A meeting of the Aneurin Bevan University Health Board Audit Committee will be held on Wednesday 3rd April 2019, commencing at 1:15pm in Conference Room 1 & 2, Conference Centre, Health Board Headquarters, St Cadoc's Hospital, Caerleon

AGENDA

1	**Private Discussions – 1:15pm**			
	1.1	**Committee members to have private discussions with Internal Audit**	Verbal	**Committee Members and Internal Audit**
2	**Preliminary Matters - 1:30pm**			
	2.1	**Apologies for Absence**	Verbal	**Chair**
	2.2	**Declarations of Interest**	Verbal	**Chair**
	2.3	**Draft Minutes of the Meeting held on 17th January 2019**	Attachment	**Chair**
	2.4	**Action Sheet**	Attachment	**Chair**
3	**Counter Fraud and Post Payment Verification – 1:45pm**			
	3.1	**Annual Counter Fraud Bribery & Corruption Report for 2018/2019.**	Attachment	**Head of Counter Fraud**
	3.2	**Annual Counter Fraud Work Plan for 2019/2020.**	Attachment	**Head of Counter Fraud**
	3.3	**Annual PPV Report**	Attachment	**Scott Lavender/ Sara Jeremiah**
4	**External Audit – 2.30pm**			
	4.1	**WAO Progress Update**	Attachment	**Wales Audit Office**
	4.2	**Approval of WAO Audit Plan and Fee**	Attachment	**Wales Audit Office**
	4.3	**Primary Care Services**	Attachment	**Wales Audit Office/ Director of Primary, Community and Mental Health**
	4.4	**2018 Structured Assessment Report**	Attachment	**Wales Audit Office**
	4.5	**2018 Annual Audit Report**	Attachment	**Wales Audit Office**
5	**NWSSP Audit & Assurance - Internal Audit & Specialist Service Unit – 3.30pm**			
	5.1	**Internal Audit Progress Report**	Attachment	**Head of Internal Audit**

	5.2	**Approval of Internal Audit Plan**	Attachment	**Head of Internal Audit**
	5.3	**Clinical Audit Follow Up Limited Assurance Internal Audit Report**	Attachment	**Internal Audit/ Medical Director**
6	**Governance and Assurance – 4.30pm**			
	6.1	**Update on Governance, Financial Control Procedures and Technical Accounting Issues**	Attachment	**Assistant Director of Finance (Financial Systems & Services)/ Board Secretary**
	6.2	**Recovery of Overpayments to Employees Policy**	Attachment	**Assistant Director**
	6.3	**Losses and Special Payments Report**	Attachment	**Assistant Director of Finance (Financial Systems & Services)**
	6.4	**Risk Management Review and Link to Assurance Framework**	Attachment	**Board Secretary**
	6.5	**Audit Recommendation Tracker Report**	Attachment	**Board Secretary**
7	**Date of Next Meetings**			
	Draft Accounts Meeting – Provisional Date: Thursday, 9th May 2019 at 1.30pm in Conference Room 3, Headquarters, St Cadoc's **Annual Accounts Meeting – Provisional Date:** Tuesday, 28th May 2019 at 1.30pm in Conference Rooms 1 & 2, Headquarters, St Cadoc's **Business Meeting:** Thursday 18th July 2019 at 1.30pm in the Executive Meeting Room, Headquarters, St Cadoc's			**Chair**

	Supplementary Papers Reasonable Assurance Internal Audit Reports submitted this period: • Clinical Futures – service redesign • Equality, Diversity and Inclusion • Falls Prevention • Health and Care Standards • Nurse Staffing Levels Act

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Audit Committee
3rd April 2019
Agenda Item: 2.3

2.3

Aneurin Bevan University Health Board

Minutes of the Audit Committee held on Thursday 17th January 2019, in Conference Rooms 1 & 2, Headquarters, St Cadoc's

Present:

Catherine Brown	-	Chair, Independent Member (Finance)
Shelley Bosson	-	Independent Member (Community)
Katija Dew	-	Independent Member (Third Sector)

In Attendance:

Kay Barrow	-	Acting Head of Corporate Governance (Secretariat)
Richard Bevan	-	Board Secretary
Glyn Jones	-	Director of Finance
Judith Paget	-	Chief Executive
Estelle Evans	-	Head of Financial Services and Accounting
Simon Cookson	-	Director of Audit & Assurance, NWSSP
James Quance	-	Head of Internal Audit, NWSSP
Stephen Chaney	-	Deputy Head of Internal Audit, NWSSP
Terry Lewis	-	Wales Audit Office
Dave Wilson	-	Wales Audit Office
Gabrielle Smith	-	Wales Audit Office
Peter Carr	-	Director of Therapies and Health Science

