, and boxes which are collapsing should be replaced.	This will be reviewed six monthly and will be an item on the agenda at Governance and Assurance Meetings.	30/06/2023	-3.02				Overdue							30/09/2023
Internal	2022.12	Records Managment	Limited	Director of Digital	Chief Nursing Information Officer	Low	R9	R9 Loose patient records should be properly filed	The CNIO will reinforce this requirement with the ward staff. The process for creating DHR supplementary folders on wards will be shared with all Divisional nurses.	31/03/2023	-6.00				Overdue			Aug-23: Health Records have found significant amounts of loose filing on wards in RGH & St Woolos. This has been collected and scanned but has a negative impact as each sheet needs to be individually checked, barcoded and scanned rather than as a complete record. The rollout of WNCR has reduced paper generation on wards and the CNIO has been	Further rollout of WNCR in YYF, YAB, NHH will reduce the loose records and guidance will be provided to the staff on the wards in these areas.	Training of ward clerks where there are issues identified is ongoing and datix reports submitted where substantial breaches are identified.		30/09/2023
Internal	2022.12	Records Managment	Limited	Director of Digital	Interim ADI - Governance & Assurance	Medium	R10	R10 Each ward should adhere to the records management process, and this should be formally monitored (e.g., through exception reports). Specific KPIs should be developed to measure problematic areas	A bespoke report will be requested from Information services and/or DHCW. Where delays in returning documentation are identified via the report, these will be flagged and escalated to ward and clinical management.	30/06/2023	-3.02				Overdue							30/09/2023

Internal	2022.12	Records Managment	Limited	Director of Digital	Interim ADI - Governance & Assurance	Medium	R11	R11 Issues of records management process slowdowns should be investigated and escalated when required.	As per 4.1 above, a bespoke report will be developed. However, staffing resource will be required to check if discharges have been actioned and records have been returned. The need for additional resources will be escalated.	31/03/2023	-6.00				Overdue							30/09/2023
Internal	2022.12	Records Managment	Limited	Director of Digital	DPO & Head of IG	Medium	R12	R12 Data recording in Datix should be improved to ensure a more accurate reporting on missing / lost records.	Reinforcement of reporting through Datix will be cascaded to ward staff in training sessions and Governance and Assurance Group meetings.	30/06/2023	-3.02				Overdue							30/09/2023
Internal	2022.12	Records Managment	Limited	Director of Digital	DPO & Head of IG Deputy Head of Health Records	Medium	R14	R14 A formal process should be developed and adopted across the Health Board to share, escalate and resolve record management issues.	a.) The Governance and Assurance group will provide the forum for divisions to report records management issues. b.) A Health records representative will attend these sessions and work with the divisions going forward to improve records management. Progress will be monitored and reported quarterly and recorded on the centrally held portfolio register for each division.	31/03/2023	-6.00				Overdue							30/09/2023
Internal	2022.12	Records Managment	Limited	Director of Digital	Deputy Director of Nursing Head of Strategic	Medium	R15	R15 We recommend the undated/ expired documents are reviewed, updated and ratified as a matter of priority.	Nurse Staffing Levels Wales (2016) Act Operational Framework and Escalation Process will now have approval date added and next review date.It is acknowledged that "The Protocol for requesting, authorising & booking bank and agency clinical workers Standard Operating Procedure" expired in 2017. The practice contained in the document remained the same up until the Covid Pandemic. During this time priority was to secure clinical staff to ensure our	01/03/2023	-6.98				Overdue			Jun 23: Approval and review date added to NSLWA and updated protocol published.				30/09/2023
Internal	2022.14	Robotic process Automation	Reasonable	Director of Digital	Chief Technology Officer	Low	R1	A formal SOP should be defined that sets out how the RPA process is to be managed. The operational service model should be fully defined and the terms of reference for the governance board reviewed and updated.	Upon successful investment case being made this will be addressed as part of the transisition to service delivery	01/06/2023	-3.97				Overdue			Aug-23: 2 posts funded for a permanent team.Recruitment underway. Team will sit within Softwrae development as part of Integration services				30/09/2023
Internal	2022.14	Robotic process Automation	Reasonable	Director of Digital	Chief Digital Officer	Medium	R2	Benefits realisation should be established as part of the go-live for automated processes, with the relevant department being required to monitor and confirm the benefits.	Benefits realisation is identified and confirmed by relevant departments and this will now be formally monitored and confirmed by the governance board. This is in part contingent on a successful business case.	28/06/2023	-3.08				Overdue			Aug-23: Service request forms and opportunity assessment form redesigned to provide better profiling of benefits. Process agreed by RPA Board for requesting service Finance BPA assurance of benefits before automations are agreed				30/09/2023
Internal	2022.14	Robotic process Automation	Reasonable	Director of Digital	Chief Digital Officer	Medium	R3	Consideration should be given to establishing a benefits sharing framework for cash releasing savings that would enable the RPA function to be self-sufficient.	This is not a unique issue to RPA but reflects the need for benefits realisation to include (when corroborated and confirmed) sharing of benefits including financial where this is the case. In order to mitigate the risk of priority based on ability to pay the process needs to be owned and curated at health board level rather than between departments. This recommendation will be considered in the case.	31/03/2023	-6.00				Overdue			Aug-23: Service request forms and opportunity assessment form redesigned to provide better profiling of benefits. Process agreed by RPA Board for requesting service Finance BPA assurance of benefits before automations are agreed				30/09/2023
Internal	2022.14	Robotic process Automation	Reasonable	Director of Digital	Chief Digital Officer	Medium	R4	The Health Board should seek to complete recruitment and staff the RPA team accordingly.	A revised business case is expected to be submitted to Executive colleagues in Q4.	01/03/2023	-6.98				Overdue			Aug-23: RPA escalation SBAR presented to Exec Board in March 2023. 2 posts agreed.				30/09/2023
Internal	2022.14	Robotic process Automation	Reasonable	Director of Digital	Chief Digital Officer	Medium	R5	The Health Board should consider the purchase of additional robot capacity.	The business case for submission in Q4 provides an option also to increase capacity of automation.	01/03/2023	-6.98				Overdue			Aug-23: RPA escalation SBAR presented to Exec Board in March 2023. Additional robot purchase not supported pending rebaselining of planned automations benefits				30/09/2023
Internal	2022.14	Robotic process Automation	Reasonable	Director of Digital	Chief Digital Officer	Medium	R6	Consideration should be given to increasing the level of ring fencing for specific robot time for time constrained processes as part of the ongoing development of the RPA service	The business case for submission in Q4 provides an option also to increase capacity of automation.	01/03/2023	-6.98				Overdue			Aug-23: Peak day time capacity consumes all current robot capacity. Additional robots have been procured from non RPA budgets to support critical functionality. The RPA architect continues to reprofile activity to ensure automations are deployed optimally to allow additional automations not dependent on in hours working to be				30/09/2023
Internal	2022.14	Robotic process Automation	Reasonable	Director of Digital	Chief Digital Officer	Medium	R7	The awareness of RPA and the change management process should be strengthened as RPA moves into an operational service. All services should be made aware of the requirement to notify Informatics of changes to any system that may interact with the robots.	Part of the transitional arrangements to operational services will be refined and robust service management arrangements. This is subject to a successful business case.	01/03/2023	-6.98				Overdue			Aug-23: Transition to BASU will be undertaken when posts are appointed q3 2023				30/09/2023
Internal	2022.15	IT Strategy	Reasonable	Director of Digital	Chief Clinical Information Officer Chief Nursing	Medium	R2	The role of the CCIO and CNIO should be fully defined.	2.1a The CCIO currently has an AMD role profile. There has been discussions for some time in terms of role design and accountability with the CCIO MD CEO and CDO. A model role profile based on the Faculty of Clinical Informatics example has been agreed and is now being localised. The CNIO has a full role profile and agreed Job description	01/06/2023	-3.97				Overdue			Aug-23: CNIO aspects of this have been met				30/09/2023
Internal	2022.15	IT Strategy	Reasonable	Director of Digital	Chief Clinical Information Officer Chief Nursing	Medium	R3	Leads within divisions should be established to work with the CCIO / CNIO	The principle of Divisional Leads is accepted by the health board. The proposition now needs to be explored and defined in a proposal by the CCIO and CNIO to the Digital Delivery Oversight Board.	01/06/2023	-3.97				Overdue			Aug-23: Clinical Informartics Council in place and meeting scheduled every 6 weeks, how service pressures have resulted in over half the meetings this year cancelled. More formal job planning needed to release resources to attend	Lack of job profiling to support time to release clinical staff to attend			30/09/2023
Internal	2022.15	IT Strategy	Reasonable	Director of Digital	Chief Digital Officer	Medium	R6	The Health Board should seek to align plans with other sources of digital projects.	Joint planning sessions with DHCW are now taking place and will be (following revised terms of reference and membership being agreed) considered by DDOB. DDOB will also receive escalations on funding/governance or priority issues whether local regional or national. The Programme Office will provide reporting against this	01/09/2023	-0.95				Overdue							30/09/2023
Internal	2022.15	IT Strategy	Reasonable	Director of Digital	Chief Clinical Information Officer and Chief Nursing	Medium	R4	Work should be undertaken to embed the Clinical Informatics Council and encourage participation therein	Agreed. The CCIO and CNIO will revisit the membership and Terms of Reference for the Clinical Informatics Council which will be included as part of	01/06/2023	-3.97				Overdue							30/09/2023
Internal	2022.16	Financial Sustainability	Reasonable	Director of Finance and Procurement	Director of Finance & Procurement / Chief Executive	Medium	R1	All delegated budgets should be formally accepted. Non-acceptance of a delegated budget should be reported to the Finance and Performance Committee and / or the Audit, Risk and Assurance Committee	Accepted for Executive level delegation letters	01/05/2023	-4.98				Overdue							30/09/2023
Internal	2022.17	Risk Management	Reasonable	Chief Operating Officer	Divisional Nurse Complex and Long Term	Low	R1	The Complex and Long Term Care Division should report the full risk register, on a periodic basis, to the Divisional Quality, Patient Safety and Experience Group	Agreed. The Complex and Long Term Care Division will report the full risk register to the Divisional Quality, Patient Safety and Experience Group	01/04/2023	-5.97				Overdue			Only high risks are requested by QPSOG, full register available when requested / required.				30/09/2023
Internal	2022.17	Risk Management	Reasonable	Chief Operating Officer	Divisional Nurse Complex and Long Term	Medium	R2	The Complex and Long Term Care Division should ensure that there is no additional risk exposure through the current approach of recording divisional risks	Agreed. The Complex and Long Term Care Division will ensure there is no additional risk exposure through the current approach of recording divisional risks	01/04/2023	-5.97				Overdue			Risks are discussed on a regular basis via numeorus daily / weekly meetings.				30/09/2023
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	Head of Patient Discharge	High	R1	Where a Health Board policy is to expire that an extension to the document is formally granted, with a revised review by date established. Such policy extensions should be reported to the Board or designated Committee and checks made to ensure that the policy remains as relevant as possible, pending any formal review.	The Health Board's clinical policies have a review date rather than an expiry date, and whilst the review date may have elapsed, the policy remains extant and does not require a formal extension. However, whilst the Policy remains extant, we recognise there may be differences between the Policy and current practice. Therefore, the current process will be reviewed and compared to the existing policy. Where gaps are identified, these will be risk assessed and	01/05/2023	-4.98				Overdue							30/09/2023
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	Head of Patient Discharge	High	R1	The Discharge Policy is updated, approved and reissued, to reflect current practice and approach to discharge planning adopted by the Health Board (Medical Fit Date for Discharge, simple and complex case approaches, and the management of the Complex List) and the related roles and responsibilities of staff.	In the interim we will identify the gaps between current practice and the current policy and ensure that it is updated. We will then ensure the Policy is approved by the appropriate Committee. Once the All-Wales Policy is published, we will ensure that any requirements are incorporated into the Health Board's Policy. The revised policies will be re-issued with training overseen by the Head of Discharge and Divisional Nurses. We will continue to monitor the	01/05/2023	-4.98				Overdue							30/09/2023
Internal	2022.20	Tredegar Health & Wellbeing Centre Final Internal	Limited	Chief Operating Officer	Chief Operating Officer	Medium	R1	See Newport East Health and Wellbeing Centre Audit Report MA2 issued December 2022.	Agreed. The issue was raised at the Februaary meeting of the Programme Board in the absence of the Director of Primary Care, Community and Mental Health services. Proposed to separate the Project Board function from the wider remit of the Programme Board.	01/06/2023	-3.97	28/08/2023	-1.08	12/09/2023	Overdue	Overdue		Aug 2023: A new SRO has been identified and a separate PB has been arranged for 28th August	None	N.A	Aug 2023: Updated PB Terms of Reference & Meeting papers	30/09/2023
Internal	2022.20	Tredegar Health & Wellbeing Centre Final Internal	Limited	Chief Operating Officer	Project Director	Low	R7	The Cost Adviser should provide assurance that appropriate sampling has been made of supporting documentation for costs claimed in respect of Plant and Materials (utilising an Open Book approach as specified at the Project Execution Plan).	Agreed. The Cost Adviser has been requested to provide such assurance.	01/06/2023	-3.97	30/09/2023		12/09/2023	Overdue	Overdue		Aug 2023: This is outstanding	None	N/A	Aug 2023: Evidence of sampling	30/09/2023
Internal	2022.21	Development of a Regional Radiotherapy Satellite Centre at	Reasonable	Director of Strategy, Planning & Partnerships	Project Director	Medium	R3	Pending implementation of the Project Bank Account, the University Health Board should seek assurances from the Supply Chain Partner in respect of the timely payment of its subcontractors.	Agreed, the University Health Board will seek evidence of timely payments from the Supply Chain Partner as part of monthly progress reporting	01/09/2023	-0.95				Overdue			The PBA will be implemented from September 2023.	Delay in sign-off by SCP Bank		Revised valuation process	30/09/2023
Internal	2022.21	Development of a Regional Radiotherapy Satellite Centre at	Reasonable	Director of Strategy, Planning & Partnerships	Project Director	Medium	R3	Deeds should be signed as a priority and the Project Bank Account established in line with Wales Procurement Policy Note WPPN 04 which is supported by the requirements of the University Health Board's Standard Financial Instructions section 15.4.8.	Agreed, the Project Bank Account Trust Deed was signed and returned to the Supply Chain Partner (SCP) on 15th March. Implementation usually takes 4 to 6 weeks including the sign up of Sub Contractors. As things stand no Sub-Contractors wish to join the PBA, evidence of refusal has been requested	01/06/2023	-3.97	30/09/2023		12/09/2023	Overdue	Overdue		Aug 2023: The PBA will be implemented from September 2023.	Aug 2023: Delay in sign-off by SCP Bank		Aug 2023: Revised valuation process	30/09/2023
Internal	2022.21	Development of a Regional Radiotherapy Satellite Centre at	Reasonable	Director of Strategy, Planning & Partnerships	Project Director	Medium	R6	User sign-off of the design and derogations should be formally recorded.	Agreed, Design & derogations will be formally and finally signed off by users to reflect very recent changes requested by the supplier of the Linear Accelerator medical devices	01/06/2023	-3.97				Overdue			Aug 2023: Derogations were signed off by the pervious Head of Operations. VT signed off design proposals and the scrutiny process required input from Shared Services to the technical design. Discussion could not place with the Linac Supplier until after FBC submission and this has subsequently led to a number of reviews of the Bunker	Aug 2023: Choice of Linac Supplier	This has not delayed project progress	Aug 2023: Final sign off by Varian and VT	30/09/2023

Internal	2022.21	Development of a Regional Radiotherapy Satellite Centre at	Reasonable	Director of Strategy, Planning & Partnerships	Programme Manager	Medium	R7	The UHB should seek to obtain the necessary collateral warranties at the earliest opportunity.	Agreed, the necessary collateral warranties will be obtained at the earliest opportunity.	01/06/2023	-3.97				Overdue			Aug 2023: At this point in time the process for the provision of collectoral warranties has not required to be actioned as the relevant works have not be completed. Not currently at the point of issuing warranties.	Aug 2023: None	N/A	Aug 2023: None, CWs have so far not been required	30/09/2023
Internal	2022.22	RGH Redevelopment & Expansion of Endoscopy	Reasonable	Director of Strategy, Planning & Partnerships	Project Director	Low	R7	There should be consistency between the capital procedures and the SFIs in terms of minimum competition levels	It is understood that Capital Procedures and SFIs are both currently being reviewed and updated. The need for consistency between the two has been highlighted.	01/09/2023	-0.95				Overdue							30/09/2023
Internal	2022.22	RGH Redevelopment & Expansion of Endoscopy	Reasonable	Director of Strategy, Planning & Partnerships	Project Director	Medium	R6	At Future Projects The contract strategy should be fully evaluated and considered (within the Business Justification Case or extant).	Future business cases will include reference to a contract strategy	01/05/2023	-4.98				Overdue			Aug 2023: This is a future action for future projects	None	N/A	Aug 2023:Future action	30/09/2023
Internal	2022.25	Integrated Wellbeing Networks	Reasonable	Director of Public Health	IWN Programme Manager	Medium	R1	Management should formalise the approach to communicating/monitoring local IWN plans and providing cover if the Service Development Lead is absent	Community Involvement Officer colleagues are often able to deputise in the absence of the SDL. The programme will explore sharing meeting facilitation with community partners and with the appointment of an 8b Programme Manager (currently out to advert) how the programme can support local meeting facilitation and programme delivery where SDL colleagues are absent for prolonged periods	01/08/2023	-1.97				Overdue							30/09/2023
Internal	2022.26	Contract Mangement	Reasonable	Chief Operating Officer	Director of Finance & Procurement Assistant Finance	High	R1	We recommend that Health Board management ensure that a contract management policy and guidance is developed, approved, issued and communicated to all relevant staff. It should incorporate the following: 1. guidance over the operational management responsibilities associated with contracts, including the management / identification of contract risks, performance monitoring, escalation of matters arising etc.; 2. template documents to record details of how individual contracts are to be	A contract Management Policy is in the process of being developed and due to be drafted by the end of July 2023 for consideration and approval by end August 2023. The policy will make reference to standard documentation in order to standardise the approach to contract management across the Health Board, and form a FCP	01/08/2023	-1.97				Overdue							30/09/2023
Internal	2022.24	Infection Prevention & Control (OPC)	Reasonable	Director of Nursing	Head of IPC	Medium	R1	Management should undertake a walk around / review of wards covered in this audit to ensure areas of noncompliance have been addressed. Any lessons to be learnt should be shared with the remaining wards to ensure compliance throughout the Health Board.	Email circulated to Divisional Nurses on the 30.05.23 asking for the above recommendation to be implemented and update via local quality and patient safety forums and the Reducing Nosocomial Transmission Group. Dashboard audits are available on the AMaT platform	01/07/2023	-2.98				Overdue							30/09/2023
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Programme Manager	Medium	R3	Consideration should be given to make the electronic recording fit for dementia services. For example, add or change menu structure or introduce a dedicated field to highlight dementia diagnose.	Workstream 5b leads, along with Performance Team support, will review the electronic information and ensure the recording is appropriate for dementia services going forward	01/08/2023	-1.97				Overdue			UPDATE JULY 2023: Dementia webpages are being reviewed to ensure the availability of the document digitally.				30/09/2023
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Informativc Programme Manager - WCCIS	Medium	R3	It should be clearly defined and communicated in what circumstance alerts should be used. In addition, staff should be trained on how to add alerts to the system	We will review the training and electronic filing requirements for 'alerts' and ensure that clear messages are communicated to the relevant staff	01/07/2023	-2.98				Overdue							30/09/2023
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Lead Nurse for OAMH / Informatics Programme Manager -	Low	R3	Training should be provided to ensure a consistent approach for the electronic and paper records completion	We will review the training components and update where required, to ensure a consistent approach is adopted	01/07/2023	-2.98				Overdue							30/09/2023
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Programme Manager	Low	R4	Consideration should be given to formally monitor (e.g. set KPIs) and report on • patients hospitalised outside of their catchment areas; and • moved from one hospital site to another one over their treatment time.	Workstream 5b (measurement) will consider appropriate KPI's and will extend an invitation to the Patient Flow Team to be members of the workstream	01/08/2023	-1.97				Overdue							30/09/2023
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Programme Manager linking in with Patient Flow Leads	Low	R4	Where operationally and clinically possible, a patient's locality should be considered as part of the admission / transfer process.	Patient Flow Team to consider this specific aspect, linked to the developed KPI's above	01/09/2023	-0.95				Overdue							30/09/2023
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Lead Nurse Dementia	Low	R4	There should be easily available information / training for staff to ensure patients can communicate with Welsh speaking staff.	The Workstream 4 (Hospital Charter) to link with the Welsh Language Lead and Workforce and Organisational Development leads to identify the number of Welsh Speaking Staff, identify how we can better identify Welsh Speakers and ensure access to Welsh Speakers as part of our Person Centred Care Dementia Care work programme.	01/09/2023	-0.95				Overdue							30/09/2023
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Head of Nursing Person Centred Care / Lead	Low	R5	Local initiatives with success stories should be channelled and discussed at existing forums.	Patient Stories are used at MDT learning events, at Board, through the Quality and Patient Safety Operational Group (QPSOG) and Board. Discussions have taken place within the Person-Centred Care Team to develop a digital portal for all patient stories. Listening and Learning is reported at QPSOG. There are also early discussions around establishing a Community of Practice for patient experience to share learning and celebrate success/best practice	01/09/2023	-0.95				Overdue							30/09/2023
Internal	2022.28	Mental Health Transformation	Reasonable	Chief Operating Officer	Divisional Director and Chief Operating Officer	Medium	R1	The Whole Person Whole System Crisis Support Programme Board and the Mental Health Transformation Board established to provide oversight have Chairs appointed who are independent of divisional management to demonstrate and deliver the independence required of such bodies.	A review will be undertaken regarding the Chairs of both the WPWS Crisis Support Programme Board and Mental Health and Learning Disability Transformation Board.	01/09/2023	-0.95				Overdue							30/09/2023
Internal	2022.28	Mental Health Transformation	Reasonable	Chief Operating Officer	WPWS Crisis Support Senior Programme Manager	Medium	R1	The Project Flash Report format should be amended to include a section on matters for escalation. Any such matters should be reported as part of a standing item within the appropriate board setting (i.e. Whole Person Whole System Crisis Support Programme Board or the Mental Health Transformation Board). The minutes should reflect the matters to be escalated or state no matters for escalation. This is also applicable of matters for escalation from the Mental Health Transformation Board.	The Project Flash Report format will be amended to include a section on matters for escalation. Any such matters for escalation have previously been verbally reported and will be reported more clearly as a stand alone agenda item within the appropriate board. For clarity, going forward the minutes will also reflect the matters to be escalated or state no matters for escalation.	01/08/2023	-1.97				Overdue							30/09/2023
Internal	2022.28	Mental Health Transformation	Reasonable	Chief Operating Officer	WPWS Crisis Support Senior Programme Manager	Medium	R1	The Whole Person Whole System Crisis Support Programme Board performs deep dives into projects to further scrutinise the information received in the Project Flash Reports.	Within the current structure of the Whole Person Whole System Crisis Support Programme Board there is currently the ability to focus on details regarding specific projects. However, a more formal approach to "deep dives" for individual projects will be introduced (12 monthly minimum) that will include comprehensive performance and benefits reporting.	01/09/2023	-0.95				Overdue							30/09/2023
Internal	2022.28	Mental Health Transformation	Reasonable	Chief Operating Officer	WPWS Crisis Support Senior Programme Manager	Medium	R1	Consideration be given to the Whole Person Whole System Crisis Support Programme Board only receiving the Project Flash Reports and for this Board to then report by exception to the Mental Health Transformation Board on matters detailed in the reports	The Mental Health and Learning Disability Transformation Programmes (Whole Person Whole System Crisis Support Programme and Complex Needs Programme) will receive the Project Flash reports for all workstreams and those Boards will then report by exception to the Mental Health and Learning Disabilities Transformation Board.	01/09/2023	-0.95				Overdue							30/09/2023
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Lead Nurse for OAMH	Low	R3	Consideration should be given to revisit the appropriateness of the paper folder file style for the MHUs, to improve efficiency of access to patient files	The OAMH Directorate will review the paper folder files and implement any improvements required.	01/07/2023	-2.98				Overdue							30/09/2023
External	2023.02EA	Structured Assessment 2022	Not Rated	Director of Corporate Governance	N/A	N/A	R1	R1 Board and Committee agendas cause some meetings to overrun. The Health Board, therefore, should review Board and committee agendas to ensure meeting business can be covered in the time available whilst also allowing for sufficient scrutiny and discussion.	Ongoing development of the Board's Assurance Framework and Risk Management Framework will enable the Board and Committees to ensure focus on priority, risk-based, areas by exception, supported by risk-based workplans. The development of Board and Committee Etiquette and Conduct of Business will also support greater effectiveness of meetings.	01/09/2023	-0.95				Overdue							30/09/2023
External	2023.02EA	Structured Assessment 2022	Not Rated	Director of Corporate Governance	Director of Finance and Director of Planning	N/A	R7	R7 The Health Board's deteriorating financial position and deterioration in savings deliver indicates that stronger accountability for financial performance and delivery is required. The Health Board, therefore, should review its Scheme of Delegation to ensure it more strongly outlines delegated accountability for the budgetary position and achievement of financial efficiencies at and below executive levels.	The Health Board's existing accountability arrangements have been endorsed by the Audit, Risk & Assurance Committee and is aligned to Standing Orders and Standing Financial Instructions. The Executive Team has commenced work with the organisation's senior leadership team to further embed a culture of empowerment, autonomy, authority and accountability, building on existing arrangements in place. This Framework will cover all aspects of the organisation's	29/09/2023	-0.03				Overdue			Approval of Framework 30 April 2023Embedding of the Framework will be ongoing				30/09/2023
Internal	2022.29	Bank Office and Temporary Workers	Reasonable	Director of Workforce & OD	Deputy Director of Nursing	Low	R2	We recommend that mismatches betweeb te BankStaff system settings/permissions and ASL listings are identified, examined and addressed.	Divisional managment will sent out a communication to all ward managers to remind them of the requirement to esnure all staff required to electronically finalise shifts on Healthroaster/BankStaff have completed the relevant forns to be added onto the ASL.	30/08/2023	-1.02				Overdue							30/09/2023
Internal	2022.29	Bank Office and Temporary Workers	Reasonable	Director of Workforce & OD	Deputy Director of Nursing	High	R3	There is no further recommendation to raise. However for completeness, the previous recommendation is detailed below. We recommend the Health Board monitor and address any compliance issues with the current process in use. Where anomalies are identified going forward, these should be investigated and training provided to assist with the embedding of the controls. Furthermore rosteres should be prepared in a timely manner; and shifts should be released to the bank, contract and off-contract agencies at the	Divisional Nursing management will send out a communication to all Senior Nurses to remind them of the requirement to ensure all rosters are approved within the requirement timetable and to remind the nurses to send all Bank shifts to Bank at the earliest opportunity in the roster period.This will be monitored in the bi weekly meetings with senior nurse managers.	30/08/2023	-1.02				Overdue							30/09/2023

Appendix 4) Internal Audit 34 Overdue Recommendations position Following Return

Audit Type	ABUHB Ref No:	Report Title	Assurance Rating	Director	Responsible Officer	Priority	Recommendation No.	Recommendation	Management Response	Deadline Agreed in Final Report	Months passed Agreed Deadline	Proposed Revised Deadline	Months passed Revised Deadline	Date Revised Deadline was approved by ARAC Comtiee	Final Report Deadline Status	Revised Deadline Status	If closed and not complete please provide justification and ensure evidence is available	Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	What evidence is available to close down the recommendation?	Reporting Date
Internal	2017.00	Medical Equipment and Devices (2017/18)	Limited	Director of Therapies and Health Science	N/A	High	R1	R1 Registers should be maintained for operational management of medical devices and equipmentson each ward and department, which should record relevant equipment details.The register format should be consistent and overseen centrally, with periodic reviews / scrutiny completed.Each areashould ascertain the total number of devices held, by reviewing each and every item (including non-electrical equipment) physically and record itupon theirregister. Discrepancies that are identified can be updated / amended on the register, so all items are correctly recorded. Going forward, relocation of equipment, disposals, additions etc. should be updated promptly to ensure an accurate record continues.	The Health Board to consider investing in an overarching equipment database register with staff resources to ensure regular updating and management.	31/03/2018	-65.87	31/03/2024	6.00		Overdue	Not Yet Due		Nov 23 - The Medical Device Committee Workplan was been updated in October to reflect the upate provided to the Committee in August. This will ensure regular updates against the actions in place e.g., New infusion device service and training manager now in post. • New database formed to record training compliance and process of inputting historical data in progress, plan to work this into HealthRoster/ESR once up to date, providing a compliance dashboard. • Audit sent out to ward managers and divisional senior nurses to determine current training compliance throughout ABUHB. • Training sessions delivered and open to substantive and bank staff to book. • Strategic plan to incorporate cascade trainers into the training provision to increase compliance.	The software development between the 3 systems (Softpro Medusa, Ram Asset 4000 and Paragon RFID) is now operational. The unrelenting service pressures however means that there is still an extensive amount of work to visit every site and tag locations and equipment. This is still an ongoing project and work in progress. Assets are being tagged as and when we see them, however the process to blitz equipment tagging is restricted by the ongoing service pressures. There is also the ongoing restructuring of services/departments throughout our LGH's.	Whilst the aim is to tag all medical Equipment & devices throughout the HB hospitals we are focused on completing one major site. This being the GUH and to date out of 3242 assets listed on our database 1341 devices have been tagged, which represents 41.3% of assets on site at the GUH. In total we have RFID tagged over 4100 medical devices to date across our HB sites. Its difficult to commit to a completion date giving the ongoing service pressures, but this work is a daily ongoing process and when time allows we will undertake a blitz approach to RFID tagging the remaining devices, starting at the GUH .Medical Electronics (EBME) & Capital Finance still record all of the equipment details on their independent systems. Medical Electronics (EBME) update the latest location on their database as equipment passes through the department. Capital Finance undertake walk about audits to tag and update locations of assets. All new assets are RFID tagged as part of our EBME commissioning checks.			30/09/2023
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	Director of Digital	N/A	R1	R1 The governance framework for IM&T / digital should be clarified and where control over aspects of IM&T has devolved to departments, there should be a process for these to feed into the relevant Committee to ensure oversight. Underneath the Committee the steering group remit and membership should be defined.	Agreed. The Health Board is establishing a new governance framework. Currently Informatics is reporting to the Audit Committee, the first report is scheduled for 8thApril. A Health Board governance framework is in development for informatics including exec oversight, investment and delivery. The management of the global pandemic has disrupted the planning work by 12 months but this is now re-initiated. Recommendations arescheduled to be presented to Exec Team(Q1 and Board in Q2.	30/06/2021	-26.95	31/01/2024	4.03		Overdue	Not Yet Due		• Training sessions delivered and open to substantive and bank staff to book.				30/09/2023
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	Director of Digital	N/A	R4	R4 The risk identification process should be formally linked to the issue / event / problem management process in order to ensure that underlying risks are identified.	A review of risk management processes has commenced. The Health Board has appointed a Chief Nursing Information Officer/Clinical Safety Officer who will lead the project to align risk management processes from Programmes, design, Service Delivery, Health Records and Information Governance and Cyber Security to inform the new assurance structure.	31/12/2021	-20.92	31/12/2023	3.02		Overdue	Not Yet Due		• Strategic plan to incorporate cascade trainers into the training provision to increase compliance.				30/09/2023
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	Director of Digital	N/A	R6	R6 Consideration should be given to the placement of all informatics provision and support across the Health Board. As part of this the current partially decentralised model, should be re-assessed in terms of its suitability for the modern use of technology.	Accepted. Following the exec review of the Target Operating Framework and overarching governance will appraise the hybrid environment of departmental asset ownership, responsibility, risk management. As the report sets out this is a largely historical and organic model which will be complex to resolve in itself. A risk based approach will be adopted andcan ostions aswer will be devolvsed forconsideration by the Board.	31/12/2022	-8.95	31/05/2024	8.00		Overdue	Not Yet Due		Nov 23: The HEMS5 maturity report has been excepted and it will be played into our Digital Strategy and IMTP planning August 2023: The new Director of Digital is currently reviewing the TOF and will present findings and an action plan for the consideration by the Executive Committee in October 2023				30/09/2023
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	Director of Digital / Assistant Director for Strategy, Planning & Design	N/A	R8	R8 An assessment of the changes needed to implement the Digital Strategy should be undertaken, and the benefits of the changes articulated, along with the consequences of no change. The Health Board should develop a single roadmap to help deliver the Digital Strategy.	As part of the review Informatics has accepted the need for P3O Portfolio management. This work is ongoing and with an initial focus to core Informatics Division activity but provides a framework for Health Board oversight and transparency. The portfolio approach will extend subject to Board approval to all information assets in a planned programme of work. This forms part of the recommendations to Execs in Q1 2021.	30/06/2021	-26.95	31/12/2023	3.02		Overdue	Not Yet Due		Nov 23: The new digital service request process is nearing completion and will shortly be launched across the Health Board. The Digital governance committee will provide assurance on the digital plan and the updated digital programmes framework ensures benefits management will be ingrained on all projects. Aug 23: Progress being made on the portfolio register to surface all digital work including new service requests and ICT projects. Resource & capacity modelling being developed along with business change tools to support service readiness for change.				30/09/2023
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	Director of Digital / Assistant Director for Strategy, Planning & Design	N/A	R9	R9 A network of champions across the organisation should be established. The Digital Strategy should be re-issued alongside the roadmap. This should form the basis for engaging the network of champions to drive the Strategy forward.	Accepted-The Channel 3 report also identified a need for more emphasis on Clinical Leadership, Design and Business Partnering. This is subject to additional investment although recently the appointment of a full-time CNIO/CSO has been a significant step forward. Outwith the Directorate recommendations will be presented to Execs on overarching exec level oversight which is intended to both strengthen accountability but also to ensure Informatics capacity is used to best effect. Benefits realisation training has commenced in Informatics and will form part of reporting. It is in principle agreed that the Health Board adopts a single methodology and framework that should be co produced to manage all priority investments.	30/09/2021	-21.93	31/12/2023	3.02		Overdue	Not Yet Due		Nov 23: Progress has been made on the request process, business partnering and governance and will be completed by the 31/12/2023. The Digital Champions Network has recently been relaunched. Aug 23: New Digital Service Request proces, business partnering and new governance group is under development				30/09/2023
Internal	2021.22	NIS Directive (Cyber Security)	Reasonable	Director of Digital	Director of Digital / Chief Technology Officer	Low	R1	R1 For future iterations of the CAF there should be greater involvement of the system owners in the review of the responses.	ABUHB will ensure that in future iterations of the CAF there is greater involvement of System Owners	31/12/2022	-8.95	31/01/2024	4.03		Overdue	Not Yet Due		Nov 23: CRU assessment now scheduled for 22/01/2024. There will be a pre assessment meeting arranged by CRU in Nov/Dec to discuss scope and Digital will ensure this includes Information Asset Owners. Aug 23: CRU have provisionally provided a date for the next NIS CAF assessment process Oct 2023. As part of the engagement CRU have suggested a hybrid approach with onsite visits and interviews with systems owners. This is being piloted currently but is a process change from the previous assessment process undertaken in 2021.				30/09/2023
Internal	2021.22	NIS Directive (Cyber Security)	Reasonable	Director of Digital	Director of Digital / Chief Technology Officer	Medium	R2	R2 Management should ensure that records of discussions and information provided to and from the CRU are captured for future annual self-assessments.	Management will ensure that during any future self-assessments records of discussions and informationsupplied to the CRU will be captured and available for internal or external review.	31/12/2022	-8.95	31/01/2024	4.03		Overdue	Not Yet Due		Nov 23: CRU will outline what documentation/evidence they expect to be provided at the pre assessment scoping meeting prior to our January assessment. This is due to be held Nov/Dec 2023 Aug 23:CRU are piloting process changes to their approach from their initial NIS assessment undertaken in 2021, Future NIS CAF assessments will include evidence eatherine ,recordine and reporting as part of the new format.				30/09/2023
Internal	2021.22	NIS Directive (Cyber Security)	Reasonable	Director of Digital	Director of Digital / Chief Technology Officer	Medium	R4	R4 The costs associated with the improvement actions should be assessed and reported to a relevant committee to enable awareness of the full picture and prioritisation of actions and funding.	The NIS Improvement Plan will be submitted through the relevant governance committee for senior Management review and sign off. Prioritisation of remedial actions and related costs will be assessed through ABUHB formal risk governance structureand relevant committees. Note ABUHB are currently implementing the recommendations of the Templar consultancy report which will create the Office of the SIRO and create a new governance frameworkto support Risk Manasement within the Health Board.	30/09/2022	-11.97	31/01/2024	4.03		Overdue	Not Yet Due		Nov 23: New Cyber Security Assurance Group will be meeting in January and will provide assurance through the Information Governance Sub-Committee including progress against the NIS action plan which has now been developed. Any associated costs will be captured as part of the Digital IMTP planning process. AUG 2023: Awaiting next HBOTS meeting.				30/09/2023
Internal	2021.22	NIS Directive (Cyber Security)	Reasonable	Director of Digital	Director of Digital / Chief Technology Officer	Medium	R5	R5 A formal reporting route for cyber security should be established to ensure that senior staff are aware of the position relating to cyber security.5.27the risk description should be reviewed, with inclusion of the potential financial penalties relating to noncompliancewith NIS.	ABUHB are adopting recommendations of the Templer Report that will establish a formal risk governance and committee structure within the Health Board which will support Cyber Security Risk Reporting.5.24a part of the improvements suggested by Templar a new Cyber Risk Register will be developed. As part of development process account will be taken to include the financial penalties associated with noncompliance to NIS regulatory requirements into the assessment methodology and reporting.	30/09/2022	-11.97	31/01/2024	4.03		Overdue	Not Yet Due		Nov 23: New Information Governance Sub-Committee will have its first meeting in February and will have a Cyber Security Assurance Group reporting too it which will have its first meeting in January 2024 Aug 2023: Awaiting next HBOTS meeting.				30/09/2023
Internal	2022.11	Policies	Limited	Director of Corporate Governance	Head of Corporate Governance	Low	R2	R2 The Health Board should not embed documents / files / forms etc. within a policy document hosted on the intranet. If a form is applicable, it should form part of the appendices or be referenced separately.	As part of a review of the Policy for the Management of Policies and Written Control Documents (WCDs), the Quality Assurance process will be strengthened and implemented.	29/09/2023	-0.03	31/01/2024	4.03		Overdue	Not Yet Due		November 2023: This is being actioned for newly approved policies and work will be undertaken to address this retrospectively as part of the review of the policy database. Work is underway to review the overarching policy framework and supporting guidance, this will include the requirements around embedded documents.	November 2023: Capacity/changes in roles within the team. Addressed via corporate governance re structure. Posts now in place and work continues	November 2023: Any new policies are checked for embedded documents prior to publication		30/09/2023
Internal	2022.11	Policies	Limited	Director of Corporate Governance	Head of Corporate Governance	Low	R3	R3 The Health Board should consider the relevant Health and Care Standards when reviewing / updating a policy or other relevant documentation. An acknowledgement of this process should be included, together with the titles of the relevant Standards included.	The introduction of the Duty of Quality, under the Health and Social Care (Quality and Engagement) (Wales) Act 2020, will see the Health and Care Standards (April 2015) removed and replaced with Quality Standards 2023. As part of a review of the Policy for the Management of Policies and Written Control Documents (WCDs), the introduction of the Quality Standards 2023 will be considered, and policy templates updated as they are reviewed/developed.	29/09/2023	-0.03	31/01/2024	4.03		Overdue	Not Yet Due		November 2023: This will be included as part of the revised framework	November 2023: Capacity/changes in roles within the team. Addressed via corporate governance re structure. Posts now in place and work continues			30/09/2023
Internal	2022.11	Policies	Limited	Director of Corporate Governance	Head of Corporate Governance	Medium	R4	R4 The Health Board, alongside recommendation 3.1 should consider automating the submission of a policy from the responsible owner, to ensure that a consistent submission format is adhered to.	An integrated electronic policy management system will be explored, learning from other health bodies, with an implementation plan developed to support the most appropriate system.	29/09/2023	-0.03	31/01/2024	4.03		Overdue	Not Yet Due		November 2023: All policies are now managed via sharepoint, with an automated flagging and reminder system in place at 6 months prior to review, 3 months and when policy is overdue. A review of templates and submission process will be included in the revised policy framework being developed.	November 2023: Capacity/changes in roles within the team. Addressed via corporate governance re structure. Posts now in place and work continues			30/09/2023
Internal	2022.11	Policies	Limited	Director of Corporate Governance	Head of Corporate Governance	High	R5	R5 The Health Board should consider fully automating the reminder / management process of all relevant policies / documentation hosted on the intranet. This could be achieved through the use of Power Automate, Lists and other apps within Office 365. An automated work flow would undertake a periodic (e.g. weekly) check of all policies listed on the central spreadsheet that are overdue for review and issue automatic emails to the document owners. Following this, escalation to the respective Executive Director can also be completed automatically if documentation is still not updated in a timely manner. This would also allow for real-time reporting of documents that are overdue for review, to provide assurance to the respective Committees.	An integrated electronic policy management system will be explored, learning from other health bodies, with an implementation plan developed to support the most appropriate system.	29/09/2023	-0.03	31/01/2024	4.03		Overdue	Not Yet Due		November 2023: Partially complete. Automated emails sent to policy manager advising of those policies due for review within 6 months/3 months and overdue in order to initiate reminders. Reporting to Committees to be established as part of the review of the policies framework and implementation of a scheme of delegation for policy approval.	November 2023: Capacity/changes in roles within the team. Addressed via corporate governance re structure. Posts now in place and work continues			30/09/2023
Internal	2022.11	Policies	Limited	Director of Corporate Governance	Head of Corporate Governance	High	R6	R6 Once the Health Board has completed a review of all existing policy documentation, document reviews should be undertaken prior to the dates stated for review. Where exceptions remain, there should be an escalation process introduced to include the responsible Executive Director and potentially the Chief Executive Officer / Audit, Risk and Assurance Committee.	As part of a review of the Policy for the Management of Policies and Written Control Documents (WCDs), the review and escalation process will be strengthened and implemented.	29/09/2023	-0.03	31/01/2024	4.03		Overdue	Not Yet Due		November 2023: Automated email notifications in place to improve reminders to policy owners when policies are due for review. Escalation process to be clarified in revised policies framework.	November 2023: Capacity/changes in roles within the team. Addressed via corporate governance re structure. Posts now in place and work continues			30/09/2023
Internal	2022.11	Policies	Limited	Director of Corporate Governance	Head of Corporate Governance	Medium	R7	R7 The Health Board should complete a data accuracy review exercise of the policies and documents, alongside recommendation 2.1. Where data discrepancies exist these should be updated immediately to the correct value.	A review of the central base (881 documents) is underway, working with divisions, to review the status of each document and respective owners.	29/09/2023	-0.03	31/01/2024	4.03		Overdue	Not Yet Due		November 2023: Review of database undertaken and checked against current policies. Executive leads have been issued with a schedule of policies assigned to them for review and confirmation of status.	November 2023: capacity to review policies given current operational and financial pressures.			30/09/2023
Internal	2022.11	Policies	Limited	Director of Corporate Governance	Head of Corporate Governance	Medium	R1	R1 The Health Board should review the types of policy documents retained and hosted, to determine if each of them should adhere to the Policy, for example, departmental standard operating procedures to be managed entirely within the respective division. Alongside this review, the document owner should be determined to ensure the responsibility remains with the most appropriate individual.	As part of a review of the Policy for the Management of Policies and Written Control Documents (WCDs), clarity will be provided on which WCDs are to be held centrally and which are to be managed within services and teams. A review of the central base (881 documents) is underway, working with divisions, to review the status of each document and respective owners.	31/03/2023	-6.00	31/01/2024	4.03		Overdue	Not Yet Due		November 2023: Policy Framework currently under review. This will provide clear definitions of policies, procedures, guidelines and what constitutes an organisational policy. Scheme of delegation to be developed to support organisational policies which will be monitored by corporate governance, and departmental policies which will be led by individual departments (but held within the overall database)	November 2023: Capacity/changes in roles within the team. Addressed via corporate governance re structure. Posts now in place and work continues			30/09/2023
Internal	2022.14	Robotic process Automation	Reasonable	Director of Digital	Chief Technology Officer	Low	R1	A formal SOP should be defined that sets out how the RPA process is to be managed. The operational service model should be fully defined and the terms of reference for the governance board reviewed and updated.	Upon successful investment case being made this will be addressed as part of the transition to service delivery	01/06/2023	-3.97	31/12/2023	3.02		Overdue	Not Yet Due		Nov 23: Unable to recruit necessary posts so investigating alternative options. Aug 23: 2 posts funded for a permanent team.Recruitment underway. Team will sit within Softerrar development as part of intervention services				30/09/2023
Internal	2022.14	Robotic process Automation	Reasonable	Director of Digital	Director of Digital	Medium	R2	Benefits realisation should be established as part of the go-live for automated processes, with the relevant department being required to monitor and confirm the benefits.	Benefits realisation is identified and confirmed by relevant departments and this will now be formally monitored and confirmed by the governance board. This is in part contingent on a successful business case.	28/06/2023	-3.08	28/02/2024	4.95		Overdue	Not Yet Due		Nov 23: Dependent on recruitment of of resources for RPA Aug 23: Service request forms and opportunity assessment form redesigned to provide better profiling of benefits. Process agreed by RPA Board for requesting service Finance BPA assurance of benefits before automations are agreed				30/09/2023
Internal	2022.14	Robotic process Automation	Reasonable	Director of Digital	Director of Digital	Medium	R3	Consideration should be given to establishing a benefits sharing framework for cash releasing savings that would enable the RPA function to be self-sufficient.	This is not a unique issue to RPA but reflects the need for benefits realisation to include (when corroborated and confirmed) sharing of benefits including financial where this is the case. In order to mitigate the risk of priority based on ability to pay the process needs to be owned and curated at health board level rather than between departments. This recommendation will be considered in the case.	31/03/2023	-6.00	28/02/2024	4.95		Overdue	Not Yet Due		Nov 23: Dependent on recruitment of of resources for RPA Aug 23: Service request forms and opportunity assessment form redesigned to provide better profiling of benefits. Process agreed by RPA Board for requesting service Finance BPA assurance of benefits before automations are agreed				30/09/2023
Internal	2022.14	Robotic process Automation	Reasonable	Director of Digital	Director of Digital	Medium	R4	The Health Board should seek to complete recruitment and staff the RPA team accordingly.	A revised business case is expected to be submitted to Executive colleagues in Q4.	01/03/2023	-6.98	28/02/2024	4.95		Overdue	Not Yet Due		Nov 23: Recruitment underway but experiencing delays in attracting the right level of candidates. Aug 23: RPA escalation SBAR presented to Exec Board in March 2023. 2 posts aened.				30/09/2023
Internal	2022.14	Robotic process Automation	Reasonable	Director of Digital	Director of Digital	Medium	R5	The Health Board should consider the purchase of additional robot capacity.	The business case for submission in Q4 provides an option also to increase capacity of automation.	01/03/2023	-6.98	28/02/2024	4.95		Overdue	Not Yet Due		Nov 23: Dependent on recruitment of of resources for RPA Aug 23: RPA escalation SBAR presented to Exec Board in March 2023. Additional robot purchase not supported pending rebaselining of planned automations benefits				30/09/2023
Internal	2022.14	Robotic process Automation	Reasonable	Director of Digital	Director of Digital	Medium	R6	Consideration should be given to increasing the level of ring fencing for specific robot time for time constrained processes as part of the ongoing development of the RPA service	The business case for submission in Q4 provides an option also to increase capacity of automation.	01/03/2023	-6.98	28/02/2024	4.95		Overdue	Not Yet Due		Nov 23: Dependent on recruitment of of resources for RPA Aug 23: Peak day time capacity consumes all current robot capacity. Additional robots have been procured from non RPA budgets to support critical functionality. The RPA architect continues to reprofile activity to ensure automations are deskewed ostinallu to allow additional automations not dependent on in hours working to be undertaken.				30/09/2023
Internal	2022.14	Robotic process Automation	Reasonable	Director of Digital	Director of Digital	Medium	R7	The awareness of RPA and the change management process should be strengthened as RPA moves into an operational service. All services should be made aware of the requirement to notify informatics of changes to any system that may interact with the	Part of the transitional arrangements to operational services will be refined and robust service management arrangements. This is subject to a successful business case.	01/03/2023	-6.98	31/03/2024	4.95		Overdue	Not Yet Due		Nov 23: Dependent on recruitment of of resources for RPA Aug 23: Transition to BASU will be undertaken when posts are appointed q3 2023				30/09/2023
Internal	2022.15	IT Strategy	Reasonable	Director of Digital	CCIO / CNIO	Medium	R3	Leads within divisions should be established to work with the CCIO / CNIO	The principle of Divisional Leads is accepted by the health board. The proposition now needs to be explored and defined in a proposal by the CCIO and CNIO to the Digital Delivery Oversight Group	01/06/2023	-3.97	31/03/2024	6.00		Overdue	Not Yet Due		Nov 23: Council not met for several meetings due to capacity issues and will need to be considered due to winter pressures so ToR will be looked at when we meet again Aug 23: Clinical Informatics Council in place and meeting scheduled every 6 weeks, however service pressures have resulted in over half the meetings this year cancelled. More formal job planning needed to release resources to attend	Lack of job profiling to support time to release clinical staff to attend			30/09/2023
Internal	2022.15	IT Strategy	Reasonable	Director of Digital	CCIO / CNIO	Medium	R4	Work should be undertaken to embed the Clinical Informatics Council and encourage participation therein	Agreed. The CCIO and CNIO will revisit the membership and Terms of Reference for the Clinical Informatics Council which will be included as part of ??	01/06/2023	-3.97	31/03/2024	6.00		Overdue	Not Yet Due		Nov 23: Council not met for several meetings due to capacity issues and will need to be considered due to winter pressures so ToR will be looked at when we meet again				30/09/2023
Internal	2022.21	Development of a Regional Radiotherapy Satellite Centre at NHH	Reasonable	Director of Strategy, Planning & Partnership	Programme Manager	Medium	R2	The UHB should seek to obtain the necessary collateral warranties at the earliest opportunity.	Agreed, the necessary collateral warranties will be obtained at the earliest opportunity.	01/06/2023	-3.97	28/02/2025	16.95		Overdue	Not Yet Due		November 2023: there are numerous collateral warranties that occur at numerous points in the contract therefore this would not be completed until the end of the contract, i.e. February 2025. At this point in time the process for the provision of collectoral warranties has not required to be actioned as the relevant works have not be completed. Not currently at the point of issuing warranties. Aug 2023: At this point in time the process for the provision of collectoral warranties has not required to be actioned as the relevant works have not be completed. Not currently at the point of issuing warranties.	Aug 2023: None	N/A	Aug 2023: None, CWs have so far not been required	30/09/2023
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Informatics Programme Manager - WCCIS	Medium	R3	It should be clearly defined and communicated in what circumstance alerts should be used. In addition, staff should be trained on how to add alerts to the system	We will review the training and electronic filing requirements for 'alerts' and ensure that the messages are communicated to the relevant staff	01/07/2023	-2.98	28/02/2024	4.95		Overdue	Not Yet Due						30/09/2023
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Lead Nurse for OAMH / Informatics Programme Manager - WCCIS	Low	R3	Training should be provided to ensure a consistent approach for the electronic and paper records completion	We will review the training components and update where required, to ensure a consistent approach is adopted	01/07/2023	-2.98	28/02/2024	4.95		Overdue	Not Yet Due		Nov 2023: Work stream 4 is the Hospital Dementia Friendly Charter, patient flow team have been invited to attend this meeting. There is also a audit perameter under the National Audit of Dementia. This will take a focused action as this aim is part if the wider hospitla admission and discharge work.	Nov 2023: This action needs to be part of the wider patient flow and discharge in ABUHB. Invites to the Dementia workstream 4 meetings will help us understand the challenges and solution and future measurements.	Nov 2023: Recorded and reviewing the membership of work stream 4 and action plan from the National Audit of Dementia.		30/09/2023
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Programme Manager	Low	R4	Consideration should be given to formally monitor (e.g. set KPIs) and report on • patients hospitalised outside of their catchment area; and • moved from one hospital site to another one over their treatment time.	Workstream 5b (measurement) will consider appropriate KPI's and will extend an invitation to the Patient Flow Team to be members of the workstream	01/08/2023	-1.97	28/02/2024	4.95		Overdue	Not Yet Due		Nov 2023: Work stream 4 is the Hospital Dementia Friendly Charter, patient flow team have been invited to attend this meeting. There is also a audit perameter under the National Audit of Dementia. This will take a focused action as this aim is part if the wider hospitla admission and discharge work.				30/09/2023
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Programme Manager linking in with Patient Flow Leads	Low	R4	Where operationally and clinically possible, a patient's locality should be considered as part of the admission / transfer process.	Patient Flow Team to consider this specific aspect, linked to the developed KPI's above	01/09/2023	-0.95	28/02/2024	4.95		Overdue	Not Yet Due		Nov 2023: The Welsh language team are invited to the Dementia Workstream 4 Hospital Dementia group. The have a dedicated Pulse page to enable staff to access resources and information to support patients to communicate in the welsh language. the person centred team also have a dedicated e mail address and can signpost people to the the Welsh Lanauage team.			Nov 2023: Pulse Welsh Language and engagement pages on the intranet as well as a Welsh Lanauage team who we collaborate with closely.	30/09/2023
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Lead Nurse Dementia	Low	R4	There should be easily available information / training for staff to ensure patients can communicate with Welsh speaking staff.	The Workstream 4 (Hospital Charter) to link with the Welsh Language Lead and Workforce and Organisational Development leads to identify the number of Welsh Speaking Staff, identify how we can better identify Welsh Speakers and ensure access to Welsh Speakers as part of our Person Centred Care Dementia Care work programme.	01/09/2023	-0.95	28/02/2024	4.95		Overdue	Not Yet Due		Nov 2023: We have 15 wards who are adopting the VIP programme. We capture patient feedback and use patient experience to inform our improvments in care. recent example was the Anticipatory Grief learning module and Dementia Conference. The patient experience is an ongoing agenda item on our PCCT monthly team meetings. This information is included in QPS reports and annual reviews.			Nov 2023: We have 15 wards who are adopting the VIP programme. We capture patient feedback and use patient experience to inform our improvments in care. recent example was the Anticipatory Grief learning module and Dementia Conference. The patient experience is an ongoing agenda item on our PCCT monthly team meetings. This information is included in QPS reports and annual reviews.	30/09/2023

Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Head of Nursing Person Centred Care / Lead Nurse Dementia with Associated Standards Workstream Leads	Low	RS	Local initiatives with success stories should be channelled and discussed at existing forums.	Patient Stories are used at MDT learning events, at Board, through the Quality and Patient Safety Operational Group (QPSOG) and Board. Discussions have taken place within the Person-Centred Care Team to develop a digital portal for all patient stories. Listening and Learning is reported at QPSOG. There are also early discussions around establishing a Community of Practice for patient experience to share learning and celebrate success/best practice (September 2023). The Dementia Specialist Practitioner through the VIPS work will be key to sharing best practice/success stories across all hospital wards.	01/09/2023	-0.95	28/02/2024	4.95		Overdue	Not Yet Due							30/09/2023

Appendix 5) Internal Audit: 33 Revised Timescale Recommendations Following Return For Approval

Audit Type	ABUHB Ref No:	Report Title	Assurance Rating	Director	Responsible Officer	Priority	Recommendation No.	Recommendation	Management Response	Deadline Agreed in Final Report	Months passed Agreed Deadline	Proposed Revised Deadline	Months passed Revised Deadline	Date Revised Deadline was approved by ARAC Comtiee	Final Report Deadline Status	Revised Deadline Status	If closed and not complete please provide justification and ensure evidence is available	Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	What evidence is available to close down the recommendation?	Reporting Date
Internal	2017.00	Medical Equipment and Devices (2017/18)	Limited	Director of Therapies and Health Science	N/A	High	R1	R1 Registers should be maintained for operational management of medical devices and equipmenton each ward and department, which should record relevant equipment details.The register format should be consistent and overseen centrally, with periodic reviews / scrutiny completed.Each areashould ascertain the total number of devices held, by reviewing each and every item (including non-electrical equipment) physically and record itupon theirregister. Discrepancies that are identified can be updated / amended on the register, so all items are correctly recorded. Going forward, relocation of equipment, disposals, additions etc. should be updated promptly to ensure an accurate record continues.	The Health Board to consider investing in an overarching equipment database register with staff resources to ensure regular updating and management.	31/03/2018	-65.87	31/03/2024	6.00		Overdue	Not Yet Due		Nov 23 - The Medical Device Committee Workplan was been updated in October to reflect the upate provided to the Committee in August. This will ensure regular updates against the actions in place e.g., New infusion device service and training manager now in post. • New database formed to record training compliance and process of inputting historical data in progress, plan to work this into HealthRoster/ESR once up to date, providing a compliance dashboard. • Audit sent out to ward managers and divisional senior nurses to determine current training compliance throughout ABUHB. • Training sessions delivered and open to substantive and bank staff to book. • Strategic plan to incorporate cascade trainers into the training provision to increase compliance.	The software development between the 3 systems (Softpro Medusa, Ram Asset 4000 and Paragon RFID) is now operational. The unrelenting service pressures however means that there is still an extensive amount of work to visit every site and tag locations and equipment. This is still an ongoing project and work in progress. Assets are being tagged as and when we see them, however the process to blitz equipment tagging is restricted by the ongoing service pressures. There is also the ongoing restructuring of services/departments throughout our LGH's.	Whilst the aim is to tag all medical Equipment & devices throughout the HB hospitals we are focused on completing one major site. This being the GUH and to date out of 3242 assets listed on our database 1341 devices have been tagged, which represents 41.3% of assets on site at the GUH. In total we have RFID tagged over 4100 medical devices to date across our HB sites. Its difficult to commit to a completion date giving the ongoing service pressures, but this work is a daily ongoing process and when time allows we will undertake a blitz approach to RFID tagging the remaining devices, starting at the GUH .Medical Electronics (EBME) & Capital Finance still record all of the equipment details on their independent systems. Medical Electronics (EBME) update the latest location on their database as equipment passes through the department. Capital Finance undertake walk about audits to tag and update locations of assets. All new assets are RFID tagged as part of our EBME commissioning checks.			30/09/2023
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	Director of Digital	N/A	R1	R1 The governance framework for IM&T / digital should be clarified and where control over aspects of IM&T has devolved to departments, there should be a process for these to feed into the relevant Committee to ensure oversight. Underneath the Committee the steering group remit and membership should be defined.	Agreed. The Health Board is establishing a new governance framework. Currently informatics is reporting to the Audit Committee, the first report is scheduled for 8thApril. A Health Board governance framework is in development for informatics including exec oversight, investment and delivery. The management of the global pandemic has disrupted the planning work by 12 months but this is now re-initiated. Recommendations arescheduled to be presented to Exec Team(Q1 and Board in Q2.	30/06/2021	-26.95	31/01/2024	4.03		Overdue	Not Yet Due		• Training sessions delivered and open to substantive and bank staff to book.				30/09/2023
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	Director of Digital	N/A	R4	R4 The risk identification process should be formally linked to the issue / event / problem management process in order to ensure that underlying risks are identified.	A review of risk management processes has commenced. The Health Board has appointed a Chief Nursing Information Officer (Clinical Safety Officer who will lead the project to align risk management processes from Programmes, design, Service Delivery, Health Records and Information Governance and Cyber Security to inform the new assurance structure.	31/12/2021	-20.92	31/12/2023	3.02		Overdue	Not Yet Due		• Strategic plan to incorporate cascade trainers into the training provision to increase compliance.				30/09/2023
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	Director of Digital	N/A	R6	R6 Consideration should be given to the placement of all informatics provision and support across the Health Board. As part of this the current partially decentralised model, should be re-assessed in terms of its suitability for the modern use of technology.	Accepted. Following the exec review of the Target Operating Framework and overarching governance will appraise the hybrid environment of departmental asset ownership, responsibility, risk management. As the report sets out this is a largely historical and organic model which will with be complex to resolve in itself. A risk based approach will be adopted andan options paper will be devolvsed forconsideration by the Board.	31/12/2022	-8.95	31/05/2024	8.00		Overdue	Not Yet Due		Nov 23: The HEMS maturity report has been excepted and it will be played into our Digital Strategy and IMTP planning August 2023: The new Director of Digital is currently reviewing the TOF and will present findings and an action plan for the consideration by the Executive Committee in October 2023				30/09/2023
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	Director of Digital / Assistant Director for Strategy, Planning & Design	N/A	R8	R8 An assessment of the changes needed to implement the Digital Strategy should be undertaken, and the benefits of the changes articulated, along with the consequences of no change. The Health Board should develop a single roadmap to help deliver the Digital Strategy.	As part of the review Informatics has accepted the need for P3O Portfolio management. This work is ongoing and with an initial focus to core Informatics Division activity but provides a framework for Health Board oversight and transparency. The portfolio approach will extend subject to Board approval to all information assets in a planned programme of work. This forms part of the recommendations to Execs in Q1 2021.	30/06/2021	-26.95	31/12/2023	3.02		Overdue	Not Yet Due		Nov 23: The new digital service request process is nearing completion and will shortly be launched across the Health Board. The Digital governance committee will provide assurance on the digital plan and the updated digital programmes framework ensures benefits management will be ingrained on all projects. Aug 23: Progress being made on the portfolio register to surface all digital work including new service requests and ICT projects. Resource & capacity modelling being developed along with business change tools to support service readiness for change.				30/09/2023
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	Director of Digital / Assistant Director for Strategy, Planning & Design	N/A	R9	R9 A network of champions across the organisation should be established. The Digital Strategy should be re-issued alongside the roadmap. This should form the basis for engaging the network of champions to drive the Strategy forward.	Accepted-The Channel 3 report also identified a need for more emphasis on Clinical Leadership, Design and Business Partnering. This is subject to additional investment although recently the appointment of a full time CNIO/CSO has been a significant step forward. Outwith the Directorate recommendations will be presented to Execs on overarching exec level oversight which is intended to both strengthen accountability but also to ensure Informatics capacity is used to best effect. Benefits realisation training has commenced in Informatics and will form part of reporting. It is in principle agreed that the Health Board adopts a single methodology and framework that should be co produced to manage all priority investments.	30/09/2021	-23.93	31/12/2023	3.02		Overdue	Not Yet Due		Nov 23: Progress has been made on the request process, business partnering and governance and will be completed by the 31/12/2023. The Digital Champions Network has recently been relaunched. Aug 23: New Digital Service Request process, business partnering and new governance group is under development				30/09/2023
Internal	2021.22	NIS Directive (Cyber Security)	Reasonable	Director of Digital	Director of Digital / Chief Technology Officer	Low	R1	R1 For future iterations of the CAF there should be greater involvement of the system owners in the review of the responses.	ABUHB will ensure that in future iterations of the CAF there is greater involvement of System Owners	31/12/2022	-8.95	31/01/2024	4.03		Overdue	Not Yet Due		Nov 23: CRU assessment now scheduled for 22/01/2024. There will be a pre assessment meeting arranged by CRU in Nov/Dec to discuss scope and Digital will ensure this includes Information Asset Owners. Aug 23: CRU have provisionally provided a date for the next NIS CAF assessment process Oct 2023. As part of the engagement CRU have suggested a hybrid approach with onsite visits and interviews with systems owners. This is being piloted currently but is a process change from the previous assessment process undertaken in 2021.				30/09/2023
Internal	2021.22	NIS Directive (Cyber Security)	Reasonable	Director of Digital	Director of Digital / Chief Technology Officer	Medium	R2	R2 Management should ensure that records of discussions and information provided to and from the CRU are captured for future annual self-assessments.	Management will ensure that during any future self-assessments records of discussions and informationsupplied to the CRU will be captured and available for internal or external review.	31/12/2022	-8.95	31/01/2024	4.03		Overdue	Not Yet Due		Nov 23: CRU will outline what documentation/evidence they expect to be provided at the pre assessment scoping meeting prior to our January assessment. This is due to be held Nov/Dec 2023 Aug 23:CRU are piloting process changes to their approach from their initial NIS assessment undertaken in 2021, Future NIS CAF assessments will include evidence eatherin ;recordine and reportina as part of the new format.				30/09/2023
Internal	2021.22	NIS Directive (Cyber Security)	Reasonable	Director of Digital	Director of Digital / Chief Technology Officer	Medium	R4	R4 The costs associated with the improvement actions should be assessed and reported to a relevant committee to enable awareness of the full picture and prioritisation of actions and funding.	The NIS Improvement Plan will be submitted through the relevant governance committee for senior Management review and sign off. Prioritisation of remedial actions and related costs will be assessed through ABUHB formal risk governance structureand relevant committees. Note ABUHB are currently implementing the recommendations of the Templar consultancy report which will create the Office of the SIRO and create a new governance frameworkto support Risk Manasement within the Health Board.	30/09/2022	-11.97	31/01/2024	4.03		Overdue	Not Yet Due		Nov 23: New Cyber Security Assurance Group will be meeting in January and will provide assurance through the Information Governance Sub-Committee including progress against the NIS action plan which has now been developed. Any associated costs will be captured as part of the Digital IMTP planning process. AUG 2023: Awaiting next HBOTS meeting.				30/09/2023
Internal	2021.22	NIS Directive (Cyber Security)	Reasonable	Director of Digital	Director of Digital / Chief Technology Officer	Medium	R5	R5 A formal reporting route for cyber security should be established to ensure that senior staff are aware of the position relating to cyber security.5.27ie this description should be reviewed, with inclusion of the potential financial penalties relating to noncompliancewith NIS.	ABUHB are adopting recommendations of the Templer Report that will establish a formal risk governance and committee structure within the Health Board which will support Cyber Security Risk Reporting.5.24ie part of the improvements suggested by Templar a new Cyber Risk Register will be developed. As part of development process account will be taken to include the financial penalties associated with noncompliance to NIS regulatory requirements into the assessment methodology and reporting.	30/09/2022	-11.97	31/01/2024	4.03		Overdue	Not Yet Due		Nov 23: New Information Governance Sub-Committee will have its first meeting in February and will have a Cyber Security Assurance Group reporting too it which will have its first meeting in January 2024 Aug 2023: Awaiting next HBOTS meeting.				30/09/2023
Internal	2022.11	Policies	Limited	Director of Corporate Governance	Head of Corporate Governance	Low	R2	R2 The Health Board should root embed documents / files / forms etc. within a policy document hosted on the intranet. If a form is applicable, it should form part of the appendices or be referenced separately.	As part of a review of the Policy for the Management of Policies and Written Control Documents (WCDs), the Quality Assurance process will be strengthened and implemented.	29/09/2023	-0.03	31/01/2024	4.03		Overdue	Not Yet Due		November 2023: This is being actioned for newly approved policies and work will be undertaken to address this retrospectively as part of the review of the policy database. Work is underway to review the overarching policy framework and supporting guidance, this will include the requirements around embedded documents.	November 2023: Capacity/changes in roles within the team. Addressed via corporate governance re structure. Posts now in place and work continues	November 2023: Any new policies are checked for embedded documents prior to publication		30/09/2023
Internal	2022.11	Policies	Limited	Director of Corporate Governance	Head of Corporate Governance	Low	R3	R3 The Health Board should consider the relevant Health and Care Standards when reviewing / updating a policy or other relevant documentation. An acknowledgement of this process should be included, together with the titles of the relevant Standards included.	The introduction of the Duty of Quality, under the Health and Social Care (Quality and Engagement) (Wales) Act 2020, will see the Health and Care Standards (April 2015) removed and replaced with Quality Standards 2023. As part of a review of the Policy for the Management of Policies and Written Control Documents (WCDs), the introduction of the Quality Standards 2023 will be considered, and policy templates updated as they are reviewed/developed.	29/09/2023	-0.03	31/01/2024	4.03		Overdue	Not Yet Due		November 2023: This will be included as part of the revised framework	November 2023: Capacity/changes in roles within the team. Addressed via corporate governance re structure. Posts now in place and work continues			30/09/2023
Internal	2022.11	Policies	Limited	Director of Corporate Governance	Head of Corporate Governance	Medium	R4	R4 The Health Board, alongside recommendation 3.1 should consider automating the submission of a policy from the responsible owner, to ensure that a consistent submission format is adhered to.	An integrated electronic policy management system will be explored, learning from other health bodies, with an implementation plan developed to support the most appropriate system.	29/09/2023	-0.03	31/01/2024	4.03		Overdue	Not Yet Due		November 2023: All policies are now managed via sharepoint, with an automated flagging and reminder system in place at 6 months prior to review, 3 months and when policy is overdue. A review of templates and submission process will be included in the revised policy framework being developed.	November 2023: Capacity/changes in roles within the team. Addressed via corporate governance re structure. Posts now in place and work continues			30/09/2023
Internal	2022.11	Policies	Limited	Director of Corporate Governance	Head of Corporate Governance	High	R5	R5 The Health Board should consider fully automating the reminder / management process of all relevant policies / documentation hosted on the intranet. This could be achieved through the use of Power Automate, Lists and other apps within Office 365. An automated work flow would undertake a periodic (e.g. weekly) check of all policies listed on the central spreadsheet that are overdue for review and issue automatic emails to the document owners. Following this, escalation to the respective Executive Director can also be completed automatically if documentation is still not updated in a timely manner. This would also allow for real-time reporting of documents that are overdue for review, to provide assurance to the respective Committees.	An integrated electronic policy management system will be explored, learning from other health bodies, with an implementation plan developed to support the most appropriate system.	29/09/2023	-0.03	31/01/2024	4.03		Overdue	Not Yet Due		November 2023: Partially complete. Automated emails sent to policy manager advising of those policies due for review within 6 months/3 months and overdue in order to initiate reminders. Reporting to Committees to be established as part of the review of the policies framework and implementation of a scheme of delegation for policy approval.	November 2023: Capacity/changes in roles within the team. Addressed via corporate governance re structure. Posts now in place and work continues			30/09/2023
Internal	2022.11	Policies	Limited	Director of Corporate Governance	Head of Corporate Governance	High	R6	R6 Once the Health Board has completed a review of all existing policy documentation, document reviews should be undertaken prior to the dates stated for review. Where exceptions remain, there should be an escalation process introduced to include the responsible Executive Director and potentially the Chief Executive Officer / Audit, Risk and Assurance Committee.	As part of a review of the Policy for the Management of Policies and Written Control Documents (WCDs), the review and escalation process will be strengthened and implemented.	29/09/2023	-0.03	31/01/2024	4.03		Overdue	Not Yet Due		November 2023: Automated email notifications in place to improve reminders to policy owners when policies are due for review. Escalation process to be clarified in revised policies framework.	November 2023: Capacity/changes in roles within the team. Addressed via corporate governance re structure. Posts now in place and work continues			30/09/2023
Internal	2022.11	Policies	Limited	Director of Corporate Governance	Head of Corporate Governance	Medium	R7	R7 The Health Board should complete a data accuracy review exercise of the policies and documents, alongside recommendation 2.1. Where data discrepancies exist these should be updated immediately to the correct value.	A review of the central base (881 documents) is underway, working with divisions, to review the status of each document and respective owners.	29/09/2023	-0.03	31/01/2024	4.03		Overdue	Not Yet Due		November 2023: Review of database undertaken and checked against current policies. Executive leads have been issued with a schedule of policies assigned to them for review and confirmation of status.	November 2023: capacity to review policies given current operational and financial pressures.			30/09/2023
Internal	2022.11	Policies	Limited	Director of Corporate Governance	Head of Corporate Governance	Medium	R1	R1 The Health Board should review the types of policy documents retained and hosted, to determine if each of them should adhere to the Policy, for example, departmental standard operating procedures to be managed entirely within the respective division. Alongside this review, the document owner should be determined to ensure the responsibility remains with the most appropriate individual.	As part of a review of the Policy for the Management of Policies and Written Control Documents (WCDs), clarity will be provided on which WCDs are to be held centrally and which are to be managed within services and teams. A review of the central base (881 documents) is underway, working with divisions, to review the status of each document and respective owners.	31/03/2023	-6.00	31/01/2024	4.03		Overdue	Not Yet Due		November 2023: Policy Framework currently under review. This will provide clear definitions of policies, procedures, guidelines and what constitutes an organisational policy. Scheme of delegation to be developed to support organisational policies which will be monitored by corporate governance, and departmental policies which will be led by individual departments (but held within the overall database)	November 2023: Capacity/changes in roles within the team. Addressed via corporate governance re structure. Posts now in place and work continues			30/09/2023
Internal	2022.14	Robotic process Automation	Reasonable	Director of Digital	Chief Technology Officer	Low	R1	A formal SOP should be defined that sets out how the RPA process is to be managed. The operational service model should be fully defined and the terms of reference for the governance board reviewed and updated.	Upon successful investment case being made this will be addressed as part of the transition to service delivery	01/06/2023	-3.97	31/12/2023	3.02		Overdue	Not Yet Due		Nov 23: Unable to recruit necessary posts so investigating alternative options. Aug 23: 2 posts funded for a permanent team.Recruitment underway. Team will sit within Softerrar development as part of intervention services				30/09/2023
Internal	2022.14	Robotic process Automation	Reasonable	Director of Digital	Director of Digital	Medium	R2	Benefits realisation should be established as part of the go-live for automated processes, with the relevant department being required to monitor and confirm the benefits.	Benefits realisation is identified and confirmed by relevant departments and this will now be formally monitored and confirmed by the governance board. This is in part contingent on a successful business case.	28/06/2023	-3.08	28/02/2024	4.95		Overdue	Not Yet Due		Nov 23: Dependent on recruitment of of resources for RPA Aug 23: Service request forms and opportunity assessment form redesigned to provide better profiling of benefits. Process agreed by RPA Board for requesting service Finance BPA assurance of benefits before automations are agreed				30/09/2023
Internal	2022.14	Robotic process Automation	Reasonable	Director of Digital	Director of Digital	Medium	R3	Consideration should be given to establishing a benefits sharing framework for cash releasing savings that would enable the RPA function to be self-sufficient.	This is not a unique issue to RPA but reflects the need for benefits realisation to include (when corroborated and confirmed) sharing of benefits including financial where this is the case. In order to mitigate the risk of priority based on ability to pay the process needs to be owned and curated at health board level rather than between departments. This recommendation will be considered in the case.	31/03/2023	-6.00	28/02/2024	4.95		Overdue	Not Yet Due		Nov 23: Dependent on recruitment of of resources for RPA Aug 23: Service request forms and opportunity assessment form redesigned to provide better profiling of benefits. Process agreed by RPA Board for requesting service Finance BPA assurance of benefits before automations are agreed				30/09/2023
Internal	2022.14	Robotic process Automation	Reasonable	Director of Digital	Director of Digital	Medium	R4	The Health Board should seek to complete recruitment and staff the RPA team accordingly.	A revised business case is expected to be submitted to Executive colleagues in Q4.	01/03/2023	-6.98	28/02/2024	4.95		Overdue	Not Yet Due		Nov 23: Recruitment underway but experiencing delays in attracting the right level of candidates. Aug 23: BPA escalation SBAR presented to Exec Board in March 2023. 2 posts aarsed.				30/09/2023
Internal	2022.14	Robotic process Automation	Reasonable	Director of Digital	Director of Digital	Medium	R5	The Health Board should consider the purchase of additional robot capacity.	The business case for submission in Q4 provides an option also to increase capacity of automation.	01/03/2023	-6.98	28/02/2024	4.95		Overdue	Not Yet Due		Nov 23: Dependent on recruitment of of resources for RPA Aug 23: BPA escalation SBAR presented to Exec Board in March 2023. Additional robot purchase not supported pending rebaselining of planned automations benefits				30/09/2023
Internal	2022.14	Robotic process Automation	Reasonable	Director of Digital	Director of Digital	Medium	R6	Consideration should be given to increasing the level of ring fencing for specific robot time for time constrained processes as part of the ongoing development of the RPA service	The business case for submission in Q4 provides an option also to increase capacity of automation.	01/03/2023	-6.98	28/02/2024	4.95		Overdue	Not Yet Due		Nov 23: Dependent on recruitment of of resources for RPA Aug 23: Peak day time capacity consumes all current robot capacity. Additional robots have been procured from non RPA budgets to support critical functionality. The RPA architect continues to reprofile activity to ensure automations are deskewed ostinallu to allow additional automations not dependent on in hours working to be undertaken.				30/09/2023
Internal	2022.14	Robotic process Automation	Reasonable	Director of Digital	Director of Digital	Medium	R7	The awareness of RPA and the change management process should be strengthened as RPA moves into an operational service. All services should be made aware of the requirement to notify informatics of changes to any system that may interact with the	Part of the transitional arrangements to operational services will be refined and robust service management arrangements. This is subject to a successful business case.	01/03/2023	-6.98	28/02/2024	4.95		Overdue	Not Yet Due		Nov 23: Dependent on recruitment of of resources for RPA Aug 23: Transition to BASU will be undertaken when posts are appointed q3 2023				30/09/2023
Internal	2022.15	IT Strategy	Reasonable	Director of Digital	CCIO / CNIO	Medium	R3	Leads within divisions should be established to work with the CCIO / CNIO	The principle of Divisional Leads is accepted by the health board. The proposition now needs to be explored and defined in a proposal by the CCIO and CNIO to the Digital Governance Oversight Group	01/06/2023	-3.97	31/03/2024	6.00		Overdue	Not Yet Due		Nov 23: Council not met for several meetings due to capacity issues and will need to be considered due to winter pressures so ToR will be looked at when we meet again Aug 23: Clinical Informatics Council in place and meeting scheduled every 6 weeks, however service pressures have resulted in over half the meetings this year cancelled. More formal job planning needed to release resources to attend	Lack of job profiling to support time to release clinical staff to attend			30/09/2023
Internal	2022.15	IT Strategy	Reasonable	Director of Digital	CCIO / CNIO	Medium	R4	Work should be undertaken to embed the Clinical Informatics Council and encourage participation therein	Agreed. The CCIO and CNIO will revisit the membership and Terms of Reference for the Clinical Informatics Council which will be included as part of ??	01/06/2023	-3.97	31/03/2024	6.00		Overdue	Not Yet Due		Nov 23: Council not met for several meetings due to capacity issues and will need to be considered due to winter pressures so ToR will be looked at when we meet again				30/09/2023
Internal	2022.21	Development of a Regional Radiotherapy Satellite Centre at NHH	Reasonable	Director of Strategy, Planning & Partnership	Programme Manager	Medium	R2	The UHB should seek to obtain the necessary collateral warranties at the earliest opportunity.	Agreed, the necessary collateral warranties will be obtained at the earliest opportunity.	01/06/2023	-3.97	28/02/2025	16.95		Overdue	Not Yet Due		November 2023: there are numerous collateral warranties that occur at numerous points in the contract therefore this would not be completed until the end of the contract, i.e. February 2025. At this point in time the process for the provision of collectoral warranties has not required to be actioned as the relevant works have not be completed. Not currently at the point of issuing warranties. Aug 2023: At this point in time the process for the provision of collectoral warranties has not required to be actioned as the relevant works have not be completed. Not currently at the point of issuing warranties.	Aug 2023: None	N/A	Aug 2023: None, CWs have so far not been required	30/09/2023
Internal	2022.27	Dementia Services	Reasonable	Informatics Programme Manager - WCCIS		Medium	R3	It should be clearly defined and communicated in what circumstance alerts should be used. In addition, staff should be trained on how to add alerts to the system	We will review the training and electronic filing requirements for 'alerts' and ensure that the messages are communicated to the relevant staff	01/07/2023	-2.98	28/02/2024	4.95		Overdue	Not Yet Due						30/09/2023
Internal	2022.27	Dementia Services	Reasonable	Lead Nurse for OAMH / Informatics Programme Manager - WCCIS		Low	R3	Training should be provided to ensure a consistent approach for the electronic and paper records completion	We will review the training components and update where required, to ensure a consistent approach is adopted	01/07/2023	-2.98	28/02/2024	4.95		Overdue	Not Yet Due		Nov 2023: Work stream 4 is the Hospital Dementia Friendly Charter, patient flow team have been invited to attend this meeting. There is also a audit perameter under the National Audit of Dementia. This will take a focused action as this aim is part if the wider hospitla admission and discharge work.	Nov 2023: This action needs to be part of the wider patient flow and discharge in ABUHB. Invites to the Dementia workstream 4 meetings will help us understand the challenges and solution and future measurements.	Nov 2023: Recorded and reviewing the membership of work stream 4 and action plan from the National Audit of Dementia.		30/09/2023
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Programme Manager	Low	R4	Consideration should be given to formally monitor (e.g. set KPIs) and report on • patients hospitalised outside of their catchment area; and • moved from one hospital site to another one over their treatment time.	Workstream 5b (measurement) will consider appropriate KPI's and will extend an invitation to the Patient Flow Team to be members of the workstream	01/08/2023	-1.97	28/02/2024	4.95		Overdue	Not Yet Due		Nov 2023: Work stream 4 is the Hospital Dementia Friendly Charter, patient flow team have been invited to attend this meeting. There is also a audit perameter under the National Audit of Dementia. This will take a focused action as this aim is part if the wider hospitla admission and discharge work.				30/09/2023
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Programme Manager linking in with Patient Flow Leads	Low	R4	Where operationally and clinically possible, a patient's locality should be considered as part of the admission / transfer process.	Patient Flow Team to consider this specific aspect, linked to the developed KPI's above	01/09/2023	-0.95	28/02/2024	4.95		Overdue	Not Yet Due		Nov 2023: The Welsh language team are invited to the Dementia Workstream 4 Hospital Dementia group. The have a dedicated Pulse page to enable staff to access resources and information to support patients to communicate in the welsh language. the person centred team also have a dedicated e mail address and can signpost people to the the Welsh Lanauage team.			Nov 2023: Pulse Welsh Language and engagement pages on the intranet as well as a Welsh Lanauage team who we collaborate with closely.	30/09/2023
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Lead Nurse Dementia	Low	R4	There should be easily available information / training for staff to ensure patients can communicate with Welsh speaking staff.	The Workstream 4 (Hospital Charter) to link with the Welsh Language Lead and Workforce and Organisational Development leads to identify the number of Welsh Speaking Staff, identify how we can better identify Welsh Speakers and ensure access to Welsh Speakers as part of our Person Centred Care Dementia Care work programme.	01/09/2023	-0.95	28/02/2024	4.95		Overdue	Not Yet Due		Nov 2023: We have 15 wards who are adopting the VIP programme. We capture patient feedback and use patient experience to inform our improvments in care. recent example was the Anticipatory Grief learning module and Dementia Conference. The patient experience is an ongoing agenda item on our PCCT monthly team meetings. This information is included in QPS reports and annual reviews.			Nov 2023: We have 15 wards who are adopting the VIP programme. We capture patient feedback and use patient experience to inform our improvments in care. recent example was the Anticipatory Grief learning module and Dementia Conference. The patient experience is an ongoing agenda item on our PCCT monthly team meetings. This information is included in QPS reports and annual reviews.	30/09/2023

Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Head of Nursing Person Centred Care / Lead Nurse Dementia with Associated Standards Workstream Leads	Low	RS	Local initiatives with success stories should be channelled and discussed at existing forums.	Patient Stories are used at MDT learning events, at Board, through the Quality and Patient Safety Operational Group (QPSOG) and Board. Discussions have taken place within the Person-Centred Care Team to develop a digital portal for all patient stories. Listening and Learning is reported at QPSOG. There are also early discussions around establishing a Community of Practice for patient experience to share learning and celebrate success/best practice (September 2023). The Dementia Specialist Practitioner through the VIPS work will be key to sharing best practice/success stories across all hospital wards.	01/09/2023	-0.95	28/02/2024	4.95		Overdue	Not Yet Due							30/09/2023

Appendix 6) Internal Audit: 45 Completed Recommendations Position Following Return

Audit Type	ABUHB Ref No:	Report Title	Assurance Rating	Director	Responsible Officer	Priority	Recommendation No.	Recommendation	Management Response	Deadline Agreed in Final Report	Months passed Agreed Deadline	Proposed Revised Deadline	Months passed Revised Deadline	Date Revised Deadline was approved by ARAC Comittee	Final Report Deadline Status	Revised Deadline Status	If closed and not complete please provide justification and ensure evidence is available	Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	What evidence is available to close down the recommendation?	Reporting Date
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	Director of Digital / Assistant Director for Strategy, Planning & Design	N/A	R7	R7 A review of the current strategic position of the Health Board in relation to its digital provision and maturity across all domains should be undertaken.	Partially accepted. The Health Board commissioned a review of the Health Boards capacity and capability to deliver the strategy with recommendations for the Board to consider. This was scheduled for Q1 2020/21 but supporting the Health Board through the pandemic became the priority. Whilst this was not a self assessment against a maturity model as in NHS England or HIMMS it provides a comprehensive framework. The report also makes recommendations about the principle of "Once for ABUHB" which if accepted will lead to a baselining of assets, processes and convention outside of the current Informatics Directorate footprint. The recommendations from the planning of the new operating framework are planned to be delivered to Peer Team Q1 and Board Q2 2021.	30/09/2021	-23.93	09/11/2023	1.31		Completed/Closed			Nov 23: The new digital service request process is nearing completion and will shortly be launched across the Health Board. The Digital governance committee will provide assurance on the digital plan and the updated digital programmes framework ensures benefits management will be ingrained on all projects. August 2023: HIMSS report has been discussed at Directors of Digital and the learning is forming part of further planning and strategic discussions at a national level.				30/09/2023
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	Director of Digital / Chief Technology Officer	N/A	R11	R11 The Informatics Directorate should develop an overarching workforce plan that sets out the resource gaps together with the skills gaps and how they are to be resolved. The plan should consider apprenticeships, coordinated departmental development and partnerships in order to maximise the use of limited financial resource.	Planning despite COVID continued on the Operating Framework based on existing mandate and footprint of Informatics portfolio. This addresses key areas of competencies and capacity. This has been supported activity with HR & OD and Finance. The new structure proposal reflects the Digital Strategy and Operating Framework but will require scrutiny challenge and approval.	30/09/2021	-23.93		-1481.93		Completed/Closed			Nov 23: completed Aug-23: ABUHB now represented at Digital Workforce Capability meeting. Work to align JD's with skills and competencies is progressing well and we have a comprehensive register of training opportunities and requests.			Systems established - Propose to close reccomendation	30/09/2023
Internal	2021.00	Clinical Futures - Transport, March 2021	Reasonable	Chief Operating Officer	Service Improvement Manager	Low	R3	R3 We recommend that the Health Board ensure that for each of the MHLD projects that benefit realisation planning is extended to cover:•the collection of baseline data;•targets or success measures with which to compare what is actually achieved;•the measurement and recording of the benefit metrics;•responsible managers; and•the oversight body of the benefits, to ensure these are achieved.	Agreed. We acknowledge that a robust benefits realisation plan needs to be developed and we are looking to commission external support to assist with this process for the SBU Programme. A tender is currently developing a tender to progress this element of the project. This is part of the OBC development and will be completed before submitted to the Board for approval.WPWS –to review benefits realisation plans for supporting projects	30/09/2021	-23.93		-1481.93		Completed/Closed			November 2023: Benefits Identification and Assessment [Stage 1] completed, with Benefits Register and baseline measures and targets for SISU included in the OBC submission approved by Health Board in March 2023. Stage 2 (Benefits Realisation Planning) to be completed as part of PBC preparation once approval to proceed has been given by WG. *Please note date of the new phone system implementation (relating to new 111#2 service) should have stated Aug 2022 (not 2023). This was a typing error. The phone system is operational and is established as business as usual and KPIs managed through adult directorate. Aug 2023: New phone systems to be implemented to enable capturing KPIs.	a/w new phone system		"RE Whole Person Whole System- Crisis Support Programme update- NHS Audit returned a separate audit recommendation report on WPWS programme. This was issued to ABUHB Exec on 28th June 2023.That content supersedes the content in this specific entry and is transferred to be covered in Book 9- MH Transformation. WPWS recommendation should be closed from this audit and picked up through latest programme audit. Nov 2023 response- The SISU commissioned Benefits Register and baseline measures work was finished in early 2023 and included in the OBC approved by the Health Board in March 2023. SISU Benefits register from SISU OBC is attached. SISU riecommendation should be closed .	30/09/2023
Internal	2021.00	Clinical Futures - Transport, March 2021	Reasonable	Chief Operating officer	Service Improvement Manager	Medium	R2	R2 The Flow Centre Team should:•review the current completion of the screening / transfer process documentation and establish a standard expectation of completeness;•provide refresher training to the team members, if required;•undertake periodic checks of all staff members, to ensure consistency and feedback any positive performances and improvements to individuals. This should also link into the PADR process;remind staff that the WAST incident number should be recorded to provide traceability; and•all screening questions shouldbe uploaded to CWS, where required.	Agreed. We will do this by:•implementing a staff review process, including an audit of referral information (this aspect is already implemented);•monitoringstaff performances e.g. logging in times and periodically listening to callsand to feedback oneperformances;•addressing any training needs that arisesand link this to one-to-ones and the PADR process;•continuingto emphasise the importance of accurately recordinginformation e.g. NHS number numbers, GP surgery etc.,•providingregular refresher trainingand•hosting team meetings to share case studies / best practicesand address any issues / concerns that arise.	30/09/2021	-23.93		-1481.93		Completed/Closed			November 2023: Greater than 10% of all calls are now audited and compliance with uploaded of documents is significantly high and a good level of assurance is gained by this. Weekly QPS dashboard will be presented to SMT to give assurance and contribute to the wider governance. Aug 2023: Band 6 nurse competency booklet has been implemented and Call audits template has been created. Due to 175 the regular auditing has be delayed. The band 3 auditing is ongoing but due to the roll out of training of the new cohorts has meant the 10% auditing of all band 3 calls target has not always been achived. Plan to roll this out to all band 6's to cover...	175 flow centre review			30/09/2023
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	PACS & RADIS Manager	High	R3	R3 Whilst we understand the Health Board isin the process of planning to upgrade to the 2016 version we highly recommend that the Health Board expeditethe upgrade.	This upgrade took place on 14thNovember however only application server was upgraded. DHCW and ABUHB are working closely to plan the rest of the upgrade. However DHCW will not touch the RadIS local database which stores all of our crystal reports and letters. This is a risk and we haveagree to our server team internally to plan anbeApupgradefor the RadIS local	30/04/2022	-16.98		-1481.93		Completed/Closed			OPWCMS risk management model delayed nationally. Expected April 2023 for implementation and training/awareness to commence.		Targetted training is provided to teams in the meantime.	Servers upgraded October 2023 to meet cyber requirements- Recommendation can now be closed.	30/09/2023
Internal	2021.15	Falls Management	Reasonable	Director of Therapies and Health Science	AD of Therapies & Health Sciences	Medium	R2	R2. The falls investigation and Datix recording process should reference the MFRA and confirm its completion in relation to the fall event. A fall should not be identified as 'unexpected' if a MFRA had not been completed, when it should have been (e.g. over the age of 65 years).	An ongoing audit process will be established aligned to evaluating the completion of DATIX incidents and the associated completion of the MFRA and will be included as an element of an audit cycle Due consideration will need to be given to the format of the incident reporting criteria within the new system.	30/09/2022	-11.97		-1481.93		Completed/Closed			November 2023: It is proposed that this recommendation is completed as the' Focus Review' has been implemented in both the Medicine and Scheduled Care Divisions and will continue to be rolled out further rolled out across other Divisions supported by the development of a Standard Operating Procedure in development by Health and Safety. The presented as a v recommendation will be tested through the Falls and Bone Health Governance Structure.	N/A	N/A	N/A	30/09/2023
Internal	2021.20	Medicines Management	Reasonable	Medical Director	Head of Pharmacy - Operational Services/Principal Technician, Pharmacy Technical Services	Medium	R2	R2.2 Once the Policy for the Management of Controlled Drugs is updated, the Health Board should undertake periodic reviews to ensure wards are adhering to the updated Policyand confirm the areas of non-compliance identified as part of this review have been rectified.	The stand operating procedure for pharmacy 6 month stock check on the wards is being updated by a Principal Pharmacy Technician. This will include updating the way reconciliation checks confirmation are documented to ensure compliance.The policy can include the need for periodic audits to review use of the policy and confirm areas of non compliance have been rectified.	31/03/2023	-6.00		-1481.93		Completed/Closed			Update Oct 2023:The Pharmacy SOP for 6-monthly stock checks has been updated and is in place. A schedule of the checks is in place for all Acute Pharmacy sites. The new SOP is being used to undertake audits at RGH and NHH and these are due to be completed in September 2023. The checks will highlight to ward staff and the responsible Pharmacist where ward non-compliance is evident and needs to be addressed. The requirement forms part of the revised Management of Controlled Drugs Policy.			SOP 100 Controlled Drugs Stock Check on wards and departments	30/09/2023
Internal	2021.22	NIS Directive (Cyber Security)	Reasonable	Director of Digital	Director of Digital / Chief Technology Officer	Medium	R3	R3 Management should ensure that an Improvement Action Plan is developed promptly in order to avoid delays in implementation.	NIS Improvement Plan is already being developed by the Cyber Team. Thecompleted plan willbe presented for management review and sign off. Currently ABUHB are still awaiting the publication ofCAF Based Cyber Risk Register for the Health Board these risks identified by CRU following the CAF assessment may include remediations that will be incorporated into the Improvement Plan currently being developed.	31/07/2022	-13.97		-1481.93		Completed/Closed			Nov 23: New Cyber Security Assurance Group will be meeting in January and will provide assurance through the Information Governance Sub-Committee including progress against the NIS action plan which has now been developed. Aug 2023: Awaiting next HBOTS meeting.			NIS CAF Remedial Action Plan is now in place and progress will be tracked by the Information Governance Sub Committee.	30/09/2023
Internal	2021.24	Flow Centre	Reasonable	Chief Operating Officer	Service Manager (USC)	Medium	R1	R1.1 The Flow Centre Team should ensure that the reason for an aborted transfers should be adequately recorded.	The Flow Centre Team have performed regular audits throughout the year and learning outcomes identified. This recommendation features on our regular 1:1s with individuals, staff weekly updates and will be a focus over the next fewmonths in line with this audits recommendations.Assurance is given via the Operational Nurse and Urgent Care Divisional meetings with a monthly frequency and contain a feedback loop to ensure learning is disseminated to the teams.Flow Navigator audit tool to be created. Key area of focus for our Flow Navigator Auditor over the next 3 months.	31/07/2022	-13.97		-1481.93		Completed/Closed			Mar 23 • We have seen a marked improvement with regards to documentation – noted through auding. We have a full time Senior Flow Navigator who is responsible for auditing to help with this aim. A Flow Navigator & Flow Nurse Audit Tool has been created, in regular use and had provided key themes for service improvement. Greater than 10% of all calls are now audited and compliance with uploaded of documents is significantly high and a good level of assurance is gained by this. Nugensis will be going through an upgrade next month to streamline the questions and data capture process making this quality indicator much more likely to be completed				30/09/2023
Internal	2021.24	Flow Centre	Reasonable	Chief Operating Officer	Flow Centre Nurse	Medium	R1	R1.2 The Flow Centre Team should ensure that the reason for an aborted transfers should be adequately recorded.	This audit has highlighted a key learning outcome regarding the process followed when closing calls on the system and the loophole associated with the system used for recording the referral (Nugensis).Learning identified and training provided to staff key area of focus for our Flow Navigator Auditor over the next 3 months.	31/07/2022	-13.97		-1481.93		Completed/Closed			Nov 23: There has been a consistent improvement in this area, I believe apart from the occasional mistake this is business as usual - Nugensis will be going through an upgrade next month to automate this process - giving a 100% assurance.				30/09/2023
Internal	2021.24	Flow Centre	Reasonable	Chief Operating Officer	Flow Centre Nurse	Low	R2	R2 The Flow Centre Team should establish the required level of information to be documented on the Transfer Form for each patient screenedand all forms should be uploaded onto CWS.	In the past 3 months an internal audit performed by the department highlighted further evidence of this practice and an action plan has been implemented to improve this area of practice.Clinical audit tool to be created. Initial audit to be completed –5% of Flow Nurse workload. Learning identified and training provided to staff	30/09/2022	-11.97		-1481.93		Completed/Closed			Mar 23 A Flow Navigator & Flow Nurse Audit Tool has been created, in regular use and had provided key themes for service improvement. Nov 23: Greater than 10% of all calls are now audited and compliance with uploaded of documents is significantly high and a good level of assurance is gained by this. Nugensis will be going through an upgrade next month to automate this process - giving a 100% assurance.				30/09/2023
Internal	2021.27	Waste Management	Reasonable	Chief Operating Officer	Environmental Manager	Medium	R1	1.1 Ensure that the Waste Management Policy has been reviewed/updated and reflective of the above findings. That the updated Policy is underpinned by formal Board Level approval with all key elements of WHTM 07-01 guidance incorporated.	1.1 The Waste Management Policy will be reviewed/updated and formally approved by the Board.	31/10/2022	-10.95	30/07/2023	-2.03	12/09/2023	Completed/Closed	Completed/Closed		Policy is currently being reviewed/updated with new Director prior to engagement with wider stakeholders.	This is not a major update and will not require formal Board approval		Complete	30/09/2023
Internal	2021.27	Waste Management	Reasonable	Chief Operating Officer	Environmental Manager	Medium	R1	1.3 Out-of-date policy / procedural documents published online should be updated.	1.3 All online policies and procedures will be reviewed and updated where necessary.	31/10/2022	-10.95	31/08/2023	-0.98	12/09/2023	Completed/Closed	Completed/Closed		Nov 2023: This can now be closed as both the Waste Policy and Environmental Policy have been reviewed and published to AllPulse				30/09/2023
Internal	2022.01	CYP Continuing Care	Reasonable	Chief Operating Officer	Assistant Service Manager	Medium	R2	Incorporate the use ofthe recently developed All Wales CCN Senior Nurse forum KPIs for CCNS within the performance monitoring process.Regular monitoring of the performance report within the CCNS with annual (minimum) reporting to the Division.	Medium(3)RL Datix to be utilised further to capture compliments as an initial step to provide more balance. 2)Key Performance Indicators for the Children's Community Nursing Service is being looked at within the All Wales Forum. Once finalised, these will be implemented locally and reported to Division two-monthlyin line with QPS framework with appropriately agreed action plans supported3)CIVICA has recently been commissioned by the UHB and will support the development of a dashboard to analyse service user feedback, key performance indicators and Quality outcome measures.	31/12/2022	-8.95		-1481.93		Completed/Closed			November 2023: RL Datix in use for capturing Compliments as well as complaints; 2)Key performance indicators work at all Wales level have been put on hold, temporary KPI's being locally agreed in the interim; 3) CIVICA in use with easy to access QR codes being uploaded on to Healthier Together platform digitally, and circulated as part of all communication with families. CAN NOW CLOSE Partial Completion 1) COMPLETED compliments being recorded on datix if received 2) All Wales KPI's not yet agreed to incorportate in our performance monitoring locally 3) CIVICA feedback implemented for Care Closer to Home and awaiting first report, wider implementation anticipated in the next 6 months	28/07/2023 As above plus staffing levels in Environment Team			30/09/2023
Internal	2022.05	Digital Benefits Realisation	Substantial	Director of Digital	Director of Digital / Assistant Director of Programmes	Low	R2	R2 The Health Board should continue with an annual reporting cycle that summarises the benefits position for the Audit, Risk and Assurance Committee. Work on the benefits dashboard should be completed and incorporated into future reporting.	Benefits updates are provided at monthly programme boards and quarterly to Programme Delivery Board (PDB). Work is ongoing with the PMO using the informatics portfolio register to develop oversight of portfolio level benefits. A local dashboard is under development for summary reporting to DDDB on a six monthly basis. This dashboard can be updated to provide an annual update to the Audit, Risk and Assurance Committee.	01/09/2023	-0.95		-1481.93		Completed/Closed			Nov 23: Director of Digital refreshing governance to establish a Digital Data & Technology Sub group which will report directly into the required HB committees.				30/09/2023
Internal	2022.06	Decarbonisation - Advisory	Not Rated	Director of Finance and Procurement	AFD	N/A	R2	DRPs should be fully costed to fully determine the total funding required.	Subgroups of the main DPB have been tasked with developing action plans relating to their delegated national initiatives. This work will include costing projects and is currently in progress. Programme/project costs to meetthe interim CO2 reduction targets are currently being analysed.	31/03/2023	-6.00		-1481.93		Completed/Closed				Financial	see progress plan	November 2023: The ability to fully cost a carbon neutral plan for ABUHB will require specialist consultancy input - given the financial position of the Health Board it would be imprudent to commission at this time. Instead the Boards Decarbonisation Programme will continue to identify opportunities to improve the Boards carbon footprint through initiatives and innovations developed as part of the programme of work.	30/09/2023
Internal	2022.06	Decarbonisation - Advisory	Not Rated	Director of Finance and Procurement	Energy & Carbon Manager DPB Workstream Leads	N/A	R4	NHS Wales Organisation's baselines should be adequately scrutinised and challenged, as errors and overreporting has been identified in a few examples to date.	Agree. Net Zero Report data sources, analysis and report generation will be subject to an internal review. The HB have now set up a Decarbonisation Programme Board which incorporates the existing metrics along with additional scrutiny of new projects coming on line within the workine ensure.	01/05/2023	-4.98		-1481.93		Completed/Closed			November 2023: Review of carbon footprint undertaken & will be regularly reviewed as new measuring methods are developed			Annual carbon report	30/09/2023
Internal	2022.07	Clinical Audit	Limited	Medical Director	Assistant Director QPS	Medium	R3	R 2.3 The local clinical audits should be recorded onto AMaT, as is currently being done with national clinical audits.	It is acknowledged that the current process in ABUHB for local audit has lacked structure and formal documentation. AMaT will be utilised for local audit and will enable the development of a formally recognised process for reviewing the organisations performance when reports are published. The AMaT report will include consideration of improvements (planned and delivered) and an escalation process to ensure the executive board is made aware when issues around participation, improvement and risk identification against recommendation are identified. The Clinical audit lead, CSEG and the Assistant Medical Directors will scope how to mandate the use of AMAT. We will agree on a formal process for registering a local audit (which sets out audit lead, reason for audit (e.g. complaint response etc etc), methodology (e.g. how will data be collected and analysed), standard being audited against, timeline, when report due and action to be taken from audit (including where result will be presented). This will be approved in advance – with prioritisation e.g. National audit takes precedence and local audit not addressing a risk issue is lowest priority. All audits will be		01/03/2023	-6.98		-1481.93		Completed/Closed						Strengthened Board financial recovery arrangements established - see Board reports	30/09/2023
Internal	2022.10	Newport HWB Centre	Reasonable	Chief Operating Officer	Capital Planning Team	Low	R15	R15 The Project Bank Account should be implemented as soon as possible.	Agreed. The UHB is awaiting a list of sub-contractors from the SCP who wish to join the PBA.	01/02/2023	-7.90	30/09/2023	0.00	12/09/2023	Completed/Closed	Completed/Closed		November: The PBA went live in September Aug 2023: The PBA will go live in September 2023 Remit of the Capital Planning Team.	None	N/A	Revised valuation process	30/09/2023
Internal	2022.12	Records Management	Limited	Director of Digital	Head of Health Record Services	High	R2	R2 The importance of maintaining record management quality should be re-iterated to clinical staff, using communications from senior clinical staff and clinical information leads	As per 1.1 above, we will seek to enforce attendance at Health Records awareness Sessions and further re-iterate the professional standards required.	31/03/2023	-6.00		-1481.93		Completed/Closed		Closed due to no support for mandatory training. Log of ward clerk training and interventions being maintained by Health Records.	Nov 23:- Log of all interventions with missing documentation at ward level and Datixes raised in respect of non compliance. Aug-23: Discussed at Finance & Audit but no commitment to mandatory training. Records Awareness sessions continue, junior doctor training but no agreement for ward clerks to be released to support their training.	No agreement to make records management training mandatory for ward clerks	health Records engage with wards where issues have been identified and offer support to the staff to rectify the situation.		30/09/2023
Internal	2022.12	Records Management	Limited	Director of Digital	Head of Health Record Services	Medium	R6	R6 It should be ensured that storage conditions for records meet basic standards.	Information on unsuitable storage areas will be presented to the Medical Director every three months by the Data Protection Officer with appropriate risk assessments. Action plan with the Medical Director will be agreed.	31/03/2023	-6.00		-1481.93		Completed/Closed			Nov 23: Llangennech on target for closure at yend of December so boxed storage removed entirely and records removed from some MH areas and rehoused in better locations while awaiting digitisation. Aug-23: Storage areas review undertaken and areas of mental health identified as requiring improvement previously identified as part of the Mental Health Business Case. Services have engaged with the proposed digitisation of mental health, child health and therapy records and work is underway to begin a programme of work to digitise these records and thereby remove the risk of loss, inappropriate access and storage arrangements. Some MH and some Child Health Records have been accommodated in a vacated area from previous acute digitisation work to alleviate storage issues within these areas.	Progression to digitisation of the remaining mental health, child health, therapy and other records will require resource or the service is limited as to how much can be achieved in the short term.	RPA is being used to good effect to release hours within the service that can be directed to do some of this work	Plans are in place for the digitisation of these records. The business case has been reviewed and software changes have been made to support new digitisation requirements for these records.	30/09/2023
Internal	2022.12	Records Management	Limited	Director of Digital	Head of Health Record Services	Low	R8	R8 Conditions of boxes used for records management should be regularly checked, and boxes which are collapsing should be replaced.	This will be reviewed six monthly and will be an item on the agenda at Governance and Assurance Meetings.	30/06/2023	-3.02		-1481.93		Completed/Closed			Nov 23: Boxed storage removed as part of Llangennech closure and MH notes being moved to more appropriate locations with removal of requirement for boxes. Aug-23: The use of boxes is being phased out as racking becomes available. The Llangennech store will be empty by the end of December 2023 and all records in NHH are being transferred to racking currently and boxes only used as an interim storage arrenagement. Boxes are reused to reolace collapsing boxes.		Ongoing work to close Llangennech store and refile records onto racking	Removal of records and destruction of backlog complete so removing boxed storage from the main system.	30/09/2023
Internal	2022.12	Records Management	Limited	Director of Digital	Head of Health Record Services	Medium	R10	R10 Each ward should adhere to the records management process, and this should be formally monitored (e.g., through exception reports). Specific KPIs should be developed to measure problematic areas	A bespoke report will be requested from Information services and/or DHCW. Where delays in returning documentation are identified via the report, these will be flagged and escalated to ward and clinical manawement.	30/06/2023	-3.02		-1481.93		Completed/Closed			Nov 23: Bespoke report in operational use. Aug-23 A bespoke report is now available and being used to flag records that are outstanding and Datix reports are being created where there is a concern. These are directed to the ward and clinical/directorate managers as			A bespoke report is now available and being used to flag records that are outstanding and Datix reports are being created where there is a concern.	30/09/2023
Internal	2022.12	Records Management	Limited	Director of Digital	Head of Health Record Services	Medium	R11	R11 Issues of records management process slowdowns should be investigated and escalated when required.	As per 4.1 above, a bespoke report will be developed. However, staffing resource will be required to check if discharges have been actioned and records have been returned. The need for additional resources will be escalated.	31/03/2023	-6.00		-1481.93		Completed/Closed			Nov 23: Bespoke report in operational use and datix raised if there are delays in the return of supplementary files for scanning. Aug-23: The bespoke report is being used and due to the release of staff from some duties as RPA is being rolled out for referral processing a proportion of these hours are being used to support the work required.			The bespoke report is being used and due to the release of staff from some duties as RPA is being rolled out for referral processing a proportion of these hours are being used to support the work required.	30/09/2023