In Attendance for Specific Items:

Martyn Edwards	-	Head of Counter Fraud
Dr Paul Buss	-	Medical Director
Nicola Prygodzicz	-	Director of Planning, Digital and IT
Matthew Mahoney	-	Head of ICT
Claire Birchall	-	Director of Operations
Nick Wood	-	Director of Primary, Community and Mental Health
Sian Millar	-	Divisional Director, Primary Care and Community
David Poland	-	Wales Audit Office
Neil Pearce	-	Acting General Manager, Facilities

Apologies:

Martine Price	-	Director of Nursing
Geraint Evans	-	Director of Workforce and OD
Dr Sarah Aitken	-	Director of Public Health

Audit 1701/01 Welcome and Introductions

The Chair welcomed members to the meeting and thanked all members for their attendance.

Audit 1710/02 Apologies for Absence

Apologies for absence were noted.

Audit 1701/03 Declarations of Interest

There were no declarations of interest to note.

Audit 1701/04 Minutes of Previous Meeting

The minutes of the meetings held on 11th October 2018 were agreed as a true and accurate record of the meeting.

Matters Arising:
Audit 1110/08 – GP Out of Hours/Primary Care Services
The Audit Committee noted that the decision of the Public Accounts Committee was for a call for evidence.

The Chief Executive informed the Committee that a visit to the Out of Hours Service was scheduled as part of the Executive Team site visit programme.

Audit 1701/05 Action Log

The actions were noted and it was acknowledged that all actions were either on the agenda or scheduled for a future meeting. However, the following point were noted:

- **Audit 2007/12 WAST Internal Audit Report**
  It was agreed that the final Health Board response would be recirculated to Committee members. **Action: Board Secretary**

Audit 1701/06 Counter Fraud Progress Report

The Committee received the update provided by the Head of Counter Fraud in relation to the work undertaken by the Local Counter Fraud Specialist (LCFS) in accordance with the National Assembly for Wales Directions to NHS Bodies on Counter Fraud Measures (WHC (2005) 095), under the

provisions of the National Health Service Act 1977. The update summarised the work carried out by the LCFS during the financial year 2018/19 to date and incorporated outcomes and learning under the standards for fraud, bribery and corruption.

The Chair welcomed the report which highlighted and evidenced the productivity of the LCFS and the delivery of its strategic goals.

In relation to the prevent and deter activities, the Committee commended the collaborative work undertaken by the LCFS relating to the detection of banking mandate fraud within the Health Board's Procurement Department and the measures put in place to mitigate the risk.

The Committee thanked the Head of Counter Fraud for the comprehensive report and for the continued support shown for the Audit Committee.

Martyn Edwards left the meeting.

Audit 1701/07 Clinical Audit Update

The Medical Director provided an overview of the progress against the recommendations of the 2016/17 Internal Audit Report and the further work that was required in order to complete these recommendations.

In discussion it was noted that robust clinical audit remained a central plank of the Health Board's approach to clinical quality.

The Medical Director informed the Committee that best practice in clinical audit was moving towards national auditing on a system wide basis with smaller local level audits undertaken to provide assurance on local areas of identified risks. The Health Board participated in 37 out of the 40 audits within the National Clinical Audit and Outcome Review Programme (NCAORP) Involvement in the NCAORP allowed the Health Board to benchmark the quality of its services and identify where improvements were needed. The Committee noted that the Health Board was currently not participating in 3 NCAs on the NCAORP, these were:

- Ophthalmology – which covered cataract surgery however, discussions were ongoing in relation to the appropriateness of the offered electronic audit tool.

- Trauma Audit Research Network (TARN) – Currently not entering data relating to trauma cases onto the TARN data warehouse, due to issues related to the capacity and availability of suitably qualified staff to ensure accuracy of data entered. Work to resolve this would be a particular focus as the Health Board moves towards becoming part of the Trauma Network.

- Inflammatory Bowel Disease – Currently not currently submitting data to the IBD Database due to transitional issues with the IBD Registry. However, work was ongoing with the service providers to re-commence participation.