Internal	2022.12	Records Management	Limited	Director of Digital	DPO & Head of IG Deputy Head of Health Records Chief Nursing Information Officer	Medium	R14	R14 A formal process should be developed and adopted across the Health Board to share, escalate and resolve record management issues.	a.) The Governance and Assurance group will provide the forum for divisions to report records management issues. b.) A Health records representative will attend these sessions and work with the divisions going forward to improve records management. Progress will be monitored and reported quarterly and recorded on the centrally held portfolio register for each division. c.) Clinical coding teams report issues via the Health Records management monthly meeting and sit on the Governance and Assurance group. As part of this process. Clinical Coding will highlight areas where loose records have been identified.	31/03/2023	-6.00		-1481.93		Completed/Closed			Nov 23: GAGs in the current format provide the vehicle for engagement via IG. Aug-23: Deputy Head of Health Records and Records Service Managers attending the GAG's to raise awareness . Health Records GAG is operational with clinical coding engagement and clinical coding are able to attend the monthly Health Records Managers Group to raise any issues. A portfolio register is on file for ech of the GAG's. The IG service hold the portfolio registers and will report quarterly to the appropriate group.			Deputy Head of Health Records and Records Service Managers attending the GAG's to raise awareness . Health Records GAG is operational with clinical coding engagement and clinical coding are able to attend the monthly Health Records Managers Group to raise any issues.	30/09/2023
Internal	2022.16	Financial Sustainability	Reasonable	Director of Finance and Procurement	Director of Finance & Procurement / Chief Executive	Medium	R1	All delegated budgets should be formally accepted. Non-acceptance of a delegated budget should be reported to the Finance and Performance Committee and / or the Audit, Risk and Assurance Committee	Accepted for Executive level delegation letters	01/05/2023	-4.98		-1481.93		Completed/Closed							Letters returned to CEO	30/09/2023
Internal	2022.17	Risk Management	Reasonable	Chief Operating Officer	Divisional Nurse Complex and Long Term Care	Low	R1	The Complex and Long Term Care Division should report the full risk register, on a periodic basis, to the Divisional Quality, Patient Safety and Experience Group	Agreed. The Complex and Long Term Care Division will report the full risk register to the Divisional Quality, Patient Safety and Experience Group	01/04/2023	-5.97		-1481.93		Completed/Closed			Only high risks are requested by QPSOG, full register available when requested / required.			High risk areas identified and shared with QPSOG. The Divisions completed risk log is available to be shared with QPSOG.	30/09/2023
Internal	2022.17	Risk Management	Reasonable	Chief Operating Officer	Divisional Nurse Complex and Long Term Care	Medium	R2	The Complex and Long Term Care Division should ensure that there is no additional risk exposure through the current approach of recording divisional risks	Agreed. The Complex and Long Term Care Division will ensure there is no additional risk exposure through the current approach of recording divisional risks	01/04/2023	-5.97		-1481.93		Completed/Closed			Risks are discussed on a regular basis via numerous daily / weekly meetings.			The Division have been working with Lucy Windsor to re evaluate & review the risk register. A new template risk register, risk to a page & guidance note has been developed, this is in draft format for the Divison & Lucy will be discussing the implementaiton at the next DLT on 22/11/23. Whilst this is in progress the Divisions risks are continually discussed at our various weekly	30/09/2023
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	Head of Patient Discharge	High	R1	Where a Health Board policy is to expire that an extension to the document is formally granted, with a revised review by date established. Such policy extensions should be reported to the Board or designated Committee and checks made to ensure that the policy remains as relevant as possible, pending any formal review.	The Health Board's clinical policies have a review date rather than an expiry date, and whilst the review date may have elapsed, the policy remains extant and does not require a formal extension. However, whilst the Policy remains extant, we recognise there may be differences between the Policy and current practice. Therefore, the current process will be reviewed and compared to the existing policy. Where gaps are identified, these will be risk assessed and mitigation implemented to reduce risk to an acceptable level. We anticipate this will include an interim update to the Policy. Following this process we will provide assurance to the QPSOG over actions to be implemented, with regular updates provided on implementation status.	01/05/2023	-4.98		-1481.93		Completed/Closed			NOV 2023 - Rquest to complete as the All Wales Reluctant Discharge Policy was endorsed for Health Board use at the Clincal Standards and Policy Group meeting in October. The All Wales Discharge Policy has been delayed, but the local Discharge Policy has been aligned with the discharge to recover and assess pathways and was presented to the Clinical Standards and Policy Group in October and signed off.				30/09/2023
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	Head of Patient Discharge	High	R1	The Discharge Policy is updated, approved and reissued, to reflect current practice and approach to discharge planning adopted by the Health Board (Medical Fit Date for Discharge, simple and complex case approaches, and the management of the Complex List) and the related roles and responsibilities of staff.	In the interim we will identify the gaps between current practice and the current policy and ensure that it is updated. We will then ensure the Policy is approved by the appropriate Committee. Once the All-Wales Policy is published, we will ensure that any requirements are incorporated into the Health Board's Policy. The revised policies will be re-issued with training overseen by the Head of Discharge and Divisional Nurses. We will continue to monitor the implementation of the policy and update training requirements as required.	01/05/2023	-4.98		-1481.93		Completed/Closed			NOV 2023 - Rquest to complete as the All Wales Reluctant Discharge Policy was endorsed for Health Board use at the Clincal Standards and Policy Group meeting in October. The All Wales Discharge Policy has been delayed, but the local Discharge Policy has been aligned with the discharge to recover and assess pathways and was presented to the Clinical Standards and Policy Group in October and signed off. Implementation and training of the policies has started.				30/09/2023
Internal	2022.20	Tredegar Health & Wellbeing Centre Final Internal Audit Report	Limited	Chief Operating Officer	Chief Operating Officer	Medium	R1	To review the constitution, capacity and function of the Programme Board - See Newport East Health and Wellbeing Centre Audit Report MA2 issued December 2022	Agreed. The issue was raised at the February meeting of the Programme Board in the absence of the Director of Primary Care, Community and Mental Health services. Proposed to separate the Project Board function from the wider remit of the Programme Board.	01/06/2023	-3.97	28/08/2023	-1.08	12/09/2023	Completed/Closed	Completed/Closed		Aug 2023: A new SRO has been identified and a separate PB has been arranged for 28th August	None	N.A	November 2023: SRO and Project Board in place for both Tredegar and Newport projects Aug 2023: Updated PB Terms of Reference & Meeting papers	30/09/2023
Internal	2022.20	Tredegar Health & Wellbeing Centre Final Internal Audit Report	Limited	Chief Operating Officer	Project Director	Low	R7	The Cost Adviser should provide assurance that appropriate sampling has been made of supporting documentation for costs claimed in respect of Plant and Materials (utilising an Open Book approach as specified at the Project Execution Plan).	Agreed. The Cost Adviser has been requested to provide such assurance.	01/06/2023	-3.97	30/09/2023	0.00	12/09/2023	Completed/Closed	Completed/Closed		Aug 2023: This is outstanding	None	N/A	November 2023: SRO and Project Board in place for both Tredegar and Newport projects Aug 2023: Evidence of sampling	30/09/2023
Internal	2022.21	Development of a Regional Radiotherapy Satellite Centre at NPH	Reasonable	Director of Strategy, Planning & Partnerships	Project Director	Medium	R3	Pending implementation of the Project Bank Account, the University Health Board should seek assurances from the Supply Chain Partner in respect of the timely payment of its subcontractors.	Agreed, the University Health Board will seek evidence of timely payments from the Supply Chain Partner as part of monthly progress reporting	01/09/2023	-0.95		-1481.93		Completed/Closed			November 2023: The PBA is active The PBA will be implemented from September 2023.	Delay in sign-off by SCP Bank		Revised valuation process	30/09/2023
Internal	2022.21	Development of a Regional Radiotherapy Satellite Centre at NPH	Reasonable	Director of Strategy, Planning & Partnerships	Project Director	Medium	R3	Deeds should be signed as a priority and the Project Bank Account established in line with Wales Procurement Policy Note WPPN 06 which is supported by the requirements of the University Health Board's Standard Financial Instructions section 15.4.8.	Agreed, the Project Bank Account Trust Deed was signed and returned to the Supply Chain Partner (SCP) on 15th March. Implementation usually takes 4 to 6 weeks including the sign up of Sub Contractors. As things stand no Sub-Contractors wish to join the PBA, evidence of refusal has been requested	01/06/2023	-3.97	30/09/2023	0.00	12/09/2023	Completed/Closed	Completed/Closed		November 2023: The PBA is active but with only one sub-contractor. Others do not wish to join. Aug 2023: The PBA will be implemented from September 2023.	Aug 2023: Delay in sign-off by SCP Bank		Aug 2023: Revised valuation process	30/09/2023
Internal	2022.22	RGH Redevelopment & Expansion of Endoscopy	Reasonable	Director of Strategy, Planning & Partnerships	Project Director	Medium	R6	At Future Projects The contract strategy should be fully evaluated and considered (within the Business Justification Case or extant).	Future business cases will include reference to a contract strategy	01/05/2023	-4.98		-1481.93		Completed/Closed			November 2023: This is written into the process for future projects Aug 2023: This is a future action for future projects	None	N/A	Aug 2023:Future action	30/09/2023
Internal	2022.25	Integrated Wellbeing Networks	Reasonable	Director of Public Health	IWN Programme Manager	Medium	R1	Management should formalise the approach to communicating/monitoring local IWN plans and providing cover if the Service Development Lead is absent	Community Involvement Officer colleagues are often able to deputise in the absence of the SDL. The programme will explore sharing meeting facilitation with community partners and with the appointment of an 8b Programme Manager (currently out to advert) how the programme can support local meeting facilitation and programme delivery where SDL colleagues are absent for prolonged periods	01/08/2023	-1.97		-1481.93		Completed/Closed			Nov 2023 - Proposal to complete the recommendation as the 8b Programme Manager is now in post; programme and facilitation of meetings communicating/monitoring local IWN plans and providing cover if the Service Development Lead is absent have been put in place.				30/09/2023
Internal	2022.24	Infection Prevention & Control (OPC)	Reasonable	Director of Nursing	Head of IPC	Medium	R1	Management should undertake a walk around / review of wards covered in this audit to ensure areas of noncompliance have been addressed. Any lessons to be learnt should be shared with the remaining wards to ensure compliance throughout the Health Board.	Email circulated to Divisional Nurses on the 30.05.23 asking for the above recommendation to be implemented and update via local quality and patient safety forums and the Reducing Nosocomial Transmission Group. Dashboard audits are available on the AMaT platform	01/07/2023	-2.98		-1481.93		Completed/Closed		Nov 2023: completed	Nov 2023: Audits standardised via AMAT, promoted with senior nurses via local teams. IPT undertake 3 monthly reviews, lead and depty nurse part of the mental health review, plus undertakes corporate visits	Nov 2023: Documentation to support local visits	Nov 2023: IPT try and have a local pres	Nov 2023: audits	30/09/2023
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Programme Manager	Medium	R2	Consideration should be given to make the electronic recording fit for dementia services. For example, add or change menu structure or introduce a dedicated field to highlight dementia diagnosis.	Workstream 5b leads, along with Performance Team support, will review the electronic information and ensure the recording is appropriate for dementia services going forward	01/08/2023	-1.97		-1481.93		Completed/Closed			Nov 2023: Update 11/11/2023 National Audit of dementia action plan has intiemented a code for the use of Clinical Work Station (CWS) using a code 136 to indicate a field for recording of Dementia Diagnosis. Actioned			Nov 2023: Clinical Workstation field (CWS) using 136 code can be filtered and viewed on patient record.	30/09/2023
Internal	2022.28	Mental Health Transformation	Reasonable	Chief Operating Officer	WPWS Crisis Support Senior Programme Manager	Medium	R1	The Project Flash Report format should be amended to include a section on matters for escalation. Any such matters should be reported as part of a standing item within the appropriate board setting (i.e. Whole Person Whole System Crisis Support Programme Board or the Mental Health Transformation Board). The minutes should reflect the matters to be escalated or state no matters for escalation. This is also applicable of matters for escalation from the Mental Health Transformation Board.	The Project Flash Report format will be amended to include a section on matters for escalation. Any such matters for escalation have previously been verbally reported and will be reported more clearly as a stand alone agenda item within the appropriate board. For clarity, going forward the minutes will also reflect the matters to be escalated or state no matters for escalation.	01/08/2023	-1.97				Completed/Closed			November 2023: Action Completed - The Senior Programme Manager has agreed governance (process & templates) in use. Any matter for decision/escalation is proactively raised by SRO in this process and clearly indicated on agenda for action. The process, reporting & escalation requirements are documented in ToR :- Context - The WPWS- CSP Board oversees workstreams that inform its agreed 'themes'. This means the workstreams overseen may be varied in focus, content as either; - a live project, directed by Board; - or, a live operational service, this is under operational responsibility and management of Directorates, however, it remains considered a workstream essential to inform the Boards oversight in benefits/lesson awareness in its 'themes' & interdependencies.	Programme Governance recognition with BAU leads		COMPLETED Evidenced in governance - Workstream reports for Board oversight are prepared with the workstream SRO/Chairs, SPM and issued with Agenda, pre Board meeting, as a matter of report. The report sections specifically have an area to indicate if any content requires escalation or not. 1) Live projects, under direction/delivery responsibility of Board; template is detailed to cover all aspects that are best practice project standards reporting, including: ü aim ü milestone management. ü Risk/issues oversight ü Escalations/decisions required 2) Workstreams not projects but embedded as live operational services; These are considered as key to inform and evidence the programme theme & benefits realization. Their template offers: ü activity oversight on activity for benefits and lessons. ü top 3 risks for the workstream ü Escalations/decisions required	30/09/2023
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Lead Nurse for OAMH	Low	R3	Consideration should be given to revisit the appropriateness of the paper folder file style for the MHAs, to improve efficiency of access to patient files	The OAMH Directorate will review the paper folder files and implement any improvements required.	01/07/2023	-2.98				Completed/Closed			Nov 2023: All wards have now received Divisionally approved "green files", to ensure robust and secure storage of interim documentation needed for us on OAMH wards. These were delivered week commencing 6th November, and ward administration asked to prioritise orderly transfer of documents.				30/09/2023
Internal	2022.29	Bank Office and Temporary Workers	Reasonable	Director of Workforce & OD	Deputy Director of Nursing	Low	R2	We recommend that mismatches betweeb te BankStaff system settings/permissions and ASL listings are identified, examined and addressed.	Divisional management will sent out a communication to all ward managers to remind them of the requirement to ensure all staff required to electronically finalise shifts on Healthroaster/BankStaff have completed the relevant forms to be added onto the ASL.	30/08/2023	-1.02				Completed/Closed			November 2023: Finance emailed Divisions to confirm and update ASL and to confirm any amendments. Initial communications was August 22 with subsequent follow up.	November 2023: Divisional Capacity	November 2023: Managers on the ASL formally authorise the shift on the system. It is therefore their responsibility to confirm that the shift is worked via the Bank Staff system.	November 2023: Email correspondance with Divisional teams and Finance. This is an ongoing exercise to ensure that the ASL is up to date with communications to Divisons the process for any staff changes.	30/09/2023
Internal	2022.29	Bank Office and Temporary Workers	Reasonable	Director of Workforce & OD	Deputy Director of Nursing	High	R3	There is no further recommendation to raise. However for completeness, the previous recommendation is detailed below. We recommend the Health Board monitor and address any compliance issues with the current process in use. Where anomalies are identified going forward, these should be investigated and training provided to assist with the embedding of the controls. Furthermore rosters should be prepared in a timely manner, and shifts should be released to the bank, contract and off-contract agencies at the appropriate time, with sufficient time to ensure all alternative options are considered.	Divisional Nursing management will send out a communication to all Senior Nurses to remind them of the requirement to ensure all rosters are approved within the requirement timetable and to remind the nurses to send all Bank shifts to Bank at the earliest opportunity in the roster period.This will be monitored in the bi weekly meetings with senior nurse managers.	30/08/2023	-1.02				Completed/Closed			November 2023: Ongoing communications with Divisional nurses			November 2023: Communications have been sent. Roster Perform (this is a live data analytical tool aligned to e-rostering) allows WOD and Divisional Teams to review rosters. Weekly meetings to discuss rosters are in place.	30/09/2023

Appendix 7) External Audit: 2 Overdue Recommendations Position Following Return

Audit Type	ABUHB Ref No:	Report Title	Assurance Rating	Director	Responsible Officer	Priority	Recommen-dation No.	Recommendation	Management Response	Deadline Agreed in Final Report	Months passed Agreed Deadline	Proposed Revised Deadline	Months passed Revised Deadline	Date Revised Deadline was approved by ARAC Comittee	Final Report Deadline Status	Revised Deadline Status	If closed and not complete please provide justification and ensure evidence is	Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	What evidence is available to close down the recommendation?	Reporting Date
External	2018.01EA	Structured Assessment 2018	Not Rated	Director of Digital	Head of Information Governance	High	R3	R3 The Health Board should improve its information governance arrangements by: improving compliance with the information governance training programme to reach the national rate of 95%.	Information Governance training reviewed to include the legislation changes as a result of GDPR. An additional module was developed and launched for Cyber Security which is mandatory for all staff to complete. The Information Governance Unit has set up Information Governance Delivery Groups (IGDG) for each of the Divisions in the organisation. The meetings are held bi monthly and training is included on the agenda for every meeting. Discussions are held specifically around compliance and Managers are tasked with improving their compliance rates. Reports are assessed at Transformation to Digital (T2D) Delivery	01/03/2020	-42.89				Overdue			• Audit sent out to ward managers and divisional senior nurses to determine current training compliance throughout ABUHB.	Identified as outstanding in Structured Assessment 2022 - The pandemic has hindered progress	Non compliance reports are being sent to senior managers within Divisions to ensure that compliance is monitored and actioned in these areas. Where non-compliance persists targeted escalation routes have been established and the appropriate corrective action will be taken. Promotion of the audio learning tool for staff groups that have dificulty in leaving the workplace or access to computer systems and e-learning will be facilitated by the IG team and attendance recorded.		30/09/2023
External	2021.01EA	Audit of Accounts Report, 2020-21 – Addendum issued December 2021	Not Rated	Director of Digital	N/A	Medium	R3	The HealthBoard should consider strengtheningtheirIT Controlsas followsi.All of the Windows server 2008 operating system should be replaced with either or Windows 2012 or higher where possible (this is almost completed with only twenty three servers left). ii.W7 and W8.1 desktop devices should be replaced as these are now de-supported. iii.Ensure that the change management procedure is finalised.iv.The IT Data Recovery Plan and Backup Policy should be updated and clearly defined.v.With regards to the Wellsky system, leavers and accesses changes should beformally recorded, and the Health Board shoulddevelop a suite of audit and security reports to run and monitor to ensure user access is appropriate.	i.With regards to our Windows Server 2008 environment, we have an active programme of work to either upgrade or decommission these servers. It is envisaged that by the end of the current quarter only a few servers may remain, although weare currently investigating options for these.ii.ABUHB have made significant progress in removing Win7/8.1 from our estate and currently have 0.4% to complete.There is an active programme of work to remove these devices from the network or upgrade them toa supported version of Win10.iii.We have an established and robust Change Management Process in place with regularly scheduled and structured Change Advisory Board meetings to manage operational change.The process has been widely socialised with all of Informatics and other Key Stake Holders, and also engages effectively with other ITIL practices such as Incident Management and Asset/Configuration Management.Critical Success Factors and Key Performance Indicators are agreed and monitored to measure effectiveness.iv.The IT Data Recovery Plan and Backup Policy is still in the process of being reviewed and updated.A draft version has been shared within the team and the finalised version will be released within the coming weeks.v.All user accounts are processedin line with NHS Wales standards.There is a current risk that unless a service request had been raised to the ICT Service Desk, staff who leave Pharmacy but remain within the organisation may still have access to WellSky. Further review of the staff	31/12/2021	-20.92				Overdue			Nov-23: Critical Server refresh ongoing, KPI's being developed for presentation at Cyber Security Assurance Group Aug-23: No update - older servers are being replaced via critical server refresh project, updated figures to be provided by SC May 23: No further update Mar-23: Discussion with 3rd party is still ongoing Jan-23 i. Currently there are 2 remaining servers left on 2008. These rely on upgrades to the software applications to enable the move to a supported Windows Server version. The team will continue to liaise with the services to remove the last 2 remaining. ii. Currently we have 3 devices remaining. The team will continue to liaise with the services to remove the last remaining. iii. Confirmed this was completed. iv. Confirmed this was completed.				30/09/2023

Appendix 8) External Audit: 4 Revised Timescale Requests Following Return For Approval

Audit Type	ABUHB Ref No:	Report Title	Assurance Rating	Director	Responsible Officer	Priority	Recommen-dation No.	Recommendation	Management Response	Deadline Agreed in Final Report	Months passed Agreed Deadline	Proposed Revised Deadline	Months passed Revised Deadline	Date Revised Deadline was approved by ARAC Comittee	Final Report Deadline Status	Revised Deadline Status	If closed and not complete please provide justification and ensure evidence is available	Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	What evidence is available to close down the recommendation?	Reporting Date
External	2021.01EA	Audit of Accounts Report, 2020-21 – Addendum issued December 2021	Not Rated	Director of Workforce & OD	N/A	High	R1	The Health Board should review the arrangements in place toensure that annual leave for all staff is accurately recorded and held centrally	The introduction of Medical E-Systems will ensure that all leave is recorded. The Health Board have agreed to procure a suite of Medical E-Systems with roll out in April 2022. However, departments have started recording leave in Electronic Staff Record (ESR). Communications will be sent to Medical Leaders in December 2021 to ensure that leave is recorded onto ESR pending the introduction of full Medical E-Systems.	30/04/2022	-16.98	31/03/2024	6.00		Overdue	Not Yet Due		November 2023: Procurement completed. Draft Implementation plan being discussed with Divisional Directors. Roll out to commence in January 2024. Aug 2023: The roll out the newly procured workforce medical e-system will resolve the logging of annual leave centrally. Incremental implementation will progress once purchased. Current technical issues with procurement. If resolved implementation will commence October 23. Nov 2022 the roll out the newly procured workforce medical e-system will resolve the logging of annual leave centrally. Incremental implementation will progress over the next 9 months.	Aug 2023: Given current pressures on staff it is not felt that a interim system change of 12 months would be beneficial Cultural issue anticipated that it will take longer than June 2023 to realise in full. Given current pressures on staff it is not felt that a interim system change of 12 months would be beneficial Cultural issue anticipated that it will take longer than June 2023 to realise in full.	Aug 2023: Executive Team. Legal and Procurement advice	September/October 2023 for full implementation following procurement and implementation of the new data base.Ongoing evaluation of OT provision. Request extension to September/October 23.	30/09/2023
External	2021.06EA	Quality Governance Review	Not Rated	Director of Nursing	with Clinical Executives	N/A	R6	R6 The Health Boards quality assurance framework includes a range of committees and groups aligned to Health and Care Standards. The framework is assisting the Health Board in identifying areas which previously had not provided assurance. However, there are still gaps in the flows of assurance from some sub-groups and in relation to elements of the Health and Care Standards. Whilst the framework is reasonably comprehensive at a corporate level, it doesn't fully articulate the operational structure and processes for quality and safety. The Health Board should:•complete its review of thequality and safety framework toensure that flows of assuranceare appropriate, and that the •framework functions asintended.•articulate the operationalstructures and processes forquality and safety within thequality assurance frameworkand how they align with thecorporate structure to provide a'floor to board' assurance.	The Quality Assurance Framework will be reviewed to assess fitness for purpose and alignment to the BAF. The revised Quality Assurance Framework will include the operational structures and processes.	31/10/2022	-10.95	28/02/2024	4.95		Overdue	Not Yet Due		**June 23**: Due to be presented to Executive Committee and PQSOC in July 2023				30/09/2023
External	2021.06EA	Quality Governance Review	Not Rated	Director of Nursing	with Clinical Executives	N/A	R8	R8 The General Surgery directorate has recently established its own patient safety and quality group. However, the group does not have a terms of reference, standardised agenda, or report templates and minutes of meetings are not taken. Whilst quality and safety did feature in bi-annual reviews with the Executive Team and monthly assurance meetings with the Director of Operations. We note the monthly assurance meetings stopped in March 2021. We found limited focus on quality and safety at Scheduled Care Divisional Management Team meetings. The Health Board should:•review the operational patientsafety and quality groups toensure they are effectivelysupporting the Health Boardsquality governancearrangements.•ensure that other operationalmeetings / forums providesufficient focus on quality andsafety alongside finance,performance, and operationalmatters.	The patient, quality and safety structures for each Division will be reviewed and outlined in the revised Quality Assurance Framework (see R6).Divisions will be reminded to ensure a robust focus on patient quality and Safety through Divisional and Directorate meetings.	31/10/2022	-10.95	28/02/2024	4.95		Overdue	Not Yet Due		**June 23:** Quality Assurance Framework due to be presented to Executive Committee and PQSOC in July 2023				30/09/2023
External	2022.03EA	Structured Assessment 2022	Not Rated	Director of Corporate Governance	Head of Board Business	N/A	R1	R1 Board and Committee agendas cause some meetings to overrun. The Health Board, therefore, should review Board and committee agendas to ensure meeting business can be covered in the time available whilst also allowing for sufficient scrutiny and discussion.	Ongoing development of the Board's Assurance Framework and Risk Management Framework will enable the Board and Committees to ensure focus on priority, risk-based, areas by exception, supported by risk-based workplans. The development of Board and Committee Etiquette and Conduct of Business will also support greater effectiveness of meetings.	01/09/2023	-0.95	31/03/2024	6.00		Overdue	Not Yet Due		November 2023: The HOBB is undertaking a review of all board processes and procedures to secure greater consistency of approach and to ensure that all regulatory and statutory requirements are addressed though an action plan to improve board buisness. This will include the timeliness of meetings and scope of papers for consideration.				30/09/2023

Appendix 9) External Audit: 13 Completed Recommendations Position Following Return

Audit Type	ABUHB Ref No:	Report Title	Assurance Rating	Director	Responsible Officer	Priority	Recommen-dation No.	Recommendation	Management Response	Deadline Agreed in Final Report	Months passed Agreed Deadline	Proposed Revised Deadline	Months passed Revised Deadline	Date Revised Deadline was approved by ARAC Comittee	Final Report Deadline Status	Revised Deadline Status	If closed and not complete please provide justification and ensure evidence is available	Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implemention?	What evidence is available to close down the recommendation?	Reporting Date
External	2017.01EA	Structured Assessment 2017	Not Rated	Chief Executive	Assistant Director of Comms and Engagement	High	R7	R7 The Health Board should review, refresh and update the Engagement Strategy – 'Hearing and acting upon the voice of our staff and citizens'.	The Health Board will undertake a review and refresh its Citizen Engagement Strategy in line with the Clinical Futures Programme and IMTP. The Health Board will also continue to take forward its programme of staff engagement in line with the Clinical Futures Programme.	31/07/2018	-61.87	29/09/2023	-0.03	06/10/2022	Completed /Closed	Completed /Closed		The Board agreed the Engagement Strategy at it's meeting in September. This has been shared via AB Pulse and uploaded to the Policy page on ABPulse.				30/09/2023
External	2021.04EA	Agile Delivery	Not Rated	Director of Workforce & OD	N/A	N/A	R6	R6 NHS bodies should seek to build on existing local and national workforce engagement arrangements to ensure staff have continued opportunities to highlight their needs and share their views, particularly on issues relating to recovering, restarting, and resetting services. NHS bodies should ensure these arrangements support meaningful engagement with underrepresented staff groups, such as ethnic minority staff.	The Health Board has initiated an innovative 12-month engagement programme called "#PeopleFirst, #CymruACymreFin, reconnecting our workforce". The origins are within the values of the Health Board and is a collaborative programme delivered by Wellbeing, OD and the Executive Board. The programme aims to re-connect staff to each other, to managers and senior leaders to empower them to raise and solve local problems locally, raise concerns to a higher level and offer the experience of feeling heard. As of December 2021, the project team have run 6 hospital site-based events, interacted with over 50 staff who have raised over 90 issues which we are working on. The project continues into the new year with cross-executive support.	31/12/2022	-8.95				Completed /Closed			June 2023: 1) As a quality assurance measure, an EQIA Group has been established to monitor EQIAs. 2) Screening tool has been developed and is being implemented	Resources and capacity	New EQIA template and evidence from working group	12.10.23 The People First Programme has been successfully implemented. The Executive Team has agreed that the actions to address the recommendation have been completed and therefore can confidently approve completion.	30/09/2023
External	2021.06EA	Quality Governance Review	Not Rated	Director of Therapies and Health Science	N/A	N/A	R1	R1 Divisional risks are presented to Quality and Patient Safety Operational Group, but there was limited evidence of in-depth analysis and discussion. There is also limited evidence that the General Surgery directorate maintain risk registers that adequately identify quality and safety risks and mitigating actions. The Health Board should: ensure there is appropriatescrutiny, challenge, cross divisional discussion and sharing of good practice around divisional risks at the Quality and Patient Safety Operational Group. ensure that risk registers arecompleted and maintainedacross all directorates thatidentify quality and safety risksand mitigating actions andthere are appropriate riskescalation arrangements.	The form and functionof Quality Patient Safety Operational Group is currently being reviewed, with the aim of strengthening oversight of Risk. ABUHB are in the process of introducing the OFWCMS with the Risk module part of a future phase of roll-out. This will be a driver for improving Divisional ownership of risk management and mitigation. A programme of Divisional awareness raising will be introduced across ABUHB to strengthen risk management processes.The responsibility of Divisional Directors will be reinforced in terms of maintaining registers and ensuring appropriate mitigation.	31/10/2022	-10.95	28/09/2023	-0.07	18/04/2023	Completed /Closed	Completed /Closed		Nov 23 - With the implementation of the Quality Strategy, the QPSOG's role and function have been reviewed and refreshed. The group is being repurposed as a QPS learning committee, which will provide a forum for deep dive reviews of QPS-related risks reported by Directorates and Divisions. The updated Risk Management and Assurance Framework (formerly the Risk Management Strategy), as well as the addition of a Risk Management Policy and Standard Operating Procedure, which is currently going through the governance process, clearly articulates the reporting hierarchy and risk escalation through the organisation. Risk will be reported through assurance meetings e.g., Local, Directorate, Divisional, Executive, and Board with escalation thresholds to ensure the risk is managed at the appropriate level. Reporting and escalation process have been simplified to ensure a clear line of sight from 'Board to Ward', 'Ward to Board', and to only use specific forums for in-depth, expert	N/A	N/A	N/A	30/09/2023
External	2022.03EA	Structured Assessment 2022	Not Rated	Director of Corporate Governance	Head of Corporate Governance	N/A	R7	R7 The Health Board's deteriorating financial position and deterioration in savings deliver indicates that stronger accountability for financial performance and delivery is required. The Health Board, therefore, should review its Scheme of Delegation to ensure it more strongly outlines delegated accountability for the budgetary position and achievement of financial efficiencies at and below executive levels.	The Health Board's existing accountability arrangements have been endorsed by the Audit, Risk & Assurance Committee and is aligned to Standing Orders and Standing Financial Instructions. The Executive Team has commenced work with the organisation's senior leadership team to further embed a culture of empowerment, autonomy, authority and accountability, building on existing arrangements in place. This Framework will cover all aspects of the organisation's business (not just a focus on finance) and will be presented to the Board for consideration in March 2023. Upon approval, further work will be required to support the embedding of the	29/09/2023	-0.03				Completed /Closed			November 2023: The perfromance and accountability framework was approved by the board at its september meeting. Approval of Framework 30 April 2023:Embedding of the Framework will be ongoing				30/09/2023
External	2020.01EA	Efficiency Savings Arrangements	Not Rated	Director of Finance and Procurement	N/A	N/A	R1	Re-visit efficiency plans to reassess their realistic cash releasing potential as soon as practically possible. Plans should be re-prioritised according to the cash releasing potential.	The Board has established additional Board and executive level financial recovery arrangements including a continuous focus on the identification of areas that can reduce costs.This will be invigorated through theIMTPprocess to further progress general efficiency, cost avoidance and cost reduction opportunities to support an improvement to the recurrent financial position of the Health Board.The Board will consider how focus is given to higher benefit schemes going forward.	31/03/2023	-6.00				Completed /Closed						IMTP Process and Savings plans included as part of financial plan for 2023/24	30/09/2023
External	2020.01EA	Efficiency Savings Arrangements	Not Rated	Director of Finance and Procurement	N/A	N/A	R2	By the end of January 2023, the Health Board shold esnure earlier preperation of deployment/sevice level savings to deliver IMTPs key efficiency programmes. Ideally the savings planning approach should be continuous going forward to prevent any hiatus at the eginning of the financial year.	To provide durther detail to the response to R1 above. The Executive team hold a monthly dinincial recovery board to identify and monitor saving delivery and includes a continuous focus on the ientification of areas that an reduce costs. The continuious identification of savings schemes are part of the action plan of BUHB finiacial recovery plan, engaging divisional teams and workforce throughout ABUHB as well as executive leads.	31/03/2023	-6.00				Completed /Closed						Strengthened Board financial recovery arrangements established - see Board reports	30/09/2023
External	2020.01EA	Efficiency Savings Arrangements	Not Rated	Director of Finance and Procurement	N/A	N/A	R3	By the end of January 2023, ensure comprehensive and effecte operational service engagement with the team preparing the compendium so that the opportunities identified within the compendium can be deliverable saving schemes.	The finance team has engaged with the Board, Sub-committees, Executive team, transformation progrmmes, divisional teams and corporate teams as part of its usual workplan to spread the opportunities for efficiency improvement throughout the organisation.The expected delivery of savings through the transformation programmes & divisions has not been achieved during 2022/23 due to operational pressures.As a result, it is accepted that more engagement work is required to gain service ownership to progress the opportunities for efficiency	31/03/2023	-6.00				Completed /Closed						Compendium and efficiency opportunities shared as part of a continuous process	30/09/2023
External	2020.01EA	Efficiency Savings Arrangements	Not Rated	Director of Strategy, Planning & Partnerships	N/A	N/A	R4	By February 2023, align the efficiencies and savings expected in the IMTP improvement programmes with other transformation work programmes utilising the key enablers including the Programme Management Office, the Value Based Healthcare Team, the Clinical Futures team and wider research and development.	The plan for 2022/23 aimed to progress service and financial sustainability & deliver efficiency through transformation. This would be enabled by the PMO structure with multi professional teams working with service teams across pathways to deliver improvement, this is more inclusive than the teams quoted.Due to operational pressures the progress has not delivered the expected results during 2022/23 but will be revisited to consider application for 23/24 as part of the IMTP review.	31/03/2023	-6.00				Completed /Closed						November 2023: The Annual Plan Process and Plan has aligned Planning, Workforce and Finance with joint workplan, messaging and timelines. The Clinical Futures Programme Board and reporting processes' have been reviewed and updated with a new value and sustainability Board commencing in September 23. The Advisory Board process over the summer prioritised the scheme that would be the focus in the short to medium term.	30/09/2023
External	2020.01EA	Efficiency Savings Arrangements	Not Rated	Director of Finance and Procurement	N/A	N/A	R5	By February 2023, strengthen scrutiny of savings plans which are risk assessed as amber or (in future) red risk rated plans. In addition:Ensure that financial savings targets and timescales are agreed and regularly updated. strengthen the effectiveness of management intervention where efficiency plans are off trac	Savings plans are developed with scrutiny through the Executive team, they are risk assessed, updated regularly,and reported formally on a monthly basis to the Exec team, WG and Board.Chief executive Officerit is recognised there is a need to reconsider & develop a new approach to Savings agreement and ownership and management intervention, this will be developed as part of the revised governance approach for ABUHB, through the financial recovery plan actions.	31/03/2023	-6.00				Completed /Closed						Revised approach to Savings reporting and accountability established through financial reporting and recovery arrangements, inlcuding ABUHB Value & Sustainability Board	30/09/2023
External	2020.01EA	Efficiency Savings Arrangements	Not Rated	Director of Finance and Procurement	N/A	N/A	R6	Update the year-end financial forecast position more regularly based on the changing level of risk to the finances, as well as the year to-date financial position.	Financial forecasts and risks are identified, reviewed, updated on an ongoing basis with formal reporting on an established monthly cycle.2022/23 remains a very volatile and uncertain year and while the forecast did not formally change until mid-year, the risk analysis was updated monthly & reflected the risk appetite of the Board.This process will continue as good practice going forward.	31/03/2023	-6.00				Completed /Closed						already in place as part of monthly financial review and reporting	30/09/2023
External	2020.01EA	Efficiency Savings Arrangements	Not Rated	Chief Executive	Director of Finance and Procurement	N/A	R7	By March 2023, ensure there is clarity of operational financial risk sharing (for example where operational directorate responsibilities for delivering savings and IMTP programme responsibilities for delivery of efficiencies overlap).	The approach to savings responsibility and accountability will be revisited and established as part of the financial recovery process and IMTP development.	31/03/2023	-6.00				Completed /Closed						IMTP process to develop agreed budget and savings plans aligned with service plans. Delegation letyers are now explicitly identifying, budgets and the performance respnsibilities explicitly.	30/09/2023
External	2020.01EA	Efficiency Savings Arrangements	Not Rated	Director of Finance and Procurement	N/A	N/A	R8	By March 2023, strengthen the use of visual management tools including service transformation trackers, saving trackers and linked risk trackers for all programmes. This performance information needs to be communicated to	The approach to more visual savings reporting will be alignedwith the response to R7 above and established as part of the financial recovery process and IMTP development.	31/03/2023	-6.00				Completed /Closed						New ABUHB Performance framework includes Financialescalation arrangements.	30/09/2023
External	2020.01EA	Efficiency Savings Arrangements	Not Rated	Chief Executive	Director of Finance and Procurement	N/A	R9	By the end of January 2023, implement stronger approaches for monitoring the deployment/delivery of savings to better understand where service improvements are and aren't delivering the necessary efficiency and financial improvement. As part of this ensure there is timely and effective corrective action.	It is recognised there is a need to reconsider & develop a new approach to Savings agreement and ownership and management intervention, this will be developed as part of the revised governance approach for ABUHB, through the financial recovery plan actions.	31/03/2023	-6.00				Completed /Closed						New ABUHB Performance framework includes Financialescalation arrangements.	30/09/2023

Appendix 10) Not Yet Due Recommendations

Audit Type	ABUHB Ref No:	Report Title	Assurance Rating	Director	Responsible Officer	Priority	Recommen-dation No.	Recommendation	Management Response	Deadline Agreed in Final Report	Months passed Agreed Deadline	Proposed Revised Deadline	Months passed Revised Deadline	Date Revised Deadline was approved by ARAC Comittee	Final Report Deadline Status	Revised Deadline Status	If closed and not complete please provide justification and ensure evidence is available	Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	What evidence is available to close down the recommendation?	Reporting Date
Internal	2017.00	Health and Safety (2017/18)	Limited	Director of Therapies and Health Science	Head of Health and Safety	High	R1	R1 The Health Board should develop a methodology / approach for establishing and undertaking an annual programme of workplace inspections. In particular, it should set out: How service areas / wards are selected for an inspection, including risk analysis, previous findings, incidents and Datix reporting; the approach to the inspection, including which health and safety areas are included. For example, there may be numerous priorities from one year to the next; methodology for undertaking the inspection, i.e. the process for completing one from start to finish; how assurance is provided to the sub-committees of the Board over how the programme of work is devised and that it is completed on schedule or otherwise; and findings from the workplace inspections are identified and acted upon.In addition, the Health Board should ensure that a programme of workplace inspections is developed and delivered in accordance with section 10.1 of the Occupational Health and Safety Policy. For example, the Health and Safety Committee may stipulate that all high risk areas are reviewed each year. Furthermore, if the programme is delivered late, then the Committee should receive assurances, together with an action plan for delivery to be returned to schedule.	An ABUHB health and safety monitoringmanual will be developed. This will include a two year plan which outlines the audit/inspection delivery programme.The manual, including programme willbe presented at the ABUHB Health and Safety Committee in March 2018 for approval. The anticipated start date of the monitoring is 1stApril 2018.Future monitoring of the health and safety audit/inspection compliance will be presented via Divisional dashboards with an overview being presented at the ABUHB Healthand Safety Committee.	30/04/2018	-64.89	31/03/2024	6.00	12/09/2023	Overdue	Not Yet Due		**March 2023** - A programme of respiratory protection equipment (RPE) inspections has been developed and commenced in October 2022. The plan to inspect all in-patient clinical areas by March 2023 is approximately 95% complete. The inspections conducted by the Corporate Health and Safety Department are recorded via the AMaT system enabling the outcomes to be analysed & reported to relevant forums i.e. Divisional QPS meetings, Site Management groups, ABUHB Health and Safety Committee, QPS Operational Group etc. A programme of health and safety environmental inspections will commence in May 2023 and will target clinical areas. The programme will be carried out over a two-year cycle, commencing with the older estate or those that have been subject to significant change i.e. Royal Gwent Hospital and Nevill Hall Hospital. The inspections will be conducted by the Corporate Health and Safety Department and recorded via the AMaT system enabling the outcomes to be analysed & reported to relevant forums i.e. Divisional QPS meetings, Site Management groups, ABUHB Health and Safety Committee, QPS Operational Group etc. The Corporate Health and Safety Department are also planning the development of self-assessment inspection tools for wards and departments to complete their own localised health and safety monitoring. This will support a programme of health and safety monitoring across the Health Board.	There are no identified barriers to implementing the revitalised plan of health and safety monitoring. Resources that were not previously available within the Corporate Health and Safety Department have now been established to ensure a sustainable system of monitoring.	The risk will reduce as the programme of health and safety monitoring is implemented.	August 2023: Notes of the Health and Safety Committee Inspection reports via AMaT	30/09/2023
Internal	2017.00	Health and Safety (2017/18)	Limited	Director of Therapies and Health Science	Head of Health and Safety	High	R2	R2 The Health Board should ensure that each area has completed an up-to-date health and safety risk assessment, by a trained co-ordinator. The risk assessment process should be overseen by the Health and Safety team, to ensure that it is completed in accordance with the Occupational Health and Safety Policy.In addition, the Health Board should review and refresh the list of safety co-ordinators and continue to do so following the initial update.The Health and Safety team should provide assurance and regular updates to the Health and Safety Committee over the status of risk assessments.	The monitoring of local risk management systems, including risk assessments will be included in the audit/inspection programme.The status of risk assessments will be reviewed and compliance reported via a dashboard to the ABUHB Health and Safety Committee and relevant Divisional forums.Further consideration is required to the utilisation of software to record and manage risk within the Health Board.	30/04/2018	-64.89	31/03/2024	6.00	12/09/2023	Overdue	Not Yet Due		**March 2023** - The Corporate Health and Safety Department have engaged with Divisions to ensure risks are recorded, monitoring and managed using the Datix system. This has improved the quality of health and safety risks on the system. The Corporate Health and Safety Department are reviewing all high risks (risk rating of 12 or above) recorded on the Datix system and where necessary support local managers to mitigate the risk. The programme of health and safety environmental inspections will support the identification and review of health and safety risks across the Health Board. Health and safety risks will be regularly reported to the ABUHB Health and Safety Committee to enable active monitoring. A revitalised education programme of health and safety risk assessment training has been approved and commenced in 2023. The register of risk assessors within the organisation has been reviewed and areas needing support will be prioritised for attendance at the risk assessment training.	The primary barrier to implementation would be lack of engagement from the areas / Divisions. Implementation of the new risk module in Datix Cymru could present a potential barrier.	The risk associated with the lack of health and safety risks will be reduced as areas engage with the risk assessment training and complete or update risks on the Datix system.	August 2023: Notes of the Health and Safety Committee Risk Assessment Training	30/09/2023
Internal	2017.00	Medical Equipment and Devices (2017/18)	Limited	Director of Therapies and Health Science	N/A	High	R2	R2 A clear robust control mechanism should be established by the divisions / directorates demonstrating the consideration and delivering of applicable training,aligned to medical equipment and devices. Training records should also be uploaded onto ESR.The poor mandatory training compliance rates with regard to infusion devices / pumps should be addressed as a matter of urgency.	From a Divisional perspective, the cascade training provided at ward level has not raised any particular safety issues, although with the increasing use of bank and agency staff, consideration should be given to accessible on site training for these members of staff. The Health Board to consider establishing a catalogue of equipment that needs specific training to operate, alongside a database of staff compliance.	31/03/2018	-65.87	30/04/2024	6.98	12/09/2023	Overdue	Not Yet Due		**November 2022** - An infusion device training strategy was presented to the April Medical Devices Committee. A training implementation plan is now under development to support the roll out of a more resilient process in line with the strategy. This aims to assure that training provision can match the need associated with both attaining and maintaining compliance levels at or above the standard. Unfortunately due to staff sickness absence, further development work has not been fully realised. • Recruitment to now vacant QPS Infusion Device Service Training Manager post is in progress. • An exercise has been started to consolidate the training records for infusion devices and provide a compliance dashboard. Piloting this will inform a plan to capture monitoring of training compliance for other groups of medical equipment.	Complex absence management factors in relation to the QPS Infusion Device Service Training Manager post have affected progress in designing and implementing the new infusion device training strategy. Input from the Clinical Practice Educators teams has maintained and increased training activity but at the expense of fragmenting the training records. Joining the records into one data bank and migrating this over to ESR will resolve this but will require time to work through. Using this solution generically across the other groups of equipment across the Health Board would expediate compliance with this Audit Recommendation. An evidenced case is required for matching the staffing associated with maintaining the training compliance levels to the standard.	This risk is currently being partially mitigated by providing ad hoc training sessions in a seminar room in OSU to ensure new starter training for end users is being delivered as able. Fresenius reps helping with staff updates as able prior to finishing in post. Cascade sessions delivered to paediatric nurses as able, to enable them to support with delivery of paeds updates. Need for fixed infusion device training base escalated and venue being sought.	New QPS Infusion Device Service Training Manager now in post. Consolidation of the infusion device training records aim to be achieved by end of Sept 23 Development of a dashboard to indicate compliance levels aim to be achieved by December 2023. Piloting migrating the infusion device training records to HealthRoster/ESR dependant on outside agencies.	30/09/2023
Internal	2021.00	Gifts, Hospitality and Declarations of Interest	Reasonable	Director of Corporate Governance	Board Secretary	Medium	R1	R1 The Health Board should add an additional section to the declaration of interests form detailing any additional action required to mitigate risk. These measures should be implementedand monitoredby the individual's line manager.b.The Policy and accompanying processes should be updated to support the changes required to mitigate the risk.	a.As identified, whilst there is adherence to the policy, the recommendation provides an opportunity to improve the mechanismswithin departments. To facilitate this the Health Boards ESR will be reviewed to determine how declarations can be digitally captured toenable improved conflictmonitoring and management.Where ESR may not be used (e.g. by Independent Members) then the manual form will be updated to reflect the recommended improvements. b.The policy and process documents will be updated to reflect the amendments.	31/10/2021	-22.92	31/03/2024	6.00	12/09/2023	Overdue	Not Yet Due		Arrangements for the declaring of interests, gifts and hospitality Included as a governance priority within the IMTP 2022-25 August 2023: Due to gaps within the corporate governance team this work has been delayed. Recruitment has recently taken place with posts expected to be filled by November 2023. This work should therefore be completed in Q4, 2023/24.				30/09/2023
Internal	2021.00	Gifts, Hospitality and Declarations of Interest	Reasonable	Director of Corporate Governance	Board Secretary	Medium	R2	R2 The procedures for receiving and processing declarations made should be formalised and include:i.the use of a shared mailbox for all declarations;ii.details of the process for receiving and processing declarationsand the associatedtimescales;iii.details of due diligence to be undertaken on completed declarations;iv.timeframes for reminders to be issued in the event where previous declarations have been submitted; andv.details of any completeness checks to be undertaken to determine if there are missingdeclarations.	To facilitate all recommendationsthe Health Boards ESR will be reviewed to determine how declarations can be digitally captured and enabled toimprove receipt and management. This will facilitate improved recording across the organisation, allow automated reminders, and provide reports to Divisional managers for completion and adherence checks and missing declarations.In addition, where ESR may not be used (e.g. by Independent Members) then the manual form will be updated to reflect the recommended improvements.	31/10/2021	-22.92	31/03/2024	6.00	12/09/2023	Overdue	Not Yet Due		Arrangements for the declaring of interests, gifts and hospitality Included as a governance priority within the IMTP 2022-25 August 2023: Due to gaps within the corporate governance team this work has been delayed. Recruitment has recently taken place with posts expected to be filled by November 2023. This work should therefore be completed in Q4, 2023/24.				30/09/2023
Internal	2021.07	Occupational Health	Substantial	Director of Workforce & OD	Director of Workforce & OD	Low	R1	The Health Board should consider:a)Automating key aspects of the processes, to reduce the workload for the Occupational Health Team. For example, auto-generation of emails / letters for referrals, self-selection of referral appointmentsby staff or a self-directed referral to an appropriate professional.b)Updating resilience / continuity plans to assist with increased demand in the future, to include reallocation of team members, setting up amended work schedules, reduced appointment slots, allocation of clerical staff to clinical staff to maximise clinic availability, overtimeoptions, re-focussing of service prioritiesand / or streamlining of processes to a bare minimumon a temporary basisetc.c)Engaging in any future All-Wales reviews of occupational health serviceswithin the NHS.	a.It is planned that the current management referral process will move from paper referral and Occupational Health response in letter format to an online referral system and subsequent report to managers in 2022. The service is currently part of an All Wales task and finish group developing this. Once implemented it should remove several administration stages of the current process. The recommendation for staff to be able to self–select would miss out the essential clinical triage process to allocate Occupational Health clinical staff resources appropriately. b.Occupational Health consistently review its skill mix and resources to meet the demands of the service. Through periods of higher administration demand for example Covid 19 PCR results and the annual Flu programme additional administrative hours are sourced. This reduces any impact on routine Occupational Health function. A detailed service review is planned for Quarter 2 in 2022 which will incorporate the recommendation of the Occupational Therapy scoping exercise which commenced on the 1st November and is planned to conclude on March 31st2022. Health function. A detailed service review is planned for Quarter 2 in 2022 which will incorporate the recommendation of the Occupational Therapy scoping exercise which commenced on the 1st November and is planned to conclude on March 31st 2022.	31/03/2022	-17.97	06/10/2023	0.20	12/09/2023	Overdue	Not Yet Due		Aug 2023: A new automated system OPASG2 is coming in on 20th September which will bring the following benefits in addition we are engaging with all Wales review and systems procurement. Applicants complete an online pre-employment health declaration – removal of paper forms! Integrated functionality between OPASG2 and the Trac recruitment system. Therefore, OH results update the applicant record directly in Trac. Transparency of applicant progress with timely updates visible in Trac such as an OH appointment booking. Reduced waiting times for Occupational Health Clearances	Aug 2023: Lessons learned from early implementers (Swansea)any any further potential dealys on an all Wales basis. Sep 2022 Awaiting decision regarding the new All Wales Occupational Health database. This has been put on hold until Spring 2023 . With regards OT implementation awaiting expressions of interest	Aug 2023: Executive team. Comprehensive training package Ongoing review of skill mix and resources to meet the deamands of the service .	Aug 2023: September/October 2023 for full implementation following procurement and implementation of the new data base.Ongoing evaluation of OT provision. Request extension to September/October 23. Autumn 2023 for full implementation following procurement and implementation of the new data base.	30/09/2023
Internal	2021.17	Corporate Governance: BAF	Reasonable	Director of Corporate Governance	Head of Risk	Medium	R4	R4. We recommend that the Health Boarddevelops a periodic report commenting on compliance/ the effectiveness of the BAFprocessand reports this to an appropriate committee.	The Health Board accepts this recommendation and will incorporate a review of the effectiveness of the BAF into Board evaluation and committee self assessment processes.	31/07/2022	-13.97	31/03/2024	6.00	12/09/2023	Overdue	Not Yet Due		August 2023: Risk Management Stratgey and Board Assurance Framework processes under review. Revised strategy due to Board in Q4, 2023/24.				30/09/2023
Internal	2021.20	Medicines Managment	Reasonable	Medical Director	Head of Pharmacy - Operational Services/Principal Technician, Pharmacy Technical Services	Medium	R2	R2.1 Management should review the Policy for the Management of Controlled Drugs and update where required.	The CD Policy is due for review during 2022/23. As in previous reviews a working group with representatives from Pharmacy and nursing will be set up to update the policy. A number of sections and standard operating procedures will be updated to make the policy more relevant and practical. This will support compliance with the policy. Controlled drug keys being held on their own may have been best practice. However, this may not be convenient on the wards. This could be removed in the updated version.The use of red pen on the wards is to make stock checks morevisible. The practicality of this will be reviewed.Keeping patients own CDs on a separate shelf may not always be possible. However, they should be clearly differentiated from ward stock.The policy will also include a description of the audit framework that will provide assurance the policy is being followed.	31/03/2023	-6.00	31/12/2023	3.02		Overdue	Not Yet Due		Update Aug 2023: The review date of the current policy is November 2023. Progress to review and update it was delayed to ensure compliance with the Welsh Government notification to ensure HB compliance with new Home Office licensing requirements for the Management of Controlled Drugs (this was issued late February 2023). Priority was given to the clinical areas where these licenses are required and to support the application process (ABSDAS services and community dental clinics). The new Home Office licensing arrangements will be included in the Management of Controlled Drugs Policy. The requirements within the Controlled Drugs Policy review identified several aspects that needed to be updated to reflect the changes in working practices. The revised operational procedures are being implemented prior to introduction of the new policy and are expected to be completed by the end August 2023. A revised Management of Controlled Drugs Policy has been drafted and is being reviewed across the Divisions and will provided to the Clinical Standards and	Delay due to HMRC licencing requirements		ABUHB_Clinical_0552 Management of Controlled Drugs Policy_Issue 6	30/09/2023
Internal	2021.24	Flow Centre	Reasonable	Chief Operating Officer	Flow Centre Nurse	Low	R3	R3 The Flow Centre Team should develop key performance indicators to help improve the delivery of the service, manage key risks and to help develop staff.	With recent changes in clinical and operational leadership of the Flow Centre a focus will be on creating these key performance indicators (KPI) and stabilising the services as we recover from the impact of COVID. Create operational KPI for Pre-Hospital Screening. Create clinical KPI for Intersite transfer service. Review the clinical and operational model of the Flow Centre.	30/09/2022	-11.97	31/12/2023	3.02	12/09/2023	Overdue	Not Yet Due		Mar 23•Some KPIs have been created, reviewed each week at SLR and will form the basis of the Flow Centre Review currently taking place	Mar 23 Review being undertaken currently			30/09/2023
Internal	2021.24	Flow Centre	Reasonable	Chief Operating Officer	Service Manager (USC)	Medium	R4	R4.1 We recommend that the Flow Centre Team review and update the business continuity plan, where required.	The business continuity plan is being reviewed and updated currently.	30/06/2022	-14.98	31/12/2023	3.02	12/09/2023	Overdue	Not Yet Due		Aug 2023: In light of recent BC events we will review update and test this accordingly Mar 23 •The BCP has been created/updated and is due for a further review in light of recent IT risks and the joining of the Urgent Care Division	Mar 23 recent Divisional changes have meant that the BCP now requires further refinement however, orginal recommendation was implemented.			30/09/2023
Internal	2021.24	Flow Centre	Reasonable	Chief Operating Officer	Service Manager (USC)	Low	R4	R4.2 We recommend that the Flow Centre Team periodically test their business continuity plan and update it with learnings from the exercise(s).	A planned test of the business continuity plan will be initiated by the target date. An unplanned test of the business continuity plan will be initiated by the target date	30/10/2022	-10.98	31/12/2023	3.02	12/09/2023	Overdue	Not Yet Due		Aug 2023: In light of recent BC events we will review update and test this accordingly Mar 23 •This is on hold until we return to our call centre.				30/09/2023
Internal	2022.01	CYP Continuing Care	Reasonable	Chief Operating Officer	General Manager	High	R1	CloseHealth Board monitoring ofthe key risks facing the CCNS to ensure:•appropriate action continues to be taken; and•support is provided to the CCNS as required	1)Engagement with families and staff in a review of service models –utilising co-production and with a compassionate leadership lens explore options of "out of family home" models of care, which may meet needs of child/young person more effectively, optimise management of scarce resources and support retention of staff.2)Workforce review to identify skill mixedworkforcersource required to deliver safe service across the various linesof commissioned service e.g.Continuing Care, Special Schools, Children's Out Patients, Clinical/Care closer to home3)Business Case/Service Review to establish options of further efficiency and priority with theidentification ofdiscrete financialbudgetlinesto meet assessed and agreed service priorities4)Developing new roles/skill mix within the Children's Community Nursing Service to enhance service provision5)Partnership Board/Welsh Governmentrecommendation required to determine the prudent delivery of care described as ancillary and incidental care needs, and multi-agency responsibilities initsdelivery.This will aid the alignment of Value-Basedhealth care and Value-Based social care	31/03/2023	-6.00	31/12/2023	3.02	12/09/2023	Overdue	Not Yet Due		Aug 2023: Awaiting sign off of Bridgeview before we can engage with our families to explore out of home model of care. 2. Workforce review completed and skill mixed model identified. Awaiting sign off of Band 4 before implementation. 3. Business case submitted detailing risks of service reduction in each area. New financial envelope was estimated from a period of high vacancies, high sickness and complaints from families due to a reduction in their statutory respite. 4. Currently no scope to develop new or additional roles within the CCNS due to financial constraints, however skills mix model has been developed through the workforce work to enhance the skills and allow a "grown our own" model for sustainability in the future of the service. 5. Ongoing discussions due to social care and health interperating the recommendations differently.	Aug 2023: Bridge view sign off. Agreement and sign off of Band 4 Senior Health Care Support Workers. Differing interperation of goevernmenet recommendations from health and social care			30/09/2023
Internal	2022.04	Agile Delivery	Not Rated	Director of Workforce & OD	N/A	High	R1	An overarching agile working plan should be developed. It should include:•An overarching vision (this could be taken from the already published Agile Working Framework).•A set of SMART goals/ milestonesto achieve this vision.•A list of Welsh Government targets which need to be achieved.•All relevant services areas should be included and engaged with.A benefits listshould be developedto sit alongside the planwhich details how the Health Board will measure its success against each of the goals. The listshould include quantifiable measurements which can be analysed to confirm the success of each goal.	Agreed, the overarching HBand WG visionwill be added to the developed Programme Plan. Overarching SMART goals will be articulated with more specific goals once the assessment and review of the estates has been undertaken.	30/11/2022	-9.97	30/11/2023	2.00	12/09/2023	Overdue	Not Yet Due		AUG 2023: An agile/vision has been drafted and presented to the Executive team in June 23. This has been further updated to reflect options around roll out and alignment with an Estate Strategy. This will be presented to the Executive Team in September 23. The originally proposed estate agile asssessments continue to be undertaken until agreement of vision and options. Nov 2022 Plan - will reconfirm the vision and SMART objectives in programme delivery board December 2022, then taken forward to executive Committee and board for final endorsement	aug 2023: Estates review, accomdation group, ICT infrastructure, service change, impact of cost of living crisis on staff, capital availibility, financial review 22: Estates review, accomdation group, ICT infrastructure, service change, impact of cost of living crisis on staff, capital availibility, financial review	Aug 2023: Executive team 22: regular review through agile delivery programme board also the cost of living risk and estates risk is highlighted on the CRR	Request extension to November 23	30/09/2023
Internal	2022.04	Agile Delivery	Not Rated	Director of Workforce & OD	N/A	Low	R2	Confirm with the Executive Team that the agile working principles noted within the Agile WorkingFrameworkstill represent the current vision. If amendments are required, the Framework should be updated.	An agreed vision for agile working had been agreed by the Executive Team previously and had developed over the response to the COVID pandemic. There are agreed priorities in place for implementing this vision. However, to work beyond the agreed priorities and to embed agile working strategically into Health Board plans it is agreed that this is a good time to re-new the vision.	30/11/2022	-9.97	30/11/2023	2.00	12/09/2023	Overdue	Not Yet Due		AUG 2023: An agile/vision has been drafted and presented to the Executive team in June 23. This has been further updated to reflect options around roll out and alignment with an Estate Strategy. This will be presented to the Executive Team in September 23. The originally proposed estate agile asssessments continue to be undertaken until agreement of vision and options. Mar 23 Proposed agile vision presented to the Executive Committee on 09 February. Drivers and enablers were presented as well and hybrid working and setting up a network of hubs to facilitate the reduction in personal office/desk space.	Aug 2023: Redesigning vision following presentation and feedback from the Executive Committee and will progress this to Board 22: Redesigning vision following presentation and feedback from the Executive Committee and will progress this to Board	Executive team	Request extension to November 23	30/09/2023