In answer to a question raised about the visibility of the local clinical audits, the Medical Director informed the Committee that clinical audits were planned and outcomes reviewed collectively at both the Quality and Patient Safety Operational Group and the Quality and Patient Safety Committee, and also discussed within each relevant Division, Directorate and with individual clinicians. He gave an example of the work undertaken within the Diabetes service. The Committee stressed the importance of effective follow up and implementation of learnings from audits, as per the audit recommendations.

The Medical Director had some reservations about the value of assurance mapping given that the Health Board already had an existing Clinical Audit Policy and Strategy. The Committee was interested in how assurance mapping could help identify where there were clinical risks and how they were being addressed through audit but also through controls other than audit.

The Committee emphasised that recommendations contained within audit reports should be developed and agreed on the basis that they were realistic and deliverable and that consistent processes were key to control within an organisation as well as strong professional leadership such as that provided by the Medical Director.

The Committee thanked Dr Paul Buss for attending and looked forward to receiving the Clinical Audit follow-up report in due course.

Dr Paul Buss left the meeting.

Audit 1701/08 Wales Audit Office (WAO) Progress Update

The Committee received and noted the WAO progress report which provided an update in relation to the financial audit work and Annual Audit Report. It was noted that WAO were working with the Health Board's Finance Team and that there were no emerging issues that the Committee should be made aware of at this time. It was confirmed that the WAO audit plan and fee would be presented to the Committee in April 2019. **Action: WAO/Secretariat**

The Committee received an update in respect of the performance audit. It was noted that the detailed work in relation to the review of Primary Care had been completed and that the final outcome would inform the national report which was expected to be issued in May 2019.

In terms of the Integrated Care Fund, the fieldwork had been completed across Wales with the local findings presented to the Regional Partnership Board in November 2018. A single national report was expected to be published in early 2019.

The Health Board's Draft Structured Assessment Report had been issued on 19th December 2018 for comments. It was noted that the report would normally be presented to the Audit Committee however, due to timelines on this occasion this was not possible. It was anticipated that, subject to the receipt of the final report, that it would be presented to the Board at its Development Session in February 2019 prior to being received formally by the Public Board at its March 2019 meeting. It was agreed that the final report would be circulated to Audit Committee members. **Action: Board Secretary**

The Committee noted the Good Practice Exchange and products and, in particular, the Good Practice Exchange seminars as detailed in Exhibit 6 and the links to NHS-related national studies and publications.

Audit 1701/09 GP Out of Hours/Urgent Primary Care Services

The Director of Primary, Community and Mental Health informed the Committee that Urgent Primary Care Services had been subject to a peer review commissioned by Welsh Government and that the terms of reference of that review were broadly similar to the WAO audit undertaken the previous year. It was noted the findings of the peer review, which had been published in November 2018, demonstrated that the service had made progress against the recommendations of the 2017 WAO audit report.

The Committee was pleased to be informed that the appointment of a new Clinical Director and Directorate Manager had stabilised the service and were seen to be making a significant difference to overall staff morale and were actively addressing a number of long term issues including recruitment and retention, clinical pathway redesign and staff engagement. They had also been instrumental in aligning some of the wider transformation work linked to the 111 launch. Wider feedback from the clinical and non-clinical teams regarding these appointments were very positive and supportive however, it was acknowledged that more was needed to be done to improve overall confidence, morale and culture within the team going forward.

The Peer Review Panel had provided positive feedback on a number of points, and also recognised that there were some areas for further development within the service.

The Committee received an update in relation to the Clinical Service Model and aligning Urgent Primary Care, 111 and the Clinical Futures strategies together so that staff could fully support the new model of care going forward. It was highlighted that the service had built up some excellent nurse triage skills/capacity however, there was a lack of co-ordination between teams and bases which was exacerbated at times of peak pressure. There was a variation of triage model during the week days compared to weekends, this was due to the increased demand experienced across the weekend. However, the triage function was being reviewed as part of the clinical pathways work and the planned 111 roll-out in April 2019. The Committee noted that team building and development opportunities were being pursued which included the "Care Aims' course which would assist

with integrated working and help to improve the wider culture.

Concerns were raised in relation to the Health Board's higher percentage of home visiting rates as an outlier across Wales and it was anticipated that this rate would reduce.