Internal	2022.06	Decarbonisation - Advisory	Not Rated	Director of Finance and Procurement	Workforce & Organisational Development Business Partner Accountant Interim Facilities General	N/A	R1	Appropriate strategies should be developed to ensure that recruitment and retention issues experienced to date do not impact significantly on the achievement of the DAPs.	Agree. We shall continue to review the roles required to implement the DAP objectives and ensure effective succession planning is in place.Directly relating to Initiative 9 – Facilities Division has recently appointed a dedicated Building Management System (BMS) Officer (due in post Jan23).Through an Academy Wales graduate developmentprogramme we shall be utilising a student placement to assist with decarbonisation metrics, reporting and engagement starting in 23/24.	01/11/2023	1.05				Not yet due							30/09/2023
Internal	2022.06	Decarbonisation - Advisory	Not Rated	Director of Finance and Procurement	Decarbonisation Programme Board (DPB) Workstream Lead	N/A	R3	DAPs should be supported by funding strategies e.g. differentiating between local/ national funding, revenue or capital funding etc.	Agree. Projects developed through the DAP shall be funded appropriately – ReFit, HSC, EFAB, revenue, discretionary capital.	01/11/2023	1.05				Not yet due							30/09/2023
Internal	2022.06	Decarbonisation - Advisory	Not Rated	Director of Finance and Procurement	Asst. Director Finance & Finance & Resources Workstream Lead	N/A	R5	As a major contributor to the achievement of the targeted reductions appropriate engagement will be established with NWSSP Procurement Services (and formalised as appropriate).	Agree. The DPB have requested suitable NWSSP Proc Serv. Representation at meetings to update and provide guidance and feedback on progress.Within the programme governance arrangements we have identified fourtask and finish working groups who will link with our local procurement team. In addition we also have a financial representative leading group 4 who directly links in with health board Director of NWSSP National initiatives which are reported at the Bimonthly board meetings within the health board.	01/11/2023	1.05				Not yet due							30/09/2023
Internal	2022.06	Decarbonisation - Advisory	Not Rated	Director of Finance and Procurement	Decarbonisation Programme Board Workstream Lead&	N/A	R7	Where decarbonisation falls within the existing environmental remit of committees/ meetings, it is important that an appropriate profile is set. Terms of Reference and agendas should be reviewed to ensure that sufficient focus is provided.	Agree. The Decarbonisation Programme Board (DPB) within its structure has 4 subgroups each with national initiatives delegated to them. The DPB and subgroups each have ToR's and scheduled meeting frequencies.	01/11/2023	1.05				Not yet due							30/09/2023
Internal	2022.06	Decarbonisation - Advisory	Not Rated	Director of Finance and Procurement	DPB & Workstream Leads	N/A	R10	Given the scarcity of funding, it is important that bids for funding are appropriately considered prior to submission.	Agree. Funding submissions are suitably scrutinised by appropriate forums e.g. Pre-Investment Panel (PIP), Capital Programme Board or DPB.	01/11/2023	1.05				Not yet due							30/09/2023
Internal	2022.06	Decarbonisation - Advisory	Not Rated	Director of Finance and Procurement	Workstream Project Leads	N/A	R11	The same rigour and monitoring should be applied to internally commissioned/ funded initiatives to ensure the outcomes are adequately recorded/reported.	Agree. Projects shall be reported to the DPB with adequate metrics developed to measure carbon reduction potential. Such projects will also be reported to WG through the bi-annual qualitative reporting requirements.	01/11/2023	1.05				Not yet due							30/09/2023
Internal	2022.10	Newport HWB Centre	Reasonable	Chief Operating Officer	Divisional Director of Primary & Community Care	Medium	R2	R2 The role and responsibilities of the Primary Care & Community Estates Programme Board, in acting as the Project Board for major Primary Care projects, should be clearly defined in the Terms of Reference.	Agreed. The role of the Primary Care & Community Estates Programme Board, in acting as the Project Board will be defined and documented.	01/02/2023	-7.90	31/10/2023	1.02	12/09/2023	Overdue	Not Yet Due		Aug 2023: The PC Programme Board did not meet after April 2023. A new SRO has been identified and a separate PB has been arranged for 17th October	None	N/A	Updated PB Terms of Reference & Meeting papers	30/09/2023
Internal	2022.10	Newport HWB Centre	Reasonable	Chief Operating Officer	Divisional Director of Primary & Community Care	Medium	R3	R3 The Primary Care & Community Estates Programme Board should meet with the agreed frequency (6-weekly) as a minimum to ensure sufficiently regular oversight of the major projects within its remit.	Agreed	01/01/2023	-8.92	31/10/2023	1.02	12/09/2023	Overdue	Not Yet Due		Aug 2023: The PC Programme Board did not meet after April 2023. A new SRO has been identified and a separate PB has been arranged for 17th October	None	N/A	As above	30/09/2023
Internal	2022.10	Newport HWB Centre	Reasonable	Chief Operating Officer	Divisional Director of Primary & Community Care	Medium	R4	R4 The constitution and capacity of the Primary Care & Community Estates Programme Board to effectively execute the Project Board role for all the Primary Care projects within its remit should be reviewed and confirmed.	Agreed. The governance structure will be reviewed	01/02/2023	-7.90	31/10/2023	1.02	12/09/2023	Overdue	Not Yet Due		Aug 2023: The PC Programme Board did not meet after April 2023. A new SRO has been identified and a separate PB has been arranged for 17th October	None	N/A	As above	30/09/2023
Internal	2022.10	Newport HWB Centre	Reasonable	Chief Operating Officer	Capital Planning Team	Medium	R8	R8 A report should be tabled at the next Primary Care & Community Estates Programme Board meeting, presenting an update against each Gateway recommendation, and identifying any actions still outstanding.	Agreed	01/01/2023	-8.92	31/10/2023	1.02	12/09/2023	Overdue	Not Yet Due		Aug 2023: The Gateway Report was presented to a previous incarnation of the Project Board. It will be submitted again to the newly convened PB on 17th October. Remit of the Capital Planning Team	None	N/A	Papers and notes of newly convened PB	30/09/2023
Internal	2022.12	Records Managment	Limited	Director of Digital	DPO & Head of IG	Medium	R5	R5 The need for records management storage places should be regularly reviewed to ensure that sufficient spaces are available for record keeping purposes.	This issue is to be raised with the All Wales Medical Directors Forum as Caldicott Guardians. The Data Protection Officer will raise this at quarterly meetings with the Medical Director and agree an action plan.	31/12/2023	3.02				Not yet due							30/09/2023
Internal	2022.12	Records Managment	Limited	Director of Digital	DPO & Head of IG Interim ADI – Governance &	Medium	R13	R13 All records should be formally tracked to ensure that they are retrievable when they are needed.	a.) The Business case for DHR phase 3 is in development, this will include the scanning of paper records to be available to view in CWS/cCube Portal negating the need for tracking. b.) Future phases for community, District Nursing, children's services and therapies are being planned and expedited and tracking will be implemented.	31/12/2023	3.02				Not yet due							30/09/2023
Internal	2022.15	IT Strategy	Reasonable	Director of Digital	Chief Technology Officer	Low	R5	The skills development work should be formalised into a skills development plan	Agreed. The skills development plan is under development and apprenticeships are actively being explored with the support of Organisational Development colleagues. Informatics are now engaging with other Health Boards who report having commenced apprenticeship schemes.	01/12/2023	2.03				Not yet due							30/09/2023
Internal	2022.17	Risk Management	Reasonable	Director of Corporate Governance	Head of Risk & Assurance	Low	R2	The Health Board should clarify how Divisions will record risk in the meantime.	The Health Board is currently revising its Risk Management Policy which is expected to be presented for endorsement at the May 2023 Board meeting. Within the revised Strategy, refined guidance on capturing and recording of risks will be included.	01/05/2023	-4.98	31/03/2024	6.00	12/09/2023	Overdue	Not Yet Due						30/09/2023
Internal	2022.18	Monitoring Action Plans	Reasonable	Director of Therapies and Health Science	Head of Health and Safety	Medium	R1	A SOP for how to manage and respond to HSE reports should be created. It should include, but not limited to: • how HSE reports are distributed to responsible staff within the Health Board; • who has designated responsibility for coordinating responses to HSE reports; • the escalation process for issues identified as part of HSE inspections; • who/which committee has responsibility for monitoring actions raised as part of the HSE reports and the process for doing this; and • when assurance reports should be produced and which committee should review them	The Health Board agrees with this recommendation. An SOP on the management of HSE reports will be developed and presented to the ABUHB Health and Safety Committee in May 2023	01/05/2023	-4.98	31/10/2023	1.02	12/09/2023	Overdue	Not Yet Due		August 2023: The development of an SOP on the management of HSE reports is being discussed at a national level via the All Wales Health and Safety Management Group. Following discussion at the national meeting in September 2023 an SOP will be prepared and shared with members of the Health and Safety Committee to share across the Health Board.				30/09/2023
Internal	2022.18	Monitoring Action Plans	Reasonable	Director of Nursing	Assistant Director of Nursing (PT Safety)	Low	R2	Management should review the number of actions raised within the HIW reports and the number of actions noted within the reports sent to committees for accuracy. Management should ensure no actions have been missed from the HIW report	The Health Board agrees with this recommendation. An update to the SOP will be developed to ensure a Quality Assurance check is undertaken, confirming that all actions have been captured and referenced	01/05/2023	-4.98	31/10/2023	1.02	12/09/2023	Overdue	Not Yet Due		August 2023: SOP updated to include the undertaking of Quality Assurance checks. In process of moving all inspections onto AMAT. The system will automatically generate reports, to include number of actions identified. "				30/09/2023
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	Head of Patient Discharge	High	R1	The Discharge Policy is updated, approved and reissued, to be compliant with the All Wales policy, when issued.	The All Wales Discharge Policy is expected to be released imminently and will be intrinsic to the development of the new Health Board policy. We acknowledge that since the policy was published current practice has moved on so that the policy does not describe the working arrangements. A Task & Finish group will be established with cross divisional representation to redraft the policy and ensure the content reflects current and emerging practice once the new All Wales Policy has been made available. This work will be completed within three months of the introduction of the All-Wales Policy. In the meantime, and as noted above we will review the current Policy. We will report any ongoing risk and position to the QPSOG. The Health Board will ensure a process is in place for regular update and review of the new policy when		-1481.93				Not yet due							30/09/2023
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	Assistant Medical Director for Planning	Medium	R2	We recommend that Health Board management ensure that formal discharge planning training is provided to both clinical and administrative staff engaged in the pathway, including updates if the process is amended.	Within the Health Board, training for discharge planning is delivered across existing induction and education programmes: Newly qualified and overseas nurses have an introduction to discharge planning through the Journey of excellence programme. The Health Boards practice educators provide ongoing education & training on discharge planning for nursing staff. The Head of Discharge has been working with the Universities to introduce a discharge planning session into student nurse training, ensuring awareness of the fundamentals before starting in their first post. Training for medical staff is currently ward based. The Assistant Medical Director for Planning will be working with a task and finish group to standardise training. Therapy staff receive discharge training throughout their undergraduate training. Much of their work is dedicated to preparing patients for discharge to their home environment or through referral to the provisions of rehabilitation or other support. Local discharge planning arrangements are disseminated through the site and ward teams.	01/10/2023	0.03				Not yet due							30/09/2023
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	Director of Nursing	Medium	R2	We recommend that Health Board management ensure that formal discharge planning training is provided to both clinical and administrative staff engaged in the pathway, including updates if the process is amended.	The Health Board has a work programme for discharge to be overseen by the newly created Discharge Improvement Board, chaired by the Executive Director of Nursing. This will strategically co-ordinate the current workstreams and include oversight of the roll out of the 'optimising discharge framework' issued by the NHS delivery unit. All workstreams currently form part of the goals 5 & 6 for improving urgent care and this will now form part of the overarching discharge programme. Embedding the optimising discharge framework will be a key priority of the Discharge Improvement Board, with a launch event hosted by a number of Health Board Executives held in January 2023. Local training has already commenced with sessions delivered across the acute sites and with plans for roll out to the other hospital sites within the next 6 months. This will be supported by the national training programme to be delivered by the NHS delivery unit. The lack of procedural documentation will be addressed through the new discharge policy formation.	01/04/2024	6.03				Not yet due							30/09/2023
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	Medical Director/Assistant Medical Director for Planning/ Director of	High	R3	All patient discharges from the care of the Health Board are effectively controlled and evidenced by issuing a timely, completed discharge notification.	The Medical Director is aware that the timeliness of some discharge notifications needs to be improved. A letter was sent to all medical staff outlining their responsibilities in respect of timely discharge notifications in 2021. This is now being followed up by the Assistant Medical Director for Planning who will be leading a task & finish group to develop standardisation of approach. This work will aim to ensure that patients are able to leave hospital with their discharge summary / notification and ensure it will be sent electronically to the GP on the same day	01/04/2024	6.03				Not yet due							30/09/2023
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	Director of Nursing	High	R3	Where an expected, standard processes is assessed as not required, for example discharge meetings held to discuss needs and establishment of care packages, that the assessment and conclusion be evidenced.	The Health Board acknowledges that there is inconsistency in the documentation of MDT meetings. The introduction of the Welsh Nursing Care Record (WNCR) may provide an opportunity to capture the content of discharge meetings as a digital record which clinical and admin staff can access and will formally record the actions agreed. The Health Board's Chief Nurse for Information has been engaged in this process. In the interim, the Head of Discharge will work with ward staff to introduce a consistent approach to documentation and evidence in the notes. It should be acknowledged that discharge arrangements will vary considerably depending on the assessed requirements of the individual.	01/04/2024	6.03				Not yet due							30/09/2023
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	Assistant Medical Director for Planning	High	R3	A consistent discharge approach is adopted for all day care appointments and for inpatient transfers between Health Board sites	In respect of day care episodes of care, there are many diagnostic / treatment areas and specialities who have different methods of notifying both the GP and patient of the care episode. We acknowledge that this is not a standard approach with some departments combining the clinical details as the discharge summary. As part of the Task and Finish group, the Assistant Medical Director for planning will ensure that discharge notifications form part of the standardised approach. For inter-site transfers an SBAR is completed for every patient that outlines the patient's condition, diagnosis and any actions needed to be	01/04/2024	6.03				Not yet due							30/09/2023

Internal	2022.19	Discharge Planning	Limited	Director of Nursing	Director of Nursing	Medium	R4	A method for identifying delays during the discharges of 'simple' cases should be introduced, monitored and reported	Discharge delays can affect both simple and complex discharges and therefore emphasis should be improving the process for all patients. Length of stay data is available to explore the feasibility and the benefits of such an approach. The Health Board continually seeks to identify the factors that delayed discharge and this work forms part of the workstream for goal 5 of the Welsh Government '6 Goals for Urgent and Emergency Care' programme. As part of this programme, the Delivery Unit has recently released the 'optimal patient flow framework', and the Health Board will be embedding these principles as 'business as usual'. The framework will also feature in the new All Wales Discharge Policy, to include the introduction of the SAFER principles, D2RA and 'red & green days'. These concepts have the potential to reduce LOS and improve discharge planning, so will be embedded within our policy.	01/04/2024	6.03				Not yet due							30/09/2023
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	Director of Nursing	Medium	R5	Determining whether to make the use of the discharge checklist mandatory (including which aspects to include) or not and if so, the document should be consistently completed. Performance should be monitored until fully embedded.	Discharge checklists are used by most wards; however, we acknowledge there is an inconsistent approach in their use. The Welsh Nursing Care Record is currently being rolled out across the Health Board and may provide the opportunity to make the checklist part of the digital record as part of a standardised approach. In the interim, the use of checklists will be reviewed as part of the Discharge Improvement Board workstreams. The use of checklists will be further defined in the new discharge policy.	01/04/2024	6.03				Not yet due							30/09/2023
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	Director of Nursing	High	R6	We recommend that the Health Board ensure that the monitoring programme is reinstated and lessons learnt from reviewing each service areas are shared throughout	The Health Board acknowledges that the monitoring as set out in the policy has not taken place. When drafting the new discharge policy we will consider the most appropriate audit mechanism to ensure that compliance is monitored and reported. The lessons learnt will be reported through the new Discharge Improvement Board and through to the 6 Six Goals Programme Board. Reporting will also be provided to the Executive Committee and BOSCC		-1481.93				Not yet due							30/09/2023
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	Planning Director / Head of Performance	Medium	R7	We recommend that the Health Board continue to analyse the reasons behind re-admissions within a suitable period of time. Where themes and trends are identified that these are investigated further	The analysis of readmission rates is acknowledged as being problematic, as without clinical input at the time of readmission, our current systems are unable to differentiate between a readmission for a reason connected to a prior episode of care, or one that relates to a completely different clinical scenario. CHKS, which is the national benchmarking solution choice for Wales looks at the number of patients who have been readmitted regardless of specialty, consultant, diagnosis etc. This makes any analysis difficult to interpret or perhaps meaningless. The planning department is currently working with clinical teams to develop a number of meaningful measures to determine and understand readmission trends, and to identify where improvement is required. A number of data viewers have been developed and can provide 'bespoke' data by request. Moving forward, these measures will be included within the outcome measures and QPS insights. The Health Board has dedicated services to address frequent or 'high impact' service users that are working across Divisional Boundaries to provide alternative pathways. There is also a workstream focusing on patients at high risk of readmission supported by Lightfoot data and linked to goals 1 and 2 of the 6 Goals for Urgent & Emergency Care programme.	01/10/2023	0.03				Not yet due							30/09/2023
Internal	2022.20	Tredegar Health & Wellbeing Centre Final Internal Audit Report	Limited	Chief Operating Officer	Project Director	Medium	R4	Management should obtain signed lease agreements with relevant parties at the earliest opportunity	Agreed. The provision of signed lease is being actively addressed so that they are in place well before the planned occupation of the building.	01/06/2023	-3.97	31/10/2023	1.02	12/09/2023	Overdue	Not Yet Due		Aug 2023: NHS Shared Services continue to progess the leases for GMS, Dental and Pharmacy accommodation	None	N/A	Aug 2023: Agreed leases	30/09/2023
Internal	2022.20	Tredegar Health & Wellbeing Centre Final Internal Audit Report	Limited	Chief Operating Officer	Project Director	Low	R6	Quantified, measurable and achievable targets should be set to appraise project benefits.	The Benefits register will be updated to reflect quantified targets as at the end of March 2023.	01/06/2023	-3.97	31/10/2023	1.02	12/09/2023	Overdue	Not Yet Due		Aug 2023: This needs discussion at the newly constituted Project Board	None	N/A	Aug 2023: Updated BRP	30/09/2023
Internal	2022.21	Development of a Regional Radiotherapy Satellite Centre at NHH	Reasonable	Director of Strategy, Planning & Partnerships	Project Director	Medium	R5	At future projects Contracts should be executed prior to the commencement of works / duties.	Agreed -Future Projects Contracts will be signed prior to the commencement of works	01/03/2024	5.02				Not Yet Due			Derogations were signed off by the pervious Head of Operations. VT signed off design proposals and the scrutiny process required input from Shared Services to the technical design. Discussion could not place with the Linac Supplier until after FBC submission and this has subsequently led to a number of reviews of the Bunker Layouts.	Choice of Linac Supplier	This has not delayed project progress	Final sign off by Varian and VT	30/09/2023
Internal	2022.21	Development of a Regional Radiotherapy Satellite Centre at NHH	Reasonable	Director of Strategy, Planning & Partnerships	Project Director	Low	R5	At future projects All contracts should be dated	Agreed - Future Projects - Contracts will be dated.	01/03/2024	5.02				Not Yet Due			At this point in time the process for the provision of collectoral warranties has not required to be actioned as the relevant works have not be completed	None	N/A	None, CW's have so far not been required	30/09/2023
Internal	2022.21	Development of a Regional Radiotherapy Satellite Centre at NHH	Reasonable	Director of Strategy, Planning & Partnerships	Project Director	Medium	R5	All contracts over £100k in value should be signed by both the Chief Executive & Chair in accordance with the UHB's Standing Orders (Scheme of Delegation)	Agreed - Future Projects Contract Values exceeding £100k will be signed by the Chief Executive & Chair in accordance with UHB Standing Orders.	01/03/2024	5.02				Not yet due							30/09/2023
Internal	2022.22	RGH Redevelopment & Expansion of Endoscopy Services	Reasonable	Director of Strategy, Planning & Partnerships	Project Director	Medium	R5	The UHB should ensure that a Project Bank Account is established and operating in line with Welsh Government policy; or an application for this project to be exempt is confirmed.	It is now too late to implement a PBA at this project. WG were made aware of the absence of a PBA at the informal CRM meetings whilst a formal application for an exemption at this project was not submitted, we will ensure due process is applied at future developments.	01/12/2023	2.03				Not yet due			Action complete - PPR templates included in the papers for Project Team & Programme Board.	None	N/A	Board Papers	30/09/2023
Internal	2022.22	RGH Redevelopment & Expansion of Endoscopy Services	Reasonable	Director of Strategy, Planning & Partnerships	Project Director	Medium	R7	An evaluation should be undertaken to determine that value for money was achieved, and why there was little interest from the market; this should inform future tendering exercises.	The tender evaluation report does explain the process that resulted in there being only 2 returned tenders. The reasons for companies not wishing to tender are also stated. The pre-tender estimate was shared with Shared Services and the returned tender scrutinised by all parties. Whilst no concerns were raised at this project, we will ensure at future projects, tenders are fully evaluated against the PTE and any significant variations and reasons for the same are highlighted at the tender report.	01/12/2023	2.03				Not yet due							30/09/2023
Internal	2022.25	Integrated Wellbeing Networks	Reasonable	Director of Public Health	IWN Programme Manager	Medium	R2	Management should clearly identify what a successful IWN project is, and future projects undertaken by the local IWN communities (e.g. projects identified within the IWN annual plans) should state SMART goals whereby the success of the project can clearly be defined. Management should also identify what success of the IWN programme in each community looks like and once that target is achieved be able to move to other areas of need and implement the programme within those locations	An independent advisory group of academics has been created due to meet in July 2023 to advise on (a) measures of evaluating progress towards the strategic objectives of the IWN programme in each place-based area of operation and (b) longitudinal methods for measuring community wellbeing in an evidence-based manner to understand how and whether the IWN programme is impacting on population wellbeing in its place-based areas. It is anticipated by September 2023 that a new evaluation framework will be proposed by this advisory group, with funding now apportioned for the appointment of a commissioned researcher to undertake an evaluation and embed this framework in programme monitoring for IWN into the longer-term. This will set the direction of success for local IWN projects, allow SMART goal planning and measure the success of the programme to enable exploration of working in other geographic areas in future. The evaluation work will be complete by 31st October 2023. The programme is planning to apply the King's Fund model for community-orientated needs assessment in defining success in each of the IWN areas to set goals for local areas and establish measures of success from 2024/25.	01/10/2023	0.03				Not yet due							30/09/2023
Internal	2022.26	Contract Mangement	Reasonable	Chief Operating Officer	Director of Finance & Procurement Director of Finance & Procurement Assistant Finance Director Hospital and Corporate / Commodity Manager, Sourcing FCP - Supported by: Head of Business Systems and Governance	Medium	R1	The introduction of contract management guidance and policy should be supported by the roll out of an appropriate training programme to all relevant staff, to assist with the embedding of the agreed approach.	Once the Policy is finalised a training programme will commence for all contract managers delivered by the Head of Procurement and Assistant Head of Procurement, supported by the Divisional Finance Business Partners	01/12/2023	2.03				Not yet due							30/09/2023
Internal	2022.26	Contract Mangement	Reasonable	Chief Operating Officer	Director of Finance Commodity Manager, Sourcing	Medium	R2	We recommend that Health Board management ensure that: a. A repository of all signed contractual documentation is established to include: all contract schedules, framework agreements, service level agreements, call off orders etc. b. The repository is placed on a shared platform such that it is accessible to all relevant staff / stakeholders.	This is difficult as Procurement services who maintain the bulk of any contract documentation sits under NWSSP who have their own architecture within SharePoint which is not readily accessible to Health Board staff. It is proposed in the contract management policy that a contract management plan will be drafted between procurement and the responsible division/contract manager with information to be issued back to procurement at regular intervals. This will ensure that all contract documentation is kept in one place and is accessible by contacting the procurement team.	01/12/2023	2.03				Not yet due							30/09/2023
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Head of Nursing Person Centred Care	Medium	R1	Formal deadlines should be set by the Health Board to ensure the timely delivery of actions to maintain compliance with the Standards. Performance against these deadlines should be monitored and reported on.	The Standards have been developed and published by Improvement Cymru. There are no National Deadlines set for the Standards. This is continuously evolving and will help all Health Boards/regions to influence, shape and improve dementia care over coming years. These are the first 20 Standards and we anticipate that new standards will be introduced by Improvement Cymru over the coming years. We have updated the Board and Quality Patient Safety and Outcomes Committee of work undertaken during the readiness year. The Regional Dementia Board consider all the standards which are part of the dementia action plan, and this is also fed back to the Regional Partnership Board. The newly appointed Dementia Programme Manager will oversee all workstreams and, alongside reporting progress, we will report by exception any issues relating to implementing the Standards. Should Improvement Cymru produce deadlines, we shall revisit this recommendation. Additionally, once KPIs have been developed over the next 12 months, we will consider how we can best set formal deadlines for reporting. Auditors' comment on management response We agree with the current approach in the absence of mandatory deadlines. Therefore, whilst formal deadlines may not be the most suitable approach, we believe that the Health Board should continue to focus on the key principles of the Standards and the implementation of these. However, as this will be closely integrated with performance metrics and current monitoring arrangements, we recommend that exceptions are regularly escalated / reported following the commencement of workstream monitoring by the Dementia Programme Manager	01/07/2024	9.02				Not yet due							30/09/2023
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Lead Nurse Dementia	Medium	R2	Spot checks / audits should be regularly carried out to review compliance with the Enhanced Observation Framework.	The Enhanced Care Framework, although not specific to Dementia aims to guide staff through what to consider prior to securing additional support. The enhanced observation policies are different on all Mental Health and Learning Disabilities Units. We shall use this recommendation to review the enhanced care framework and associated policies. Workstream 4 leads will be asked to review the Enhanced Care Policy and determine how this can better align to VIPS monitoring for people with dementia.	01/10/2023	0.03				Not yet due							30/09/2023
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Lead Nurse Dementia	Medium	R2	There should be a programme of work implemented, to undertake an assessment of the environmental suitability of wards that provide beds for patients with dementia	This will be discussed at the In-Patient Hospital Group on 28th of June and confirm who leads on this	01/06/2023	-3.97	31/01/2024	4.03	12/09/2023	Overdue	Not Yet Due		UPDATE JULY 2023. Audit recommendations discussed at meeting. Agreement that a review of the in-patient action plan will be undertaken in September 2023. A dedicated inpatient workshop focussing on the All Wales Dementia Friendly Hospital Charter will be held in November 2023. This will include a review of the resources required to undertale an environmental audit of in patient wards				30/09/2023

Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Head of Nursing Person Centred Care / Lead Nurse Dementia with Associated Standards Workstrea	Low	R2	Consideration should be given to digitalise the "this is me" document and use it as a dementia passport document. Also, make it as a live document which could be further used for home care and nursing home settings	This is me is not a mandatory/Once for Wales NHS tool. There are numerous documents/versions of information that would identify a person needs etc. We shall discuss this and other documents at the next Dementia Board and suggest that Workstream 2a and Workstream 3 leads on this recommendation and determine the feasibility of adding this document to the newly developed patient information portal.	01/06/2023	-3.97	31/01/2024	4.03	12/09/2023	Overdue	Not Yet Due						30/09/2023
Internal	2022.28	Mental Health Transformatio n	Reasonable	Chief Operating Officer	WPWS Crisis Support and Complex Needs Senior Programme Managers	Medium	R1	The control and oversight of each individual mental health transformation project is formally allocated, documented and communicated to all interested parties to the project. This should include any third-party bodies engaged and ensure that any duplication or omission of effort is identified and addressed. There is a need to ensure that assurance mechanisms, including those provided by third-parties can be relied upon. b. Any such document should ensure that key aspects of a project's development and implementation are considered including time, cost, benefits, linkage of projects to strategic objectives, management of risk and ongoing monitoring of targets etc.	A review of the control and oversight of each of the individual mental health transformation projects will be undertaken to ensure it is appropriately allocated, documented and communicated to relevant stakeholders. The document will cover the areas outlined in recommendation 1.1b	01/10/2023	0.03				Not yet due							30/09/2023
External	2022.05EA	Structured Assessment 2022	Not Rated	Director of Nursing	N/A	N/A	R3	R3 There is limited use of patient and staff stories at Board. The Health Board should consider how it can increase and maximise the benefit of patient and staff stories in Board and committees to help centre and focus meetings on the things that matter most, and to help triangulate this intelligence with formal agenda items.	A Digital Story Protocol for staff and patient stories is currently under development and once approved an electronic digital repository of stories will be created. Digital Story Telling training has been commissioned. The CIVICA Citizen Feedback System now allows people to leave narrated stories. A selection of these will be played at the start of every Board meeting. The Executive Team will agree a programme of staff and patient stories that help triangulate intelligence with formal agenda items.	31/03/2023	-6.00	31/12/2023	3.02	12/09/2023	Overdue	Not Yet Due		June 23: A Patient Experience & Involvment Strategy has been developed which includes Digital Patient Narratives and Stories. A patient story has been presented at a Board Development Session and PQSOC this year. Update July 2023: The Digital Story Protocol is drfated but is now being revised due to recent decisions to support 'in-person' patient experiences at Board. To date, a patient story has been played at each Board during 2023. Additionally, digital stories are being used at listening and learning events and development days. There is all Wales discussion around a digital toolkit. The CIVICA system is being rolled out with a specific focus on supporting teams with training to retrieve their own data. Patient verbal narratives are not yet on the system. The first CIVICA report will be presented at Executive Team in September 2023.					30/09/2023
Internal	2022.29	Bank Office and Temporary Workers	Reasonable	Director of Workforce & OD	Recruitment Service Improveme nt Manager	Medium	R1	We recommend that outstanding tasks on the starter task checklist are completed at the earliest available opportunity and that going forward, these checklists are fully completed before new workers are allowed to work their first full shift.	A progress review took place across internal and external appointments to bank with an implementation date of 24.04.2023 to ensure that all check lists are on the TRAC system. A plan is in place to quality check the older records in TRAC and ESR in priority order, oldest records first followed by those that have already started.	01/10/2023	0.03				Not Yet Due							30/09/2023

Agenda Item:3.10

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	28 November 2023
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Committee Risk Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Head of Corporate Risk and Assurance

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

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to provide assurance to the Audit, Risk, and Assurance Committee that the strategic risks associated with achieving the Board's strategic priorities are effectively managed.

Cefndir / Background

At its meeting in July 2023, the Board approved the refreshed assessment of its strategic risks and agreed on **8** high-level strategic risks comprising **18** sub-risks. The Board delegates responsibility for receiving and scrutinising assurances against specific strategic risks to various committees for focus and assurance aligned to the agenda of the Committee.

The Audit, Risk, and Assurance Committee's role is to assure the Board that the risk management processes in place are effective in reducing or mitigating the level of risk to the Board's strategic priorities. By receiving this report, the Committee has oversight of the strategic risks and can determine whether the risk management processes, controls, and assurances in place are adequate to mitigate or prevent the risk being realised.

Table 1 sets out the 8 high-level strategic risks compromising 18 sub-risks by risk level, theme, and oversight committee. The full Strategic Risk Register is included as **Appendix A** and the individual risk assessments for the 18 sub-risks are included as **Appendix B**.

Table 1

High-Level Strategic Risks	Number of Sub-Risks	Risk Level		Sub-Risk Theme	Delegated Committee
		High (10 – 12)	Extreme (15 – 25)		
SRR 001 - There is a risk that the Health Board will be unable to deliver and maintain high quality safe and sustainable services which meet the changing needs of the population.	**7** (A-G)	2	2	People	People and Culture Committee
		2	-	Service Delivery	Partnerships, Public Health & Planning Committee
		-	1	Financial Sustainability	Finance and Performance Committee
SRR 002 - There is a risk that there will be significant failure of the Health Board's estate.	**2** (A -B)	1	1	Compliance and Safey	Partnerships, Public Health & Planning Committee
SRR 003 - There is a risk that the Health Board breaches its duties in respect of safeguarding the needs of children and adults at risk of harm and abuse.	**2** (A – B)	-	2	Compliance and Safey	Patient Quality, Safety & Outcomes Committee
SRR 004 - There is a risk that the Health Board is unable to respond in a timely, efficient, and effective way to a major incident, business continuity incident or critical incident.	**1**	-	1	Compliance and Safey	Partnerships, Public Health & Planning Committee
SRR 005 - There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system.	**1**	1	-	Service Delivery	Patient Quality, Safety & Outcomes Committee
SRR 006 - There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.	**3** (A – C)	2	1	Service Delivery	Finance and Performance Committee
SRR 007 - There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population	**1**	-	1	Transformation & Partnership Working	Partnerships, Public Health & Planning Committee

SRR 008 - There is a risk that the Health Board fails to build positive relationships with patients, staff, and the public.	**1**	-	1	Transformation & Partnership Working	Patient Quality, Safety & Outcomes Committee

Asesiad / Assessment

The Committee Risk Report includes an update for each of the 18 sub-risks. Although they have been reviewed by the respective Executive Risk Owner to ensure the risks are up-to-date four sub-risks, as shown in Table 2, have not received focused scrutiny since the last Audit, Risk, and Assurance Committee meeting. This is due to the Finance and Performance Committee not meeting until 21 December 2023.

Table 2

High-Level Strategic Risks	Sub-Risks	Risk Level		Sub-Risk Theme	Delegated Committee
		High (10 – 12)	Extreme (15 – 25)		
SRR 001 - There is a risk that the Health Board will be unable to deliver and maintain high quality safe and sustainable services which meet the changing needs of the population.	**G**	-	1	Financial Sustainability	Finance and Performance Committee
SRR 006 - There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.	**A-C**	2	1	Service Delivery	Finance and Performance Committee

Furthermore, since the last Committee meeting, the Strategic Risk Report that was presented to the Board on 22 November 2023, included a recommendation for a new risk to be added to the Strategic Risk Register, which would be monitored by the Partnerships, Population Health, and Planning Committee. The risk is described below, with more information available in the risk assessment, which is attached as **Appendix C**.

High-Level Strategic Risk	Sub-Risk	Risk Level	Sub-Risk Theme	Delegated Committee
SRR 009 - The Health Board will be unable to protect those most vulnerable to serious disease.	Due to delays in providing COVID-19 vaccinations as a result of challenges with the recruitment of registered and unregistered immunisers, as well as changes to the vaccination delivery programme.	**Extreme** (20)	Service Delivery	Partnerships, Population Health, and Planning Committee

Work will continue with risk owners to assess and refine the controls and assurances, as well as to focus on the financial context and its impact on the individual strategic risks, to ensure a thorough assessment of the risk. This will be completed and documented as part of the next reporting cycle to the delegated

committees and to this Committee and the Board for strategic oversight and assurance.

Argymhelliad / Recommendation

The Committee is requested to:

- **NOTE** the Strategic Risk Register and Risk Assessments for the 18 sub-risks; and,
- **NOTE** the risk assessment for the newly identified strategic risk **SRR 009.**

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	The Corporate Risk Register is informed by Datix, ensuring a bottom-up approach to risk escalation.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Choose an item. The Corporate Risk Register assesses risk that could impact achievement of all strategic priorities.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

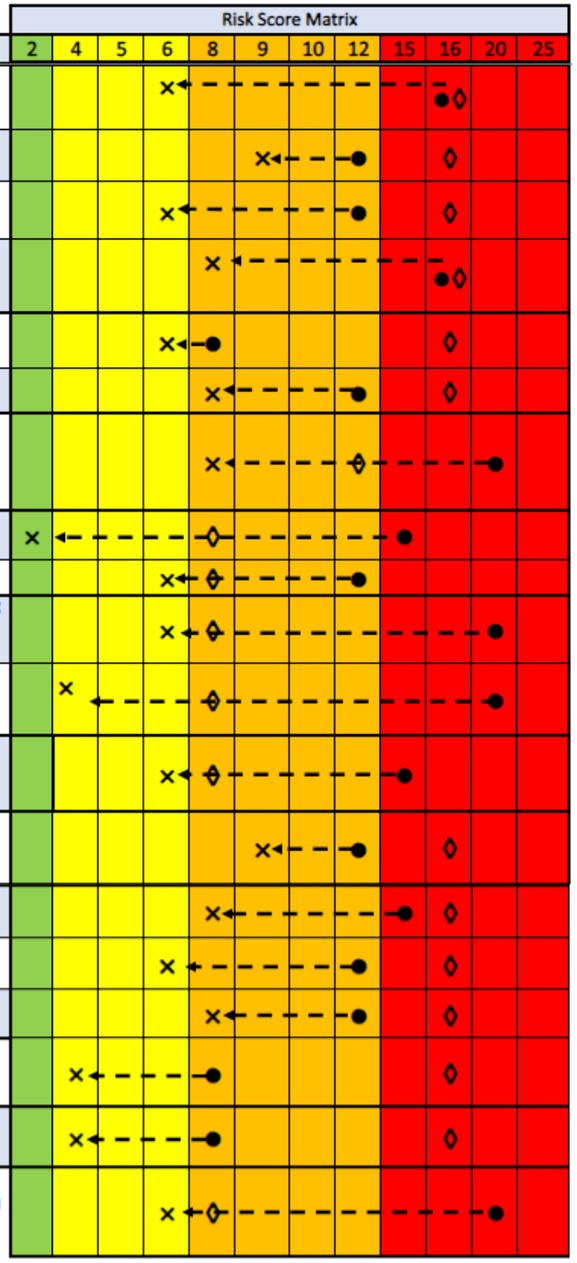
Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	Explained within the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	N/A

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

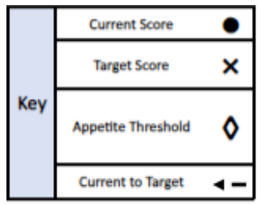
Risk ID	Monitoring Committee	Risk Theme	Risk Owner	Risk Description	Reason For The Risk	Impact	Current Risk Score				Risk Appetite		Actions to Reduce Risk to Target	Assurance that the Risk is being manged effectively	Target Risk Score				Review of Risk	
							Likelihood Of The Risk Occuring	Impact Of Risk Occuring	Current Risk Score	Risk Level	Current Status Against Appetite	Risk Appetite and Threshold Explained			Likelihood Of The Risk Occuring	Impact Of Risk Occuring	Target Risk Score	Risk Level	Last Reviewed	Next Review
SRR 001	People & Culture Committee	People	Director of Workforce and Organisational Development	There is a risk that the Health Board will be unable to deliver and maintain high quality safe and sustainable services which meet the changing needs of the population	a)Due to an inability to recruit and retain staff across all disciplines and specialities.	•Adverse impacts on delivery of care to patients across acute and non-acute settings •Non-compliance with safe staffing principles and standards •Reliance on agency and bank staff •Litigation & Financial Penalties	4	4	16	Extreme	Above Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	**Staff attendance** Continuing support for staff who are absent in line with Managing Attendance at Work Policy, including those on long term absence with a view to signposting to self-help support, and adapting/adjusting roles to enable a safe return to work., "Hot spot" areas identified and plans in place to support. **Recruitment** Engagement with national recruitment campaigns such as BAPIO, Train, Work, Live and Student Streamlining for Registered Nurses, Physician's Associates, Midwives, and therapy staff and with HEIW for Junior Doctor, Annual programme of Apprentice recruitment, Overseas Nursing (All Wales), Nursing Workforce Strategy, Streamlining and improve recruitment timescales through recruitment modernisation programme (started Oct 22) , Partnerships with employability schemes such as Kickstart and Restart, Actively working with Local Authorities to promote joint recruitment activities and Registration – Temporary register extended for 2 years to enable staff to return to practice. **Retention:** Development of career pathways (e.g., non-clinical to clinical), Engagement chat cafes providing information and support for key topics such as Agile Working, Learning and Development, Wellbeing Activity, Occupational Health, and Complex HR, Internal Exit interview group has been established with a view to 1) Increase the numbers of people completing the forms and 2) Turn the data into intelligence so that we can understand and respond to organisational and local level impacts, Changes in pension regulation and flexile retirement options from October 23 and reduced break in service required following retire and return, Agency reduction and Plan in place to monitor and review all agency, bank pay incentives supply and demand. **E- Systems** Effective deployment of current staff - Programme Plan to introduce Workforce Medical E-Systems to support effective deployment of medical staff, Development of alternative and new roles , Continued implementation of new roles such as Physician Associates, Enhanced and Advanced roles to support workforce skills gaps in line with IMTP, Primary Care workforce The Regional Integrated Fund (RIF) Workforce Programme is in development to support the wider health and social care staffing issues as required in Healthier Wales. and Gwent Workforce Board is being tweaked to support scaling up of initiatives and pace. **Training** The HEIW Education & Training Plan continues the investment in education and training in Wales that has been increasing over past years - Adult Nursing (36%) and Mental Health Nursing (20%), Healthcare science, Allied Health Professionals Clinical Psychology (11%- 43%). This will increase the number of graduates coming out of training in 2022 and beyond which are required to support turnover and existing vacancies, HEIW are increasing the capacity of training through creating more spaces for training the future Primary Care workforce. Including Primary Care Academy, Development of Leadership Development programmes for key roles such as the Clinical Director post (CDs) started with 3 cohorts in September 2022 and recruiting the 4th cohort to start Oct 23. Nursing Academy, Leadership Development program (entry level) and Leading People (advanced Level) programs fully booked. Core Leadership prog currently delivering to 200 staff. **Vacancy Numbers and establishment control** Quarterly reporting of vacancy numbers for each staff to the WG. Last reporting period March 23 there were circa 728 WTE vacancies and Development of ESR establishments commenced on a national basis w/c 03/09/23.	Medium	3	2	6	Low	24/09/2023	24/10/2023
					b) Due to a deterioration in, and a failure to improve, the well-being of our staff	•High absence levels, with some sustained long periods •Adverse impacts on delivery of care to patients across acute and non-acute settings •Non-compliance with safe staffing principles and standards •Reputational damage to the health board as an employer •Work-related industrial injury claims •Moral injury	3	4	12	High	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Continue to work with other Health Boards and Trust in NHS Wales (recent work with WAST & Powys delivering well-being webinars)., Increase wellbeing initiatives: Implement and progress new Integrated Psychological Well-being roles and peer support networks within divisions and hospital sites, Identify, training and develop Respect and Resolution advocates (similar to Mental Health first aiders), Train Mediators so there is team and organisational resilience and network, Regular Schwartz rounds arranged across the Health Board, Taking Care giving care Rounds integrated into our leadership offers and available for teams to undertake either with support or on their own. Close links with the Arts in Health programme, Promotion of walking meetings in leadership programmes Working with Planning and Estates team to ensure the Queens Canopy is designed to promote clear walking routes for that can be used during breaks for meetings Inclusion of break times and staff rooms in wellbeing survey to audit current provision. Chaplaincy service for staff , Re-launching Chill out in the Chapel, Recruitment of staff counsellors, Establishment of new bilingual Health and Well-being AB Pulse page on the intranet with library of resources for staff well-being , Scope, design and deliver a programme of research 'Healthy Working Day', Enhanced our financial well-being offer. Support offered to Trade Union Representatives and their members to ensure a positive experience of work and rapid escalation when appropriate. Support availability of "Safe Space" conversations for senior medical leaders from Faculty of Medical Leadership & Management, Drafting of a 10-year plan focusing on optimising the employee experience of work., The Avoidable Employee Harm Programme was launched on 5th July 2022 initially focusing on HR processes it will then look to other formal processes that inadvertently cause harm to all those involved and the organisation. The training day that supported the launch has evaluated very well and organisations beyond ABUHB are keen to engage. Within ABUHB we have subsequently seen a >60% reduction in gross misconduct investigations. **Occupational Health** Occupational Health and NWSSP are working in partnership to implement a new Occupational Health Software system across Wales called OPASG2. OPASG2 provides benefits to employment and recruitment processes, Occupational Health and the Well-being Service continue to work with Therapies colleagues on support for staff experiencing Long Covid-19. Reviewed Occupational Health provision and consider options to improve sustainability within the service, paper drafted, Support equality and diversity of workforce Review of staff diversity networks, Review of wellbeing survey through and equality lens to understand variations within diverse workforce demographic profile. Development of a buddy system to assist international medical staff with induction and orientation and support values and current norms. Development of an empowerment passport to support disabled staff and reasonable adjustments and wellbeing. **Other** Assessment of compliance against BMA Rest and Facilities charter complete with action plan developed, reporting to LNC, Reducing fatigue poster developed	Medium	3	3	9	Moderate	24/09/2023	24/12/2023
					c) Due to insufficient and ineffective leadership levels throughout the organisation.	•Adverse impacts on delivery of care to patients across acute and non-acute settings •Failure to deliver health board priorities, required improvements and achieve sustainability •Poor levels of accountability and delivery •Reputational damage to the health board as an employer •Adverse impacts on staff recruitment and retention	3	4	12	High	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Talent and Succession Planning lead appointed in July 2023 on a 6-month secondment funded by HEIW to create an organisational talent management framework to enable the organisation to deliberate and consistently attract, identify and develop talent for critical roles across ABUHB Pilot planned for Finance, Occ Health and divisional managers focusing on how to identify critical roles, development sessions on holding career conversations and culminating in a Talent Management Strategy Local management trainee scheme scoped, and project plan created, JDPS created and evaluated. Project team convened. Paused in May 2022 due to lack of funding. 2021/23 HEIW schemes complete. Two HEIW Grads have successfully completed the programme and have secured promotional roles within NHS in Wales; one within the health board and one at Powys, both at Band 7 level 1 x HEIW funded graduate management trainee successfully appointed August 2023 following additional recruitment process. Executive Director of Planning sat on interview panel. Trainee commences scheme 5th September 2023 at HEIW at joins ABUHB Friday 8th September. Development leadership capabilities Designing learning journeys and access to Gwella Leadership journey and programmes mapped and 1 pager flyer designed & on intranet. Exploring Directorate Manager development. CDs Leadership Development for clinical directors completed for 2022/23 with 45 attendees and CDs cohort 2 starts October 23- open for current and aspiring CDs 2022/2024 Academi Wales scheme the Health Board are sharing a graduate with Monmouthshire Council, our Graduate joined the Health Board in March 2023 and is supporting the decarbonisation agenda.	Medium	3	2	6	Low	24/09/2023	24/12/2023
					d) Due to the threat of Industrial Action during ongoing disputes and negotiations at a national level	•Adverse impacts on delivery of care to patients across acute and non-acute settings •Non-compliance with safe staffing principles and standards •Litigation & Financial Penalties •Reputational damage to the health board and loss of public confidence	4	4	16	Extreme	Above Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Services Business continuity plans in place. All Wales training sessions provide by legal and risk to support industrial action. Ensure early identification of mandated Statutory, and core critical clinical services. Trade union provides a list of the categories of employee to which the affected employees belong, figures on the number of employees in each category, figures on the numbers of employees at each workplace, the total number of affected employees. Such information will enable the employer to readily deduce the total number of employees affected, the categories of employee to which they belong, the number of employees concerned in each of those categories, the workplaces at which the employees concerned work and the number of them at each of these workplaces. Reducing impact on patients - Support for early supported discharge prior to industrial action. Trade Unions specifies: (i) whether the union intends the industrial action to be "continuous" or "discontinuous" (14); and (ii) the date on which any of the affected employees will be called on to begin the action (where it is continuous action), or the dates on which any of them will be called on to take part (where it is discontinuous action). Establish WOD hub with emergency planning to stand up as required Ensure early identification of mandated Statutory, and core critical clinical services. Review of business continuity plans Map services and staff provision and impacts of industrial action. Assess variable pay usage in case of work to rule applies. Assess current vacancies. Working with partners in Gwent on a system wide basis. Implementation of business continuity plans. Communication plans. Establish working mechanisms with NWSSP to consider derogations for junior doctors (who are the employer).	Medium	2	4	8	Moderate	24/09/2023	24/10/2023
	Partnerships, Public Health & Planning Committee	Service Delivery	Director of Strategy, Planning and Partnerships.		e)Due to inadequate strategic plans which respond to population health and socio-economic needs	•Increased demand •Increased patient acuity levels •Worsening of health inequalities •Worsening of health outcomes •Failure to train teams in multi-morbidity management •Failure to comply with the Wellbeing of Future Generations Act (Wales) •Reputational damage and loss of public confidence	2	4	8	High	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Area plan is being refreshed through the RPB Marmot Region Implementation Plan Population health management – test and learn using segmentation and risk satisfaction using linked data to target resource. Refresh organisational strategy with a central focus on population health and wellbeing. Action through SEW Regional Collaborative to identify additional service areas where collaboration and networking would support sustainability.	Medium	2	3	6	Low	10/10/2023	10/01/2024
					f)Due to unsustainable service models	•Harm or injury to patients and/or staff •Adverse impacts on delivery of care to patients across acute and non-acute settings •Increased demand •Increased patient acuity levels •Worsening of health inequalities •Worsening of health outcomes •Failure to deliver health board priorities, required improvements and achieve sustainability •Reputational damage and loss of public confidence	3	4	12	High	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Area plan is being refreshed through the RPB. Population health management – test and learn using segmentation and risk satisfaction using linked data to target resource. Review of enhanced local general hospital service models to ensure sustainable quality services. Development of SEW plan for fragile. Review of organisational strategy – to launch Summer 2024.	Medium	2	3	6	Low	10/10/2023	10/01/2024
	Finance & Performance Committee	Financial Sustainability	Director of Finance and Procurement		g)Due to long term financial sustainability plans not being achieved through underachievement of strategic and operational delivery plans to reduce costs to funded levels and improve outcomes	•Breach of statutory duty to breakeven over 3 years •Instigation of NHS Wales Escalation & Intervention Arrangements •Non – delivery of health board priorities, required improvements and achieve longer-term sustainability •Prioritisation and possible disinvestment in service delivery •Reputational damage and loss of public confidence	5	4	20	Extreme	Above Appetite Level	Cautious = 12 or below - Preference for safe, though accept there will be some risk exposure: medium likelihood of occurrence of the risk after application of controls.	Update performance management framework Assessment of financial control environment within divisions and corporate teams.	Medium	2	4	8	Moderate	10/09/2023	10/10/2023
SRR 002	Partnerships, Public Health & Planning Committee	Compliance and Safety	Chief Operating Officer	There is a risk that there will be significant failure of the Health Board's estate	a) Due to the presence of Reinforced Autoclaved Aeriated Concrete (RAAC) within structures	•Harm or injury to patients and/or staff •Adverse impacts on delivery of care to patients across acute and non-acute settings •Non-compliance with Health & Safety legislation •Litigation & Financial Penalties	3	5	15	Extreme	Above Appetite Level	Minimal = 8 or below - Ultra-Safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurance of the risk after application of	At this stage, the controls in place are appropriate and practicable to monitor the issues and prepare medium-term responses in line with the timelines within the expert report.	Medium	1	2	2	Very Low	27/09/2023	27/10/2023
					b) Due to significant levels of backlog maintenance	•Harm or injury to patients and/or staff •Adverse impacts on delivery of care to patients across acute and non-acute settings •Non-compliance with Health & Safety legislation •Litigation	3	4	12	High	Above Appetite Level	Minimal = 8 or below - Ultra-Safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurance of the risk after application of controls.	Active estate rationalisation (including leases) is required to reduce estate demands and help prioritise capital spend to reduce backlog maintenance. A water/ventilation engineer to enable all critical ventilation systems to undergo annual validation in accordance with HTM 04/01. Ongoing attempts to recruit to workforce gaps and a new model of Estate Officer also being developed to assist with recruitment and retention of staff in the workforce. Planning function leading a review of capital priorities which may help identify additional funding priority given to backlog maintenance.	Medium	3	2	6	Low	10/10/2023	10/01/2024
			Director of Nursing		a)Due to poor compliance with mandated level 3 safeguarding training being undertaken by registered health and care practitioners	•Missed safeguarding concerns, resulting in harm or death •Vulnerable individuals not identified appropriately, resulting in harm or death •Lack of staff understanding of reporting and escalation process •Health Board breaches statutory duties •Litigation & Financial Penalties •Reputational damage and loss of public confidence	4	5	20	Extreme	Above Appetite Level	Minimal = 8 or below - Ultra-Safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurance of the risk after application of controls.	Updated training packages. Training sessions booked for children and adult level three safeguarding training. Communication with practitioners, via share point intranet pages, emails to divisional nurses. Protected time to complete Level 2 and 3 training where possible. Clear mandate of level 3 training is required on ESR.	Medium	3	2	6	Low	14/09/2023	14/10/2023