The Committee noted the wider clinical and corporate governance processes and the implementation of new performance standards with the roll-out of 111. It was agreed that a presentation of the new performance standards should be demonstrated to the Finance and Performance Committee at a future meeting. **Action: Secretariat**

The Committee raised concerns in relation to incident reporting and the variation between Health Boards in the number of incidents reported and questioned whether the reporting mechanism was correct. It was highlighted that incidents and near-miss reporting were entered onto the DATIX incident logging system for management reporting. However, the system was difficult to use and a review of DATIX reporting system was being undertaken on an all Wales basis. It was noted that all quality and patient safety metrics were discussed at the Division's Quality and Patient Safety Group, Senior Divisional Management Team and at the Quality and Patient Safety Operational Group.

The Committee thanked Nick Wood and Sian Millar for the comprehensive progress update and asked for the updated action plan to be appended to the minutes of the meeting. **Action: Secretariat**

Nick Wood and Sian Millar left the meeting

Audit 1701/10 Estates Review Report

The Committee received the WAO report

The Committee noted that performance reporting of the KPIs would be undertaken on a quarterly basis to the Divisional Assurance meeting and also half-yearly and annually as part of the Divisional Review with the Executive Team. However, consideration would need to be given as to how the KPIs could be reported and monitored through

the Capital Board and an appropriate sub-committee of the Board. **Action: Executive Team**

It was noted that there was an error in paragraph 71 in which it states that "the Estates team obtains feedback from users via the Hospital Environment Committee which is chaired by an Independent Member". This statement was incorrect in as much as the Environment Committee is chaired by the Associate Director of Nursing/Consultant Nurse for Infection Prevention. **Action: WAO**

The Committee thanked Neil Pearce and David Poland for attending.

Neil Pearce and David Poland left the meeting.

Audit 1710/11 Internal Audit Progress Report

The Head of Internal Audit provided an overview of the Internal Audit Progress Report highlighting progress against the 2018/19 Internal Audit Plan together with an overview of other activity undertaken since the previous meeting.

The Committee noted that the following audits had been completed since the last report which had received Reasonable Assurance:

- Divisional Review – Facilities
- Budgetary Control

In terms of the Budgetary Control high priority recommendation related to the Scheduled Care Division, the Director of Finance informed the Committee that the Divisional Business Partner Accountant does hold regular budget meetings with all of the Division's component Directorates at which financial performance was challenged. However, the meetings were not formally documented and could not be evidenced for audit purposes. The Committee noted that this had since been rectified. For assurance purposes, the Director of Operations advised that financial performance was an agenda item for all Divisional Assurance meetings.

The Committee noted the change to the Internal Audit Plan to defer the Absence Drop-down audit. The Head of Internal Audit advised that the Internal Audit Plan would be

presented at the next meeting of the Audit Committee. **Action: Internal Audit**

The Committee noted that the General Manager for Facilities had shared the best practice in relation to the implementation of a Divisional Business Unit with the other Divisions. The Director of Operations informed the Committee that Divisions had been challenged with replicating the central Divisional Business Unit and would be following this up at the Divisional Assurance meetings. The Chair asked that the Committee receive an update in relation to the outcome of the challenge. **Action: Director of Operations**

The Chair expressed her appreciation for the work of the Executive Team in driving forward the improvement in assurance and the use of the audit tracker to monitor and manage progress.

Audit 1701/13 Interim Head of Internal Audit Opinion Update

The Head of Internal Audit informed the Committee that work on his overall opinion, across all the assurance domains, was ongoing however, based on the work undertaken to date, his draft Head of Internal Audit opinion was that the Health Board would potentially achieve a reasonable status overall. Although, this was subject to change, based on the audits yet to be completed.

Audit 1701/12 IT Service Management Limited Assurance Internal Audit – Follow Up Report Update

The Chair advised that the Committee had expressed their significant concerns in relation to the issues raised in the Internal Audit report and, particularly the nature of the responses to the recommendations, which did not enable the Committee to have any confidence that the issues identified were being appropriately addressed. Subsequently, the Committee was made aware that since the responses had been provided in May 2018, further resources had been allocated to Informatics to ensure that the issues identified could be properly addressed. The Committee agreed that a follow up report, presented by the responsible Executive Director, outlining what was being done to address the recommendations and to resolve the risks and issues flagged in the report.

The Director of Planning, Digital and IT provided an update on progress to address the 10 recommendations which focussed on 4 cross cutting themes

1. Engagement with the organisation to align services to business need and the development of formal service level agreements (SLA).
2. Improvement in knowledge management and service knowledge management systems – including standard operating procedures (SOP).
3. Greater focus on supplier and contract management.
4. Monitoring of Informatics performance.

It was agreed that the management responses on the recommendation tracker should be updated to be clear, and specific as to actions and timings. **Action: Director of Planning, Digital and IT**

The Committee thanked Matthew Mahoney for his hard work and support in addressing the risks and issues flagged in the report.

Audit 1701/14 **Patient Discharge Process Internal Audit Final Report and Management Response – Limited Assurance Report**

The Committee received the report and observed that while it was disappointing that performance was not better, it was pleasing to note that the recommendations and responses were very clear as to how to address the issues.

The Director of Operations expressed her disappointment with the overall audit findings, given that the Health Board had invested significant resources in managing patient flow. She explained that discharge was a multi-disciplinary team focus across the whole health and social care system. The Committee noted that the Discharge Policy was under review and being consulted on across the whole Health Board. The improvement measures being implemented in relation to monitoring, auditing, spot checking and holding individuals to account were also noted.

The Committee thanked Claire Birchall for attending.

Audit 1701/15 **Update on Governance, Financial Control Procedures and Technical Accounting Issues**

The Committee received the report and noted that a number of policies were currently being reviewed as follows:

- Stores and Stock
- Budgetary Control (FCP)
- Capital Assets and Charges
- Capital Procedures & Guidance Notes

The Recovery of Overpayments to Employees had been amended following a period of consultation with managers and trade unions and considered at the Workforce & OD Policy Group on 6th November 2018, and following some slight amendments was scheduled to be presented to the Executive Team in February 2019 and to the Audit Committee for final approval at its meeting in April 2019. **Action: Secretariat**

In relation to the implementation of IFRS16 within the public sector, the Committee noted that the commencement date had been deferred to 1st April 2020. The work to identify a comprehensive list of leases within the Health Board affected by the accounting rule changes was ongoing.

The Committee noted that the recommendation to approve write offs was an error in the report as there were no write offs for approval.

The Committee noted the report and, in particular, the position in relation to the Funded Nursing Care payments to local authorities, the change to the discount rate to be applied to the Early Retirement and Personal Injury Benefit Provisions advised by HM Treasury and the key dates for the Annual Accounts and Public Disclosure Statements for 2018/19.

Audit 1701/16 **Losses and Special Payments Report**

The Committee received and noted the report.

Audit 1701/17 **Risk Management Review and Assurance Framework Development Report**

The Committee received the report. The Board Secretary provided a brief overview in relation to the current work on

the risk management review and initial feedback and also a timeline for the finalisation of the Assurance Framework and Risk Appetite Statement.

The Board Secretary thanks the Head of Internal Audit for his advice and support and informed the Committee that 2 Risk Management Landscape Review Development Workshops were to be held on 22nd February and 4th March 2019 and invited Committee members and officers to attend if they were able.

It was clarified that the outcome of the review would be an implemented set of actions to improve performance in risk management.

Concerns were raised in relation to the timescales and the development of the implementation plan. The Head of Internal Audit advised that he had met with the Board Secretary and Jeff Brown and that the review work would feed into the implementation plan. He explained that he had commenced the risk review and would ensure the closing of the loop in terms of the implementation plan. **Action: Board Secretary**

Audit 1701/18 **Wales Audit Office (WAO) and Internal Audit High Level Tracker**

The Committee reviewed the tracker and the following points were noted:

- Progress with the implementation of recommendations was noted and welcomed, and the Executive Team under the leadership of the Chief Executive were thanked for their focus on this critical area.
- Recommendation 1 **–** Concerns raised about recruitment. The Committee agreed that this recommendation should be changed to Amber and monitored at Executive Team. **Action: Board Secretary**
- Recommendation 16 – Concerns raised in relation to whether Private Patient training should be part of mandatory training. It was noted that the Private Patient Follow-up report would be presented at the next Committee meeting and may address this matter. **Action: Internal Audit**
- Apart from recommendation 1, all other Green recommendations to be removed from the tracker.

Action: Board Secretary

- IT Service Management Audit responses to be updated. **Action: Director of Planning, Digital and IT**
- Concerns that some recommendations do not have timelines. Deliverable dates to be added for the next meeting. **Action: Board Secretary**
- The Committee asked whether other audit/inspection report such as HIW reports to be added to the tracker. It was noted that HIW report related to quality and patient safety and were presented and considered at the Quality and Patient Safety Committee. It was noted that Health and Safety reports were discussed at the Health and Safety Committee and were presented and considered at the Quality and Patient Safety Committee. The Committee asked for an assurance report and a copy of the Recommendation Tracker from the Quality and Patient Safety Committee for wider assurance. **Action: Board Secretary**

The Chair commented that the quality and patient safety assurance mapping process being undertaken by the Medical Director, Director of Nursing and Director of Therapies and Health Science was an important piece of work and need to align with this work.