SRR 003	Patient, Quality, Safety and Outcomes Committee	Compliance and Safety	Chief Operating Officer	There is a risk that the Health Board breaches its duties in respect of safeguarding the needs of children and adults at risk of harm and abuse	b)Due to limited availability of in-patient facilities and availability of care packages for children and young people, there can be delays in appropriate placement	•Harm or injury to patients and/or staff •Health Board breaches statutory duties •Litigation & Financial Penalties •Reputational damage and loss of public confidence	**4**	**5**	**20**	**Extreme**	**Above** Appetite Level	Minimal = 8 or below - Ultra-Safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurance of the risk after application of controls.	Development of the CAMHS Crisis Hub (CCH), based at Bettws ward in St Cadoc's. We are in the process of developing a safe space for families and young people who are in distress, so that they have access to a team of people, out of hours, who can work directly with them in order to attempt to prevent burgeoning emotional distress from developing into a crisis situation that can cause further trauma. The CCH is being developed in order to help young people who fit the following criteria: Young people whose distress compels them to frequently attend the Emergency Department, or who frequently find themselves detained under section 136 of the Mental Health Act. Young people who having been assessed under Section 136 at the Section 136 suite at Adferiad, find themselves discharged with no immediate safe discharge destination. Young people who having presented at the Emergency Department following self-harm or overdose requiring medical treatment, are admitted overnight for treatment as per NICE guidelines, but once medically fit do not have a safe discharge destination, resulting in an extended stay at GUH for social reasons. In these cases, qualified professionals and BOOST support workers will work closely with the family and colleagues from social care, in order to ensure that a safe discharge can be agreed. Young people who are currently working with a CAMHS professional and are felt to be at risk of experiencing imminent mental health crisis and cannot be supported out of hours by the referring professional. The aim will be to focus on helping young people to stay safe by working with them to develop a short- term plan of what to do in the moment. The CCH will provide a venue that is safe, so that community -based treatment at the point of crisis can be implemented in the least restrictive of settings. Regular Crisis Hub planning meetings; ongoing development of the SOP; recruitment of a Crisis Hub team lead.	**Medium**	**2**	**2**	**4**	**Low**	14/09/2023	**14/10/2023**
SRR 004	Partnerships, Public Health & Planning Committee	Compliance and Safety	Director of Strategy, Planning and Partnerships.	There is a risk that the Health Board is unable to respond in a timely, efficient and effective way to a major incident, business continuity incident or critical incident	a)Due to ineffective and insufficient emergency planning arrangements at a corporate and operational level	•Adverse impacts on delivery of care to patients across acute and non-acute settings •Harm or injury to patients and/or staff •Health Board breaches statutory duties under the Civil Contingencies Act 2004 •Litigation & Financial Penalties •Reputational damage and loss of public confidence	**3**	**5**	**15**	**Extreme**	**Above** Appetite Level	Minimal = 8 or below - Ultra-Safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurance of the risk after application of controls.	Testing programme of business continuity plans. Review of revised Civil Contingency Act anticipated later this year to determine the impact on the Health Board. Improved Engagement with Divisions, Directorates, and service areas to embed contingency planning in the culture of the organisation, Conduct BIAs develop plans, Exercise, review, to mitigate the risks and threats to service delivery. Repository being created on intranet for BC plans to be added by areas for audit, maintenance, review of interdependencies. Joint planning with PH response in response to infection disease and public health incidence. Provide quarterly training sessions for on call gold and silver managers, to maintain skills in incident management, update knowledge in relation to risks and learning from local and national incidents. Test and exercise using the multiagency Joint decision model and the principles of joint working (JESIP). Embed an alert, activation and escalation pathway that follows the Health Board predefined C3 (Command, control, and Co-Ordination) structure of strategic, tactical, and Operational. Working with ICT to scope how to maintain critical communications during loss of IT linked telephone systems or national power outages. Work with the communication team to improve incident cascade during an event to ensure Health Board wide awareness in a timely manner. Continue to promote awareness in a timely manner. Continue to promote awareness of the requirement for BC across the Health Board. A tabletop BC exercise is planned for the 10th of October 2023. Continuing participation in multi-agency exercises. Programme plan to be developed to address the weaknesses in business continuity planning. Review of revised Civil Contingency Act anticipated later this year to determine the impact on the Health Board. Development of Pandemic Plan.	**Medium**	**2**	**3**	**6**	**Low**	10/10/2023	**10/11/2023**
SRR 005	Patient, Quality, Safety and Outcomes Committee	Service Delivery	Chief Operating Officer	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system	a)Due to inadequate arrangements to support system-wide patient flow	•Avoidable deaths or significant harm •Delays in releasing ambulances from hospital sites back into the community •Delayed discharges from acute and non-acute settings resulting in deteriorating patients •Litigation & Financial Penalties •Reputational damage and loss of public confidence	**3**	**4**	**12**	**High**	**Below** Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Escalation framework – evidence suggesting inconsistent escalation of ambulance position / long waits and rationale. Winter planning – Ahead of winter 23/24 there are a series of meetings which will ensure that tangible / practical plans are put in place to ensure: Focus Processing power Capacity Mental health-focussed flow meeting – implement a MH-focussed daily forum to ensure the flow requirements and risk profile is understood across all MH sites. Build in more impromptu, OoH and site visits to check on processes i.e., patient safety, risk, and performance across the Divisions. Regional flow processes not always supported with neighbouring HBs (Health Board)	**Medium**	**3**	**3**	**9**	**Moderate**	14/09/2023	**14/12/2023**
SRR 006	Finance & Performance Committee	Service Delivery	Director of Digital	There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery	a)Due to the full or partial failure of existing digital infrastructure and systems	•Harm or injury to patients and/or staff •Adverse impacts on delivery of care to patients across acute and non-acute settings •Data breaches •Litigation & Financial Penalties •Reputational damage and loss of public confidence	**3**	**5**	**15**	**Extreme**	**Below** Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Information Governance and Cyber Security governance and assurance processes are now under review. Governance group terms of reference agreed, and reporting arrangements discussed with Director of Corporate Governance. Meetings will commence in November with clear reporting on progress to the relevant committees on our cyber security action plan. SIRO training arranged for the 25th September for the Director of Digital (SIRO) and Chief Information Officer (Deputy SIRO).	**Medium**	**2**	**4**	**8**	**Moderate**	10/09/2023	**10/10/2023**
					B)Due to an adverse impact on service delivery in the implementation of new digital systems	•Harm or injury to patients and/or staff •Adverse impacts on delivery of care to patients across acute and non-acute settings •Data breaches •Litigation & Financial Penalties •Reputational damage and loss of public confidence	**3**	**4**	**12**	**High**	**Below** Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Additional governance being put in place with the Digital, Data and Technology Sub-Committee which will report to the Finance & Performance Committee	**Medium**	**2**	**3**	**6**	**Low**	10/09/2023	**10/12/2023**
					c)Due to a failure to develop digital solutions that are sustainable and fit for the future	•Harm or injury to patients and/or staff •Adverse impacts on delivery of care to patients across acute and non-acute settings •Failure to deliver health board priorities, required improvements and achieve sustainability •Reputational damage and loss of public confidence	**3**	**4**	**12**	**High**	**Below** Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	New governance structures to be put in place by the end of 2023. Review of New Digital Request processes considering governance changes.	**Medium**	**2**	**4**	**8**	**Moderate**	10/09/2023	**10/12/2023**
SRR 007	Partnerships, Public Health & Planning Committee	Transformation and Partnership Working	Director of Strategy, Planning and Partnerships.	There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population	Due to ineffective relationships with strategic partners	•Unmet patient need resulting in harm •Ineffective use of combined resources •Delayed decision making •Adverse impacts on delivery of care to patients across acute and non-acute settings •Failure to deliver health board priorities, required improvements and achieve longer-term sustainability •Reputational damage and loss of public confidence	**2**	**4**	**8**	**High**	**Below** Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Governance review of Regional Partnership Board undertaken in August 2023. Renewed Strategy for strategic partnership Capital in place and revised governance processes. New Long-Term Strategy for Health Board to focus on Partnership approach.	**Medium**	**2**	**2**	**4**	**Low**	10/10/2023	**10/01/2024**
SRR 008	Patient, Quality, Safety and Outcomes Committee	Transformation and Partnership Working	Director Of Nursing	There is a risk that the Health Board fails to build positive relationships with patients, staff, the public and partners	Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement	•Adverse impact on patient experience •Failure to deliver health board priorities, required improvements and achieve longer-term sustainability •Reputational damage and loss of public confidence •Failure to deliver Duty of Quality	**2**	**4**	**8**	**High**	**Below** Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Structured graduated approach to roll out of Civica to ensure divisional teams can use and access data. This will ensure sustainable progress. PCCT staff training to support Civica data entry and retrieval. Programme Manager for Dementia working regionally to improve public engagement and promote the role of Community Listeners. Employment of dedicated PALS team in progress who will have a key role in gaining feedback from patients, staff and relatives. Completion of surveys limited to QR code access or physical presence of PCCT to manually ask and in-put data. No SMS provision. National directives around new national surveys that need to be managed additional to internal roll out programme. Volunteer feedback to be reviewed to identify themes.	**Medium**	**2**	**2**	**4**	**Low**	14/09/2023	**14/12/2023**
SRR 009	Partnerships, Public Health & Planning Committee	Compliance and Safety	Director of Public Health and Strategic Partnerships	The Health Board will be unable to protect those most vulnerable to serious disease	Due to delays in providing COVID-19 vaccinations as a result of challenges with the recruitment of registered and unregistered immunisers, as well as changes to the vaccination delivery programme.	•Adverse impacts on delivery of vaccinations to patients across the vaccine service – including outreach/in reach delivery to vulnerable population, childhood immunisation & MMR catch up and flu wrap-around service. • Harm or injury to patients and/or staff - Winter modelling suggests a peak in Covid-19 cases and associated bed pressures is anticipated during December 2023 and in mid-January 2024. Potential for Nosocomial spread, increase in acuity of patients, and length of stay. • Resource – potential increase in staff sickness due to lack of protection from the vaccine in staff member groups. • Financial implications due to the extension of venues. • Reputational damage and loss of public confidence.	**5**	**4**	**20**	**Extreme**	**Above** Appetite Level	Minimal = 8 or below - Ultra-Safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurance of the risk after application of controls.	Secured additional funding against the existing allocation for bank vaccination staff. Exploring deployment options to the Vaccination programme and use of those previously trained as vaccinators that are on the bank. Alternative advertising methods of vacant shifts to improve uptake – liaising with bank co-ordinator to improve this. Draft community pop-up plan to be further explored. If required, extend venue licence in key location(s).	**Medium**	**2**	**3**	**6**	**Moderate**	03/11/2023	**03/12/2023**

Reference	Risk Owner	Risk Description	Reason For The Risk
SRR 001	Director of workforce and OD	There is a risk that the Health Board will be unable to deliver and maintain high quality safe and sustainable services which meet the changing needs of the population	a)Due to an inability to recruit and retain staff across all disciplines and specialities.
			b) Due to a deterioration in, and a failure to improve, the well-being of our staff
			c) Due to insufficient and ineffective leadership levels throughout the organisation.
			d) Due to the threat of Industrial Action during ongoing disputes and negotiations at a national level
	Director of Strategy, Planning and Partnerships.		e) Due to inadequate strategic plans which respond to population health and socio-economic needs
			f) Due to unsustainable service models
	Director of Finance and Procurement		g) Due to long term financial sustainability plans not being achieved through underachievement of strategic and operational delivery plans to reduce costs to funded levels and improve outcomes
SRR 002	Chief Operating Officer	There is a risk that there will be significant failure of the Health Board's estate	a) Due to the presence of Reinforced Autoclaved Aeriated Concrete (RAAC) within structures
			b) Due to significant levels of backlog maintenance
SRR 003	Director of Nursing	There is a risk that the Health Board breaches its duties in respect of safeguarding the needs of children and adults at risk of harm and abuse	a) Due to poor compliance with mandated level 3 safeguarding training being undertaken by registered health and care practitioners
	Chief Operating Officer		b) Due to limited availability of in-patient facilities and availability of care packages for children and young people, there can be delays in appropriate placement
SRR 004	Director of Strategy, Planning and Partnerships.	There is a risk that the Health Board is unable to respond in a timely, efficient and effective way to a major incident, business continuity incident or critical incident	a) Due to ineffective and insufficient emergency planning arrangements at a corporate and operational level
SRR 005	Chief Operating Officer	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system	a) Due to inadequate arrangements to support system-wide patient flow
SRR 006	Director of Digital	There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery	a) Due to the full or partial failure of existing digital infrastructure and systems
			B) Due to an adverse impact on service delivery in the implementation of new digital systems
			c) Due to a failure to develop digital solutions that are sustainable and fit for the future
SRR 007	Director of Strategy, Planning and Partnerships.	There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population	Due to ineffective relationships with strategic partners
SRR 008	Director Of Nursing	There is a risk that the Health Board fails to build positive relationships with patients, staff and the public	Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement
SRR 009	Director of Public Health & Startegic Pasrtnerships	The Health Board will be unable to protect those most vulnerable to serious disease.	Due to delays in providing Covid-19 Vaccinations as a result of challenges with the recruitment of registered and unregistered immunisers, as well as changes to the vaccination delivery programmee.



Assessment of adequacy of assurances	POSITIVE = Identified assurances are deemed robust in telling us that the controls in place are working effectively.
	REASONABLE = Identified assurances are deemed adequate in telling us that the controls in place are working effecively, however some gaps have been identified which need to be addressed.
	NEGATIVE = Identified assurances are deemed insufficent in telling us that the conrols in place are working effectively with substantial gaps identified which need to be addressed.

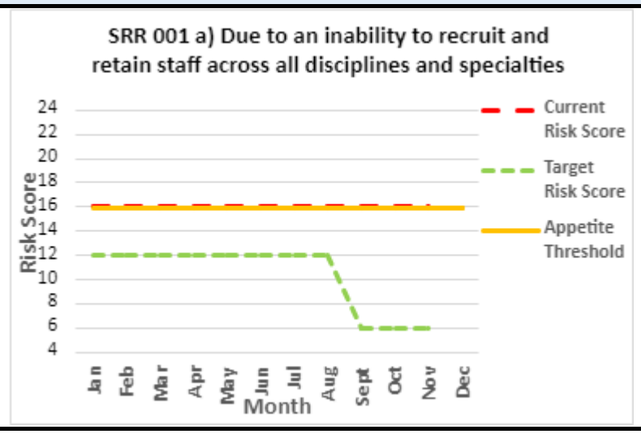


RISK THEME	PEOPLE			
Strategic Risk (SRR 001A)	**The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**			
Strategic Threat	**a)** Due to an inability to recruit and retain staff across all disciplines and specialties.			
Impact	➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Non-compliance with safe staffing principles and standards ➢ Reliance on agency and bank staff ➢ Litigation & Financial Penalties			
Lead Director	Director of Workforce & Organisational Development	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	People & Culture Committee	**Likelihood**	4 *(Likely)* x	3 *(Possible)* x
Initial Date of Assessment	01/06/2023	**Impact**	4 *(Major)*	2 *(Minor)*
Last Reviewed	10/10/2023	**Risk rating**	**= 16** *(Extreme)*	**= 6** *(Moderate)*

Risk Appetite Level – Open
Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.

Risk Appetite Threshold - Score 16 and below
Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.

SUMMARY
The current risk level is **outside** of target level and appetite threshold. The target level to be achieved is **within** the set appetite threshold.



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Monitoring Framework to support roll-out of the People Plan. • Workforce Dashboard to track activity – recruitment, turnover, sickness absence. • Supply and demand tracker (Nursing). • People Plan tracker to support delivery of actions within the People Plan 2022-25. • Health Care Support Worker tracker. • Agency Reduction Plan approved June 2022 and supported by the Programme Board. • Management of attendance through All Wales Management Attendance at Work Policy. • Duty of Quality - Section 6.8.2 Workforce and Section 6.8.3 Culture. • Nurse Staffing Levels (Wales) Act 201625b/25c. • Review of staffing and recruitment plan internally in line with Royal College Guidance, i.e., RCP. • Development of new roles to support vacancies. • Recruitment KPI's.	**Staff attendance** • Continuing support for staff who are absent in line with Managing Attendance at Work Policy, including those on long term absence with a view to signposting to self-help support, and adapting/adjusting roles to enable a safe return to work. • "Hot spot" areas identified and plans in place to support. **Recruitment** • Engagement with national recruitment campaigns such as BAPIO, Train, Work, Live and Student Streamlining for Registered Nurses, Physician's Associates, Midwives, and therapy staff and with HEIW for Junior Doctor. • Annual programme of Apprentice recruitment • Overseas Nursing (All Wales) • Nursing Workforce Strategy • Streamlining and improve recruitment timescales through recruitment modernisation programme (started Oct 22) • Partnerships with employability schemes such as Kickstart and Restart. • Actively working with Local Authorities to promote joint recruitment activities. • Registration – Temporary register extended for 2 years to enable staff to return to practice. **Retention:**	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Workforce reports to the Nurse Strategic Workforce Group. • Update reports on Agile working data and support to the Agile Programme Board to promote the benefits of agile working. • Daily sickness monitoring reports. • Filled and unfilled shift reports (RN). • Occupational Health and Wellbeing dashboards report KPIs. **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Reports to the People and Culture Committee and the Board on the progress of the People Plan 2022-25 • Workforce Dashboard presented to the Executive Committee, P&CC Committee, and the Board. • Measurements of Wellbeing through the ABUHB Staff Survey. • Routine Reporting against nurse staffing levels. **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)*	**Gaps in Assurance** • Under review **Action to Address Gaps in Assurance**	**Positive Assurance**

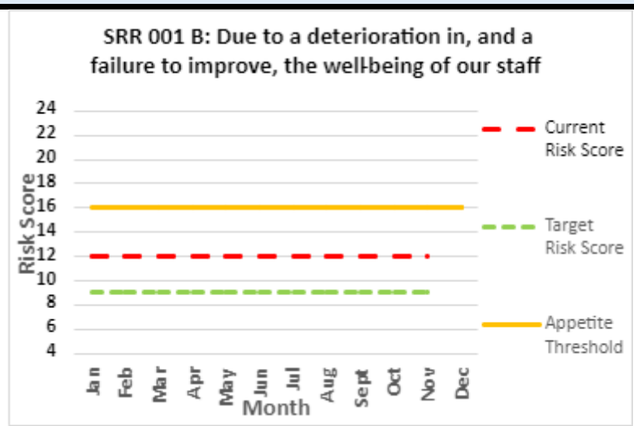
• IMTP Educational Commissioning. • Workforce Establishment controls national working group has been instigated.	• Development of career pathways (e.g., non-clinical to clinical). • Engagement chat cafes providing information and support for key topics such as Agile Working, Learning and Development, Wellbeing Activity, Occupational Health, and Complex HR. • Internal Exit interview group has been established with a view to 1) Increase the numbers of people completing the forms and 2) Turn the data into intelligence so that we can understand and respond to organisational and local level impacts. • Changes in pension regulation and flexile retirement options from October 23 and reduced break in service required following retire and return. **Agency reduction** • Plan in place to monitor and review all agency, bank pay incentives supply and demand. **E- Systems** • Effective deployment of current staff - Programme Plan to introduce Workforce Medical E-Systems to support effective deployment of medical staff. **Development of alternative and new roles** • Continued implementation of new roles such as Physician Associates, Enhanced and Advanced roles to support workforce skills gaps in line with IMTP. • Primary Care workforce The Regional Integrated Fund (RIF) Workforce Programme is in development to support the wider health and social care staffing issues as required in Healthier Wales. Gwent Workforce Board is being tweaked to support scaling up of initiatives and pace. **Training** • The HEIW Education & Training Plan continues the investment in education and training in Wales that has been increasing over past years - Adult Nursing (36%) and Mental Health Nursing (20%), Healthcare science, Allied Health Professionals Clinical Psychology (11%- 43%). This will increase the number of graduates coming out of training in 2022 and beyond which are required to support turnover and existing vacancies. • HEIW are increasing the capacity of training through creating more spaces for training the future Primary Care workforce. Including Primary Care Academy • Development of Leadership Development programmes for key roles such as the Clinical Director post (CDx) started with 3 cohorts in September 2022 and recruiting the 4th cohort to start Oct 23. Nursing Academy, Leadership Development program (entry level) and Leading People (advanced Level) programs fully booked. Core Leadership prog currently delivering to 200 staff. **Vacancy Numbers and establishment control** • Quarterly reporting of vacancy numbers for each staff to the WG. Last reporting period March 23 there were circa 728 WTE vacancies. • Development of ESR establishments commenced on a national basis w/c 03/09/23.	**Internal Audit Reviews 2023 -24** 1. Long Term Sickness Absence Management (Q4) 2. Flexible Working (Q4) • External quarterly vacancy reporting to WG • External reporting on Nursing Staffing Levels • National Acuity Audits (Nursing) • National Workforce Implementation Plan: Addressing NHS Wales Workforce Challenges - The Strategic Workforce Implementation Board will report to the Minister for Health and Social Services with a collective view from a range of key partners including policy and professional leads in WG, and representatives of NHS employers, staff organisations and professional representative.		

RISK THEME	PEOPLE			
Strategic risk (SRR 001B)	**The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**			
Strategic Threat	**b)** Due to a deterioration in, and a failure to improve, the well-being of staff.			
Impact	➢ High absence levels, with some sustained long periods ➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Non-compliance with safe staffing principles and standards ➢ Reputational damage to the health board as an employer ➢ Work-related industrial injury claims ➢ Moral injury			
Lead Director	Director of Workforce & Organisational Development	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	People & Culture Committee	**Likelihood**	**3** *(Possible)* *x*	**3** *(Possible)* x
Initial Date of Assessment	01/06/2023	**Impact**	**4** *(Major)*	**3** *(Moderate)*
Last Reviewed	10/10/2023	**Risk rating**	**= 12** *(High)*	**= 9** *(High)*

Risk Appetite Level – Open
Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.

Risk Appetite Threshold – Open Score 16 and below
Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.

SUMMARY
The current risk level is **outside** of target level but within appetite threshold. The target level to be achieved is **within** the set appetite threshold.



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall)*
• Monitoring Framework to support roll out of the People Plan. • Monitoring delivery of the #peoplefirst project though Executive Team reports, KPI sickness metrics underpinned by People Plan Delivery framework. Engagement ongoing with divisional management teams. • Monitoring of absence, reasons for absence and trends in referrals to Occupational Health and Employee Well-being Service through Workforce Performance Dashboard. • Dashboard reported to Executive Team, TUPF and LNC colleagues and People and Culture Committee with regular summary of Well-being and Occupational Health activity. • Strategic Equality plan • Rest and Facilities charter – monitoring and compliance • Staff related policies.	• Continue to work with other Health Boards and Trust in NHS Wales (recent work with WAST & Powys delivering well-being webinars). • Increase wellbeing initiatives: • Implement and progress new Integrated Psychological Well-being roles and peer support networks within divisions and hospital sites. • Identify, training and develop Respect and Resolution advocates (similar to Mental Health first aiders) • Train Mediators so there is team and organisational resilience and network. • Regular Schwartz rounds arranged across the Health Board • Taking Care giving care Rounds integrated into our leadership offers and available for teams to undertake either with support or on their own. • Close links with the Arts in Health programme • Promotion of walking meetings in leadership programmes Working with Planning and Estates team to ensure the Queens Canopy is designed to promote clear walking routes for that can be used during breaks for meetings Inclusion of break times and staff rooms in wellbeing survey to audit current provision. • Chaplaincy service for staff • Re-launching Chill out in the Chapel • Recruitment of staff counsellors • Establishment of new bilingual Health and Well-being AB Pulse page on the intranet with library of resources for staff well-being • Scope, design and deliver a programme of research ‘Healthy Working Day’. • Enhanced our financial well-being offer.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Monitoring Framework to support roll out of the People Plan 22-25 • Monitoring of demand on wellbeing services • Staff diversity networks • Race/LGBT groups **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • People and Culture Committee reports (People Plan 22-25) • Local surveys • LNC – reporting of compliance of BMA Rest and Facilities **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • National workforce surveys • Monitoring and compliance of BMA Rest and Facilities via NHS Employers	**Gaps in Assurance** • Under review **Action to Address Gaps in Assurance** • Meetings with Divisions ongoing.	**Positive Assurance**

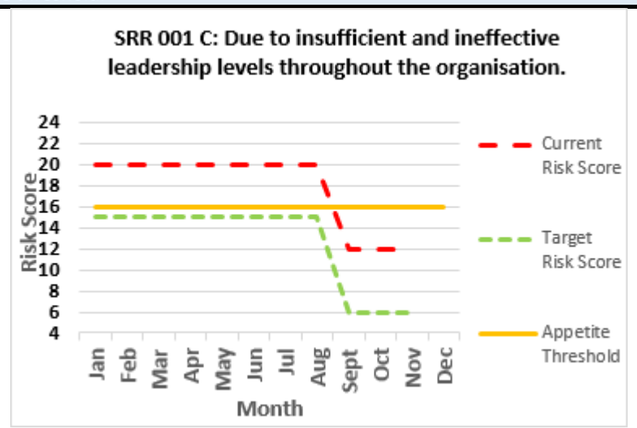
	• Support offered to Trade Union Representatives and their members to ensure a positive experience of work and rapid escalation when appropriate. • Support availability of "Safe Space" conversations for senior medical leaders from Faculty of Medical Leadership & Management. • Drafting of a 10-year plan focusing on optimising the employee experience of work • The Avoidable Employee Harm Programme was launched on 5th July 2022 initially focusing on HR processes it will then look to other formal processes that inadvertently cause harm to all those involved and the organisation. The training day that supported the launch has evaluated very well and organisations beyond ABUHB are keen to engage. Within ABUHB we have subsequently seen a >60% reduction in gross misconduct investigations. **Occupational Health** • Occupational Health and NWSSP are working in partnership to implement a new Occupational Health Software system across Wales called OPASG2. OPASG2 provides benefits to employment and recruitment processes. • Occupational Health and the Well-being Service continue to work with Therapies colleagues on support for staff experiencing Long Covid-19. • Reviewed Occupational Health provision and consider options to improve sustainability within the service, paper drafted. **Support equality and diversity of workforce** • Review of staff diversity networks • Review of wellbeing survey through and equality lens to understand variations within diverse workforce demographic profile. • Development of a buddy system to assist international medical staff with induction and orientation and support values and current norms. • Development of an empowerment passport to support disabled staff and reasonable adjustments and wellbeing. **Other** • Assessment of compliance against BMA Rest and Facilities charter complete with action plan developed, reporting to LNC. • Reducing fatigue poster developed			

RISK THEME	PEOPLE			
Strategic risk (SRR 001C)	**The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**			
Strategic Threat	c) Due to insufficient and ineffective leadership levels throughout the organisation			
Impact	➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Failure to deliver health board priorities, required improvements and achieve sustainability ➢ Poor levels of accountability and delivery ➢ Reputational damage to the health board as an employer ➢ Adverse impacts on staff recruitment and retention			
Lead Director	Director of Workforce & Organisational Development	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	People & Culture Committee	**Likelihood**	**3** *(Possible)* *x*	3 *(Possible)* x
Initial Date of Assessment	01/06/2023	**Impact**	**4** *(Major)*	2 *(Minor)*
Last Reviewed	10/10/2023	**Risk rating**	**= 12** *(High)*	**= 6** *(Moderate)*

Risk Appetite Level – Open
Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.

Risk Appetite Threshold - Score 16 and below
Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.

SUMMARY
The current risk level is **outside** of target level but within appetite threshold. The target level to be achieved is **within** the set appetite threshold.



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Monitoring Framework to support roll out of the People Plan- focus on Talent and Succession Planning • Monitoring frameworks with HEIW	**Talent and Succession Planning** • lead appointed in July 2023 on a 6-month secondment funded by HEIW to create an organisational talent management framework to enable the organisation to deliberate and consistently attract, identify and develop talent for critical roles across ABUHB • Pilot planned for Finance, Occ Health and divisional managers focusing on how to identify critical roles, development sessions on holding career conversations and culminating in a Talent Management Strategy • Local management trainee scheme scoped, and project plan created, JDPS created and evaluated. Project team convened. Paused in May 2022 due to lack of funding. • 2021/23 HEIW schemes complete. Two HEIW Grads have successfully completed the programme and have secured promotional roles within NHS in Wales; one within the health board and one at Powys, both at Band 7 level • 1 x HEIW funded graduate management trainee successfully appointed August 2023 following additional recruitment process. Executive Director of Planning sat on interview panel. Trainee commences scheme 5th September 2023 at HEIW at joins ABUHB Friday 8th September. **Development leadership capabilities** • Designing learning journeys and access to Gwella • Leadership journey and programmes mapped and 1 pager flyer designed & on intranet. Exploring Directorate Manager development. • CDx Leadership Development for clinical directors completed for 2022/23 with 45 attendees and CDx cohort 2 starts October 23- open for current and aspiring CDs	Level 1 Operational *(Implemented by the department that performs daily operation activities)* • WOD Divisional reporting • Evaluation of internal leadership programmes Level 2 Organisational *(Executed by risk management and compliance functions.)* • Reporting to People and Culture Committee - progress against People Plan 22-25 **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • Internal Audit Review • Talent and Succession Board	**Gaps in Assurance** • Under review **Action to Address Gaps in Assurance**	**Positive Assurance**

	• 2022/2024 Academi Wales scheme the Health Board are sharing a graduate with Monmouthshire Council, our Graduate joined the Health Board in March 2023 and is supporting the decarbonisation agenda.			

RISK THEME	PEOPLE			
Strategic Risk (SRR 001D)	**The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**			
Strategic Threat	d) Due to the threat of Industrial Action during ongoing disputes and negotiations at a national level			
Impact	➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Non-compliance with safe staffing principles and standards ➢ Litigation & Financial Penalties ➢ Reputational damage to the health board and loss of public confidence			
Lead Director	Director of Workforce & Organisational Development	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	People & Culture Committee	**Likelihood**	**4** *(Likely)* x	**2** *(Unlikely)* x
Initial Date of Assessment	01/06/2023	**Impact**	**4** *(Major)*	**4** *(Major)*
Last Reviewed	10/10/2023	**Risk rating**	**= 16** *(Extreme)*	**= 8** *(High)*

Risk Appetite Level – Open
Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.

Risk Appetite Threshold – Open Score 16 and below
Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.

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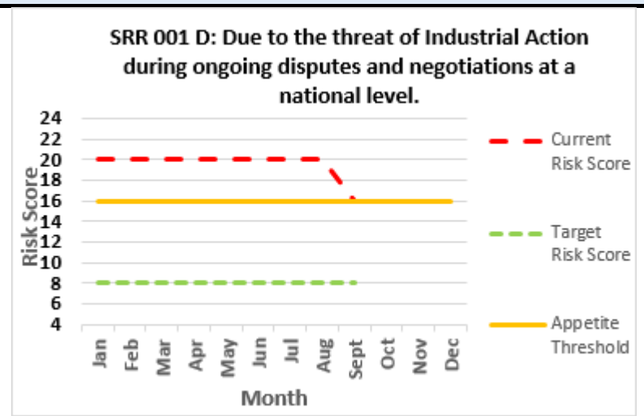


Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Section 234A of the Trade Union and Labour Relations (Consolidation) Act 1992; and • CODE OF PRACTICE Industrial Action Ballots and Notice to Employers • Under sections 231 and 231A of the 1992 Act a union must, as soon as reasonably practicable after holding an industrial action ballot, take steps to inform all those entitled to vote18, and their employer(s), of the number of individuals entitled to vote in the ballot; the number of votes cast in the ballot. • Business Continuity Processes - Redeployment Principles and Risk Assessment agreed. • Duty of Quality - Section 6.8.2 Workforce and Section 6.8.3 Culture • Operational planning, led by the Chief Operating Officer, to respond to implications of strikes action in other NHS organisations.	• Services Business continuity plans in place. • All Wales training sessions provide by legal and risk to support industrial action. • Ensure early identification of mandated Statutory, and core critical clinical services. • Trade union provides a list of the categories of employee to which the affected employees belong, figures on the number of employees in each category, figures on the numbers of employees at each workplace, the total number of affected employees. Such information will enable the employer to readily deduce the total number of employees affected, the categories of employee to which they belong, the number of employees concerned in each of those categories, the workplaces at which the employees concerned work and the number of them at each of these workplaces. • Reducing impact on patients - Support for early supported discharge prior to industrial action. • Trade Unions specifies: (i) whether the union intends the industrial action to be "continuous" or "discontinuous" (14); and (ii) the date on which any of the affected employees will be called on to begin the action (where it is continuous action), or the dates on which any of them will be called on to take part (where it is discontinuous action). • Establish WOD hub with emergency planning to stand up as required • Ensure early identification of mandated Statutory, and core critical clinical services. • Review of business continuity plans • Map services and staff provision and impacts of industrial action. • Assess variable pay usage in case of work to rule applies.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Local Staff re-deployments assessment • Trade Union Partnership meetings **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Reporting to Executive team • Business Continuity groups **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)*	**Gaps in Assurance** • Unknown outcome of current BMA ballot and outcomes if members vote for industrial action the level of action imposed or if all medical staff will be involved, mitigating actions would not support whole scale medical workforce. **Action to Address Gaps in Assurance**	**Reasonable Assurance**

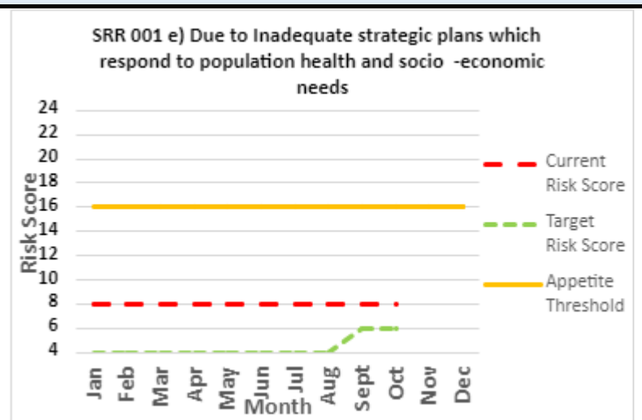
	• Assess current vacancies. • Working with partners in Gwent on a system wide basis. • Implementation of business continuity plans. • Communication plans. • Establish working mechanisms with NWSSP to consider derogations for junior doctors (who are the employer).	• All Wales IA group		

RISK THEME	SERVICE DELIVERY			
Strategic risk (SRR 001)	**There is a risk that the Health Board will be unable to deliver and maintain high quality, safe and sustainable services which meet the changing needs of the population.**			
Strategic Threat	**E) Due to inadequate strategic plans which respond to population health and socio-economic needs.**			
Impact	➢ Increased demand ➢ Increased patient acuity levels ➢ Worsening of health inequalities ➢ Worsening of health outcomes ➢ Failure to train teams in multi-morbidity management ➢ Failure to comply with the Wellbeing of Future Generations Act (Wales) ➢ Reputational damage and loss of public confidence			
Lead Director	Director of Strategy, Planning and Partnerships.	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Partnerships, Public Health & Planning Committee	**Likelihood**	2 *(Unlikely)*	2 *(Unlikely)* x
Initial Date of Assessment	01/06/2023	**Impact**	4 (*Major)*	3 *(Moderate)*
Last Reviewed	10/10/2023	**Risk rating**	**= 8** *(High)*	**= 6** *(Moderate)*

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

Risk Tolerance Level - Open Score 16 and below
Risks relating to all aspects of our ability to deliver, manage and improve service quality and performance along with all relating risks relating to the current performance of our infrastructure such as IM&T and estates including our ability to deliver associated strategy.

SUMMARY
The current risk level is **outside** of target level and appetite threshold. The target level to be achieved is **within** the set appetite threshold.



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Health Board IMTP and associated KPIs • Public Health Wales surveillance data • Qliksense – performance dashboard • Population Needs Assessment and Area Plan • Marmot Region Programme	• Area plan is being refreshed through the RPB Marmot Region Implementation Plan Population health management – test and learn using segmentation and risk satisfaction using linked data to target resource. Refresh organisational strategy with a central focus on population health and wellbeing. Action through SEW Regional Collaborative to identify additional service areas where collaboration and networking would support sustainability.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Qliksense – performance information • SFN – performance information **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • IMTP Delivery and Outcomes Reporting to Board • Marmot Region Programme • RPB reporting to Board and Population Health, Planning and Partnerships Committee • Regional Planning reporting to Population Health, Planning and Partnerships Committee • Clinical Futures Programme Reporting to Population Health, Planning and Partnerships Committee **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* Internal Audit Reviews 2023-24	**Gaps in Assurance** • Under review **Action to Address Gaps in Assurance**	**Reasonable Assurance**

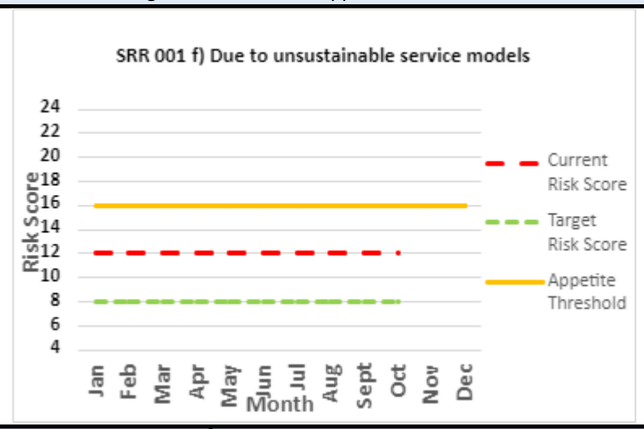
		1. IMTP Planning (Q1) Outcome – Reasonable Assurance		

RISK THEME	SERVICE DELIVERY			
Strategic risk (SRR 001)	**There is a risk that the Health Board will be unable to deliver and maintain high quality, safe and sustainable services which meet the changing needs of the population.**			
Strategic Threat	**F) Due to unsustainable service models**			
Impact	➢ Harm or injury to patients and/or staff ➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Increased demand ➢ Increased patient acuity levels ➢ Worsening of health inequalities ➢ Worsening of health outcomes ➢ Failure to deliver health board priorities, required improvements and achieve sustainability ➢ Reputational damage and loss of public confidence			
Lead Director	Director of Strategy, Planning and Partnerships.	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Partnerships, Public Health & Planning Committee	**Likelihood**	3 *(Possible)* x	2 *(Unlikely)* x
Initial Date of Assessment	01/06/2023	**Impact**	4 *(Major)*	4 *(Major)*
Last Reviewed	10/10/2023	**Risk rating**	**= 12** *(High)*	**= 8** *(Moderate)*

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

Risk Tolerance Level - Open Score 16 and below
Risks relating to all aspects of our ability to deliver, manage and improve service quality and performance along with all relating risks relating to the current performance of our infrastructure such as IM&T and estates including our ability to deliver associated strategy.

SUMMARY
The current risk level is **outside** of target level but within appetite threshold.



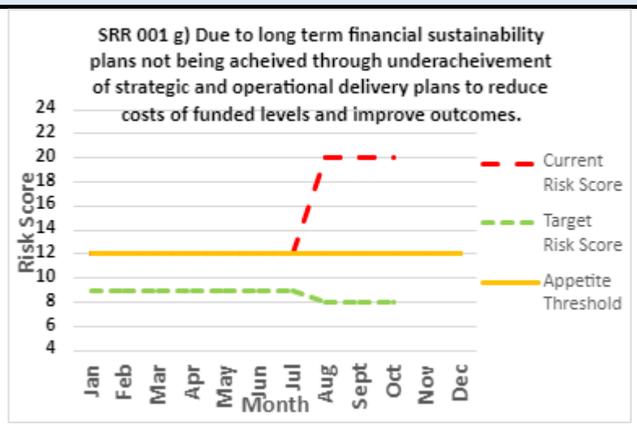
Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
The Health Board IMPT and associated KPIs Clinical Futures Transformation programmes. Public Health Wales surveillance data – Covid, flu and other communicable diseases. Qliksense – performance information. Population needs assessment and area plan development by the RPB. Southeast Wales Plan for fragile services.	Area plan is being refreshed through the RPB. Population health management – test and learn using segmentation and risk satisfaction using linked data to target resource. Review of enhanced local general hospital service models to ensure sustainable quality services. • Development of SEW plan for fragile. Review of organisational strategy – to launch Summer 2024.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Public Health Wales surveillance data – COVID, flu and other communicable diseases. • Qliksense – performance information. **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • IMTP delivery and outcomes reporting to Board. • RPB reporting to Board and Population Health, Planning and Partnerships Committee. • Regional Planning reporting to Population Health, Planning and Partnerships Committee. • Clinical Futures Programme Reporting to Population Health, Planning and Partnerships Committee. **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • Internal Audit Reviews 2023-24 • IMTP planning Q1 Outcome – Reasonable Assurance.	**Gaps in Assurance** • To be determined. **Action to Address Gaps in Assurance**	**Reasonable Assurance**

RISK THEME	FINANCIAL SUSTAINABILITY			
Strategic Risk (SRR 001)	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**			
Strategic Threat	**G) Due to long-term financial sustainability plans not being achieved through underachievement of strategic and operational delivery plans to reduce costs to funded levels and improve outcomes.**			
Impact	➢ Breach of statutory duty to breakeven over 3 years. ➢ Instigation of NHS Wales Escalation & Intervention Arrangements. ➢ Non–delivery of health board priorities, required improvements, and achieving longer-term sustainability. ➢ Prioritisation and possible disinvestment in service delivery. ➢ Reputational damage and loss of public confidence			
Lead Director	Director of Finance and Procurement	**Risk Exposure**	**Current Level**	**Target**
Monitoring Committee	Finance & Performance Committee	**Likelihood**	5 *(Almost certain)* x	2 *(Unlikely)* x
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Major)*	4 *(Major)*
Last Reviewed	10 November 2023	**Risk rating**	**= 20** *(Extreme)*	**= 8** *(Moderate)*

Risk Appetite Level - Cautious.
Preference for safe, through accept there will be some risk exposure: medium likelihood of occurrence of the risk after application of controls.

Risk Appetite Threshold - Score 12 and below
Risks relating to all aspects of our financial performance and our ability to manage cost and efficiencies.

SUMMARY
the current risk level is **outside** of the target and appetite threshold. The target level to be achieved is **within** the set appetite threshold.



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• IMTP 2023/24-25/26 • IMTP Delivery Framework • Accountability Framework • Performance Framework • Scheme of Delegation • Standing Financial Instructions (SFIs) • Standing Orders (SOs) • Financial Control Procedure (FCP) Budgetary control • Financial Budget Intelligence (FBI) • Budget holder training • Cost intervention procedures • 23/24 savings plans & opportunities. • Health Board financial escalation processes. • Health Board Pre-Investment Panel (PIP) process. • Financial assessment and review to incorporate the financial impact of COVID-19 and other key costs.	• Update performance management framework – in place • Assessment of financial control environment within divisions and corporate teams. – in place	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Adherence to SO/SFI/FCPs • Regular AFD meetings to discuss position and performance. • Divisional Assurance meetings are in place to implement savings plans and deliver service and workforce plans within available resources. **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Regular monitoring at the Executive Team reviewing the level of deliverable recurrent savings along with assessing cost avoidance and deferred investments. • Performance escalation meetings established • Financial assessment and review report to the Board and Finance & Performance Committee • Financial Governance and Accounting reports to the Audit, Risk and Assurance Committee. • Board Briefing sessions on the financial position. **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* **Internal Audit Reviews 2023 - 24** 1. Savings Programmes - Q3 Not yet undertaken. 2. Financial Controls – Q2 Not yet reported. 3. Asset Management – Q3 Not yet undertaken.	**Gaps in Assurance** • Greater focus is required on service, workforce, and financial plans all balancing to achieve financial sustainability. **Action to Address Gaps in Assurance** • Revise accountability arrangements being progressed as part of Executive governance. – in place	**Medium Assurance**

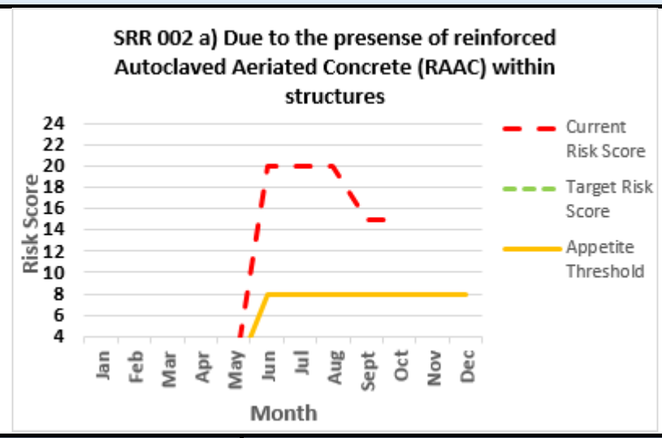
• Quarterly financial budget plan approach agreed. • Executive groups and structures established to deliver statutory duties		**External Audit Reports 2023 -24** 1. Efficiency Review Q3/Q4 2. Structured Assessment Q3/Q4 3. Audit of Financial Statements Q4 4. Financial assessment and review reports to Welsh Government		

RISK THEME	COMPLIANCE AND SAFETY			
Strategic Risk (SRR 002)	**There is a risk that there will be significant failure of the Health Boards Estates.**			
Strategic Threat	a) Due to the presence of Reinforced Autoclaved Aeriated Concrete (RAAC) within structures.			
Impact	Harm or injury to patients and/or staff. Adverse impacts on the delivery of care to patients across acute and non-acute settings. Non-compliance with health and safety legislation. Litigation and financial penalties			
Lead Director	Chief Operating Officer	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Partnerships, Public Health & Planning Committee	**Likelihood**	3 *(Possible)* x	1 (*Rare)* x
Initial Date of Assessment	01 June 2023	**Impact**	5 *(Catastrophic)*	2 *(Minor)*
Last Reviewed	10 October 2023	**Risk rating**	**= 15** *(Extreme)*	**= 2** *(Low)*

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

Risk Appetite Threshold - SCORE 8 AND BELOW
Risks relating to all aspects of patient safety but also including safeguarding, staff & public security in addition to risks relating to compliance and/or legal implications.

SUMMARY
The current risk level is **outside** of the target level and appetite threshold. The target level to be achieved is **within** the set appetite threshold



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Work to access the risk has been undertaken with expert external surveyor advice. • Current measures including props and additional support have been put in place in line with the latest guidance and learning from other organisations working through RAAC issues. Plans will be modified in line with any further guidance. • Remediation work to areas of high-risk areas	• Additional Surveys are to take place with expert surveyors to inform the next steps relating to further remediation of the issues.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Weekly checks in place for the additional props and will be undertaken by an external company in the coming weeks. • Ongoing engagement with expert surveyor and monitoring of RAAC. • The estate's function has controlled access to roof areas and has developed and implemented toolbox talks for awareness for estate teams and contractors to work in those areas. **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Estates and Facilities Divisional Compliance team engaged in supporting estate's function response to the ongoing management. • Health Board Fire and Health and Safety function engaged in fortnightly governance group to monitor risks and issues associated with any remedial measures implemented. **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • Weekly dialogue with Welsh Government and Shared Services Estates.	**Gaps in Assurance** • Ongoing management of the issues. **Action to Address Gaps in Assurance** • Additional surveys have been commissioned and will be undertaken as promptly as possible through the contractor to provide assurance on the work to date as well as determine further management of the risk/issues.	**Reasonable Assurance**

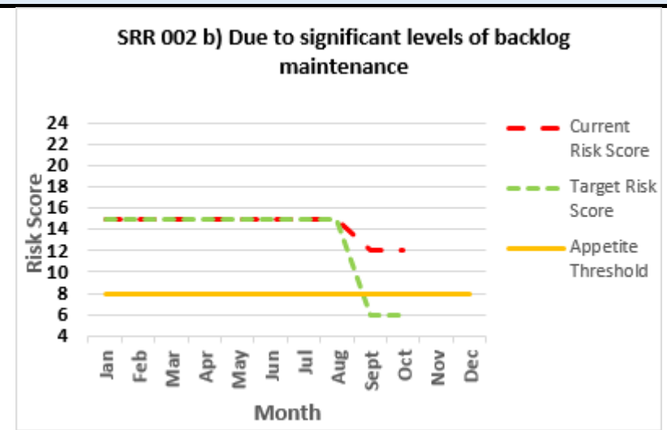
		• Links with NHS England and other Health Boards in Wales for shared learning. • Ongoing engagement of external surveyors for regular monitoring of the situation in line with recommended timelines.		

RISK THEME	COMPLIANCE AND SAFETY			
Strategic Risk (SRR 002)	**There is a risk that there will be a significant failure of the Health Board Estates.**			
Strategic Threat	B) Due to significant levels of backlog maintenance.			
Impact	Harm or injury to patients and/or staff. Adverse impacts on the delivery of care to patients across acute and non-acute settings. Non-compliance with health and safety legislation. ➢ Litigation and financial penalties.			
Lead Director	Chief Operating Officer	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Partnerships, Health Protection & Planning Committee	**Likelihood**	3 *(Possible)* x	3 *(Possible)* x
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Major)*	**2** *(Minor)*
Last Reviewed	10 October 2023	**Risk rating**	**= 12** *(High)*	**= 6** *(Moderate)*

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

Risk Appetite Threshold – SCORE 8 AND BELOW
Risks relating to all aspects of patient safety but also including safeguarding, staff & public security in addition to risks relating to compliance and/or legal implications.

SUMMARY
The current risk level is **outside** of the target level and appetite threshold. The target level to be achieved is **within** the set appetite threshold.



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Health Board Estates Rationalisation Strategy • Health Board Estates Strategy • Health Board policies and procedures related to the maintenance of Health Board estate. • 6 Facet survey completed in 2019. • Divisional Risk Register	• Active estate rationalisation (including leases) is required to reduce estate demands and help prioritise capital spend to reduce backlog maintenance. • A water/ventilation engineer to enable all critical ventilation systems to undergo annual validation in accordance with HTM 04/01. • Ongoing attempts to recruit to workforce gaps and a new model of Estate Officer also being developed to assist with recruitment and retention of staff in the workforce. • Planning function leading a review of capital priorities which may help identify additional funding priority given to backlog maintenance. • Policies being reviewed and priority given to out-of-date policies, but all policies will be reviewed for effectiveness and compliance with HTM.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Estates and Facilities division improved statutory compliance processes and forum led by Designated Person - DP (Divisional Director) • Divisional reporting of Statutory and Mandatory training of staff • Staff training levels are monitored and reported regularly. If areas of non-compliance are noted, targeted training can be resourced to ensure compliance. • The divisional risk register is reviewed quarterly by the Senior Management Board this is reported to the Quality & Patient Safety Operational Group. **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Outcome of the Asbestos reinspection programme • Regular reporting on estate condition to the Executive Committee and Partnerships, Health Protection & Planning Committee	**Gaps in Assurance** • AE reports have shown a deterioration in ratings last year. • Membership of HB-wide compliance groups needs to be extended to provide wider HB intelligence of estates. **Action to Address Gaps in Assurance** • The Divisional Director (and DP) is implementing a clear approach to compliance monitoring and escalation of AE reports.	**Reasonable Assurance**

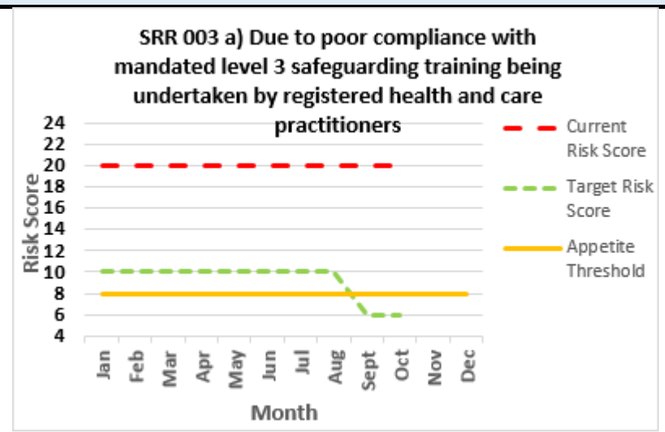
• Multiple policies and SOPs published and communicated to staff. • A robust internal training programme in place covering all aspects of estate management including food hygiene. • Asbestos reinspection programme (over the next 3 years)	• Drive clinical service engagement in compliance meetings where engagement is low. • Additional escalation for capital funding by the Division Estates and Facilities to support the prevention of seasonal issues and plant failure if possible.	**Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* **Internal Audit Reviews 2023- 24** 1. Estates Assurance - Estate Condition to be undertaken in Q3. 2. Authorising Engineer (Shared Service Estates) reports in line with normal timelines, but active engagement with AEs through compliance processes. 3. Health Board contributes to annual Estates Facilities and Performance Managements (EFPMS) at all Wales level	• HB-wide groups on compliance (such as Ventilation and water) are being widened in membership to ensure clinical services are active participants.	

RISK THEME	COMPLIANCE AND SAFETY			
Strategic risk (SRR 003)	**There is a Risk that the Health Board breaches its duties in respect of safeguarding the needs of children and adults at risk of harm and abuse.**			
Strategic Threat	a) Due to poor compliance with mandated level 3 safeguarding training being undertaken by registered health and care professionals.			
Impact	➢ Missed safeguarding concerns, resulting in harm or death. ➢ Vulnerable individuals not identified appropriately, resulting in harm or death. ➢ Lack of staff understanding of reporting and escalation process ➢ Health Board breaches statutory duties ➢ Litigation & Financial Penalties ➢ Reputational damage and loss of public confidence			
Lead Director	Director of Nursing	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Patient, Quality, Safety and Outcomes Committee.	**Likelihood**	4 *(Likely)* x	3 *(Possible)* x
Initial Date of Assessment	01 June 2023	**Impact**	5 *(Catastrophic)*	2 *(Minor)*
Last Reviewed	14 September 2023	**Risk rating**	**= 20** *(Extreme)*	**= 6** *(Moderate)*

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

Risk Appetite Threshold – Minimal SCORE 8 AND BELOW
Risks relating to all aspects of patient safety but also including safeguarding, staff & public security in addition to risks relating to compliance and/or legal implications.

SUMMARY
The current risk level is **outside** of target level and appetite threshold. The target level to be achieved is **within** the set appetite threshold.



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Safeguarding policies • Safeguarding Training offered at level 1 & 2 via ESR. (Current compliance data - adult & child level 1 -81%; Children level 2 55.7% Adult level 2 58.0) • Supervision and case review available. • Safeguarding Hub –for ad hock advise from a band 7 safeguarding lead nurse: Monday – Friday 09.00 – 17.00 • Utilising all communication methods available to promote completing safeguarding training.	• Updated training packages. • Training sessions booked for children and adult level three safeguarding training. • Communication with practitioners, via share point intranet pages, emails to divisional nurses. • Protected time to complete Level 2 and 3 training when possible. • Clear mandate of level 3 training is required on ESR.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Training compliance reported at Senior Nursing Team meetings. • Good use of the adult and child safeguarding hub facility **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Robust monitoring of safeguarding activity through the Safeguarding Committee via quarterly reporting • Safeguarding Committee Assurance Report to the Patient Quality, Safety & Outcomes Committee *(PQSOC)* • Audit Reports reviewed by the Audit, Risk and Assurance Committee (ARAC) • Progress of Audit Recommendations monitored and tracked through the ARAC. **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* **Internal Audit 2023 – 24**	**Gaps in Assurance** • As level three training is mandated every three years, the expectation is that we will not see a full level of compliance until 2026. • Level 2 safeguarding training compliance levels below expectation of 85%. **Action to Address Gaps in Assurance** • Spot check of Level 2 safeguarding training through ESR to target improvement. • Monitor at SMT	**Reasonable Assurance**

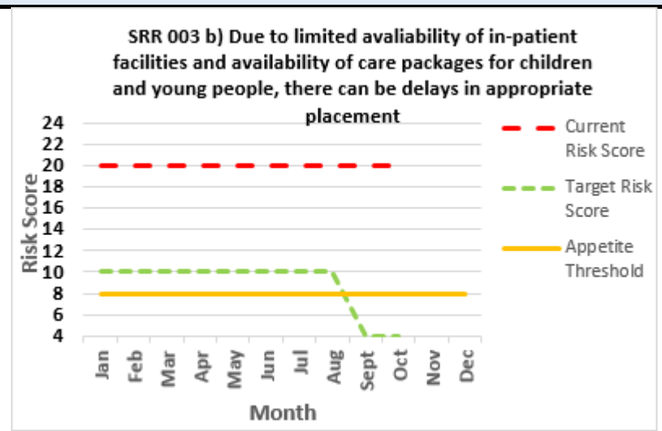
		1. Safeguarding (Q1) Reasonable Assurance Outcome 2. HIW Inspections		

RISK THEME	COMPLIANCE AND SAFETY			
Strategic risk (SRR 003)	**There is a Risk that the Health Board breaches its duties in respect of safeguarding the needs of children and adults at risk of harm and abuse.**			
Strategic Threat	b) **Due to limited availability of in-patient facilities and availability of care packages for children and young people, there can be delays in appropriate placements.**			
Impact	➢ Harm or injury to patients and/or staff ➢ Health Board breaches statutory duties ➢ Litigation & Financial Penalties ➢ Reputational damage and loss of public confidence			
Lead Director	Chief Operating Officer	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Patient, Quality, Safety and Outcomes Committee.	**Likelihood**	4 *(Likely)* x	2 *(Unlikely)* x
Initial Date of Assessment	01 June 2023	**Impact**	5 *(Catastrophic)*	2 *(Unlikely)*
Last Reviewed	14 September 2023	**Risk rating**	**= 20** *(Extreme)*	**= 4** *(Moderate)*

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

Risk Appetite Threshold – Minimal SCORE 8 AND BELOW
Risks relating to all aspects of patient safety but also including safeguarding, staff & public security in addition to risks relating to compliance and/or legal implications.

SUMMARY
The current risk level is **outside** of the target level and appetite threshold. The target level to be achieved is **within** the set appetite threshold.