Claire Birchall left the meeting.

Audit 1701/19 Draft Committee Work Programme for 2019

The Committee received the draft Committee Work Programme for 2019 which was work in progress. The Head of Internal Audit agreed to liaise with the Board Secretary outside of the meeting to finalise the key internal audit dates. **Action: Head of Internal Audit**

The Chair commented that it was good to see the Executive Director level engagement at the meeting.

Audit 1701/20 Date of Next Meeting

Wednesday, 3rd April 2019 at 1.30pm in Conference Room 1 & 2, Conference Centre, Headquarters, St Cadoc's, Caerleon.

Primary Care & Community Services Division
Urgent Primary Care Service

Updated Response to Audit Committee Feedback – January 2019

Welsh Audit Office Report Response

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer	Update at January 2019
R1b	Give regular updates to staff as plans develop and opportunities for further participation.	Staff are well informed and understand service development plans.	Yes	Yes		continue as required until April 2019 as part of 111 go live	Richard Pryce/ Senior OOHs Team	111 education sessions have been delivered to all OOH staff during Q3 18/19 as planned. Nursing Staff have been supported by the CD and Senior Divisional Leads

to understand the anxieties caused by the introduction of 111 and the change in service delivery. Nursing future opportunities workshop held on 21st Dec 2018, supported by Divisional Leadership team and Ass. Dir Nursing. CD has presented the future vision of the OOH service to all of the nursing staff throughout Q3.

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer	Update at January 2019
R2	The Health Board's GP out-of-hours leaders should seek to repeat a staff survey to understand whether staff perceive any improvement in the management of the service since the restructure.	To understand whether staff feel the management of the service has improved since the restructure.	Yes	Yes	The Health Board's GP out-of-hours leaders should seek to repeat a survey staff to understand whether staff perceive any improvement in the management of the service since the restructure. We have made a number of changes since the review. We have a senior manager in post leading the service and ensuring the redesign and structured governance arrangements into the Divisional and organisational processes are in place amongst a range of other elements and	Initially done in April 18 – Repeated in November 2018 Repeat of staff survey in March 2019 with support from W&OD.	Richard Pryce / OOHs Senior Team/HR support	CD launched an anonymous poll via survey monkey to the cohort of GP's identified who had left the service or chosen to remain registered with ABUHB but not working clinical shifts. Results showed that staff felt that at the time the working culture was poor, they felt disregard and unsupported by the management team and the senior team was not open to communication.

					there is now a Clinical Director in post.			Substantive staff have not been subject to a formal survey of their opinion to date, the All Wales peer review allowed staff the platform to discuss their views openly with the review team. Staff surveys will be repeated in March 2019 to review progress, this will give the planned management restructure time to take effect.

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer	Update at January 2019
R3a	As part of annual appraisals, make sure all staff have a personal development plan where training needs can be identified and progressed.	Staff are encouraged to reach their full potential.	Yes	Yes	The Health Board should: a. Increase appraisal rates; b. Undertake more robust monitoring of appraisal completion rates, perhaps as part of operational managers meetings. c. As part of annual appraisals, make sure all staff have a personal development plan where training needs can be identified and progressed. d. Carry out work to understand the reasons for low morale amongst staff. The elements of training and development need to be discussed in these PADR processes. A large number of	Ongoing	Richard Pryce	Appraisal Rates are currently at 67% for the service. This is against a mandatory requirement of 85%. Weekly assurance meetings have been initiated by DM with all reviewers to give exception reporting into non-compliance with recovery plans detailing projection to 85% + compliance. The compliance is fed back to the Divisional GM via the DM as part of DMT.

					nonclinical staff work small numbers of hours across our service as they have other jobs. GPs are appraised at a Deanery level – we only have 3 salaried GPs who have a job plan agreed with the Clinical Director. Action: This will be an item on the Senior management team Operational meeting for monitoring of PADRS, sickness and mandatory training performance.			