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• CAMHS now have a team of healthcare support workers, at band 4 (our BOOST team), who are in the process of being trained, prior to being ready to be available over 7days to directly support young people who are in hospital because of a delayed discharge. • CAMHS have an agreement with adult Mental Health Services in place, enabling us to access a 'holding bed 'situated in the Extra Care area at Ty-Cyfanol ward, at YYF. This allows us to support young people experiencing suspected serious mental illness for up to 72 hours, whilst a gatekeeping assessment is carried out by our colleagues at the tier 4 in-patient unit. • Our Emergency Liaison Team are present at GUH on a daily basis, assessing young people at the point of need.	• Development of the CAMHS Crisis Hub (CCH), based at Bettws ward in St Cadoc's. We are in the process of developing a safe space for families and young people who are in distress, so that they have access to a team of people, out of hours, who can work directly with them in order to attempt to prevent burgeoning emotional distress from developing into a crisis situation that can cause further trauma. The CCH is being developed in order to help young people who fit the following criteria: • Young people whose distress compels them to frequently attend the Emergency Department, or who frequently find themselves detained under section 136 of the Mental Health Act. • Young people who having been assessed under Section 136 at the Section 136 suite at Adferiad, find themselves discharged with no immediate safe discharge destination.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Senior Management Team meetings to track progress against the action plan. • Twice-daily X-Site flow meetings to provide a position report **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Regular reporting to the Patient Quality, Safety & Outcomes Committee • Regular reporting to the Mental Health Act Monitoring Committee • Reporting to the Executive Committee **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)*	**Gaps in Assurance** • Under review **Action to Address Gaps in Assurance**	**Reasonable Assurance**

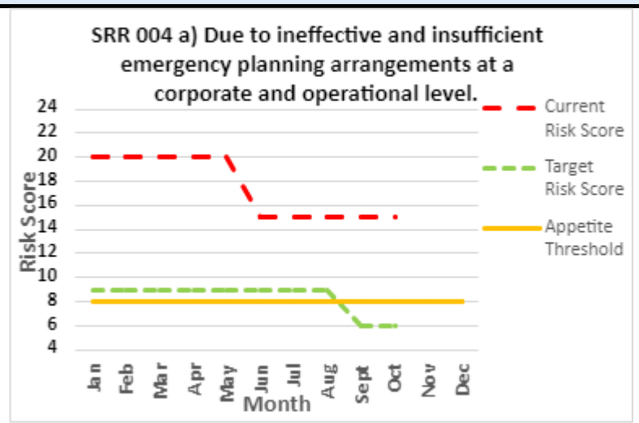
• Windmill farm therapeutic residential home, a partnership project between CAMHS and social services, is now open and can accommodate young people struggling with complex mental distress that are environmental and not organic. There are 4 places at the home, and we have already successfully placed, supported, and transitioned several young people who may previously have required an out of county placement. • BOOST team manager in place. • Crisis Outreach Team are the designated team who manage and co-ordinate admission to the holding bed. • Standard Operational Policy in place for CAMHS teams to be able to access BOOST workers. • Agreed referral process to Windmill Farm, with a gatekeeping team comprised of CAMHS and social care colleagues who are able to advise whether or not a referral is suitable; attendance at Complex Needs panels to operationalise the gatekeeping process. • Standard operational policy and care pathway in place for admission to the holding bed. • Detailed Standard Operational Policy in place for Windmill Farm. • Regular communication meetings between CAMHS teams and the Windmill Farm team.	• Young people who having presented at the Emergency Department following self-harm or overdose requiring medical treatment, are admitted overnight for treatment as per NICE guidelines, but once medically fit do not have a safe discharge destination, resulting in an extended stay at GUH for social reasons. In these cases, qualified professionals and BOOST support workers will work closely with the family and colleagues from social care, in order to ensure that a safe discharge can be agreed. • Young people who are currently working with a CAMHS professional and are felt to be at risk of experiencing imminent mental health crisis and cannot be supported out of hours by the referring professional. The aim will be to focus on helping young people to stay safe by working with them to develop a short- term plan of what to do in the moment. The CCH will provide a venue that is safe, so that community -based treatment at the point of crisis can be implemented in the least restrictive of settings. • Regular Crisis Hub planning meetings; ongoing development of the SOP; recruitment of a Crisis Hub team lead.	• HIW Inspections of Mental Health Wards across all sites		

RISK THEME	COMPLIANCE AND SAFETY			
Strategic risk (SRR 004)	**There is a risk that the Health Board is unable to respond in a timely, efficient, and effective way to a major incident, business continuity incident or critical incident.**			
Strategic Threat	a) Due to ineffective and insufficient emergency planning arrangements at a corporate and operational level.			
Impact	➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Harm or injury to patients and/or staff ➢ Health Board breaches statutory duties under the Civil Contingencies Act 2004 ➢ Litigation & Financial Penalties ➢ Reputational damage and loss of public confidence			
Lead Director	Director of Strategy, Planning and Partnerships	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Partnerships, Public Health & Planning Committee	**Likelihood**	3 *(Possible)* x	2 *(Unlikely)* x
Initial Date of Assessment	01/06/2023	**Impact**	5 (*Catastrophic)*	3 *(Moderate)*
Last Reviewed	10/10/2023	**Risk rating**	**= 15** *(Extreme)*	**= 6** *(Moderate)*

Risk Appetite Level – Minimal
Ultra-safe leading to only minimum risk exposure as far as practicably possible; a negligible/ low likelihood of occurrence of the risk after application controls**.**

Risk Appetite Threshold – Minimal Score 8 and below
Risks relating to all aspects of patient safety but also including safeguarding, staff and public security in addition risks relating to compliance and/or legal implications.

SUMMARY
The current risk level is **outside** of target level and appetite threshold. The target level to be achieved is **within** the set appetite threshold.



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
Major Incident • Health Board major incident plan in place. • Local/Divisional action cards are in place. • Training undertaken service-specific relating to local response. • Regular liaison with Gwent Local Resilience Forum (Strategic and tactical) **Business Continuity (BC) /Critical Incident** • BC Policy • BC Response Guidance • BC Template • BC Exercise • BC debrief learning. • HB and LRF Plans. 3 C (Command/Control, Communication) structure in place to respond to incidents.	• Testing programme of business continuity plans. • Review of revised Civil Contingency Act anticipated later this year to determine the impact on the Health Board. • Improved Engagement with Divisions, Directorates, and service areas to embed contingency planning in the culture of the organisation, Conduct BIAs develop plans, Exercise, review, to mitigate the risks and threats to service delivery. • Repository being created on intranet for BC plans to be added by areas for audit, maintenance, review of interdependencies. • Joint planning with PH response in response to infection disease and public health incidence. • Provide quarterly training sessions for on call gold and silver managers, to maintain skills in incident management, update knowledge in relation to risks and learning from local and national incidents. Test and exercise using the multiagency Joint decision model and the principles of joint working (JESIP).	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Departmental debrief following an incident to inform learning and enhance controls. **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Debrief with key stakeholders following an incident to inform learning and enhance controls. • Report to the Executive Committee following any incident. **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* **Internal Audit Review(s)** 1. Business Continuity Planning (Q1) outcome report published.	**Gaps in Assurance** • Robustness of service business continuity plans **Action to Address Gaps in Assurance** • Recommendations for strengthening resilience following testing of service business continuity plans	**Reasonable Assurance**

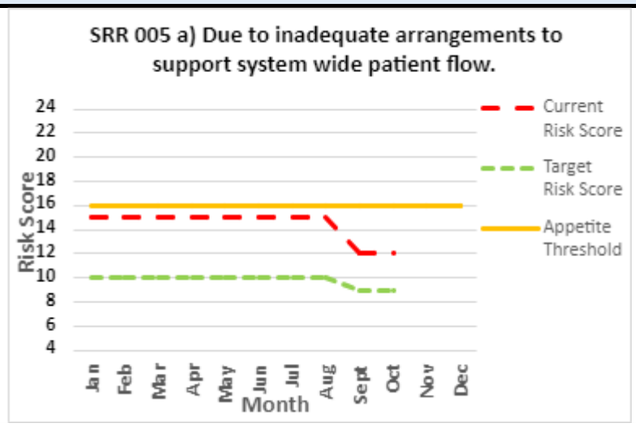
• Ongoing Participation in exercise UK, Wales, LRF and HB.	• Embed an alert, activation and escalation pathway that follows the Health Board predefined C3 (Command, control, and Co-Ordination) structure of strategic, tactical, and Operational. • Working with ICT to scope how to maintain critical communications during loss of IT linked telephone systems or national power outages. • Work with the communication team to improve incident cascade during an event to ensure Health Board wide awareness in a timely manner. • Continue to promote awareness in a timely manner. • Continue to promote awareness of the requirement for BC across the Health Board. • A tabletop BC exercise is planned for the 10th of October 2023. • Continuing participation in multi-agency exercises. • Programme plan to be developed to address the weaknesses in business continuity planning. • Review of revised Civil Contingency Act anticipated later this year to determine the impact on the Health Board. • Development of Pandemic Plan.	2. Outcome and feedback from national exercises		

RISK THEME	SERVICE DELIVERY			
Strategic Risk (SRR 005)	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system.**			
Strategic Threat	a) **Due to inadequate arrangements to support system-wide patient flow**			
Impact	➢ Avoidable deaths or significant harm ➢ Delays in releasing ambulances from hospital sites back into the community ➢ Delayed discharges from acute and non-acute settings resulting in deteriorating patients; ➢ Litigation & Financial Penalties ➢ Reputational damage and loss of public confidence			
Lead Director	Chief Operating Officer	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Patient Quality, Safety & Outcomes Committee	**Likelihood**	3 *(Possible)* x	3 *(Possible)* x
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Catastrophic)*	3*(Minor)*
Last Reviewed	14 September 2023	**Risk rating**	**= 12** *(High)*	**= 9** *(High)*

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

Risk Appetite Threshold – Open SCORE 16 AND BELOW
Risk related to all aspects of our ability to deliver, manage, and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.

SUMMARY
The current risk level is **outside** of target level but **within** appetite threshold.



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Escalation Policy. • Performance and Accountability Framework • Major incident Procedures • Daily X-site flow meetings - Twice daily flow calls to receive updates from all acute sites as well as community services. Allowing opportunity for escalation of risks. • Escalation communications – ambulance focussed email escalation when congestion begins to build up on the GUH forecourt. Aim to escalate to senior management to aid in quick risk-based decision making. Includes members of the Executive team. • Weekly safety flow forum – Cross divisional focused forum to look at priority areas to improve flow from across the system. Action focussed and task driven. • Range of performance measures/metrics in place • Repatriation mechanism with neighbouring Health boards – Daily repatriation calls between head of operations and counterparts in south Wales to ensure regular dialogue to repeat patients between hospitals and health boards.	• Escalation framework – evidence suggesting inconsistent escalation of ambulance position / long waits and rationale. • Winter planning – Ahead of winter 23/24 there are a series of meetings which will ensure that tangible / practical plans are put in place to ensure: • Focus • Processing power • Capacity • Mental health-focussed flow meeting – implement a MH-focussed daily forum to ensure the flow requirements and risk profile is understood across all MH sites. • Build in more impromptu, OoH and site visits to check on processes i.e., patient safety, risk, and performance across the Divisions. • Improve regional acceptance of flow processes with neighbouring Health Boards	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • The Escalation Framework has been enacted and is effective in mitigating threats and impact to services. • Performance report against measures/metrics **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Divisional Assurance reviews. • Performance against measures/metrics reported to the Executive Committee **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • **Internal Audit Reviews**	**Gaps in Assurance** • Evidence that the Escalation Framework is delivering improvements across all areas of patient flow e.g., ambulance handovers. • The impact of the Performance and Accountability framework in improving patient flow **Action to Address Gaps in Assurance** • Close monitoring and reporting of the frameworks in practice to support learning and improvements.	**Reasonable Assurance**

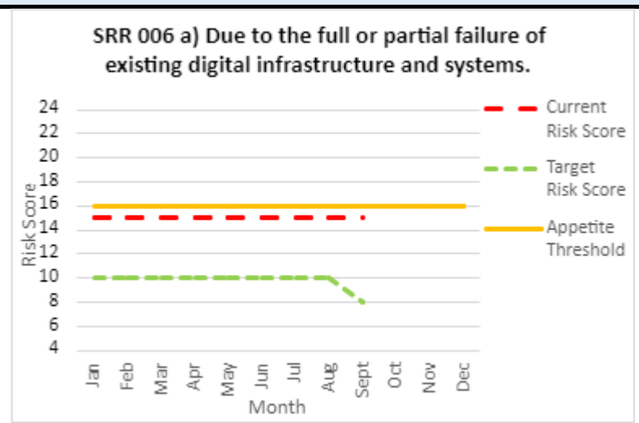
• Maximum Capacity Plan – Executive team agreed maximum capacity plan to ensure there is clear description ad guide for where extra capacity can be accessed to ensure patient flow is maintained. • Planned care recovery meetings with the NHS execs • Regular Dialogue with WAST regarding flow across the patch/regional and attending national calls. • WG – IQPD meetings to review areas of focus.		• Intra-site Patient Transfers (Q1) - Not Yet Reported (expected to be received at Audit, Risk & Assurance Committee in February 2024. • External inspections/visits.		

RISK THEME	SERVICE DELIVERY			
Strategic Risk (SRR 006)	**There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.**			
Strategic Threat	a) Due to the full or partial failure of existing digital infrastructure and systems.			
Impact	➢ Harm or injury to patients and/or staff ➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Data breaches ➢ Litigation & Financial Penalties ➢ Reputational damage and loss of public confidence			
Lead Director	Director of Digital	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Finance & Performance Committee	**Likelihood**	3 *(Possible)* x	2 *(Unlikely)* x
Initial Date of Assessment	01/06/2023	**Impact**	5 *(Catastrophic)*	4 *(Major)*
Last Reviewed	14/11/2023	**Risk rating**	**= 15** *(Extreme)*	**= 8** *(Moderate)*

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

Risk Appetite Threshold - Score 17 and below
Risk related to all aspects of our ability to deliver, manage and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.

SUMMARY
The current risk level is outside of target level but within appetite threshold. The target level to be achieved is within the set appetite threshold.



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall)*
• Cyber has developed a Remedial Action Plan to address issues identified within the NIS CAF assessment 2021. This Action Plan has also supported ABUHB risk remediation responses to ABUHB's NIS CAF Risk Register which by CRU to address risks identified during the NIS CAF assessment. The remedial actions proposed have been accepted by CRU and progress will be reviewed annually. • Cyber is fully engaged with IG colleagues to implement the recommendations of the Templar report. Cyber now supports all the Governance and Assurance Groups intending to increase cyber security awareness and build cyberculture amongst non-ICT staff • Cyber now undertakes scheduled monthly vulnerability scans of all ABUHB-managed servers to include third-party servers. The results of these scans will now be reported in the Monthly Cyber Report. • Cyber has also worked with Business Systems and Desktop Teams to ensure that patching compliance for internally managed systems and third-party systems is monitored and	• Information Governance and Cyber Security governance and assurance processes are now under review. Governance group terms of reference agreed, and reporting arrangements discussed with Director of Corporate Governance. Meetings will commence in November with clear reporting on progress to the relevant committees on our cyber security action plan. • SIRO training arranged for the 25th September for the Director of Digital (SIRO) and Chief Information Officer (Deputy SIRO).	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Internal directorate meetings being setup monthly to monitor risks to regularly update and to provide assurance over outstanding action plans. **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Regular Reporting to the Finance & Performance Committee **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • Internal audit for cyber security in April 2023 provided Digital with a substantial audit for its cyber security improvement plan, reporting and backup systems.	**Gaps in Assurance** • Governance and assurance groups. • Oversight from NHS Wales Cyber Resilience Unit. **Action to Address Gaps in Assurance**	**Reasonable assurance**

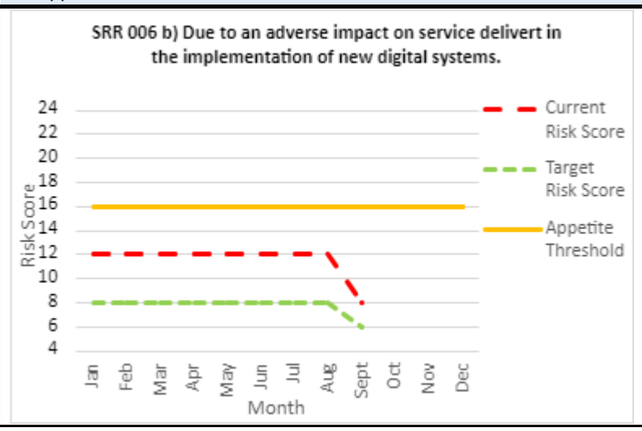
reported monthly. Monthly review meetings are held between Cyber and the Teams to review compliance levels against policy. Results are captured within the monthly Cyber Report. • Cyber has worked with ICT Support Teams and the Log4j version 2 vulnerability has been resolved within the Health Board. The less service impacting Version 1 is being managed through ICT Departmental risk management process. • Cyber has maintained the use of Trust ware for all emails Trustwave provides inspection and protection from malicious links embedded within emails • Cyber has begun the roll out simulated phishing campaigns the initial phish has been tested on ICT Department and reported within the Cyber Report. Cyber will continue campaigns during 2023 to increase email security awareness among staff. • Cyber has also introduced scenario-based incident response exercising using National Cyber Security Centre developed 'Exercise in a box' the aim is to assess our current skills in responding to real-life cyber security incident scenarios and to identify improvements. Cyber plans to run several more exercises during 2023				

RISK THEME	SERVICE DELIVERY			
Strategic Risk (SRR 006)	**There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.**			
Strategic Threat	b) Due to an adverse impact on service delivery in the implementation of the new digital systems.			
Impact	➢ Harm or injury to patients and/or staff ➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Data breaches ➢ Litigation & Financial Penalties ➢ Reputational damage and loss of public confidence			
Lead Director	Director of Digital	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Finance & Performance Committee	**Likelihood**	3 *(Possible)* x	2 *(Unlikely)* x
Initial Date of Assessment	01/06/2023	**Impact**	4 *(Major)*	4 *(Major)*
Last Reviewed	14/11/2023	**Risk rating**	**= 12** *(High)*	**= 8** *(Moderate)*

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

Risk Appetite Threshold - Score 17 and below Risk related to all aspects of our ability to deliver, manage and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.

SUMMARY
The current risk level is outside of target level but within appetite threshold. The target level to be achieved is within the set appetite threshold



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Adoption of formal project management methodologies PRINCE 2 to ensure project plans are developed in conjunction with services. • Formal governance arrangements in place through project boards and programme boards where risks and issues are managed and mitigated. • Each project has a senior responsible officer from the service who can provide challenge and assurance over the delivery of the project works packages. • Each clinical project has clinical leaf who would advise and support potential impacts on service delivery caused by the implementation of new digital services. • Business change team in place to support services in improvement of clinical and administrative processes.	• Additional governance being put in place with the Digital, Data and Technology Sub-Committee which will report to the Finance & Performance Committee	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Internal directorate meetings being setup monthly to monitor risks to regularly update and to provide assurance over outstanding action plans. • Project Boards meet monthly and report into the quarterly Programme Delivery Board • Digital Directorate meetings being held monthly to monitor risks to regularly update and to provide assurance over outstanding action plans. • Risk management approach and escalation processes in place in line with the Health Board's Risk Framework. • Governance and assurance groups. • Oversight from NHS Wales Cyber Resilience Unit. **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Regular Reporting to the Finance & Performance Committee	**Gaps in Assurance** **Action to Address Gaps in Assurance**	**Reasonable assurance**

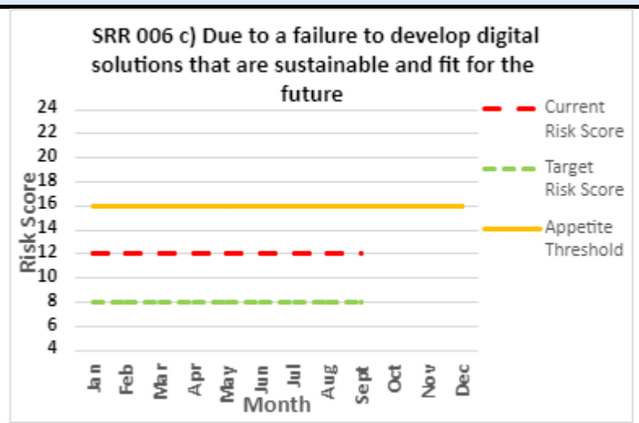
• Benefits team in place who identify, track and ensures any benefits are realised which will ultimately improve service delivery. • Projects support backfilling of clinical time where required		**Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • Internal audit for cyber security in April 2023 provided Digital with a substantial audit for its cyber security improvement plan, reporting and backup systems.	Information Governance Sub Committee Terms of Reference have been drafted and are under review. Cyber Security Sub Group ToR also drafted and membership agreed.	

RISK THEME	SERVICE DELIVERY			
Strategic Risk (SRR 006)	**There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.**			
Strategic Threat	c) Due to failure to develop digital solutions that are sustainable and fit for the future.			
Impact	➢ Harm or injury to patients and/or staff ➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Data breaches ➢ Litigation & Financial Penalties ➢ Reputational damage and loss of public confidence			
Lead Director	Director of Digital	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Finance & Performance Committee	**Likelihood**	3 *(Possible)* x	2 *(Unlikely)* x
Initial Date of Assessment	01/06/2023	**Impact**	4 *(Major)*	4 *(Major)*
Last Reviewed	14/11/2023	**Risk rating**	**= 12** (High)	**= 8** *(Moderate)*

Risk Appetite Level – OPEN
Willing to consider all potential options, subject continued application and /or establishment of controls; recognising that there could be a high-risk exposure.

Risk Appetite Threshold - Score 17 and below
Risk related to all aspects of our ability to deliver, manage and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.

SUMMARY
The current risk level is outside of target level but within appetite threshold. The target level to be achieved is within the set appetite threshold



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• New Digital Service Request process in place which provides governance in several key areas: • Information Governance – ensuring new services have appropriate controls to keep patient information safe. • Cyber Security – ensuring new services adopted or developed meet the requirements of the cyber assessment framework. • Patient Safety – ensuring services do not introduce any patient safety risks.	• New governance structures to be put in place by the end of 2023. • Review of New Digital Request processes considering governance changes.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Internal directorate meetings being setup monthly to monitor risks to regularly update and to provide assurance over outstanding action plans. **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Regular Reporting to the Finance & Performance Committee **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)*	**Gaps in Assurance** To be determined **Action to Address Gaps in Assurance**	**Reasonable assurance**

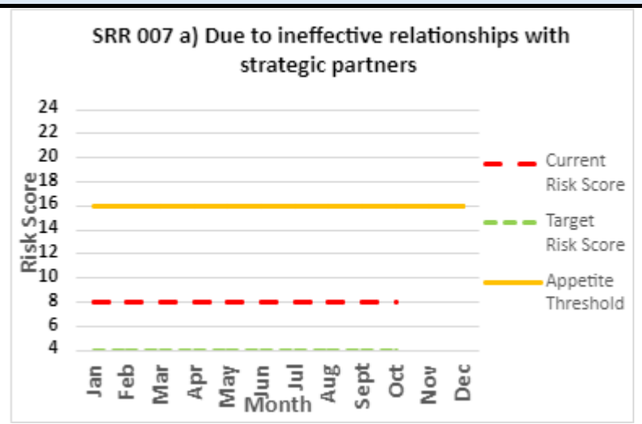
• Records – ensuring new systems comply with the requirements of records management. • Strong business analysis function in operation which ensures the “as-is” and “to-be” process mapping is undertaken which provides assurance that new services implemented are fit for purpose and delivery what stakeholders require. • Business change function which ensures implemented systems are effective and deliver the benefits required. • Formal framework in place for the adoption of new digital services and best practice guidance followed. • Operational delivery aligned to ITIL standards		• Internal audit for cyber security in April 2023 provided Digital with a substantial audit for its cyber security improvement plan, reporting and backup systems.		

RISK THEME	TRANSFORMATION AND PARTNERSHIP WORKING			
Strategic Risk (SRR 007)	**There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population.**			
Strategic Threat	a) **Due to ineffective relationships with strategic partners**			
Impact	➢ Unmet patient need resulting in harm ➢ Ineffective use of combined resources ➢ Delayed decision making ➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Failure to deliver health board priorities, required improvements and achieve longer-term sustainability ➢ Reputational damage and loss of public confidence			
Lead Director	Director of Strategy, Planning, and Partnerships.	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Partnerships, Public Health & Planning Committee	**Likelihood**	2 *(Unlikely)* x	2 *(Unlikely)* x
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Major)*	2 *(Minor)*
Last Reviewed	10 October 2023	**Risk rating**	**= 8** *(Moderate)*	**= 4** *(Moderate)*

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

Risk Appetite Threshold - S**CORE 16 AND BELOW**
All risks relating to our ability to engage effectively with other organisations including development of collaborations and partnerships along with all risks associated with innovation, transformation, and strategic change.

SUMMARY
The current risk level is **outside** of target level but **within** appetite threshold. The target level to be achieved is **within** the set appetite threshold.



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
The Health Board plays an active role in a range of formal partnership arrangements to enable integrated working for the population including: 1. **The Gwent Public Services Board (Gwent PSB)** brings public bodies together to work to improve the economic, social, environmental, and cultural well-being in Gwent. They are responsible, under the Wellbeing of Future Generations (Wales) Act, for overseeing the development of the new Local Wellbeing Plan which is a long-term vision for the area. 2. **The Gwent Regional Partnership Board** As set out in the Partnership Arrangements (Wales) Regulations 2015, local authorities and local health boards (RPB) manage and develop services to secure strategic planning and partnership working. RPBs also need to ensure effective services and care and support is in place to best meet the needs of their respective population. Through these statutory forums formal partnership arrangements take place.	• Governance review of Regional Partnership Board undertaken in August 2023. • Renewed Strategy for strategic partnership Capital in place and revised governance processes. • New Long-Term Strategy for Health Board to focus on Partnership approach.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • PMO reporting to the Director of Strategy, Planning and Partnerships. • Regional Leadership Group Reporting **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Assurance reporting to the Population Health, Partnerships, and Planning Committee. • Assurance reporting to the Board. **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)*	**Gaps in Assurance** • Systematic reporting of outcomes • Systematic evaluation of schemes • Governance of financial control arrangements **Action to Address Gaps in Assurance** • Implementation plan to be developed following RPB governance review. • Health Board strategy development approach to focus on partnership approach.	**Reasonable Assurance**

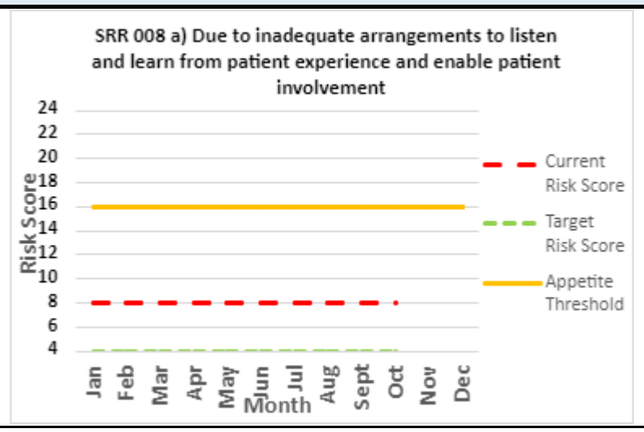
In addition to these statutory forums the Health Board has a range of interfaces with key stakeholder bodies, including regular liaison with local authorities, neighbouring Health Boards, housing associations, and third-sector partners. Joint working between operational teams including integrated operational arrangements and combined multidisciplinary teams, for example, Community Resource Teams		• Internal Audit Governance Review 2023/24 (Q2) – Underway – due to be reported to the Audit, Risk & Assurance Committee in February 2024.		

RISK THEME	TRANSFORMATION AND PARTNERSHIP WORKING			
Strategic Risk (SRR 008)	**There is a risk that the Health Board fails to build positive relationships with patients, staff and the public.**			
Strategic Threat	a) **Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement.**			
Impact	➢ Adverse impact on patient experience ➢ Failure to deliver health board priorities, required improvements and achieve longer-term sustainability ➢ Reputational damage and loss of public confidence ➢ Failure to deliver Duty of Quality			
Lead Director	Director of Nursing	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Patient Quality, Safety & Outcomes Committee	**Likelihood**	2 (Unlikely) x	2 *(Unlikely)* x
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Major)*	2 *(Minor)*
Last Reviewed	14 September 2023	**Risk rating**	**= 8** *(High)*	**= 4** *(Moderate)*

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

Risk Appetite Threshold – Open SCORE 17 AND BELOW
All risks relating to our ability to engage effectively with other organisations including development of collaborations and partnerships along with all risks associated with innovation, transformation, and strategic change.

SUMMARY
The current risk level is **outside** of target but within the appetite threshold. Target level is **within** the set appetite threshold.



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Corporate Engagement Team • Patient Experience and Involvement Strategy- organisational ownership • Person Centred Care (PCC) Surveys via CIVICA • PCC KPI's (support PCC Quality pillar) • 'You said…… we did' public facing information for service areas • PLO service at GUH • Introduction of PALS Service (Oct 23) • Volunteer Patient Experience Feedback • Collaboration to recruit community listeners to support Dementia Awareness • Digital patient stories to support listening and learning. • Patient Experience and Involvement Strategy • DATIX	• Structured graduated approach to roll out of Civica to ensure divisional teams can use and access data. This will ensure sustainable progress. • PCCT staff training to support Civica data entry and retrieval. • Programme Manager for Dementia working regionally to improve public engagement and promote the role of Community Listeners. • Employment of dedicated PALS team in progress who will have a key role in gaining feedback from patients, staff and relatives. • Completion of surveys limited to QR code access or physical presence of PCCT to manually ask and in-put data. No SMS provision. • National directives around new national surveys that need to be managed additional to internal roll out programme. • Volunteer feedback to be reviewed to identify themes.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Person Centred Care Team oversee patient experience through dedicated work programme and link in with divisional teams. • Concerns are fed back to divisional teams when identified. • Outcome of the volunteer feedback to drive improvements. **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Regular reporting to the Patient Quality, Safety & Outcomes Committee (PQSCO) • Listening and Learning reported through QPSOG/ Outcomes Committee **Level 3 Independent**	**Gaps in Assurance** • No SMS provision to increase the number of PCC surveys. • No single point of contact or 'drop in' provision for patients/families/staff to raise initial patient experience concerns. **Action to Address Gaps in Assurance** • Discussions with VBHC team to consider SMS through DrDoctor • PALS Single point of contact is being established. PALS officers will have key role in patient experience and involvement- including establishing 'drop in' clinics on	**Reasonable Assurance**

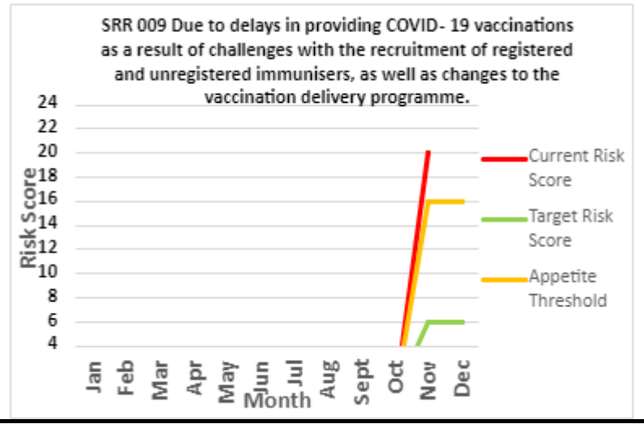
		(Implemented by both auditors internal and external independent bodies.) • LLais Reports • HIW inspections	hospital sites should patients/staff/relatives wish to discuss concerns. • PCC KPI's and common themes need to be identified and reported through the PCC Survey. These will be added to a template patient experience report and CIVICA surveys will be built into ward accreditation. • Implement PALS DATIX Module	

RISK THEME	SERVICE DELIVERY			
Strategic Risk (SRR 009)	**The Health Board will be unable to protect those most vulnerable to serious disease.**			
Strategic Threat	A) Due to delays in providing COVID- 19 vaccinations as a result of challenges with the recruitment of registered and unregistered immunisers, as well as changes to the vaccination delivery programme.			
Impact	➢ Harm or injury to patients and/or staff - Winter modelling suggests a peak in Covid-19 cases and associated bed pressures is anticipated during December 2023 and in mid-January 2024. Potential for Nosocomial spread, increased acuity of patients, and length of stay. ➢ Adverse impacts on delivery of vaccinations to patients across the vaccine service – including outreach/in reach delivery to vulnerable population, childhood immunisation & MMR catch up and flu wrap-around service. ➢ Resource – potential increase in staff sickness due to lack of protection from the vaccine in staff member groups. ➢ Financial implications due to the extension of venues. ➢ Reputational damage and loss of public confidence.			
Lead Director	Director of Public Health & Strategic Partnerships	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Partnerships, Population Health, and Planning Committee	**Likelihood**	5 *(Almost Certain)* *x*	2 *(Unlikely)* *x*
Initial Date of Assessment	06 November 2023	**Impact**	4 (*Major*)	3 *(Moderate)*
Last Reviewed	10 November 2023	**Risk rating**	**= 20** *(Extreme)*	**= 6** *(Moderate)*

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

Risk Appetite Threshold – SCORE 16 AND BELOW
Risk related to all aspects of our ability to deliver, manage, and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy

SUMMARY
The current risk level is **outside** of target level and appetite threshold. The target level to be achieved is **within** the set appetite threshold.



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• **Dedicated** pool of bank staff to fill shifts – although there have been challenges in filling shifts within this pool of staff. • Opening venues on additional days to allow more vaccine appointments to be offered (provided staff are available) • Daily monitoring of public vaccinations administered. • Weekly planning and delivery meetings to monitor progress, identify alternative solutions, and implement or escalate as appropriate. • Weekly programme board to approve key decisions and escalate potential risks. • Health protection Incident plan has been drafted for approval by the Executive Committee (Dec 2023) • Monitoring filled/non-filled shifts report. • Monitoring costs associated with the use of Bank staff. • Monitoring uptake of staff vaccination • Dedicated internal and external communications support.	• Secured additional funding against the existing allocation for bank vaccination staff. • Exploring deployment options to the Vaccination programme and use of those previously trained as vaccinators that are on the bank. • Alternative advertising methods of vacant shifts to improve uptake – liaising with bank co-ordinator to improve this. • Draft community pop-up plan to be further explored. • If required, extend venue licence in key location(s).	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Costs of bank staff reported to Programme Board • Uptake on staff vaccination reported to Programme Board • National and regional data shared with Programme Board on the % of the population vaccinated **Level 2 Organisational** *(Executed by risk management and compliance functions)* • Risk monitored by the Partnerships, Population Health, and Planning Committee via the Committee Risk Report • Exception reporting to the Executive Committee regarding uptake of the vaccine by staff and public, and capacity to deliver the milestones. **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies)* • Monthly reporting to Welsh Government on uptake • PHW national data on vaccination uptake	**Gaps in Assurance** • Reporting on filled and non-filled shifts to determine the slippage in milestones of the programme. **Action to Address Gaps in Assurance** • Start reporting the filled and non-filled shifts report to the Programme Board • Model delivery based on the current resource, dedicated bank staff, and wider bank staff to determine the workforce resource to deliver.	**Reasonable Assurance**

Internal Audit Progress Report

Audit, Risk and Assurance Committee

November 2023

Aneurin Bevan University Health Board

NWSSP Audit and Assurance Services

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1. Introduction

The purpose of this report is to:

- confirm the status of the audit work for the 2023/24 Internal Audit Plan for Aneurin Bevan University Health Board (the 'Health Board') to the November 2023 Audit, Risk and Assurance Committee (the 'Committee');
- seek approval for changes to the 2023/24 Internal Audit Plan, as listed within Section 5; and
- provide an overview of other activity undertaken since the previous meeting.

2. Remaining 2022/23 Internal Audit Reports

The following review is now finalised and reported to this Committee.

Audit	Final Rating
Putting Things Right	Advisory Review

3. Progress against the 2023/24 Internal Audit Plan

There are 29 individual reviews in the 2023/24 Internal Audit Plan and an additional review included regarding Facilities. In addition, our Specialist Services Unit (SSU) undertake assurance work over major capital projects.

The table below details progress against the 2023/24 Internal Audit Plan.

Number of audits in plan:	29
Additional review: Facilities	1
Revised total	30
Number of audits reported as final	5
Number of audits reported as draft	3
Number of audits work in progress	10
Number of audits at planning stage	4
Number of audits not started	8

The following 2023/24 final reports have been issued since the meeting of the Audit, Risk and Assurance Committee on 12th September 2023:

AUDIT ASSIGNMENT	ASSURANCE RATING
Business Continuity Planning	Reasonable
Clinical Coding	Reasonable
IT Infrastructure	Reasonable

The delivery status of the audits is illustrated within Appendix A and further information over the assurance rating detailed above is included within Appendix B.

4. 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 and advisory reports issued since the last meeting on 12th September 2023.

Business Continuity Planning (reasonable assurance)

The audit sought to review the Health Board's arrangements for maintaining business continuity in the event of a critical incident, including how learnings from the Covid-19 pandemic have been considered.

Overall, we found detailed guidance in place as required by the Civil Contingencies Act 2004. Furthermore, whilst there was evidence of engagement from the Emergency Planning Team, there was not always a timely reciprocation from the directorates. Within our sample of seven services areas, we found six had continuity plans in place, with one still in the process of being developed (Medicine). The key matters which require management attention include:

- Business continuity plans and action cards are not tested, reviewed or fully embedded.
- Staff awareness and training is not monitored or reviewed regularly to ensure engagement.
- Post pandemic reviews and / or lessons learnt have not been incorporated into continuity plans at an operational level.

Clinical Coding (reasonable assurance)

We undertook a review to determine if the Finished Consultant Episodes (FCE) were processed in accordance with the Clinical Coding Standards.

Whilst we found that the quality of the cases processed was high, the total volume completed in any given month is often restricted by resource capacity. This has resulted in an output performance less than the Welsh Government requirements.

We also found that only a small percentage of the backlog of cases not processed in their designated month are processed in subsequent months and as a result significant volumes remain uncoded.

Finally, we raised recommendations to assist in maintaining the quality of clinician notes.

IT Infrastructure (reasonable assurance)

The audit assessed the adequacy of the systems and controls in place for the management of the network and IT Infrastructure assets.

There is a wide-ranging network and infrastructure in place, with an appropriate network capacity. This is provided using Dell servers and Avaya and Cisco switches. There are old, vulnerable switches in place and we note a programme of renewal in place. Equipment is covered by extended warranty to mitigate the risk of loss of

service with older equipment. Servers are patched however switches are not routinely patched.

Equipment is held securely and core data centres have good environmental controls. There is a monitoring and alert process and work is underway to ensure meaningful alerts are provided.

The key actions that require management attention are:

- Formalising VPN provision with WAST.
- Establishing a single asset register / CMDB.
- Ensuring appropriate patching of all equipment.
- Providing segregation within the network.

Putting Things Right (advisory review)

This advisory review sought to determine if there are alternative processes or approaches that can be adopted by the Health Board to improve the overall management of Putting Things Right. Therefore, we undertook a review of internal processes, performance and external directives and guides, with the aim of providing recommendations to assist the Health Board.

We found that during the review that an increasing number of concerns and complaints are being resolved through the 'Early Resolution' pathway, complaints are all logged, documented and managed effectively in a centralised database tool (Datix) and policies, procedures, guidance and training materials are in place.

We also found that during quarters one and two of 2022/23, the Health Board performance was on a par with its peers in its handling of complaints, and performed better than some other NHS Wales organisations, in some respects. Furthermore, only a low percentage of complaint outcomes are referred to the Ombudsman by complainants.

However, as we progressed through the review, we found compliance with the 30 day complaint resolution standard fell to a low of 41% in January 2023. Although there was an upward trend at one point since, it still had only reached 58% by April 2023, which is substantially lower than the 75% target.

Overall, we found that the following areas could be strengthened:

- analysis of complaint cases to increase learning;
- a review of the current structure / resources throughout the Health Board to ensure complaints are dealt with the most efficient manner and lessons learnt are fully embedded;
- complaint investigation process, including the use of Datix; and
- action plans to embed lessons learnt that are also monitored at an appropriate level.

5. Potential Audit Plan Changes

As we progress with our delivery of the 2023/24 Internal Audit Plan, we continue to evaluate risk, the allocation of our resources and the remainder of the agreed plan.

We have completed planning for two audits (Allegations against Staff Policy and Job Planning), where work is still underway within the Health Board to implement the necessary controls.

Furthermore, the Putting Things Right advisory review has identified numerous actions for implementation that are still in progress. The outline scope of the Health and Social Care (Quality and Engagement) (Wales) Act audit is an assessment of the implementation of the Duty of Candour, which is also dependent upon the completion of the Putting Things Right audit actions.

As there is still significant work underway within the Health Board regarding these reviews, we propose that they are deferred into 2024/25.

Therefore, we are seeking **approval** from the Audit, Risk and Assurance Committee for this amendment to the 2023/24 Internal Audit Plan and the deferral of the following audits:

- Allegations against Staff Policy
- Job Planning
- The Health and Social Care (Quality and Engagement) (Wales) Act

If approved, whilst this will reduce the overall number of audits for this year by two (an additional review has been included for Facilities), the audit work on some individual reviews has, thus far, increased. Due to the depth of those audits reported, we are typically increasing testing to account for complexity with developing our audit conclusions.

Consequently, we are maintaining a watching brief on the remaining audit assignments. Alongside this, we will ensure that our audit work does not overlap with the work of external auditors / assurance providers. If there is a significant duplication with the proposed work, we will raise the matter with the Committee for consideration.

6. Other Activity

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

- monthly meetings with the Director of Corporate Governance;
- monthly meetings with the Director of Finance, Procurement and Value;
- Audit, Risk and Assurance Committee pre-meeting with the Audit, Risk and Assurance Committee Chair;
- review and advice over financial control procedures and workforce procedures; and
- liaison with senior management.

7. Recommendation

The Audit, Risk and Assurance Committee is invited to **note** the above points within the report and to **review** and **approve** the 2023/24 Internal Audit Plan changes proposed within Section 5.

Appendix A: Progress against 2023/24 Internal Audit Plan

Audits	Status
Savings Programmes	Not started
Financial Controls	Not started
Decarbonisation	Planning
Asset Management	WIP
Medical Equipment & Devices	WIP / Draft report
Risk Management & Assurance	Not started
Follow-up of High Priority Recommendations	Planning
The Health & Social Care (Quality & Engagement) (Wales) Act	WIP (possible defer)
Integrated Medium Term Plan	Final report
Integrated Performance Dashboard - Data Quality	WIP
Business Continuity Planning	Final report
Safeguarding	Final report
Waiting List Management	WIP / Draft report
Directorate Review - Theatres	Not started
Job Planning	WIP (possible defer)
Clinical Coding	Final report
Providing Care to Asylum Seekers & Refugees	Planning
Early Supported Discharge - Stroke	WIP
Intra-site Patient Transfers	WIP
Regional Partnership Board	Draft report
Long Term Sickness Absence Management	Not started
Maternity (Action Plan)	WIP
Flexible Working (advisory)	Not started
Allegations against Staff Policy	WIP (possible defer)
Network Infrastructure (VPN)	Final report
Stakeholder Engagement on IT Projects	Planning
LINC Programme	Not started
Bevan Health & Wellbeing Centre	Not started
Estates Assurance - Estate Condition	Draft report
Facilities Bank Approval Process	Draft report

Appendix B: Audit Assurance Ratings

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

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

Clinical Coding
Final Internal Audit Report

November 2023

Aneurin Bevan University Health Board

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

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

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Review reference:	AB-2324-015
Report status:	Final
Fieldwork commencement:	7th August 2023
Fieldwork completion:	12th September 2023
Draft report issued:	24th October 2023
Debrief meeting:	19th October 2023
Management response received:	3rd November 2023
Final report issued:	10th November 2023
Auditors:	Stephen Chaney, Acting Head of Internal Audit Chris Scott, Internal Audit Manager
Executive sign-off:	Paul Solloway, Director of Digital
Distribution:	Lloyd Bishop, Chief Digital Officer Lynne Wilde, Interim Assistant Director of Information Services Louise Williams, Clinical Coding Service Development 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 Chartered Institute of Public Finance & Accountancy in April 2023

Acknowledgement
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Disclaimer notice - please note
This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit, Risk and Assurance Committee.

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

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with the Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Executive Summary

Purpose

This internal audit has been undertaken to provide an opinion over the timely recording of Finished Consultant Episodes (FCE), in accordance with clinical coding standards.

Overview

Overall, whilst we noted internal and external auditing of the function coding accuracy was seen to exceed target rates, we found a number of weaknesses in the arrangements and processes which are adversely affecting the generation of timely and complete management information. We noted the potential impact of inconsistencies with the structure and content of patient records, in particular, the efficiency of the coding activity and its possible link to a long standing performance issue that places the coding output significantly below the Welsh Government target.

We also found that only a small percentage of the backlog of cases not processed in their designated month are processed in subsequent months and as a result significant volumes remain uncoded. We were informed that this has been the practice since 2016/17, following a loss of qualified coders and clinical coding auditors.

Matters arising are summarised in the table at the beginning of the next section and all of these are referenced in the main body of the report and detailed further in the matters arising and management actions table in Appendix A.

Report Classification

		Trend
Reasonable	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	No recent audit

Assurance summary[1]

Assurance objectives		Assurance
1	Policies & procedures	Reasonable
2	Coding quality & accuracy	Reasonable
3	Engagement and coding staff training	Reasonable
4	Clinical coding monitoring & reporting	Limited

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

Matters arising

		Assurance Objectives	Control Design or Operation	Recommendation Priority
1	Policy document review and affirmation	1	Operation	Low
2	Clinician guidance on patient note writing	1	Design	Low
3	Logging problem coding cases	3	Design	Low
4	KPI underperformance and uncoded backlog	4	Operation	High

1. Introduction

1.1 The review of Clinical Coding was completed in line with the 2023/2024 Internal Audit Plan. Aneurin Bevan University Health Board (the 'Health Board') recognises the importance of clinical coded data being accurate and complete to deliver safe patient care. Clinical coding is defined by the NHS classifications service as 'the translation of medical terminology, as written by the consultant, to describe a patient's complaint, problem, diagnosis, treatment or reason for seeking medical attention into a coded format which is nationally and internationally recognised'. This process is completed by a clinical coder, which is a specialised role, requiring extensive experience. Training within the role is supported by a dedicated qualification.

1.2 Clinical coded data is essential to the information used by NHS organisations to govern business and ensure resources are used efficiently and effectively. Coded data has a part to play in decision making and strategic plans as well as playing an important role in reporting and mortality rates.

1.3 There are two key elements relating to clinical coding. The first is the accuracy and quality of the coding completed i.e. that Finished Consultant Episodes (FCEs) are recorded accurately. Secondly, that FCEs are coded in a timely manner. The target set by the Welsh Government is 95% coded within one month from completion.

1.4 The risks considered in this review included:

- Failure to comply with the National Clinical Coding Standards.
- Failure to check and review data to ensure the correct clinical codes are used resulting in inaccurate data being produced.
- A lack of staff training and engagement between clinical and coding staff to enable the improvement in the accuracy of the coded data.
- Clinical coding not being regularly monitored or reported resulting in reputational damage for the Health Board.

2. Detailed Findings

Objective 1: There are relevant policies and procedures in place aligned with the clinical coding standards that ensure coded data is completed in a timely manner as stipulated by the Welsh Government and the Clinical Coding Standards.

2.1 We sought to establish the scope, availability and currency of the Health Board's policy and procedure documentation that provides guidance for the clinical coding teams on day-to-day coding processes.

2.2 The Health Board's internal policy document describes roles and responsibilities within the Clinical Coding Staff group at each of the levels in its structure. For the protocols, rules and formats that must be adopted by the coders, the policy refers to the international ICD-10 (coding of episode diagnoses) and OPCS 4.10 (coding of episode interventions and procedures) industry coding standards documents in issue.

2.3 The document indicates it is stored in a shared location where it may be readily accessed, although we noted that the path recorded in the current version of the policy was out of date and needs to be re-stated in the next revision.

2.4 The review cycle for the policy document is given as one to two years and we noted the current version provided by the Clinical Coding Service records a date of May 2021 meaning its review was due by May 2023 and is now overdue (see **Matter Arising 1**).

2.5 The policy is a shared resource and states it is intended to be used by clinical coding staff, clinical analysts, and clinicians but we noted that it does not contain any instructions or other guidance for the attention of clinicians on patient note writing protocols. Furthermore, we were advised that there is currently no other clinical policy or procedure document in issue that covers these (see **Matter Arising 2**).

Conclusion:

2.6 We have raised a number of matters arising under this objective relating to policy and procedure documentation and therefore have provided **reasonable assurance** over this area.

Objective 2: All coded data is accurate and reviewed on a regular basis to ensure correct reporting as per the clinical coding standards.

2.7 We sought to establish the scope and effectiveness of data capture and quality review controls that operate across the clinical coding activity.

2.8 We note coding accuracy is continuously monitored through error identification work which covers two different aspects:

- the accuracy of episode code selection from patient written notes by the coders is tested by re-performance of the code selection of a sample of coded episodes;
- integrity checks are performed on data sets of coded episodes using a list of validity rules derived from the detail of the coding standards (e.g. invalid code combinations) to identify anomalies, exceptions and errors.

2.9 In summary, the following quality / accuracy checking processes are in operation:

- there is an ongoing internal audit process (carried out by a dedicated member of the Clinical Coding Team), where a sample of the work of each clinical coder is audited annually;
- an annual external audit is carried out by Digital Health & Care Wales (DHCW);
- weekly manual validation report scrutiny where spreadsheet data sets are searched for anomalies e.g. invalid combinations of codes that indicate miscoding;
- daily scrutiny of Qlik Sense validation reports that use SQL scripts on the code data to identify and report error cases using the same rules based approach; and

- a DHCW clinical coding data quality dashboard that draws on the Admitted Patient Care (APC) data submitted by the Health Board to DHCW each month.

2.10 **Internal reviews**

Internal reviews are undertaken by an experienced and trained reviewer within the team. The records show that 16 audits / reviews were conducted during 2022/23 (there were 18 coders working that year). Typically, 20 episodes that have been coded are selected within each review and the approach is to re-perform the code selection using the patient notes for the episode. Error rates are reported against target levels, coding errors are listed and remedial action is recorded. We reviewed a summary record of results of the reviews during 2022/23, including two recent example reports and noted in these cases, coding error rates were within tolerance levels i.e. accuracy levels were satisfactory.

2.11 **DHCW external audit**

DHCW confirmed an annual cycle of audit of the Health Board's clinical coding has been in place over recent years and we examined the report of June 2023. As with the internal reviews, the approach again is to re-perform the coding of a sample of episodes (330 in this case), using the patient notes for the episode to assign codes and then compare this to those originally assigned. Errors are recorded and error rates computed and analysed. The results of this audit showed that the clinical coding department at the Health Board achieved in excess of the required quality percentage for all of the four categories of activity: primary diagnosis, secondary diagnosis, primary procedure, and secondary procedure coding.

2.12 We noted, however, that the report in its recommendations referred to the difficulties encountered by coders where information in patients' medical records was in some cases 'minimal and or of poor quality'. References were made in the DHCW report to standards over structure and content of patient records and the need for clinicians to observe these, but as noted under objective 1 above, these were found to be absent (see **Matter Arising 2**).

2.13 **Manual validation review**

Listings of coded episodes are run weekly and manually reviewed by management within the Clinical Coding Team, in a process to identify anomalies and exceptions using a list of coding rules. Coding exceptions are then shared with the original coders who re-examine the cases and correct the assigned codes where appropriate.

2.14 A random sample of one week, from each of the five months of 2023/24 that had elapsed at the time the audit, was reviewed to ensure that this control was operating as described. There were no issues identified.

2.15 We were advised that whilst there is no formal review process in place to confirm that items found in error are appropriately corrected, coders are required to advise the management team member who issued the exception list when they have been addressed.

2.16 **Qlik Sense validation report**

This automated report which runs on the WPAS system is used to identify any further coding anomalies and exceptions not corrected through the manual process. Similarly, these are shared with their original coders for attention and correction where necessary.

2.17 **DHCW clinical coding data quality dashboard**

Utilising the same data validation rules, the DHCW clinical coding data quality dashboard reports coding anomalies and exceptions in the data sets exported by all health boards, each month from their WPAS systems. Both this and the Qlik Sense validation report have drill through capability to identify episode coders to whom the lists are sent for action.

2.18 We noted that combined, these review activities provide a robust control framework for both data cleansing and the identification and correction of original coding errors.

Conclusion:

2.19 We found robust review processes in operation but noted references in the DHCW annual audit to patient note quality and because of the potential impact of this factor on coding efficiency and accuracy have provided **reasonable assurance** over this area.

Objective 3: There is staff engagement across the health board and relevant staff are adequately trained and experienced in clinical coding.

2.20 We sought to establish that protocols for the recording of patient notes by clinicians are set and being followed and to establish the scope and completeness of staff training in the Clinical Coding Team.

2.21 Achieving accurate and timely coding of closed episodes is contingent on a range of factors, all of which must operate together to support the process:

- clinical notes in patient files must be consistent in structure, clear, concise, unambiguous and complete;
- patient files must be readily available to coding teams promptly after patient discharge;
- there must be integration and collaboration between the coding and medical teams to ensure the consistent use of standards and protocols in the recording of patient notes and to support the prompt resolution of any queries raised by the coders; and
- there must be sufficient resources of the necessary skill level in the coding teams to cover the volume of cases presented.

2.22 **Clinical notes**

We were advised that the Clinical Coding Team does encounter cases where notes on patients' files are difficult to interpret, are incomplete or absent (electronic discharges were cited as examples where incomplete or absent records are seen).

That said, we were informed that cases, where it is not possible for a coder to determine diagnoses and procedures from what has been recorded, are rare. Where this does occur, these are resolved by contacting the relevant clinicians for clarification or further information. We understand there is a low incidence of these cases and although they are not logged or listed, we were advised there were none awaiting resolution at the time of the audit.

2.23 Whilst cases that require further clinician input for resolution in order to determine the diagnoses, procedures and code for an episode are few, we understand there are also cases where coders may need to cross reference episode notes to other patient documentation. This is to help understand what took place, and occasions where coding colleagues may need to be consulted to assist in interpreting the material recorded. Similarly, these cases are not logged or listed, meaning it is not possible to assess their volume or impact on the running of the coding operation. However, it is reasonable to infer that they may reduce efficiency of the coding work and introduce delay (see **Matter Arising 3**).

2.24 **Availability of patient files**

Coders work from approximately 50% paper records and 50% scanned records (Clinical Work Station (CWS)) and the former should be available to coders 48 hours after a patient is discharged. A daily report of discharged cases is generated by the Clinical Coding Team that records the location of the patient file or indicates the records that have been scanned. Our discussion with staff regarding this element of the workflow, identified that the coding activity can be delayed by patient record availability i.e. it is not available promptly following a patient being discharged.

2.25 **Integration and collaboration between the coding and medical teams**

We have recorded earlier in this report that we were unable to establish whether appropriate guidance documents have been issued to the clinician community, to promote the use of patient notes recording standards. However, we believe that clinical engagement regarding the coding process is limited, which may ultimately impact the accuracy of the codes assigned and the time taken to code episodes.

2.26 **Coding team resource levels**

We were advised that at the work rate of 30 coded episodes per day by each individual (accepted national standard), the current team of 26 WTE clinical coders do not have the capacity to code more than 169k cases per year. For 2022/23, using the number of FCEs submitted as part of the WCR4 annual costing return for 2022/23, this would equate to only 82.4%.

2.27 We reviewed the scope and completeness of staff training in the Clinical Coding Team by examining the records held by the team.

2.28 We noted that new staff are engaged in an induction programme and ongoing training activities that include the National Clinical Coding Qualification (NCCQ) examinations and accreditation. At the time of the audit 14 of the 29 staff (including management) in the Coding function have NCCQ accreditation.

Conclusion:

2.29 We have raised one matter arising under this objective relating to the potential impact of unclear or incomplete patient notes on coding activity efficiency and therefore have provided **reasonable assurance** over this area.

Objective 4: Clinical coding performance is regularly monitored and reported at an appropriate forum and Board.

2.30 We sought to establish the extent and frequency of function management, Health Board committee and Board oversight of the clinical coding activity that operates and how matters are escalated when issues arise.

2.31 We were advised that informal meeting cycles operate across the management structure of the function where activity updates are provided between function managers. In these cycles, issues are either addressed or if they cannot be, are escalated to the next level of management.

2.32 We noted that this cycle of oversight meetings does not include formal documentation. Therefore, we were unable to assess through evidence whether there were any significant unresolved issues being dealt with by the Clinical Coding Team management team at the time of the audit.

2.33 Clinical coding matters are included in the remit of the Chief Information Officer on which the Finance and Performance Committee are updated at each meeting. The scope of the performance remit is broad, and areas are raised by exception only where there are issues to share.

2.34 The accuracy of code assignment is assessed through internal and external audit reviews (see under objective 2 above) and we noted through the results of the reviews carried out in the year that accuracy targets were achieved in 2022/23 and prior years (over recent years there has been an improvement in the accuracy of clinical coding across Wales).

2.35 One of the two Clinical Coding statutory KPIs is included in the Health Board's Integrated Performance Report (IPR), but we noted no commentary is submitted with this and there were no other coding related updates provided to the Finance and Performance Committee or Board meetings during 2022/23.

2.36 Regarding the statutory KPI referred ('percentages of episodes clinically coded within one reporting month post episode discharge end date'), we noted that resource levels dictate the coding activity consistently underperforms against the target (see **Matter Arising 4**).

2.37 Across the months of 2022/23 this ranged from a high of 88% to a low of 68% against a national target of 95% (see figure 1), as shown in Figure 1.

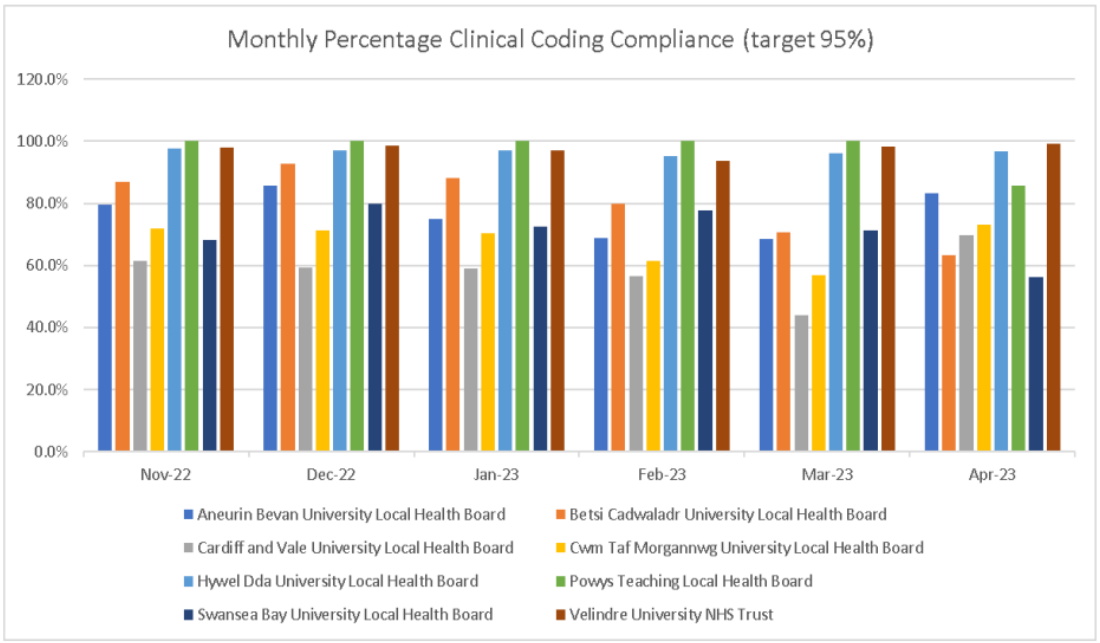

Figure 1: monthly percentage clinical coding rates achieved by the health boards of Wales

2.38 Not evident in the IPR, however, or other performance commentary, is that excepting mortality cases which are all targeted for coding, the uncoded 'backlog' is not carried over into the next processing month to be actively and systematically cleared. Analysis of coding data submitted to DHCW by the Health Board reveals low volumes of backlog from any given month are picked up in the subsequent 3 to 4 months processing of cases (adding typically 2 to 4% to that month's coded case percentage). However, beyond that they are not processed and the balance remains uncoded. Figure 2 below illustrates the volumes of cases that are coded from the backlog that remain after the one month processing window for the month in question is passed, and the uncoded volume that remains after all backlog coding has ceased.

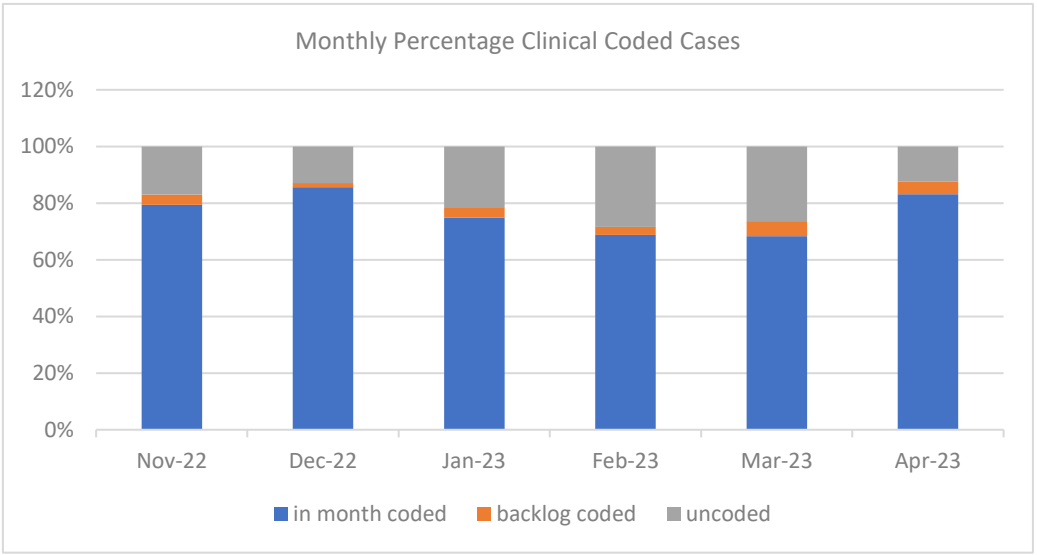

Figure 2: in-month coded, backlog coded and uncoded volumes achieved by Aneurin Bevan University Health Board

2.39 This impacts the accuracy of the broader data set, and potentially adversely affects the robustness of information for strategic decision-making, service monitoring and mortality data (see **Matter Arising 4**).

Conclusion:

2.40 We have raised a finding on the underperformance of clinical coding against statutory targets as well as on the uncoded backlog and therefore have provided **limited assurance** over this area.

Appendix A: Management Action Plan

Matter arising 1: Policy document review and affirmation (Operation)		Impact
We noted that the current version of the Clinical Coding Service Policy and Procedure Document dated 2021 in issue expired in May 2023 and therefore a review, ratification and re-issue is overdue.		Potential risk that policy documents do not reflect current standards or statutes
Recommendations		**Priority**
1.1 We recommend that the Clinical Coding Service Policy and Procedure Document is reviewed, ratified, re-dated and re-issued.		Low
Management Responses	**Target Date**	**Responsible Officer**
1.1 The Clinical Coding Service Policy and Procedure Document will be reviewed by the end of December 2023.	31st December 2023	Chief Information Officer

Matter arising 2: Clinician guidance on patient note writing (Design)	Impact
We noted that there have been no policy or procedure notes issued to clinicians to guide them in the accepted protocols, conventions and standards for the structure and content of patient records. Although we were not provided with any data to gauge the impact of, we were advised that patient record structure and content varies in clarity, quality and completeness. In some cases this presents coders with difficulty identifying the diagnoses and/ or procedures undertaken (this issue was raised in the 2023 DHCW external audit of the function). This extends the time taken to code the caseload as a whole, reduces the volume of cases that are processed and in turn decreases the proportion of coded patient episodes available for analysis.	Potential risk that incorrect codes are assigned to patients diagnoses or procedures from unclear clinician notes

Recommendations	Priority
2.1 We recommend that the Health Board issues guidance to clinicians covering the accepted protocols, conventions and standards for the structure and content of patient records.	Low

Management Responses	Target Date	Responsible Officer
2.1 Monthly meetings between the Medical Director and the Clinical Coding Manager were re-established in October 2023. These meetings will in part be used to formulate guidance to clinicians regarding the standards and content required in patient records.	31st December 2023	Chief Information Officer

Matter arising 3: Logging problem coding cases (Design)	Impact
Whilst the incidence of difficult to interpret patient notes cases are reported as low, we noted that cases are not documented in a log or other record, but rather remain on the work lists of the individual coders and are addressed alongside the regular cases. We were unable to obtain statistics of either the numbers or category of the problems encountered in these cases nor the length of time taken to resolve them. However, we consider it reasonable to infer that they increase the time taken to process the closed episode caseload and consequently reduce the number of cases that ultimately are coded by the Clinical Coding Team. Logging these cases and recording the processing issues and how these were resolved if then shared with clinical staff could contribute to learning and reduce further instances.	Potential risk that episodes where diagnoses or procedures notes are unclear are not resolved and the cases go uncoded

Recommendations		Priority
3.1	We recommend that where patient notes pose interpretation challenges and the coder assigned requires further information to progress these – e.g. difficulties with clarity, content, form, structure, completeness etc. – that these cases are processed as exceptions and logged to provide a record of the issue, how it was resolved and the time taken to close. Logs can then subsequently be used in clinician communications.	Low

Management Responses		Target Date	Responsible Officer
3.1	The content of clinical notes will be discussed in the monthly meeting between the Medical Director and the Clinical Coding Manager. This will include detailing the volume of notes that have been difficult to interpret and areas of notable concern.	31st December 2023	Chief Information Officer

Matter arising 4: KPI underperformance and uncoded backlog (Operation)	Impact
We noted the sole KPI of coding activity that is currently measured and reported in the Integrated Performance Report (IPR) is a time based metric (i.e. coding cases processed within one month of completion of the Finished Consultant Episodes). The average completion rate of coded episodes within one month, across the quarter one of 2023/24 stood at 82% against a target of 95%. However, in the 12 months of 2022/23 this ranged from a high of 88 to a low of 68%. Whilst this correctly states the volumes of episodes which had been processed within the stated time period, it falls short of the 95% target and does not convey that only a small proportion, typically 2 to 4%, of the uncoded backlog cases from each month are coded in the subsequent months. The remainder of the backlog is not coded and data sets are consequently incomplete. Whilst we were informed that there is a drive to process as many of the backlog by the 20th June cut-off date (which is the final date for that year's figures to be incorporated into costing models across Wales), as mentioned above, we still only observed a slight uplift of backlog coding as the year progressed.	Clinical coding targets are not met Clinical coding performance may not be fully / accurately reported

Recommendations		Priority
4.1	We recommend that the Health Board devise a plan to address the longstanding underperformance in the monthly coding of episodes. The performance of the plan should be reported regularly to the Board or an appropriate forum.	**High**
4.2	We recommend that the Health Board devise a plan to address the longstanding underperformance in clearing the backlog of uncoded episodes. The performance of the plan should be reported regularly to the Board or an appropriate forum.	**High**

Management Responses		Target Date	Responsible Officer
4.1	The Executive Committee approved the restructuring of the Clinical Coding Department in August 2023, the agreed restructure when complete will deliver on the monthly coding of episodes target.	30th June 2024	Chief Information Officer
4.2	Backlog of episodes will be systematically coded when the new Clinical Coding Structure is implemented. The new structure provides the workforce with the capability to deliver on the monthly coded episodes target and address backlog.	30th June 2024	Chief Information Officer

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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Business Continuity Planning
Final Internal Audit Report

November 2023

Aneurin Bevan University Health Board

Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

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Committee:	Audit, Risk and Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023

Acknowledgement
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Disclaimer notice - please note
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Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with the Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Executive Summary

Purpose

An audit of the arrangements that the Health Board has in place to maintain business continuity in the event of a critical incident, including how learnings from the Covid-19 pandemic have been considered.

Overview

We have issued reasonable assurance on this area. This audit focused on the role of the business continuity team and how embedded business continuity is across the Health Board. We found the team very focused and knowledgeable, with detailed guidance in place as required by the Civil Contingencies Act 2004. Whilst there was evidence of engagement from the Emergency Planning Team, there was not always a timely reciprocation from the directorates. Within our sample of seven services areas, we found six had continuity plans in place, with one still in the process of being developed (Medicine).

The key matters which require management attention include:

- Business continuity plans and action cards are not tested, reviewed or fully embedded.
- Staff awareness and training is not monitored or reviewed regularly to ensure engagement.
- Post pandemic reviews and / or lessons learnt have not been incorporated into continuity plans at an operational level.

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

Report Opinion

		Trend
Reasonable	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	2017/18

Assurance summary[1]

Objectives		Assurance
1	Continuity plans and processes	Reasonable
2	Staff awareness	Reasonable
3	Business continuity communication	Reasonable
4	Lessons learnt from Covid-19 pandemic	Limited

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

Key Matters Arising		Objective	Control Design or Operation	Recommendation Priority
1	Business continuity plans and processes	1	Design	Medium
2	Staff Awareness	2	Operation	Medium
3	Communication	3	Operation	Low
4	Lessons learnt from during the pandemic	4	Design	Medium

1. Introduction

1.1 The review of Business Continuity Planning was completed in line with the 2023/24 Internal Audit Plan. NHS Organisations and providers of NHS funded care must take reasonable steps to ensure that in the event of a service interruption, essential services will be maintained, and normal services restored as soon as possible.

1.2 "Business Continuity is defined as the capability of the organisation to continue delivery of products or services at acceptable predefined levels following and during a disruptive incident" (ISO 22301)

1.3 As a Category 1 responder, with key emergency response duties under the Civil Contingencies Act (2004), the Health Board is required to ensure that it has robust plans in place for emergency preparedness, resilience and response.

1.4 The main risk considered in this review is that the Health Board is unable to maintain critical services during a business continuity event, leading to significant disruption and potential risk to patients.

2. Detailed Audit Findings

Objective 1: There are appropriate business continuity plans and supporting processes in place, which cover the Health Board's critical operations

2.1 The Health Board's Emergency Planning Team has produced comprehensive business continuity guidance: the Business Continuity Policy, Business Continuity Response Guidance and the Business Continuity Planning Guidance "short version" and these are all on the Health Board's SharePoint site for staff to access.

2.2 Within this suite of guidance there is a clear methodology of how to complete an impact assessment, business continuity plans and action cards with the necessary templates to assist service areas.

2.3 From discussions with some business continuity leads it is evident that they have knowledge of what to do in an incident, but there is limited assurance that all staff within their respective teams have such knowledge.

2.4 We contacted seven directorates across the Health Board and viewed action cards from six of them. From the review there was no evidence to suggest that all business continuity action cards had been tested or communicated throughout the teams.

2.5 We found some of the action cards were generic ones which had been written by the Informatics Team, so they are for the Health Board wide IT systems and more specific ones had not been completed. We could also see that it was not clear as to when the action cards were last reviewed or updated, and some had review dates for 2020.

The above points are included within **matter arising one.**

Conclusion:

2.6 There is comprehensive business continuity guidance in place along with assistance from the Emergency Planning Team. We can see service areas sampled are engaging, as they have leads and have plans/action cards documented. However, it is not clear whether some of these have been tested or if staff are aware of what actions they need to take if a business continuity incident happens. Therefore, we have provided **reasonable assurance** for this objective.

Objective 2: Staff are aware of the business continuity plans and actions required during an incident

2.7 We found there is limited staff awareness for business continuity across the Health Board, only leads involved in the process know about the process and guidance. However, we obtained a list of critical areas within the Health Board, where the Emergency Planning Team reach out and maintain a status update of business continuity plans, testing and action cards in place. There is regular engagement and monitoring of non-compliant service areas by the Team.

2.8 As stated in the business continuity policy the Emergency Planning Team work to develop and deliver training, either one to one with business continuity leads, teams or in relation to major incidents. This is held on the Health Board's SharePoint site, however we found this is not clearly signposted. Training records are not kept or monitored, but registers for the sessions are kept. It is not clear how many staff have had business continuity training or when it is up for a refresh.

2.9 The Team also produce guidance which is held on the intranet for staff to access and they also assist with lessons learnt from incidents. However, this only happens if there is engagement from the service areas.

2.10 During the pandemic the '3Cs' (Control, Command and Co-ordination) structure was established, the Executive team sat at Strategic, Tactical was representation from sites/services and Operational was site and service teams. Operational issues that could not be resolved locally were fed up to tactical and issues not resolved at tactical fed to strategic, alongside regular site representatives. Decisions and direction would then go to tactical and operational as required. There was also a nosocomial group to provide expert advice and guidance to clinical services.

2.11 The Business Continuity (BC) group was in place pre pandemic but was paused as all services focused on in response mode for the pandemic, also the Emergency Planning team were working on organising / delivering pathways, PPE, testing, temporary mortuary, antibody testing, management of deceased patient belongings and the mass vaccination programme.

The above points are included within **matter arising two.**

Conclusion:

2.12 The Emergency Planning Team develop and deliver training when it is requested, however there is no monitoring mechanism in place with regards how many have had training or need a refresh with such training. There is awareness amongst business continuity leads who are engaged in the process but there is no assurance

that staff within their divisions have sufficient awareness. Therefore, we have provided **reasonable assurance** for this objective.

Objective 3: Appropriate command structure and communications are in place in the event of a continuity event occurring

2.13 There is an appropriate command structure in place across the Health Board, the '3Cs' structure interlinks with the response levels of Strategic, Tactical and Operational. This was tested during the pandemic and is communicated through the business continuity operational response guidance.

2.14 Communication according to the business continuity operational response guidance *"is a fundamental part of business continuity under the Civil Contingencies Act (CCA). Alerting and escalating the incident to Health Board strategic and tactical command structures must form part of the local BCP action cards"*. Regular communication is fundamental and should be a constant throughout any incident, so all involved are aware of the position.

2.15 There is an expectation for all teams, to engage and discuss what can and cannot be achieved. The lack of communication was a major theme from the business continuity resilience day held during October 2023. Whilst we did not test any continuity events in real-time, we believe there is value in exploring this feedback further and implementing any remedial action, as required. This is included within **matter arising three.**

2.16 The Health Board's Communications and Engagement Team has a role in linking with the Emergency Planning Team (the 'Team') and the command structure when it comes to delivering key messages and information, during a business continuity incident or major incident. The Team has a business continuity action card which they are in the process of reviewing, to ensure it is fit for purpose, with an action card for each distinct role.

Conclusion:

2.17 The Health Board has a clear and appropriate command structure, and this interlinks with the response levels of Strategic, Tactical and Operational. However, there was a key theme of communication issues during the feedback provided from the business continuity resilience that we observed. Therefore, we have provided **reasonable assurance** for this objective.

Objective 4: The Health Board has incorporated lessons from the Covid-19 pandemic into business continuity planning

2.18 We reviewed post-pandemic reports that summarised the impact of steps taken during the pandemic and reflections since. Whilst these documents are still in draft and the focus is centred around the operations in place during the pandemic (e.g. test and trace), we found elements that would help inform the updating / revision of business continuity plans at an operational / service level. These and other relevant documents should be utilised to update existing continuity plans throughout the Health Board. For example, to incorporate the risk / impact

probability assessments, the impact of home working, changes to supply processes and digital working etc. Overall, whilst the above is in place there was no evidence of learnings from the pandemic considered as part of the continuity planning process within the service areas.

2.19 Of the seven service areas we sampled, none of them have lessons learnt logs to document changes and / or follow-up actions. It is evident that some processes have been updated following the pandemic, but there is no formal document which details them all and business continuity action cards do not appear to have been updated.

2.20 There is a Covid-19 Investigations Team which is funded for two years by the Welsh Government to look at each of the waves of the pandemic, where they are currently in the process of reviewing 3k cases of nosocomial Covid. This is being completed by looking at data from Datix and reviewing actions and outcomes to see what the common themes are from the review. Any serious cases or concerns are escalated to the Patient Quality, Safety and Outcomes committee, which up until now have been very few. To date, the main themes from the review have related to documentation, administration, nursing, communication with patients and families and delays in testing. There have been no points raised regarding business continuity.

2.21 A recent paper was presented to the Executive Team (August 2023), and this was in response to a recent BT IT outage which impacted the Health Board in many ways. One of its recommendations was to put in place a business continuity group which would feed into the Emergency Planning, Preparedness, Response and Recovery (EPRR) Group.

2.22 We understand the above arrangements are in the process of being implemented. With Executive Director support this would help with engagement, overseeing adherence to the Civil Contingencies Act (CCA), business continuity planning and lessons learnt falling out of Covid-19 and this would be cascaded to Directorates / Divisions across the Health Board.

The above points are included within **matter arising four.**

Conclusion:

2.23 Discussions and processes have been completed post-pandemic, but it was not evident that business continuity plans and action cards have been reviewed and updated accordingly. Therefore, we have provided **limited assurance** for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Business Continuity Plans and Processes (Design)	Impact
The Health Board's Emergency Planning Team has produced comprehensive business continuity guidance through a Business Continuity Policy, Business Continuity Response Guidance and the Business Continuity Planning Guidance "short version". Within this suite of guidance there is a clear methodology of how to complete business continuity impact assessments, plans and action cards along with templates to assist Directorates / Divisions in completing them. The team engage across the Health Board and offer support and advice, when required. We sample tested seven service areas across the Health Board, including the reviewing of business continuity arrangements: • Six of them had action cards in place. There was a mixture of specific and generic ones relating to disaster recovery scenarios (i.e. Health Board IT Systems failing) and the subsequent impact therein. • There was no evidence that scenario testing had taken place within any of the sample, to ensure they remain robust and fit for purpose. • For four of the sample, it was not clear if any of the action cards had been recently reviewed or updated, as this evidence was not provided. • The action cards were clear and detailed. • No post pandemic reviews, lessons learnt and / or subsequent updates to the documentation have been completed. • One service area (Medicine) is still developing their business continuity plans. We were informed that work is being completed by the Emergency Planning Team to retain a repository on the Health Board's business continuity, SharePoint page. This should enable Directorates / Divisions to view plans and action cards from across the Health Board, to help with the sharing of best practice.	Potential risk of: • Business continuity plans/action cards do not cover all the service areas within the Health Board. • Limited awareness of business continuity risks. • No real accountability within the planning process.

Recommendations		Priority
1.1	Business continuity plans and associated documentation should be completed for all service areas within the Health Board. The Health Board may wish to incorporate this process with the wider operational risk management processes There needs to be accountability and escalation routes if such plans/action cards not completed.	**Medium**
1.2	Business continuity plans/action cards should be regularly tested, to ensure steps taken are the most effective. Following a continuity event test being completed, lessons learnt and updates to the documentation should be completed.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
1.1	Recommendation accepted – the requirement for business continuity plans is within the Policy and BC planning guidance. The emergency planning team have plans in place to further engage with specific service areas. The new intranet repository will provide further information and will be easier to access and submit plans and a summary tracker of progress of business continuity will be established to monitor the progress of plans. The newly established EPRR group will be well suited to be the forum for escalation.	Repository in place by Dec 2023 EPRR and BC group in place from Jan 2024	Head of Planning – Civil Contingencies
1.2	Recommendation accepted – this is included within the policy and business continuity planning guidance. Outcome from exercises and tests can be added to the repository and monitored by the emergency planning team and be available to share with others for learning and via the EPRR group.	Repository in place by Dec 2023 EPRR and BC group in place from Jan 2024	Head of Planning – Civil Contingencies

Matter Arising 2: Staff awareness and training (Operation)	**Impact**
As per the Business Continuity policy, the Emergency Planning Team (the 'Team') work to develop and deliver training and produce the relevant guidance and templates. This is held on the Health Board's SharePoint, although training delivery requires direct engagement with the Team. The Team offer advice and guidance, and this works well when regular engagement is in place with senior management across the Health Board's Directorates/Divisions. Training is delivered to business continuity leads, but with major incidents, this is mainly done on a one-to-one basis or in teams, when requested. It is not clear how many staff have had such training or when staff need a refresh for business continuity or major incidents, as training records are not kept or monitored. Only registers are kept from the training sessions. The implementation of the Emergency Planning, Preparedness, Response and Recovery (EPRR) group and Business Continuity group would help with identifying future business continuity leads and to help raise awareness.	Potential risk of: • Staff are not clear of their roles and responsibilities in the event of a business continuity incident.

Recommendations		**Priority**
2.1	Business continuity should be promoted throughout the Health Board on a regular basis, to help raise awareness throughout all service areas.	**Medium**
2.2a	The training resource on ABUHB SharePoint should be clearly signposted so staff know what the team delivers and what training they will need either on business continuity or a major incident.	**Medium**
2.2b	There should be regular monitoring of training delivery by the Emergency Planning Team to ensure staff have the appropriate knowledge.	

Agreed Management Action		Target Date	Responsible Officer
2.1a	Recommendation accepted - Emergency planning promote business continuity on the intranet and to service leads, this will be increased by quarterly updates on the intranet, using AB Pulse and with support from the communication team across other internal media platforms and through the EPRR group and the BC group.	Commence quarterly from January 2024	Head of Planning – Civil Contingencies
2.2a	Recommendation accepted - Promote and signpost services to the guidance via the intranet and using the EPRR and BCM group. The repository will be in place by Dec 23, easily accessed via the front page of AB-pulse and agree a weekly promotion of the link with the comms team for the first month, and then quarterly as per 2.1.	Repository in place by Dec 2023 Promote awareness as 2.1	Head of Planning – Civil Contingencies
2.2b	This will be identified by through the summary tracker. The summary tracker will capture training, meetings, exercise and workshops, this will sit within the repository.	Dec 2023	

Matter Arising 3: Business Continuity Communication (Operation)	**Impact**
There is an appropriate command structure in place across the Health Board - the 3Cs (Control, Command and Co-ordination) - which interlinks with the response levels of Strategic, Tactical and Operational. This was tested during the pandemic and communicated through the business continuity operational response guidance as shared on Health Board's SharePoint. The Health Board's Communications and Engagement Team links with the Emergency Planning Team (the 'Team') and the command structure to deliver business continuity messages or a major incident, including recent examples. The Team has a business continuity action card, which they are currently reviewing, to ensure it is still fit for purpose and that there is an action card for each distinct role. However, when observing the Business Continuity Resilience Day, significant feedback was obtained from the divisions / representatives within the Health Board. The overarching theme was that of communication during an event. Whilst we did not observe any examples within our testing, there is value in collating this information and implementing any action required.	Potential risk of: • Lack of clarity over common responsibilities • There is a lack of knowledge of what needs to be communicated, to whom and when necessary.

Recommendations		**Priority**
3.1	The Emergency Planning Team should undertake a 'deep-dive' of the information received on the Business Continuity Resilience Day and implement any improvement actions required.	**Low**

Agreed Management Action		**Target Date**	**Responsible Officer**
3.1	Recommendation accepted. The emergency planning team, divisions and directorates will continue to undertake debriefs following exercises and events to identify learning. Plans and actions card will be amended according following this process. These will be shared via the BCM or EPRR group as appropriate. The EP will develop a bespoke BC debrief workshop for spring 2024	March 2024	Head of Planning – Civil Contingencies

Matter Arising 4: Lessons Learnt from during the Pandemic (Design)	**Impact**
We found that some methodology has been adopted from the management of the pandemic (e.g. command structure), and a review has been completed around the operations in place during the pandemic (e.g. test and trace). Within this process, we identified elements that would help inform the updating / revision of business continuity plans at an operational / service level. However, there has been no formal post pandemic reviews within the divisions / service areas sampled or evidence that learnings had been incorporated. A recommendation has been presented to the Executive Team for the establishment of groups to assist with business continuity management, with an Executive Director as the Chair of the Emergency Planning, Preparedness, Response and Recovery (EPRR) Group. This would assist with engagement, planning post pandemic, overseeing adherence to the Civil Contingencies Act and business continuity planning and guidance.	Potential risk of: • Lessons are not being learnt from the pandemic or are not being collated centrally.

Recommendations		**Priority**
4.1	The Health Board should ensure that operational areas incorporate best practice, learning, lessons and other experiences from the pandemic within their business continuity plans.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
4.1	Recommendation accepted. The BC guidance incorporates debrief requirement to identify lessons to inform planning, this will be amended to incorporate learning from the pandemic. An updated version will be shared with BC leads highlighting this requirement to incorporated in new plans and current plans to be reviewed to ensure learning included. This will be highlighted in all training and at the BC group meetings. This will also be monitored on the summery tracker reported into the BC and EPRR group as part of planned monitoring process.	The guidance has been updated will be posted and circulated December 2023 Monitoring From March 2024	Head of Planning – Civil Contingencies

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

	Substantial assurance	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	Reasonable assurance	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	Limited assurance	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	Unsatisfactory	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	Assurance not applicable	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

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

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

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Putting Things Right

Final Advisory Review Report

November 2023

Aneurin Bevan University Health Board

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

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

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Committee:	Audit, Risk and Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023

Acknowledgement
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Disclaimer notice - please note
This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit, Risk and Assurance Committee.

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

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with the Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Executive Summary

Purpose of the Review

To determine if there are alternative processes or approaches that can be adopted by the Health Board to improve the overall management of Putting Things Right.

This is an advisory review and so, although recommendations have been raised the review has not been given an assurance rating.

Summary of Health Board Position

	Area of consideration	Health Board position
1.	Review against good practice standards	
2.	Actions to address complaint causes	
3.	Complaints handling resource capacity	

Key:

No concern	No risks or issues identified / recommendations identified for enhancing existing process
Strengthen	Management attention needed to address medium to low risk matters
Escalate	Urgent management attention needed to address matters of high risk with potential substantial impact

Overview of Findings

What's Working Well

- An increasing number of concerns and complaints are being resolved through the 'Early Resolution' pathway.
- Complaints are all logged, documented and managed effectively in a centralised database tool (Datix).
- Policies, procedures, guidance and training materials are in place.
- In Q1 and 2 of 2022/23, the Health Board performed on a par with its peers in its handling of complaints, and performed better than some other NHS Wales organisations in some respects.
- Only a low percentage of complaint outcomes are referred to the Ombudsman by complainants.
- Though lean and in some cases shared, divisions do not appear under-resourced in their complaint handling resources.

Areas to Further Strengthen

- Increased analysis of individual complaint case causes could further increase learning and may prompt further interventions in service improvements and human resource management.
- A review of the current structure / resources within the Health Board is needed to ensure complaints are dealt with in the most efficient manner and lessons learnt are fully embedded.

Areas of Concern

- Compliance with the 30 day complaint resolution standard fell to a low of 41% in January 2023. Although this has shown an upward trend since and had reached 58% by April 2023, this is still substantially lower than the 75% target.
- Improvements to the complaint investigation timeline management may reduce response delays from participants and reduce the number of 30 day breaches. This should include uploading of all necessary complaint information onto Datix case records and ensuring appropriate detail is retained for learning to be implemented.
- Change actions identified in complaint outcomes and through broader learning should be captured in action plans of appropriate teams, where they should be monitored and managed to closure.

1. Introduction

1.1 The review of Putting Things Right (PTR) was completed in line with Aneurin Bevan University Health Board's (the 'Health Board') 2022/23 Internal Audit Plan.

1.2 The review examined the model used by the Heath Board for the handling and resolution of complaints. To assess its effectiveness, the review sought to compare the model adopted by the Heath Board with that of other NHS organisations and published best practice in order to identify any alternative approaches, practices or procedures where results indicate these are successful in managing the area.

1.3 This advisory review followed an assurance review conducted in 2021/22, which sought to provide the Health Board with assurance that it was complying with the relevant standards for the handling of complaints, both in terms of quality and content and timeliness. The previous review, which provided 'reasonable' assurance, reported that actions to resolve complaints were not being tracked to closure, and that lessons to be learned from these were not being shared across the organisation effectively.

Associated Risks

1.4 The overall risk in this area is that the model currently used by the Health Board to manage Putting Things Right is ineffective and leads to a high volume of complaints not being resolved in the required timescales and / or lessons learnt.

Advisory Review

1.5 Further details of the scope of the review and the work undertaken are included in Appendices One and Two.

1.6 This is an advisory review therefore we have **not provided an assurance rating**. We have identified learning and provided recommendations to strengthen the Putting Things Right process. Our recommendations, which management may wish to consider, are set out in Appendix Three.

2. Advisory Review Findings

Review of good practice in operation at other NHS organisations

2.1 We determined how the Health Board is currently managing their complaint investigations. We did so in order to understand the processes that they are operating and through this identify strengths and weaknesses with the processes in place.

2.2 In conducting the evaluation process, we examined the complaint workflows of five sample divisions across the Health Board listed below:

- Scheduled Care;
- Medicine;
- Urgent Care;
- Family and Therapies; and
- Primary Care and Communities.

2.3 We examined the steps in the work flows within the divisions. Where we saw variations across the divisions, or where we assessed strengths / weakness are noted below:

- resources provided in the divisions for the handling of concerns and complaints was seen to vary. In some cases we saw a number of dedicated concerns handling officers, in others not, and divisional staff took on the coordination or administration of the complaints alongside the duties of their main role;
- several of the divisions we examined used their own documented process workflows, although these did not significantly deviate from the work flows set out in the Putting Things Right policy and procedures documentation;
- one division reported that there may be a time lag from the complaint being received by the Health Board and it being received in the division, thus reducing the time the division have to complete their investigation;
- some divisions have appointed dedicated investigating officers who will take all of the complaint cases that are raised. In others, investigating officers are selected from a broader pool of generally senior divisional staff;
- more than one division reported difficulty in obtaining approval of the draft report from the clinicians involved in the cases and in some instances, difficulty in obtaining the formal approval of the contents of a draft report from the senior divisional management, both of which can lead to delays; (**Matter Arising 1**)
- one of the divisions reported there can be limited investigation documents and divisional approval records attached to the case's Datix record (materials are usually attached to Datix by concerns coordinators who are reliant on receiving the material from the investigating officers); (**Matter Arising 2**)

- there is no distinction made between straight-forward and complex complaints when applying the 30 day closure target imposed by the regulations and all cases that exceed this are reported as breaches, including those which would be accepted as complex for which the regulations permit a closure target of six months. (**Matter Arising 3**)

2.4 We questioned staff within the divisions about bottlenecks and stress points in the workflow that may create delays in the progress of the complaint cases that they handle. The following issues were raised:

- cases transferred from the PTR Team into the division in some cases do not belong to the division;
- some of the cases transferred from the PTR Team to the division cover multiple divisions and there is then debate between parties as to which division should take the case;
- some case investigations are delayed by slow responses from clinicians to requests for input to the investigation;
- some investigating officers reported that they are continually chasing other colleagues internally e.g. those providing documentation, medical records etc.;
- sickness and absence among staff involved in case investigations can delay investigation progress;
- there may be delay when a complaint needs to be considered for a breach of duty and legal services must be consulted for their opinion; (**Matter Arising 1**)
- there have been some complaint investigation cases where an outsourced care provider who carried out the procedures, which were the subject of the complaint, have not responded to requests for information;
- in some cases final reports that have been approved by the division are being rejected by the Chief Executive prior to issue and returned for amendments or changes in language etc. meaning that the PTR Team have to send the reports back to the division/ investigating officer for amendments to be made.

2.5 Investigating officer training is provided by the PTR Team and is a comprehensive training course covering a wide range of aspects of the investigating officer role. In the period September 2020 to February 2023 we were advised that a total of 211 consultants, senior nurses, ward managers, directorate managers, Allied Health Professionals, Executives, safeguarding representatives, quality and patient safety leads and external partners received the training across all the divisions of the Health Board.

2.6 We looked at the way in which complaint cases are reported both internally at corporate level as well as externally and noted the following:

Divisions report to PTR information to the Quality and Patient Safety Operational Group (QPSOG).

This is then sent to the Health Board's Patient Quality, Safety & Outcomes Committee (PQSOC) for information.

Reports containing themes, statistics and trends are reviewed at divisional quality and patient safety meeting and divisional management team meetings.

The PTR Team meet with the Executive Team weekly, where case data and significant complaints (graded four or five) are discussed.

The PTR Team have regular meetings with the PSOW to monitor progress on the complaint cases that have been referred to them.

An analysis of open ombudsman cases is provided to the Chief Executive and separately to each of the divisions.

The PTR Team submit quarterly returns of complaint case numbers to the Welsh Government and compile and submit an annual report. They also hold quarterly meetings with the Ombudsman where they review status and progress of these cases.

2.7 We looked at how the Health Board ranked against other NHS organisations in Wales to assess its complaint handling performance. For this we used data collected and presented by the Ombudsman for the period April to September 2022 presented in figure 1 below. The Health Board has the second highest population of all of the health boards in Wales, but during this period recorded one of the lower complaint rates per capita. However, since then the more recent performance data is showing a significant deteriorating trend.

	Population	Complaints Received	Complaints Received per 1000 residents (adjusted)	Complaints Closed	Within 30 days %	Referred to Public Services Ombudsman for Wales	Referred %	PSOW Cases Closed	PSOW Intervened %	Early resolution %	PSOW Upheld%
Aneurin Bevan University Health Board	591,225	1,656	5.60	1,568	80%	83	5%	70	23%	10%	10%
Betsi Cadwaladr University Health Board	698,369	1,786	5.11	1,473	62%	114	8%	102	35%	24%	10%
Cardiff and Vale University Health Board	496,413	2,509	10.11	2,357	83%	65	3%	61	20%	15%	5%
Cwm Taf Morgannwg University Health Board	445,190	1,676	7.53	1,558	88%	77	5%	65	17%	9%	8%
Hywel Dda University Health Board	385,615	1,269	6.58	1,164	75%	43	4%	45	51%	38%	13%
Powys Teaching Health Board	132,447	76	1.15	82	40%	15	18%	13	23%	15%	0%
Swansea Bay University Health Board	389,372	1,066	5.48	986	66%	68	7%	57	26%	16%	9%
Velindre University NHS Trust	-	84	-	73	99%	3	4%	3	100%	33%	33%
Welsh Ambulance Services NHS Trust	-	619	-	443	55%	22	5%	26	15%	4%	4%
										-	
Wales	3,138,631	10,741	6.84	9,704	76%	490	5%	413	28%	18%	9%

Figure 1: complaint statistics Welsh health boards, April – September 2022

2.8 As stated above the Health Board's compliance rate with this measure has been decreasing substantially and compliance with the 30 day complaint resolution standard fell to a low of 41% in January 2023. Although this has shown an upward trend since and had reached 58% by April 2023 (primarily due to senior management / Executive involvement, which is not sustainable in the long term), it is significantly lower than the 75% target (**Matter Arising 4**).

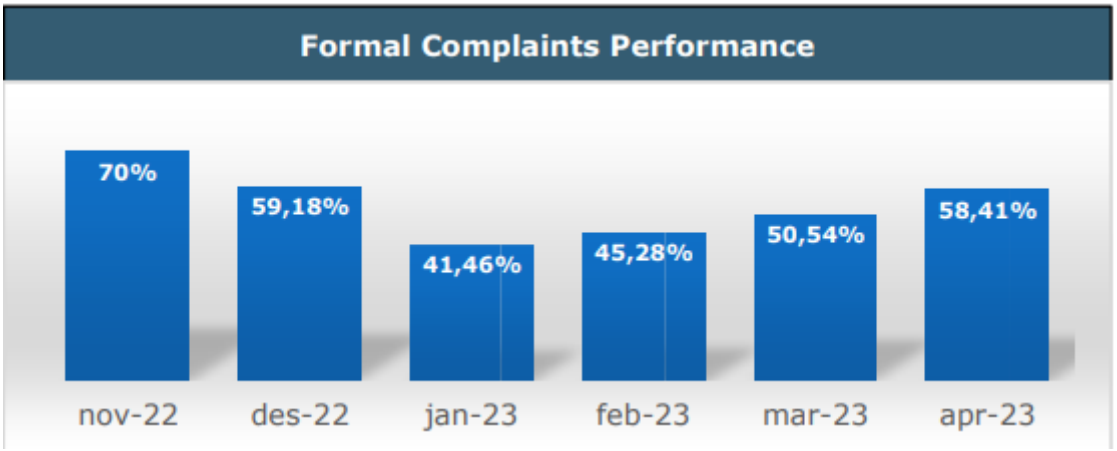

Figure 2: Health Board formal complaints performance, percentage of cases achieving the 30 day resolution standard

2.9 We were able to obtain complaints policy documentation from other NHS organisations and when we examined them, we noted a common high level framework being set out.

Actions that could be undertaken by the Health Board to address the underlying causes of the complaints

2.10 An effective patient complaints management system, as well as collecting and analysing complaints data, entails acting upon this information. Our research found that improving the use of complaints data in service quality improvement and human resource management has been to be an effective intervention with complaints raised.

2.11 Regulation 49 of The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 provides that each responsible body must ensure that it has processes in place to ensure that any deficiencies in its actions or service provision that are identified as part of an investigation of a concern in accordance with these Regulations are acted upon and monitored.

2.12 This is seen to carry over into the Health Board's policy documentation which states the following requirements;

- 'Learning mechanisms shall be implemented in line with this Policy through the Organisational and Divisional Action Plans arising from incidents'; and
- The role of the Senior Investigations Manager 'includes implementing a system across the Health Board to ensure remedial actions are taken to avoid recurrence of concerns and the sharing of lessons learnt across the organisation and beyond.'

(ABUHB Putting Things Right Policy (Complaints, Claims and Patient Safety Incidents)).

2.13 There are a broad variety of ways in which learning from events are cascaded through the organisation. Prominent in the process is the quality and patient safety arm of each of the divisions of the Health Board who receive regular reports of the complaints and their outcomes.

2.14 Divisional based staff involved in complaint investigations also employ different mechanisms of sharing learning with staff in their directorate.

2.15 Information emerging from complaint investigations is cascaded through the Quality and Patient Safety (QPS) meetings and to the staff of the service areas. This is communicated to the division's QPS meetings, and then on to the PQSOC.

2.16 Our discussions with staff involved in the investigation of complaints in the divisions we looked at in the review identified the following learning mechanisms/ activities taking place;

- complaint investigation officers attend meetings with groups of senior nurses, midwives and medical teams where information from investigation outcomes is shared;
- some divisions raise alert bulletins (e.g. ERASE Educational Information Posters) which are shared across all staff groups;
- QPS officers bring a report of patient safety matters (including complaints) to divisional management team meetings (DMT). However, we noted the level of complaint case analysis provided in these reports varies across the divisions (**Matter Arising 5**);
- DMT 'Assurance of Learning' meetings bring together and review action lists arising from the investigated complaints in the division;
- there are regular meetings between divisional QPS officers and directorates to review the cases and find ways to progress these;
- there is sharing of learning at a range of for a / meetings, for example the Clinical Governance Day (Family and Therapies) attended by doctors and midwives of all levels;
- divisions conduct learning events prompted by complaint investigation outcomes.

2.17 Learning and remedial actions on complaints are closely linked and may emerge from more than one source.

2.18 Direct actions may be identified in a complaint investigation where outcomes record specific changes that are required to address a weakness. However, actions may also be identified in the pathways of broader organisational learning, where themes have been shared across the divisions and at a corporate level and from which policy or procedural change needs emerge.

2.19 Direct actions associated with a complaint will be stated in the complaint outcome. The subject of the investigation is shared with the teams and assigned accordingly. In these cases, we would expect to see conventional

action plans that record the action, the individual assigned and the action target date. However, although we saw some individual examples of complaints related action plans created by divisional QPS officers and monitored accordingly, we were unable to identify a process where these are systematically captured in action / progress logs across the teams. (**Matter Arising 6**)

2.20 Actions derived from broader shared learning will be determined according to the impact of an issue in the area it is being considered and what needs to be done by that area to address it. However, we were unable to identify a process or mechanism that ensures that all areas affected are responding with an appropriate action to reduce the recurrence of complaints (**Matter Arising 6**) which are seen through themes analysis to continue year after year.

2.21 Investigation outcome reports of serious incidents (SI), PSOW investigations and Redress cases (complaints cases where there is a breach of duty and a consequent liability) will include clear recommendations which may be presented in the form of an action plan. For these cases, there is a higher degree of scrutiny placed on the delivery of actions arising (e.g. for redress cases, the Welsh Risk Pool will not make redress payments until they have received evidence that report recommendations have been actioned) and therefore a greater likelihood that the weaknesses that gave rise to the events that were the subject of the complaints are addressed.

The capacity of the resources handling the complaints process in the light of the number and complexity of the complaints the Health Board receives

2.22 The Health Board has a central PTR resource dedicated to the management of concerns, complaints, serious incidents etc. For complaint cases, the PTR Team performs a largely administrative role. The PTR Team receive and log the complaints cases that are received and distribute these to the divisions to which they relate, who then take on and report the investigations. The PTR Team has a broader role covering serious incidents (SI) and Ombudsman (PSOW) investigations of complaints referred by complainants and analysis and reporting.

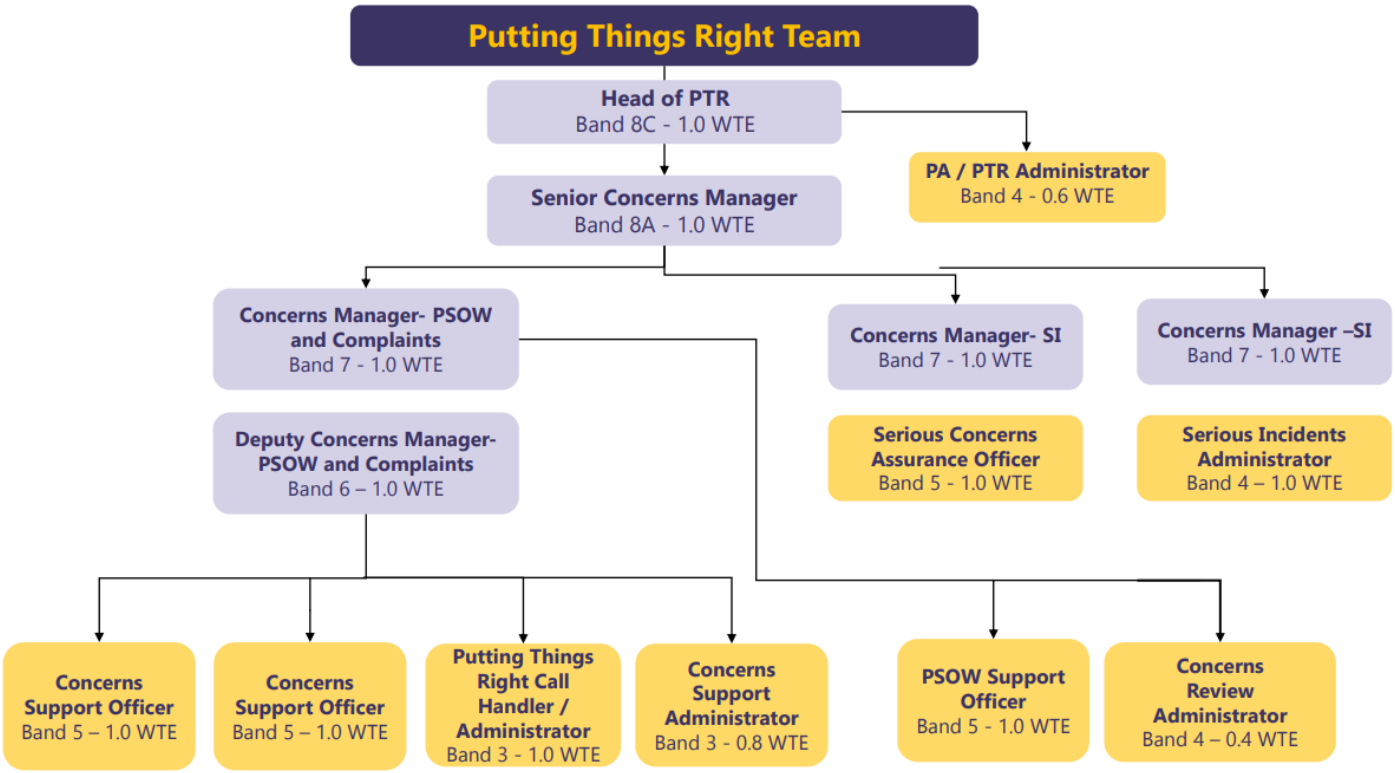

Figure 3: Putting Things Right team organisation chart, February 2023

2.23 All of the divisions we reviewed have a level of dedicated complaints staff within their structure, although the number of these varies. In addition to these, typically one or more divisional QPS officers have within their remit the analysis and reporting of complaint activity within their division. One of the divisions has a dedicated investigating officer who will cover all of the complaint cases but generally, investigating officers are selected from the senior staff of the division according to the directorate or team the complaint concerns.

2.24 Divisions vary in their structure, configuration, activity levels, case volumes, medical specialties, complexity and locations. Taking all of these aspects into consideration, each has a unique profile. Additionally, the complaint handling element of shared roles (e.g. QPS officer roles) may vary across the divisions and for all these reasons, meaningful comparison of complaints handling resource levels between them is difficult. Figure 4 provides divisional resource data, but in the absence of measures of parameters of case complexity etc. it is not possible to rank divisional resource levels from an efficiency perspective.

Division	Dedicated complaints staff in the division	Other divisional staff with a complaints remit (usually QPS)	Annual complaint cases managed through PTR (2022)	Open complaint cases at December 2022
Scheduled Care	Concerns Manager Concerns Co-ordinator Complaints Administrator 0.53 WTE	QPS Officer	382	157
Medicine	Complaints Administrator 0.8 WTE Complaints Administrator 0.6 WTE (Shared with Urgent Care division)	QPS Officer	287	126
Urgent Care	Complaints Administrator 0.8 WTE Complaints Administrator 0.6 WTE (Shared with Medicine division)	QPS Officer 0.5 WTE QPS Officer 0.5 WTE	170	53
Family and Therapies	Clinical Lead Midwife for Concerns	PA to General Manager QPS Officer	138	62
Primary Care and Community	Assistant QPS Managers – one at 0.9 FTE, one at 0.7 FTE (complaint review, reports and data, some investigations) Clinical Lead for QPS – Investigating officer and complaint oversight Investigating Officer and complaint oversight QPS Support Officer – 0.4 FTE – ad hoc complaints administrative support	QPS Officers (Concerns Administrators plus wider QPS Agenda) – one WTE and one at 0.9 WTE covering North and South Areas with cross cover	127	42

Figure 4: Complaints staff in the sample divisions, February 2023

2.25 Similarly, complaint handling resource level comparisons with other healthcare providers are difficult to compare. As a result, we were unable to gauge how well resourced the Health Board is with complaints officers compared to other health boards or organisations. However, we recommend that the current structure arrangements are reviewed throughout the Health Board to ensure that an appropriate level of resource is in place for each key component of the process e.g. staff to implement lessons learnt or to process complaints (**Matter Arising 7**).

Appendix One: Terms of Reference

Scope	The overall objective of this review is to determine if there are alternative processes or approaches that can be adopted by the Health Board to improve the overall management of Putting Things Right. To achieve this, we will consider the following aspects: 1. a review of good practice in operation at other NHS organisations; 2. actions that could be undertaken by the Health Board to address the underlying causes of the complaints; and 3. the capacity of the resources handling the complaints process in the light of the number and complexity of the complaints the Health Board receives.
Associated risks	The overall risk in this area is that the model currently used by the Health Board to manage Putting Things Right is ineffective and leads to a high volume of complaints not being resolved in the required timescales and / or lessons learnt.
Limitations to scope	N/A

Appendix Two: What We Did

Our approach was to:

a. undertake a review of the health board's current complaints handling workflows in the divisions to understand their strengths and weaknesses;

b. ascertain what processes are in place to implement change actions that result from individual complaint findings:

c. understand how themes are determined from complaint cases and how related learning is shared across the health board;

d. challenge how learning from complaint investigations impacts health board policies and procedures and delivers changes in practices;

e. review the level of the resources the health board provides for the investigation and resolution of complaints at corporate and divisional levels.

To achieve this, we undertook the following review activity:

We engaged with the following Health Board staff, either through interview or email correspondence:

- Jennifer Winslade, Executive Director of Nursing (review scoping)
- Tracey Partridge Wilson, Assistant Director of Nursing
- Jane Rowlands-Mellor, Head of Putting Things Right (PTR)
- Emma Wilkins, Deputy Concerns Manager PTR
- Kerry Richards, Concerns Manager Complaints and Public Services Ombudsman for Wales (PSOW) PTR
- Emma Evans, PSOW Support Officer PTR
- Helen Morgan, Divisional Nurse Family and Therapies
- Julie Winstone, PA to General Manager & Divisional Director Family and Therapies
- Gwyneth Ratcliffe, Quality and Patient Safety Lead Family and Therapies
- Adele Baker, Clinical Lead Midwife for Concerns Family and Therapies
- Amanda Hale, Divisional Nurse Scheduled Care

High-level review of:

Internal resources

- Putting Things Right Team policy and procedure documentation
- Putting Things Right Team intranet resources – toolkits, guides etc.
- Putting Things Right Annual Report 2021-22 – ABUHB
- RL Datix Feedback module – complaints capture system

External directives and guides

- Key strategies to improve systems for managing patient complaints within health facilities – what can we learn from the existing literature? - PubMedCentral
- A review into the quality of NHS complaints investigations - Parliamentary and Health Service Ombudsman (PHSO)
- A guide to handling complaints and representations by local authority social services - Welsh Government
- Ending Groundhog Day - Lessons from Poor Complaint Handling - Public Services Ombudsman for Wales
- NHS England Complaints Policy

- Christine Palmer, Concerns Manager Scheduled Care
- Sue Pearce, Divisional Nurse Medicine
- Angela Downward, Assistant Quality and Patient Safety Manager Medicine
- Kylie Crook, Senior Nurse Quality & Patient Safety Medicine
- Chris Morgan, Divisional Nurse Urgent Care
- Sally Moseley, Quality and Patient Safety Assistant Manager Urgent Care
- Caroline Rowlands, Deputy Head of Nursing, QPS and Nurse Education Locality Offices Primary Care and Community
- Grace Martin, Assistant Quality & Patient Safety Manager Primary Care and Community
- Scott Taylor, Head of Health and Safety
- Lynne Davies, Health and Safety Administrator

- NHS Complaint Standards - Model Complaint Handling Procedure for providers of NHS services in England
- Principles of Good Complaint Handling PHSO
- Putting Things Right - Guidance on dealing with concerns about the NHS - Welsh Government
- Putting Things Right Guidance 2023 – Welsh Government (The Health and Social Care (Quality and Engagement) (Wales) Act 2020)
- Improving your complaints process for complainants and for you - Queen Margaret University Scotland
- Resolving problems and making a complaint about NHS care in Wales - Age Cymru
- PSOW published complaints statistics for Welsh Health Boards and Trusts April-September 2022

Appendix Three: Recommendations and Management Actions

	Para.	Risk / Potential Impact	D/O[2]	Recommendation	Priority[3]	Agreed Management Action	Responsible Officer
1	2.3, 2.4	Slow responses from clinicians in confirming the contents of a complaint draft report and from legal services for opinion on potential breach of duty question may delay the complaint closure.	D	A timeline plan for the path to the closure of the case should be prepared and shared with all persons involved in the case, in order that participants can plan and prepare for their input and schedule time to do so.	**Medium**	A review of the complaint process will be undertaken following the OCP process to realign Quality Patient Safety resources to the Nursing Directorate. A new Quality Patient Safety Manger has been appointed who will be responsible for the complaint process Since period of review the PTR, Legal and QPS teams are aligning under one structure, this will bring together enhanced knowledge and skills of the PTR Regulations, legal tests and required timelines. The new structure will triangulate the whole complaint process, bringing improved quality and timeliness to concern responses. End March 2024	Director of Nursing
2	2.3, 2.4	Complaint investigation evidence not readily available in the event of a query that could prevent the Health Board from successfully defending a PSOW referral or breach of duty assessment	O	All investigation evidence should be attached to the complaint Datix record for ease of reference in the event of queries.	**Medium**	A review of the complaint process will be undertaken following the OCP process to realign Quality Patient Safety resources to the Nursing Directorate. A new Quality Patient Safety Manger has been appointed who will be responsible for the complaint process Since the period of review the PTR, Legal and QPS teams are aligning	Director of Nursing

	Para.	Risk / Potential Impact	D/O[2]	Recommendation	Priority[3]	Agreed Management Action	Responsible Officer
						under one structure, this will bring together enhanced knowledge and skills of the PTR Regulations, legal tests and required timelines. The new structure will triangulate the whole complaint process, bringing improved quality and timeliness to concern responses. End March 2024	
3	2.3, 2.4	All complaint investigations cases that exceed the 30 day closure target imposed by the regulations are reported as breaches, including those which would be accepted as complex for which the regulations permit a closure target of six months. Therefore, the figure may be overstated.	D	Complex complaint cases which. under the regulations. are permitted an investigation period of up to six months should be excluded from the 30 day breach statistics.	**Low**	Welsh Government are Currently reviewing PTR regulations. End of Jan 2024	Director of Nursing
4	2.8	Compliance with the 30 day complaint resolution standard fell to a low of 41% in January 2023, but has shown an upward trend and had reached 58% by April 2023, which is still substantially lower than the 75% target.	O	Current barriers that are leading to poor resolution target and compliance rates require identification and resolution urgently.	**High**	An urgent review of any immediate barriers and quick winds will be undertaken. Dec 2023 The PALS service was launched in November which will aim to resolve more complaints through early engagement with families	Director of Nursing
5	2.16	The level of complaint case analysis provided to divisional oversight groups varies across the Health Board and may not support learning.	D	Complaint case analysis detail level should be sufficiently granular, to provide learning to recipients and to prevent recurrence.	**Medium**	Review of all QPS resources being undertaken via an OCP which will include learning. End of Dec 2023 A review of Divisional QPS structures and assurance mechanisms will be required following the OCP. This will form	Director of Nursing and Chief Operating Officer Director of Nursing

	Para.	Risk / Potential Impact	D/O[2]	Recommendation	Priority[3]	Agreed Management Action	Responsible Officer
						part of a wider delivery plan for the Quality Strategy and a clear accountability framework between the Nursing Directorate and the Operational Divisions for QPS.	
6	2.19 2.20	Actions identified to address weaknesses, that have led to poor practices and subsequent complaints, are not being delivered and as a result these practices continue.	D	Actions to address the circumstances that have led to individual complaints and those that have been identified to address complaint themes through broader learning pathways should be captured in action plans. The delivery of the plans should be monitored by appropriate oversight groups.	**High**	Review of all QPS resources being undertaken via an OCP which will include learning. End of Dec 2023 Learning and actions will be collated centrally once the QPS resources form part of the wider Nursing Directorate March 2024	Director of Nursing and Chief Operating Officer
7	2.25	Insufficient or inappropriate use of resource for the end to end management of complaints.	D	Actions to review the current structure throughout the Health Board mapped to the end to end process. Where gaps in or additional resource requirements are identified these should be implemented to meet the requirements of the Health Board.	**Medium**	Review of all QPS resources being undertaken via an OCP. End of Dec 2023	Director of Nursing and Chief Operating Officer

2. C = Control Design weakness: a gap in the design of the system or process giving rise to increased risk.
   O = Operating Effectiveness issue: non-compliance(s) with the laid down system / process giving rise to increased risk.

3. Recommendation priority rating definitions can be found here.

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

Date issued: November 2023

Document reference: 3503A2023

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

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

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About this document

1 This document provides the Audit, Risk and Assurance Committee with an update on our current and planned accounts and performance audit work at Aneurin Bevan University Health Board.

2 We also provide additional information on:

- Other relevant examinations and studies published by the Audit General.
- Relevant corporate documents published by Audit Wales (e.g. fee schemes, annual plans, annual reports), as well as details of any consultations underway.

3 Details of future and past Good Practice Exchange (GPX) events are available on our website.

Accounts audit update

4 Exhibit 1 summarises the status of our current and planned accounts audit work.

Exhibit 1 – Accounts audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Audit of Accounts	Rob Holcombe – Director of Finance and Procurement	We will follow the audit approach designed as part of our planning work and undertake appropriate audit testing to enable to Auditor General to provide his opinions on the financial statements of the health board.	Complete	Audit of Accounts report presented to committee at July 2023 Audit. Risk and Assurance Committee
Charitable Funds: • Planning • Audit of Charitable Fund	Rob Holcombe – Director of Finance and Procurement	• This work involves undertaking risk assessment procedures to identify risks of material misstatement within the Charitable Fund's financial statements. The subsequent design and	Plan in place to deliver certified accounts by the statutory deadlines set by the Charity	To be confirmed

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Financial Statements		performance of our audit approach will be responsive to each assessed risk. • We will follow the audit approach designed as part of our planning work and undertake appropriate audit testing to enable to Auditor General to provide his opinion on the financial statements of the Charitable Fund.	Commission. Work due to start w/c 27 November 2023.	

Performance audit update

5 Exhibit 2 summarises the status of our current and planned performance audit work.

Exhibit 2 – Performance audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Structured Assessment 2023 – Core	Nicola Prygodzics – Chief Executive Officer	Our core structured assessment work is designed to examine the existence of proper arrangements for the efficient, effective, and economical use of resources. Our 2023 core Structured Assessment work reviewed: • Corporate systems of assurance; • Corporate planning arrangements; and • Corporate financial planning, management, and performance arrangements.	Report finalised and included in today's committee papers	November 2023
		In addition to the core structured assessment work, we will also undertake "deeper dive" work in a specific area. We had initially identified digital transformation as the deeper dive topic for 2023. However, given the financial challenges facing the NHS at present, we are looking to now focus our deep dive work in health boards on financial savings / cost improvement plans. The focus of this work is currently being developed and further details will be shared in due course.	Planning	To be confirmed

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Follow-Up of Primary Care Services	Leanne Watkins – Chief Operating Officer	Follow-up of recommendations made in our Primary Care services review	Report issued	February 2024
All-Wales thematic on workforce planning arrangements	Sarah Simmonds – Executive Director of Workforce and Organisational Development	This work will examine the workforce risks that NHS bodies are experiencing currently and are likely to experience in the future. It will examine how local and national workforce planning activities are being taken forward to manage those risks and address short-, medium- and longer-term workforce needs. The work will be tailored to align to the responsibilities of individual NHS bodies in respect of workforce planning.	We are expecting to issue the draft report in November 2023	February 2024
Unscheduled Care Arrangements	Leanne Watkins – Chief Operating Officer	This work has been carried forward from the 2020 Audit Plan, after having initially been postponed due to the pandemic. Our phase one work has examined discharge planning arrangements and patient flow. We will assess the Health Board's progress against the 2017 audit recommendations we made on discharge planning. We are also producing a report for the Health Board and its partners on the Regional Partnership Board that describes progress being made in developing whole system solutions to delayed discharges.	Reporting	To be confirmed

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Quality Governance Review Follow up	Jennifer Winslade – Executive Director of Nursing James Calvert – Medical Director Peter Carr – Executive Director of Therapies and Health Sciences	The work will assess the extent to which previous audit recommendations arising from our thematic review of Quality Governance arrangements have been implemented and are delivering the intended outcomes / benefits. It will also focus on the Health Board's preparedness for the Duty of Quality and Candour and the effectiveness of its governance arrangements in providing assurance over its compliance.	Planning	To be confirmed
Tackling NHS Waiting Lists	Leanne Watkins – Chief Operating Officer	This work will be completed across all health boards and follows on from our national overview report on the planned care backlog in May 2022. Although we are still in the scoping phase, we intend to consider waiting list performance and arrangements to improve elective waits.	Planning	To be confirmed

Other relevant publications

6 Exhibit 3 provides information on other relevant examinations and studies published by the Auditor General in the last six months. The links to the reports on our website are provided. The reports highlighted in **bold** have been published since the last committee update.

Exhibit 3 – Relevant examinations and studies published by the Auditor General

Title	Publication Date
NHS Workforce Data Briefing	September 2023
NHS Wales Finances Data Tool - Up to March 2023	September 2023
Approaches to achieving net zero across the UK	September 2023

Additional information

7 Audit Wales recently consulted on its fee rates. The closure for response was 10 October 2023.

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Structured Assessment 2023 – Aneurin Bevan University Health Board

Audit year: 2023

Date issued: November 2023

Document reference: 3866A2023

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Summary report

About this report

1 This report sets out the findings from the Auditor General's 2023 structured assessment work at Aneurin Bevan University Health Board (the Health Board). Our structured assessment work is designed to help discharge the Auditor General's statutory requirement under section 61 of the Public Audit (Wales) Act 2004 to be satisfied that NHS bodies have made proper arrangements to secure economy, efficiency, and effectiveness in their use of resources. Our review of the Health Board's corporate approach to setting new well-being objectives in accordance with the sustainable development principle is being undertaken to help discharge the Auditor General's duties under section 15 of the Well-being of Future Generations (Wales) Act 2015

2 Our 2023 Structured Assessment work took place at a time when NHS bodies were still responding to the legacy of the COVID-19 pandemic as they look to recover and transform services and respond to the additional demand in the system that has built up during the pandemic. Furthermore, health bodies are also dealing with a broader set of challenges associated with the cost-of-living crisis, the climate emergency, inflationary pressures on public finances, workforce shortages, and an ageing estate. More than ever, therefore, NHS bodies and their Boards need to have sound corporate governance arrangements that can provide assurance to themselves, the public, and key stakeholders that the necessary action is being taken to deliver high-quality, safe and responsive services, and that public money is being spent wisely.

3 The key focus of the work has been on the Health Board's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically, with a specific focus on Board transparency, cohesion, and effectiveness, corporate systems of assurance, corporate approach to planning, and corporate approach to financial management. We have not reviewed the Health Board's operational arrangements as part of this work.

4 Our work has been informed by our previous structured assessment work, which has been developed and refined over a number of years. It has also been informed by:

- Model Standing Orders, Reservation and Delegation of Powers
- Model Standing Financial Instructions
- Relevant Welsh Government health circulars and guidance
- The Good Governance Guide for NHS Wales Boards (Second Edition)
- Other relevant good practice guides

We undertook our work between September 2023 and October 2023. The methods we used to deliver our work are summarised in **Appendix 1**.

5 We also provide an update in this report on the Health Board's progress in addressing outstanding recommendations identified in previous structured assessment reports in **Appendix 2**.

Key findings

6 **Given its financial and performance challenges, the Health Board needs a clear plan to set out how it will achieve financially sustainable service models. In general, Board and committee governance arrangements and the corporate arrangements for developing plans are reasonably effective. However, there is scope to provide clarity on both the impacts of actions set out in plans and actions taken to improve performance.**

Board transparency, effectiveness, and cohesion

7 We found that **Board and Committee arrangements are reasonably effective; however, there are opportunities to improve the quality and timeliness of information to ensure effective oversight over the Health Board's key challenges.**

8 Board and committees operate transparently, with appropriate discussions on key financial, performance, and quality challenges. However, there is opportunity to improve public access to committee meeting records. It could do this by ensuring that it livestreams or publishes recording of its committee meetings or publish unconfirmed committee meeting minutes shortly after meetings. The Health Board's committee structure is embedded, and meetings are well chaired. There are reasonably effective arrangements to support flows of assurance from the committees to the Board; however, the quality and timeliness of the information the Board and committees receive requires improvement. The Board is increasingly cohesive and demonstrating a commitment to continuous improvement through its board development programme, and Board and Committee effectiveness self-assessments. Arrangements to hear from patients, services users, and staff are improving.

Corporate systems of assurance

9 We found that **the Health Board is making good progress in developing and refining its systems of assurance. However, it will need to effectively embed new arrangements across the organisation to manage the finance, performance, and quality risks it faces.**

10 The Health Board is progressing work on its arrangements for monitoring risk, performance, and quality and safety of services. It is strengthening its risk management arrangements but needs to ensure that they are embedded across the organisation. The Health Board is implementing a new Performance Management and Accountability Framework, but it needs ensure that performance reports set out clearly the actions required to address underperformance and, where relevant, the impact of past actions taken. Its arrangements for tracking and monitoring outstanding audit and inspection recommendations are improving but will require more focus to close overdue recommendations.

Corporate approach to planning

11 We found that **the Health Board is developing a new long-term strategy which provides an opportunity to plan more sustainable services. There are reasonably effective arrangements for developing corporate plans; however, progress reports do not provide enough detail to demonstrate delivery is on track.**

12 The Health Board's approach for developing its strategic and corporate plans is generally effective. It has engaged appropriate stakeholders as part of strategy and plan development and is now starting to develop a new long-term strategy and annual plan. However, the Health Board is facing increasing challenges, including growing demand for care with need becoming more complex, continued 'legacy' from the COVID-19 pandemic and substantial financial pressures. The Board will need to give careful consideration to sustainable clinical service models to ensure improved efficiency and productivity as part of the strategy development.

13 The Health Board's Integrated Medium-Term Plan (IMTP) for 2023-26 continues to follow the life course approach which aims to reduce inequalities across communities and improving population health. Its arrangements for developing the IMTP and corporate strategies are reasonably effective. However, reports setting out the progress to deliver plans need strengthening. Our review found data quality and timeliness issues, and a lack of information to identify if intended outcomes of improvement actions have been achieved.

Corporate approach to managing financial resources

14 We found that **the Health Board is facing significant financial challenges. Whilst there are reasonably effective financial planning and financial management arrangements, the Health Board needs to establish control over savings delivery to prevent the financial position from deteriorating.**

15 The Health Board did not achieve financial balance for 2022-23 and is forecasting a deteriorating position for 2023-24. While it has a reasonable approach to financial planning, several factors are impacting its ability to achieve the plan, including blocked beds, prescribing spend, Continuing Healthcare costs, service demand and wider inflation-related cost increases. The Health Board established an ambitious savings plan but has not acted quickly enough to respond to delivery risks. The measures it is now taking are unlikely to have the intended positive impact on the 2023-24 financial position. There are generally effective financial management arrangements and scrutiny and oversight of the Health Board's financial performance. Finance reports continue to provide sufficient information, but they should be clearer on the extent that actions that it is taking are having the desired impact. There are also opportunities to enhance the quality of financial information provided in other Health Board reports.

Recommendations

16 **Exhibit 1** details the recommendations arising from our work. These include timescales and our assessment of priority. The Health Board's response to our recommendations is summarised in **Appendix 3**.

Exhibit 1: 2023 recommendations

Recommendations
Committee Transparency The Health Board does not livestream or publish recordings of its committee meetings. Furthermore, committee meeting minutes are only published after they have been confirmed at the subsequent meeting, therefore limiting timely public access to records of committee business. R1 The Health Board should provide more timely access to records of committee meetings. It could do this either by ensuring that it livestreams or publishes recording of its committee meetings, or alternatively it could publish unconfirmed committee meeting minutes shortly after the meeting. **(Medium Priority)**
Quality of Information Board and committee reports can be overly long and detailed, and presentation of some information in supporting papers are occasionally unclear. The Health Board should ensure information is appropriately summarised and attention drawn to key areas of focus. R2 The Health Board should develop training and guidance for Health Board staff around the reporting expectations and quality of information presented to the Board and its committees. **(High Priority)** R3 The Health Board should establish a robust quality assurance mechanism to review the quality of reports for its Board and committees. **(High Priority)**
Strategic / Corporate Risk Management The Health Board's updated Strategic Risk and Assurance report provides a clear overview of its strategic risks, key controls, improvement plans and sources of assurance. However, further work is required to address assurance gaps. Furthermore, whilst the Health Board is identifying gaps and strengthening aspects of its Risk Management Strategy, it needs to effectively embed the risk management arrangements across the organisation.

Recommendations

R4 The Health Board needs to rapidly complete remaining work to identify and address assurance gaps on its Strategic Risk and Assurance report and ensure it is actively owned by the Board and inform committee agenda setting. **(High Priority)**

R5 The Health Board needs to complete the remaining work on its Risk Management Strategy and effectively embed arrangements across the organisation to help it manage the significant finance, performance, and quality risks it faces. **(High Priority)**

Integrated Performance Dashboard

The Health Board's Integrated Performance Dashboard provides an overview of performance against Welsh Government targets over the last year. While useful in showing performance trends, it does not clearly articulate actions taken to improve performance or whether they are achieving the intended impact.

R6 In the Integrated Performance Dashboard, the Health Board should provide more information on the actions required to address underperformance, the impact of past actions taken and where appropriate include benchmarking with other health bodies. **(High Priority)**

Integrated Medium-Term Plan Progress Report

Our review of the Health Board IMTP Progress Report found several issues around the quality and timeliness of data, a lack of clarity around the impact of past and ongoing improvement actions, and duplication of information.

R7 The Health Board should strengthen the IMTP Progress Report to ensure that it can be used as an effective tool for monitoring progress against the delivery of its strategic objectives. By including up to date data, and clear narrative on the impact of past and ongoing improvement actions. **(High Priority)**

Detailed report

Board transparency, effectiveness, and cohesion

17 We considered whether the Health Board's Board conducts its business appropriately, effectively, and transparently.

18 We found that **Board and Committee arrangements are reasonably effective. However, there are opportunities to improve the quality and timeliness of information to ensure effective oversight over the Health Board's key challenges.**

Public transparency of Board business

19 We considered whether the Board promotes and demonstrates a commitment to public transparency of board and committee business. We were specifically looking for evidence of:

- Board and committee meetings that are accessible to the public;
- Board and committee papers being made publicly available in advance of meetings;
- Board and committee business and decision-making being conducted transparently; and
- Board and committee meeting minutes being made publicly available in a timely manner.

20 We found that **while the Board demonstrates reasonable levels of public transparency, there are opportunities to increase public access to committee business.**

21 Members of the public can observe Board meetings virtually through the livestream and, since January 2023, they can also attend in person. The Health Board provides signposting and instructions to join to upcoming Board meetings via its website homepage and social media channels.

22 The Health Board aims to publish Board and committee meeting agendas and papers on its website a week in advance. However, some papers continue to be updated at short notice. This gives little time for Board members and stakeholders to review all papers in advance **(**See **Appendix 2, R2 2022)**.

23 The Health Board ensures that Board and committee business is conducted in public sessions, with private sessions used only for sensitive and confidential matters. Where private sessions are used, the Health Board provides a good summary of its in-committee/private business in the subsequent public meeting.

24 Board members hold open and frank discussions in Board and committee meetings regarding its performance, finance, and quality challenges. Executive Directors feel they can be open about the Health Board's challenges and the priority areas for action and feel well supported by the entire Board in responding to them.

25 Recordings of Board meeting are made publicly available 24 hours after the meeting. However, the Health Board does not livestream or publish recordings of its committee meetings. Unconfirmed committee meeting minutes are published on the website only when included in papers for the next meeting around 2 to 3 months after. This limits timely public access to records of committee business **(Recommendation 1)**.

Arrangements to support the conduct of Board business

26 We considered whether there are proper and transparent arrangements in place to support the effective conduct of Board and committee business. We were specifically looking for evidence of:

- a formal, up-to-date, and publicly available Reservation and Delegation of Powers and Scheme of Delegation in place, which clearly sets out accountabilities;
- formal, up-to-date, and publicly available Standing Orders (SOs) and Standing Financial Instructions (SFIs) in place, along with evidence of compliance; and
- formal, up-to-date, and publicly available policies and procedures in place to promote and ensure probity and propriety.

27 We found that **the Health Board has generally good arrangements to support the effective conduct of Board business and is taking appropriate improvement action where needed.**

28 The Health Board has adequate arrangements to support the effective conduct of Board and committee business. It has adopted the Welsh Government's Model Standing Orders and Standing Financial Instructions and the model Scheme of Delegation. These were recently reviewed and approved by the Board in September 2023 and are available on the Health Board's website. The process for declaring interests at Board and committee meetings is well established and up to date.

29 The Health Board's policies on standards of business conduct, which include declarations of interest, and receipts of gifts and hospitality are overdue for review but remains extant. Both we and Internal Audit[1] have previously identified concerns about wider policy management and highlighted a number of policies that require updating. The Health Board has developed an improvement plan to address this during 2023. Some progress has already been made, including targeted work with some divisions to ensure policies are brought up to date.

[1] Audit Wales Structured Assessment Report 2022 and Internal Audit's review on Policy Management in January 2023.

Effectiveness of Board and committee meetings

30 We considered whether Board and committee meetings are conducted appropriately and effectively. We were specifically looking for evidence of:

- an appropriate, integrated, and well-functioning committee structure in place, which is aligned to key strategic priorities and risks, reflects relevant guidance, and helps discharge statutory requirements;
- Board and committee agendas and work programmes covering all aspects of their respective Terms of Reference as well being shaped on an ongoing basis by the Board Assurance Framework;
- well-chaired Board and committee meetings that follow agreed processes, with members observing meeting etiquette and providing a good balance of scrutiny, support, and challenge;
- clear and timely Board and committee papers that contain the necessary / appropriate level of information needed for effective decision making, scrutiny, and assurance; and
- committees receiving and acting on required assurances and providing timely and appropriate assurances to the Board.

31 We found that **the Board and committee structure is operating effectively. Meetings are well chaired with reasonably effective scrutiny, however, there are opportunities to strengthen the quality and timeliness of information presented.**

32 The Health Board introduced a new committee structure in March 2022. It is now fully embedded and provides a clear focus on strategy, delivery, performance, and culture. Committee workloads are manageable. The Health Board is establishing a Clinical Advisory Forum and is also planning to review arrangements for the Stakeholder Reference Group which was disbanded in October 2022.

33 The Board and its committees have up-to-date terms of reference, and annual cycles of business are regularly reviewed and updated as appropriate. The Health Board should ensure that cycles of business provide appropriate coverage and consideration of the controls and sources of assurances for strategic risks and any action to close gaps as soon as the Strategic Risk and Assurance report (Board Assurance Framework) is fully populated and live (see **paragraph 53**).

34 Board and committee chairs are actively involved in the agenda setting of meetings. Meetings continue to be generally well chaired, mostly run to time, and demonstrate good discussion on key issues. Independent Members participate fully in meetings, providing reasonably effective scrutiny on the information presented. There is a stronger focus on finance and digital matters in the relevant meetings compared to last year.

35 Board and some committee meetings support both in-person and virtual board member attendance which continues to offer flexibility to Board members. While the use of technology and virtual meeting etiquette is well embedded (see **Appendix 2, R1 2022**), some of the issues we reported in our 2022 Structured

Assessment report remain. For example, there have been occasions where we were unable to see or clearly hear staff presenting reports for specific agenda items.

36 The Health Board has reasonably effective arrangements in place to support flows of assurance from committees to the Board and the referral of information between committees. Committee reporting to the Board is effective and appropriate. There are appropriate processes to ensure actions identified in meetings are transferred to other committees where appropriate. The Chair of Board holds monthly meetings with Independent Members, both collectively and separately, which supports effective information sharing.

37 Board and committee papers are generally clear and contain the information required for effective decision making. However, on occasions, papers are overly long and too detailed. There are opportunities to more effectively summarise information using the revised Board and committee cover report template. We also found the presentation of some information in supporting papers and appendices to be unclear. Whilst officers make suggestions to improve the quality of information presented at committee meetings, report writing training and guidance alongside a robust quality assurance process is necessary to secure required improvements. In paragraph 22 we comment on issues around Board and committee meeting agendas and papers being updated at short notice **(Recommendations 2 and 3)**.

Board commitment to hearing from patients/service users and staff

38 We considered whether the Board promotes and demonstrates a commitment to hearing from patients/service users and staff. We were specifically looking for evidence of:

- The Board using a range of suitable approaches to hear from patients/service users and staff.

39 We found that **the Health Board has strengthened its arrangements to hear from patients, services users, and staff.**

40 The Health Board has established a Communications and Engagement strategy and is strengthening its arrangements to hear from patients, service users, and staff. This has provoked good Board member discussion and challenge. It is evident that Board members triangulate this information with performance information and wider intelligence gained from Board member walkabouts. However, the latest Trade Union Partnership Forum Annual Report continues to highlight concerns in relation to the lack of meaningful engagement between Trade Union representatives and managers. This indicates that the Health Board needs to be more proactive on engaging with staff representatives about operational challenges.

41 The Board continues to include a patient and public engagement item at every Board meeting which includes a report from the new citizens' voice body, 'Llais'.

The Patient Quality Safety and Outcomes Committee also receives patient and staff stories and demonstrate a commitment to listening and learning from staff, as illustrated within its performance report (see **Appendix 2, R3 2022**).

Board cohesiveness and commitment to continuous improvement

42 We considered whether the Board is stable and cohesive and demonstrates a commitment to continuous improvement. We were specifically looking for evidence of:

- a stable and cohesive Board with a cadre of senior leaders who have the appropriate capacity, skills, and experience;
- the Board and its committees regularly reviewing their effectiveness and using the findings to inform and support continuous improvement; and
- a relevant programme of Board development, support, and training in place.

43 We found that **the Board is cohesive and committed to continuous improvement, with good Board member induction and training opportunities and ongoing self-assessment arrangements.**

44 The Board is becoming more cohesive, with positive working relationships, good lines of communication, and awareness of respective roles and responsibilities. The Health Board has taken steps to stabilise its leadership arrangements. Since our 2022 Structured Assessment report, the following permanent appointments have been made: Executive Director of Strategy, Planning and Partnerships; Executive Director of Public Health; and Director of Digital. The Medical Director has been confirmed as the Deputy Chief Executive and a new Chief Operating Officer role has been created[2].

45 Executive Director portfolios are generally appropriately balanced and have clearly defined responsibilities. We nevertheless have some concerns about the breadth of the Chief Operating Officer's remit whose additional responsibilities add further pressure to an already demanding role. We understand the Chief Operating Officer is using ringfenced funding to establish a supporting management structure which, if effective, may alleviate the risk. However, the Health Board should keep the role under review.

46 The Health Board is currently in the process of appointing to one Independent Member vacancy, but there is some further turnover expected in 2024 which the Health Board will need to manage.

47 The Health Board has effective local induction arrangements for Executive Directors and Independent Members. These include meetings with other Board

[2]. The Chief Operating Officer role will encompass primary care, community and mental health, and learning disabilities services alongside responsibilities for operational planning and acute services.

Members and stakeholders alongside detailed training materials. Independent members indicated they feel supported in their ongoing learning and development.

48 There are effective arrangements to support Board self-review and evaluation. The Board continues to review its effectiveness using the NHS England Well-Led Framework[3] and are progressing improvement actions. Committees are planning to complete self-assessments during October and November 2023. Board development and briefing sessions cover appropriate topic areas[4], with Board members commenting positively on the quality of these sessions.

Corporate systems of assurance

49 We considered whether the Health Board has a sound corporate approach to managing risks, performance, and the quality and safety of services.

50 We found that **the Health Board is making good progress in developing and refining its systems of assurance. However, it will need to effectively embed new arrangements across the organisation to manage the finance, performance, and quality risks it faces.**

Corporate approach to overseeing strategic risks

51 We considered whether the Health Board has a sound corporate approach to identifying, overseeing, and scrutinising strategic and corporate risks. We were specifically looking for evidence of:

- an up-to-date and publicly available Board Assurance Framework (BAF) in place, which brings together all of the relevant information on the risks to achieving the organisation's strategic priorities / objectives;
- the Board actively owning, reviewing, updating, and using the BAF to oversee, scrutinise, and address strategic risks;
- an appropriate and up-to-date risk management framework in place, which is underpinned by clear policies, procedures, and roles and responsibilities;
- the Board providing effective oversight and scrutiny of the effectiveness of the risk management system; and
- the Board providing effective oversight and scrutiny of corporate risks.

52 We found that **the Health Board is improving its approach to managing strategic and corporate risks but reporting and scrutiny require**

[3] The NHS England Well-led framework Sets out how NHs bodies should carry out developmental reviews of their leadership and governance

[4] Including the new requirements of the Health and Social Care (Quality and Engagement) (Wales) Act 2020, risk and assurance, equality and diversity, and primary care sustainability.

strengthening. It also needs to finalise and effectively embed the approach across the organisation.

53 Since our last Structured Assessment report, the Health Board has redesigned its Strategic Risk and Assurance report (Board Assurance Framework), which sets out how it manages its strategic risks. The new Strategic Risk and Assurance report provides a clear summary of the Health Board's strategic risks, and their key controls, improvement plans and sources of assurance. Executive Directors are responsible for strategic risks within their respective portfolios. However, the Health Board needs to identify and take action to address assurance gaps and fully embed the new approach **(Recommendation 4)**. Once, fully embedded this will help to increase the scrutiny of strategic risks by the Board.

54 The Board's approach for managing its risk appetite is maturing. The Health Board has now developed a draft risk appetite statement with the aim of improving how the Board and divisions manage their risks.

55 The Health Board's arrangements for identifying and escalating corporate risks are improving. It is strengthening aspects of its Risk Management Strategy, including providing clear guidance around the risk escalation structure, reporting thresholds, and developing an Executive Risk Register to provide an additional layer of control. The Health Board is also developing a risk on a page report template to reduce the complexity of reports to Board and the committees.

56 Board members commented positively on the progress and planned improvements to the risk management approach. However, it is now crucial that the Health Board finalises and embeds its risk management framework effectively to manage the finance, performance, and quality risks it faces **(Recommendation 5)**.

Corporate approach to overseeing organisational performance

57 We considered whether the Health Board has a sound corporate approach to identifying, overseeing, and scrutinising organisational performance. We were specifically looking for evidence of:

- an appropriate, comprehensive, and up-to-date performance management framework in place, underpinned by clear roles and responsibilities; and
- the Board and committees providing effective oversight and scrutiny of organisational performance.

58 We found that **the Health Board is strengthening its performance management arrangements. However, reporting of performance to the Board and committees does not provide sufficient clarity on the actions needed to improve performance, or the impact of actions taken.**

59 While there have been some in-month performance improvements, the Health Board continues to experience significant service pressures which means that performance against some key Welsh Government performance measures is

below target. These areas include elective, cancer and some mental health service waits and timeliness of unscheduled care services.

60 The Health Board's new Performance Management and Accountability Framework, approved by Board in September 2023, sets out an integrated approach to managing performance covering quality, performance, activity, workforce, and financial expectations. The framework clearly outlines roles and responsibilities, oversight and accountability arrangements, local escalation arrangements and associated support and intervention processes. Nevertheless, the Health Board now needs to ensure the framework is rapidly and effectively embedded across the organisation(see **Appendix 2, R7 2022**).

61 The Health Board is planning to strengthen performance reporting to Board. It reports performance in its Board IMTP progress report. This includes the Health Board's Integrated Performance Dashboard which provides an overview of the performance against Welsh Government targets over the last year. While useful in showing performance trends against these targets, it does not include benchmarking of performance with other health bodies or clearly articulate actions taken to determine whether they are achieving the intended impact. This has led Independent Members to question whether they are receiving the information they need **(Recommendation 6)**. We discuss the remaining elements of the IMTP progress report in **paragraph 85** (see **Appendix 2, R4 2022**).

62 Despite the shortcomings in the Health Board's operational performance reporting, we found scrutiny of the information to be reasonably effective, with Independent Members pursuing knowledgeable and insightful lines of questioning.

Corporate approach to overseeing the quality and safety of services

63 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising the quality and safety of services. We were specifically looking for evidence of:

- corporate arrangements in place that set out how the organisation will deliver its requirements under the new Health and Social Care (Quality and Engagement) Act (2020);
- a framework (or similar) in place that supports effective quality governance;
- clear organisational structures and lines of accountability in place for clinical/quality governance; and
- the Board and relevant committee providing effective oversight and scrutiny of the quality and safety of services.

64 We found that **the Health Board is strengthening its corporate arrangements for overseeing the quality and safety of services and is focussing on embedding the arrangements across the organisation.**

65 We undertook a review of the Health Board's quality governance arrangements in 2022. In 2024, we intend to follow-up the organisation's progress in implementing our recommendations and as part of this assess the progress that the Health Board is making implementing the requirements of the Health and Social Care (Quality and Engagement) Act (2020). Whilst we will report more fully after that review, our high-level observations of actions the Health Board is taking to strengthen arrangements for overseeing the quality and safety of services includes the development of:

- separate strategies for quality, and patient experience and involvement (approved by the Board in March 2023); and
- a Quality Strategy Implementation Plan, Quality Outcomes Framework, and Quality Governance Assurance Framework (presented to the Health Board's Patient Quality, Safety and Outcomes Committee in July 2023).

66 The Implementation Plan details the deliverables and timescales for their delivery over the next financial year and includes a new governance and reporting structure to provide oversight of quality performance and progress.

Corporate approach to tracking recommendations

67 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising systems for tracking progress to address audit and review recommendations and findings. We were specifically looking for evidence of:

- appropriate and effective systems in place for tracking responses to audit and other review recommendations and findings in a timely manner.

68 We found that **while the Health Board is making good progress in strengthening arrangements for tracking recommendations, there are several overdue recommendations.**

69 The Health Board continues to have reasonably effective arrangements for monitoring progress against internal audit, external audit, and Healthcare Inspectorate Wales recommendations. It uses two trackers, one for internal and external audit recommendations which is received by the Audit, Risk, and Assurance Committee. The Healthcare Inspectorate Wales recommendations are captured on a separate tracker, which is periodically reviewed at the Patient, Quality, Safety and Outcomes Committee. While it has made good progress in addressing overdue recommendations, more work is needed. The latest updates in February and September 2023 highlight a number of overdue recommendations / improvement actions (75 internal audit, 4 external audit, and 43 Healthcare Inspectorate Wales). A recent Internal Audit review of the audit recommendations tracker gave reasonable assurance, but highlighted opportunities for improvement including removing superseded recommendations and updating the implementation timeframes for some overdue recommendations.

Corporate approach to planning

70 We considered whether the Health Board has a sound corporate approach to producing strategies and corporate plans and overseeing their delivery.

71 We found that **the Health Board is developing a new long-term strategy which provides an opportunity to plan more sustainable services. There are reasonably effective arrangements for developing corporate plans. However, progress reports do not provide enough detail to demonstrate delivery is on track.**

Corporate approach to producing strategies and plans

72 We considered whether the Health Board has a sound corporate approach to producing, overseeing, and scrutinising the development of strategies and corporate plans. We were specifically looking for evidence of:

- a clear Board approved vision and long-term strategy in place which are future-focussed, rooted in population health, and informed by a detailed and comprehensive analysis of needs, opportunities, challenges, and risks;
- an appropriate Board approved long-term clinical strategy;
- appropriate and effective corporate arrangements in place for developing and producing the IMTP, and other corporate plans; and
- the Board appropriately scrutinising the IMTP and other corporate plans prior to their approval.

73 We found that **the Health Board has generally effective arrangements for developing strategic plans and is developing a new long-term strategy which provides an opportunity to plan more sustainable services.**

74 The Health Board's Clinical Futures Strategy has been extant for more than a decade. The Health Board has achieved several of its key objectives, including service reconfiguration associated with the opening of the Grange University Hospital, the establishment of the Enhanced Local General Hospitals network, and developments in community services. However, the Health Board is facing increasing challenges, including growing demand for care with need becoming more complex, the continued legacy from the COVID-19 pandemic and substantial financial pressures. In response, the Health Board is commencing the development of a new long-term strategy with a focus on population health, community-based services, and developing sustainable acute services. The Board will need to give careful consideration to sustainable clinical service models and improved efficiency and productivity as part of the strategy development.

75 An initial Board briefing session on the strategy development during September 2023 considered draft proposals, a development timeline, and required governance arrangements. The proposed governance structure will include groups with both Independent Members and Executive Director representation to ensure collective oversight of strategy development. The Health Board is planning to engage

extensively with both internal and external stakeholders as part of the strategy development. This will provide an opportunity for the Health Board to proactively engage with communities to design sustainable healthcare services. The Health Board intends to publish the long-term strategy by September 2024(see **Appendix 2, R5 2022**).

76 The Health Board's IMTP 2023-26 continues to build on its 'life course approach' which aims to reduce inequalities across communities through improving population health. The approach outlines five clear strategic objectives aligned to key stages in an individual's life course, underpinned by a set of outcomes and measures to achieve them.

77 The Health Board engages well with both internal and external stakeholders when developing operational and strategic plans. It discussed the IMTP 2023-26, Quality Strategy, and Communications and Engagement Strategy with staff in a range of different forums. It shared draft strategies/plans with Independent Members and facilitated discussion at Board development sessions prior to formal approval at public Board meetings. The Health Board involved wider partners in its development of the 2023-26 IMTP including Trade Union Partnership Forum, Cluster Planning Groups, Community Health Council, and Regional Partnership Board.

78 The Health Board is now starting its Annual Plan 2024-25 development on the assumption that it is unlikely to submit a financially balanced three-year IMTP. There is a clear development timeline with opportunities for good Board and stakeholder engagement (see **Appendix 2, R6 2022**).

79 Nevertheless, the financial position, service demand and associated operational pressures represent significant challenges. While some improvements may be achieved over the life of the annual plan, it is likely it will take some time for the Health Board to return to a financially sustainable position.

80 The Health Board has adopted the principles of the Wellbeing of Future Generations Act (Wales) 2015 (the Act) and is intending to formally review its wellbeing objectives during the next year alongside the development of the next Integrated Medium-Term Plan or Annual Plan.

Corporate approach to overseeing the delivery of strategies and plans

81 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising the implementation and delivery of corporate plans. We were specifically looking for evidence of:

- corporate plans, including the IMTP, containing clear strategic priorities/objectives and SMART[5] milestones, targets, and outcomes that aid monitoring and reporting; and
- the Board appropriately monitoring the implementation and delivery of corporate plans, including the IMTP.

82 We found that **not all corporate plans are supported by SMART actions and progress reports do not provide sufficient clarity on delivery progress and whether the intended benefits are being achieved.**

83 The Integrated Medium Term Plan 2023-26 and Quality Strategy 2023-24 provide clear objectives and are underpinned by measurable outcomes. They include appropriate information about priorities, supporting actions, milestones for delivery, and intended outcomes.

84 However, in other plans we found there are opportunities to improve the articulation of proposed actions. For instance, in the Communications and Engagement Strategy, actions are categorised as 'ongoing' or 'as required' rather than given a specific target date for delivery. Furthermore, we found that the Research and Innovation Strategy was not underpinned by a detailed delivery plan. The omission of a delivery plan and / or SMART delivery actions means the progress reporting is unlikely to provide sufficient assurance that delivery is on track.

85 The Health Board's IMTP progress reporting needs strengthening. The Health Board uses its quarterly IMTP progress report to track progress in delivering its IMTP priorities, Clinical Futures Programmes priorities, and ministerial priorities. However, our review of the report identified data quality and timeliness issues, and a lack of clarity around the impact of past and ongoing improvement actions **(Recommendation 7)**. A recent Internal Audit review on the IMTP gave reasonable assurance but highlighted required improvements in relation to timeliness of performance data, division-level accountability for IMTP delivery and reporting progress against Clinical Futures delivery milestones.

86 The Board and committees oversee implementation and delivery of some corporate strategies too. For example, a People Strategy update presented at the July 2023 Board meeting set out implementation progress made during the first 12 months. However, there are opportunities to improve reporting delivery of plans to ensure it is clear whether delivery is on track and achieving the intended impact.

[5] Specific, measurable, achievable, relevant, and time-bound

Corporate approach to managing financial resources

87 We considered whether the Health Board has a sound corporate approach to managing its financial resources.

88 We found that **the Health Board is facing significant financial challenges. Whilst there are reasonably effective financial planning and financial management arrangements in place, the Health Board needs to establish greater control over savings delivery to prevent the financial position from deteriorating.**

Financial objectives

89 We considered whether the Health Board has a sound corporate approach to meeting its key financial objectives. We were specifically looking for evidence of:

- the organisation meeting its financial objectives and duties for 2022-23, and the rolling three-year period of 2020-21 to 2022-23; and
- the organisation being on course to meet its objectives and duties in 2023-24.

90 We found **that the Health Board did not achieve financial balance for 2022-23 and is forecasting a deteriorating position for 2023-24.**

91 The Health Board did not meet its financial duty to spend within its allocation over the three-year period for 2020-23, reporting a £36.8 million deficit in 2022-23 for revenue expenditure. However, it did meet its Capital Resource Limit target of £40.7 million with a small underspend of £0.043 million in 2022-23 and its 2022-25 Integrated Medium-Term Plan was approved.

92 The current and forecast financial position for 2023-24 is challenging. The Month 5 financial report presented at the September 2023 Board meeting highlights a growing underlying deficit and worsening in-year financial deficit forecast. There are several factors impacting the Health Board's financial position including, variable pay, spend to release blocked beds, increasing prescribing spend, Continuing Healthcare costs, service demand and wider inflation-related cost increases. In the Month 5 report, the Health Board forecasted a best-case year-end deficit of £112.8 million, but this will increase further if it does not achieve its savings target, receive anticipated additional funding[6], or experiences further cost pressures. The Health Board has estimated likely and worst-case deficit forecasts of £145 million and £160 million respectively and is due to revise its forecast following an evaluation of the effectiveness of actions that it is taking.

[6] Welsh Government announced an addition £425 million for NHS Wales on 17 October 2023.

Corporate approach to financial planning

93 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising financial planning. We were specifically looking for evidence of:

- clear and robust corporate financial planning arrangements in place;
- the Board appropriately scrutinising financial plans prior to their approval;
- sustainable, realistic, and accurately costed savings and cost improvement plans in place which are designed to support financial sustainability and service transformation; and
- the Board appropriately scrutinising savings and cost improvement plans prior to their approval.

94 We found that **the Health Board has a sound approach to financial planning and has a clear understanding of its financial challenges. However, the delay to establish stronger control over savings delivery means that recently introduced measures are unlikely to have a significant impact on the 2023-24 financial position.**

95 The Health Board's financial plan for 2023-24 was scrutinised and approved by Board in March 2023. The plan acknowledges the Health Board's financial challenges and recognises the unprecedented factors within its internal and external operating environment. The Health Board is focussing on service transformation to help achieve financial sustainability but acknowledges that this alone is not enough and has developed an ambitious savings plan. The Health Board set out in its IMTP 2023-26 that it was aiming to achieve financial balance over the life of the plan, but as reported in **paragraph 92** this is a significant challenge. If the Health Board cannot reduce its underlying deficit, the ability to achieve financially sustainable services in the medium-term is unlikely.

96 As part of the financial planning process, the Health Board established an alternative method for delegating budgets. It has stopped budgeting on the basis of incrementally increasing internal allocations based on historic costs plus inflation. Instead, it is now allocating budgets based on the resources needed to deliver IMTP objectives and the extent that services can deliver financial savings without compromising performance.

97 There is a significant risk that the Health Board's savings plan will not be delivered. The worsening financial position has led to an ambitious £51.5 million savings target. It hasn't yet identified all the specific saving schemes to deliver it and is currently off-track. The Health Board's Month 5 financial report indicated that savings delivery as of August 2023 totalled £9.3 million, with forecast year-end savings of £30.2 million. It will therefore need to deliver existing savings schemes as well as identify and deliver additional schemes to achieve its original £51.5 million savings target.

98 The Health Board recently introduced a Quality Impact Assessment process to assess the potential impact of savings schemes on service performance and

quality and safety of services. As a result of assessments made, the Clinical Advisory Forum recommended the removal of some savings scheme proposals. Board members have indicated the rejected proposals may need to be revisited should the Health Board's forecast position deteriorate. This may require difficult decisions affecting timely patient access to care.

99 The Health Board is introducing savings governance arrangements through a newly established Value and Sustainability Board which will focus on core saving themes. It is too early to comment on the effectiveness of these arrangements. However, the Auditor General will be commenting further on the Health Board's approach to identifying, delivering, and monitoring financial savings in a separate piece of work that we will report in the early part of 2024.

Corporate approach to financial management

100 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising financial management. We were specifically looking for evidence of:

- effective controls in place that ensure compliance with Standing Financial Instructions and Schemes of Reservation and Delegation;
- the Board maintaining appropriate oversight of arrangements and performance relating to single tender actions, special payments, losses, and counter-fraud;
- effective financial management arrangements in place which enable the Board to understand cost drivers and how they impact on the delivery of strategic objectives; and
- the organisation's financial statements for 2022-23 were submitted on time, contained no material misstatements, and received a clean audit opinion.

101 We found that **the Health Board has generally effective arrangements to oversee financial management.**

102 The Health Board intends to review the Scheme of Delegation to ensure financial limits and decision-making authority remain appropriate (see **Appendix 2, R7 2022**). During 2023, Internal Audit has completed work covering Bank Office and Temporary Workers, Off-Contract Agency Staff, and Financial Sustainability. In general, Internal Audit found that the financial controls within these specific areas appear to be reasonably effective, with the exception of the use the off-contact agency staff which was given a limited assurance rating[7].

103 The Audit, Risk, and Assurance Committee effectively oversees financial controls assurances. The committee regularly receives, discusses, and where required questions officers on reports on losses and special payments, counter fraud work,

[7] The Internal Audit review of off-contract agency staff identified weakness in the processes to minimise use of agency staff and the management approval of agency staff use.

public sector payment policy, and procurement controls (such as single tender actions and payments exceeding £100,000). The reports include the required information for assurance and to enable good scrutiny.

Board oversight of financial performance

104 We considered whether the Board appropriately oversees and scrutinises financial performance. We were specifically looking for evidence of:

- the Board receiving accurate, transparent, and timely reports on financial performance, as well as the key financial challenges, risks, and mitigating actions; and
- the Board appropriately scrutinising the ongoing assessments of the organisation's financial position.

105 We found that **Board financial reports are transparent, but there are opportunities for reporting to be clearer on the impact of action taken to improve the financial position.**

106 The Board and Finance and Performance Committee oversees financial performance. Finance reports continue to provide sufficient information to enable appropriate scrutiny and oversight. While broadly similar reports are presented to both forums, the Financial and Performance Committee receive additional reporting on savings delivery and efficiency opportunities, providing opportunities to challenge on specific risks. Finance reports provide sufficient information on the financial position and risks, however, there are opportunities to be clearer on the impact of mitigating actions. There is also scope to increase the level and quality of financial information in other reports, such as the cost and impact on the financial position, to aid decision making.

107 Board reports are open and transparent about the Health Board's financial challenges and the potential impact on service quality and safety when making difficult decisions with the aim of improving the financial position. We identified increasing levels of scrutiny and challenge by Independent Members on financial matters. The Board has had opportunities to collectively scrutinise the financial position at board briefings and Public Board meetings. However, this can impact on the level of scrutiny provided at Finance and Performance Committee. The Health Board is therefore reflecting on the opportunities for scrutiny and challenge at these forums alongside the introduction of the new Value and Sustainability Board.

Appendix 1

Audit methods

Exhibit 2 below sets out the methods we used to deliver this work. Our evidence is limited to the information drawn from the methods below

Element of audit approach	Description
Observations	We observed Board meetings as well as meetings of the following committees: • Public Board • Finance and Performance Committee • Audit Risk and Assurance Committee; and • Patient Quality, Safety and Outcomes Committee

Element of audit approach	Description
Documents	We reviewed a range of documents, including: • Board and Committee Terms of Reference, work programmes, agendas, papers, and minutes; • key governance documents, including Schemes of Delegation, Standing Orders, Standing Financial Instructions, Registers of Interest, and Registers of Gifts and Hospitality; • key organisational strategies and plans, including the IMTP; • key risk management documents, including the Board Assurance Framework and Corporate Risk Register; • key reports relating to organisational performance and finances; • Annual Report, including the Annual Governance Statement; • relevant policies and procedures; and • reports prepared by the Internal Audit Service, Health Inspectorate Wales, Local Counter-Fraud Service, and other relevant external bodies.

Interviews	We interviewed the following Senior Officers and Independent Members: • Chair of Health Board. • Chief Executive. • Director of Corporate Governance. • Executive Director of Finance and Procurement. • Director of Strategy and Partnerships. • Chief Operating Officer. • Independent Member – Finance & Chair of Audit, Risk and Assurance Committee. • Independent Member – Local Authority & Chair of Finance and Performance Committee. • Independent Member - Community

Appendix 2

Progress made on previous year recommendations

Exhibit 3 below sets out the progress made by the Health Board in implementing recommendations from previous structure assessment reports.

2022 Recommendation	Description of progress
Agenda / meeting management R1 Board and Committee agendas cause some meetings to overrun. The Health Board, therefore, should review Board and committee agendas to ensure meeting business can be covered in the time available whilst also allowing for sufficient scrutiny and discussion	Our assessment on progress against the recommendation: **Complete** More detail can be found at paragraph 32 to 37.
Quality of Information to Board and committees R2 Information presented to Board and committees does not always provide the required assurance. Some papers are too long, detailed, and technical. Cover reports continue to follow an SBAR format, but there is variation in their use. The Health Board, therefore, should develop training and guidance for	The Health Board arrangements to ensure the quality and timeliness of information presented to Board and committees still require strengthening. Papers are generally clear and contain the information required for effective decision making. However, there are issues concerning the Health Board's Integrated Performance Dashboard, IMTP progress report and financial reports relating to data quality and timeliness, a lack of information on whether intended outcomes of improvement actions have been achieved and limited benchmarking of performance with other Health Board's. We also found the presentation of some information in supporting papers and appendices

2022 Recommendation	Description of progress
Health Board staff around the reporting expectations and quality of information presented to the Board and its committees.	unclear. Board and Committee reports can be overly long and detailed, and there are opportunities to better summarise the information (see **2023 recommendations 2 and 3**). This should help reports focus on key matters and reduce the overall volume of papers for Board and Committee meetings. Our assessment on progress against the recommendation**:** **Ongoing**
Patient and Staff Stories R3 There is limited use of patient and staff stories at Board. The Health Board should consider how it can increase and maximise the benefit of patient and staff stories in Board and committees to help centre and focus meetings on the things that matter most, and to help triangulate this intelligence with formal agenda items	Our assessment on progress against the recommendation**:** **Complete** More detail can be found at paragraph 40 and 41.
Performance Reporting R4 The Integrated Performance Report has remained unchanged for several years, and at present it doesn't clearly articulate the impact of past and ongoing improvement actions. The Health Board should strengthen this report to provide more information to Board and committees on the actions required to address underperformance or the impact of past actions taken.	The Health Boards' Integrated Performance Dashboard provides an overview of the Health Board performance against Welsh Government targets over the last year. While useful in showing the Health Board performance trends and progress against these targets. It continues to not clearly articulate actions being taken to improve performance and their impact. The Health Board recognises the weaknesses in its performance reporting and is planning to complete improvement work alongside embedding its Performance Management and Accountability Framework. Our assessment on progress against the recommendation**:** **Ongoing**
Clinical Futures Strategy and Long-Term Clinical Plan	The Health Board's is commencing development of a new long-term strategy which will provide an opportunity for it to proactively engage with communities to help design and shape sustainable healthcare services for the region.

2022 Recommendation	Description of progress
R5 The Clinical Futures Strategy has remained in place for over a decade, but the pressures the Heath Board is facing have changed substantially in this time. The Health Board, therefore, should: a. review of the Clinical Futures Strategy to ensure it helps to shape financially and clinically sustainable service models; and b. develop a detailed long-term clinical plan that underpins the Clinical Futures Strategy.	Our assessment on progress against the recommendation: **Ongoing**
Working with wider partners in Integrated medium-term plan development R6 The Health Board discussed plans with both Welsh Government and the Community Health Council during the 2022-25 Integrated Medium-Term Plan development, but there was limited engagement with wider partners. The Health Board, therefore, should better involve wider partners to help collectively develop solutions to growing service challenges, particularly where services interface.	Our assessment on progress against the recommendation**: Complete** See paragraphs 77 and 78 for more information.
Schemes of Delegation R7 The Health Board's deteriorating financial position and deterioration in savings deliver indicates that stronger accountability for financial performance and delivery is required. The Health Board, therefore, should review its Scheme of Delegation to ensure it more strongly outlines delegated accountability for	The new Performance Management and Accountability Framework sets out the Health Board's approach for managing financial accountability. The Health Board still intends to review the Scheme of Delegation to ensure financial limits and decision-making authority remain appropriate. Our assessment on progress against the recommendation: **Ongoing**

2022 Recommendation	Description of progress
the budgetary position and achievement of financial efficiencies at and below executive levels.	

Appendix 3

Organisational response to audit recommendations

Exhibit 4: Aneurin Bevan University Health Board response to our audit recommendations

Ref	Recommendation	Organisational response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R1	The Health Board should provide more timely access to records of committee meetings. It could do this either by ensuring that it livestreams or publishes recording of its committee meetings, or alternatively it could publish unconfirmed committee meeting minutes shortly after the meeting. **(Medium Priority)**	The Health Board remains fully committed to operating with openness and transparency. Greater transparency of the Board's committee business will be implemented, building on existing practices.	April 2024	Director of Corporate Governance

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R2	The Health Board should develop training and guidance for Health Board staff around the reporting expectations and quality of information presented to the Board and its committees. **(High Priority**	The Health Board will be working to review and update its corporate report templates, alongside developing clear guidance and support for the preparation of Board and Committee reports. Securing additional training will also be explored.	April – June 2024	Director of Corporate Governance
R3	The Health Board should establish a robust quality assurance mechanism to review the quality of reports for its Board and committees. **(High Priority)**	The Health Board is currently reviewing its board and committee administration processes, including key performance measures. This will include a focus on the quality assurance process with clarity on expected standards. This will also be supported by work in respect of report writing development (R2).	April 2024	Director of Corporate Governance

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R4	The Health Board needs to rapidly complete remaining work to identify and address assurance gaps on its Strategic Risk and Assurance report and ensure it is actively owned by the Board and inform committee agenda setting. **(High Priority)**	The Health Board is actively progressing work to strengthen its strategic risk and assurance reporting, aligning risks to the Board and Committee business cycles. This work will be progressed alongside work to embed strengthened risk management and assurance arrangements at all levels of the organisation (R5).	April 2024	Director of Corporate Governance
R5	The Health Boards needs to complete the remaining work on its Risk Management Strategy and effectively embed arrangements across the organisation to help it manage the significant finance, performance, and quality risks faced. **(High Priority)**	The Health Board will consider its revised Risk Management Framework and underpinning Policy and its meeting in January 2024. The Audit, Risk and Assurance Committee will receive these in draft form for comment in November 2023. Implementation of these throughout the organisation as the organisation's approach to risk management matures.	January 2024 with implementation ongoing	Director of Corporate Governance

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R6	In the Integrated Performance Dashboard, the Health Board should provide more information on the actions required to address underperformance, the impact of past actions taken and where appropriate include benchmarking with other health bodies. **(High Priority)**	As part of the IMTP progress report specific attention has been given to the improvement actions to address underperformance including assurance mechanisms. This can be seen in the Quarter 2 report and will continue to be strengthened in future reports. Where available the data for the current quarter is presented and dates provided for data availability. Benchmarking data will be included in the dashboard where available. Not all performance measures have benchmarking data available, an assessment of available benchmarking data will be undertaken to determine what benchmarking data can be included in the dashboard.	December 2023	Director of Strategy, Planning & Partnerships

Ref	Recommendation	Organisational response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R7	The Health Board should strengthen the IMTP Progress Report to ensure that it can be used as an effective tool for monitoring progress against the delivery of its strategic objectives. By including up to date data, and clear narrative on the impact of past and ongoing improvement actions. **(High Priority)**	As part of the IMTP progress report specific attention has been given to the improvement actions to address underperformance including assurance mechanisms. This can be seen in the Quarter 2 report and will continue to be strengthened in future reports. Where available the data for the current quarter is presented and dates provided for data availability. It remains important for the Health Board to maintain a mix of definitive progress measures and measures of longer-term population outcome. For population outcome measures the Health Board may not be the sole influencing factor and measurement may be reported over a long-term timescale, however as a population health organisation it is important the Board is sighted on these measures.	December 2023	Director of Strategy, Planning & Partnerships

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