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer	Update at January 2019
R3b	Carry out work to understand the reasons for low morale amongst staff, perhaps by giving staff the opportunity to sit on or lead working groups to resolve the issues causing low morale.	To understand and tackle reasons for low staff morale.	Yes	Yes	As above	December 2018	Senior Team	Regular forums set up for all grades of staff to attend since November 2018. Attendance has been good to date – this will stay in place in future. – Initial impression from staff is that providing access to the heads of service has created a sense of inclusion and increased feeling of appreciation. Exit interviews are now being offered to all staff who leave the service as of January 2019 – this will include the staff TUPE'd to 111.

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Audit Committee
3rd April 2019
Agenda Item: 2.4

Audit Committee
17th January 2019
Action Sheet

(The Action Sheet also includes actions agreed at previous meetings of the Audit Committee and are awaiting completion or are timetabled for future consideration for the Committee. These are shaded in the first section. When signed off by the Audit Committee these actions will be taken off the rolling action sheet.)

Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
Audit 1701/05	**2007/12 WAST Internal Audit Report** Health Board's response to the Audit Report to be recirculated.	**Board Secretary**	N/A	The Health Board response has been obtained from the Director of Operations and will be circulated to the Audit Committee Members for information.
Audit 1701/08	**WAO Progress Update** WAO Audit Plan and fee to be presented at the April Committee.	**WAO**	April 2019	WAO Audit Plan and Fee added to the April Committee meeting agenda.
	The final version of the Structured Assessment Report to be circulated to Committee members prior to the March Board.	**Board Secretary**	March 2019	Completed.

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Audit Committee
3rd April 2019
Agenda Item: 2.4

Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
Audit 1701/09	**GP Out of Hours/Urgent Primary Care Services** Presentation of the new 111 performance standards to be demonstrated to the Finance and Performance Committee once the Health Board has completed its 111 roll-out.	**Secretariat**	N/A	Action transferred to Finance and Performance Committee.
	Updated Action Plan to be appended to the minutes of the Committee.	**Secretariat**	Completed	Action Plan appended to the minutes of the meeting.
Audit 1701/11	**Estates Review** Consideration to be given as to how the Facilities KPIs could be reported and monitored through the Capital Board and an appropriate sub-committee of the Board.	**Executive Team**	In progress	A proposal is being submitted to Capital Board to monitor Facilities KPIs as part of its work programme. Following Capital Board consideration reporting on progress will be to the Finance and Performance Committee.
	Amendment to paragraph 71 to replace the words "an Independent Member" with the Associate Director of Nursing/Consultant Nurse for Infection Prevention."	**WAO**	Completed	No further report required.

Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
Audit 1701/11	**Internal Audit Progress Report** Internal Audit Plan to be presented at the April Committee	**Internal Audit**	April 2019	Internal Audit Plan added to the April Committee meeting agenda.
	Committee to receive an update in relation to the Director of Operations challenge to the Divisions to replicate the central Divisional Business Unit model adopted by the Facilities Division.	**Director of Operations**		The General Manager for facilities has presented the Divisional Business Unit approach to the other Divisional General Managers. The Director of Operations has challenged the other Divisions to consider establishing a similar approach in their own Divisions. This may require some Divisions to undertake admin reviews.
Audit 1701/12	**IT Service Management Limited Assurance Internal Audit – Follow Up Report Update** Management responses on the audit recommendations tracker to be updated.	**Director of Planning, Digital and IT**	April 2019	These have been reviewed and updated.

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Audit Committee
3rd April 2019
Agenda Item: 2.4

Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
Audit 1701/15	**Update on Governance, Financial Control Procedures and Technical Accounting Issues** The Recovery of Overpayments Policy to be presented at the April Committee.	**Secretariat**	April 2019	The Recovery of Overpayments to Employees Policy added to the April Committee meeting agenda.
Audit 1701/17	**Risk Management Review and Assurance Framework Development Report** The Head of Internal Audit to ensure the closing of the loop in terms of the Implementation Plan as part of his risk review.	**Head of Internal Audit/Board Secretary**	April 2019	The risk review has been completed along with an action plan. These are being submitted to the Audit Committee meeting in April 2019.
Audit 1701/18	**WAO and Internal Audit High Level Tracker** Recommendation 1 to be changed to Amber and monitored at Executive Team	**Board Secretary/ Executive Team**	Ongoing	The recommendations have been reviewed and updates provided for each recommendation.
	Recommendation 16 - Follow-up report on Private Patients to be presented at the next Committee meeting. This may address this matter relating to private patient training as part of mandatory training programme.	**Internal Audit**	April 2019	Private Patients Follow Up report added to the April Committee meeting agenda.

Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
	IT Service Management Audit responses to be updated on the audit tracker.	**Director of Planning, Digital and IT**	April 2019	These have been reviewed and updated.
	Recommendations without deliverable dates to be added to the audit tracker.	**Board Secretary**	April 2019	This has been completed.
	The Audit Committee to receive an assurance report and recommendation tracker from the Quality and Patient Safety Committee.	**Board Secretary**	July 2019	The Health Board has an electronic tracking mechanism for HIW and Community Health Council recommendations administered in the department of the Director of Nursing. The QPSC meeting on 12th June 2019 will receive its first tracking report produced from the system and the Audit Committee will receive a copy of this for their assurance.
Audit 1701/19	**Draft Work Programme for 2019** The Head of Internal Audit to liaise with the Board Secretary to finalise the key internal audit dates outside of the meeting.	**Head of Internal Audit**	April 2019	The draft 2019/20 Internal Audit Plan, with indicative timings, is included on the agenda for the April meeting of the Committee.

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Audit Committee 3rd April 2019 Agenda Item: 3.1

3.1

Aneurin Bevan University Health Board
Annual Counter Fraud Bribery & Corruption Report 2018/19

Executive Summary			
An executive overview has been prepared for the Aneurin Bevan University Health Board (ABUHB) Audit Committee. It highlights the Counter Fraud work conducted by the Local Counter Fraud Specialist (LCFS) for 2018/19.			
The Audit Committee is asked to: (please tick as appropriate)			
Approve the Report			
Discuss and Provide Views	√		
Receive the Report for Assurance/Compliance			
Note the Report for Information Only	√		
Executive Sponsor: Glyn Jones – Director of Finance			
Report Author: Martyn Edwards – Head of Counter Fraud			
Report Received consideration and supported by : Director of Finance			
Executive Team		**Committee of the Board [Committee Name]**	**Audit Committee**
Date of the Report: 15th March 2019			
Supplementary Papers Attached: No			

Purpose of the Report

To comply with the below legal directions which require the LCFS to provide a written report to the LHB (at least annually) on Counter Fraud work and to illustrate compliance, outcomes and learning under the Standards for NHS Bodies (Wales).

Background and Context

This report is in accordance with the National Assembly for Wales Directions to NHS Bodies on Counter Fraud Measures WHC (2005) 095 under the provisions of the National Health Service Act 1977. This work is also undertaken in compliance with the counter fraud bribery and corruption measures under the Minister for Health and Social Service Directions and the service agreement between the NHS Counter Fraud Authority under S.83 of the Government of Wales Act 2006.

Assessment and Conclusion

This report will form the basis of the Quality Assurance Self-Review as evidence that the LHB has complied with the Standards for NHS Bodies (Wales). The report content and style complies with the model prescribed by the (NHSCFA) for Quality Assurance Assessment.

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

Audit Committee
3rd April 2019
Agenda item: 3.1

3.1

On behalf of

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

COUNTER FRAUD BRIBERY & CORRUPTION REPORT

1st April 2018 to 31st March 2019

Martyn Edwards
Head of Counter Fraud
Aneurin Bevan University Health Board

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1. Management Summary

1.1. The annual report for the period 1st April 2018 to 31st of March 2019 has been written in accordance with the provisions of the WG Directions on Counter Fraud Measures (WHC 095 of 2005) which require Local Counter Fraud Specialists (LCFS) to provide a written report, at least annually, to the LHB on Counter Fraud work. The report content and style used complies with the model prescribed by the NHS Counter Fraud Authority (NHSCFA) formerly NHS Protect and predecessor organisation NHS Counter Fraud Security Management Service (CFSMS).

1.2. Effective from April 2010, Martyn Edwards was appointed as Head of Counter Fraud for Aneurin Bevan LHB and assumed the role of Lead LCFS assisted by Jeff Howells as Support LCFS.

1.3. The reorganisation of the NHS in Wales and the resulting redeployment of BSC LCFS staff left the Counter Fraud provision with a deficiency of one WTE LCFS for year 2010/11. That aspect was redressed in 2011 and a new WTE LCFS i.e. Joanne Bodenham was appointed which impacted upon year 2011 onwards.

1.4. Martyn Edwards completed his Counter Fraud training in February 2009 and was accredited in March 2009. Jeff Howells completed his Counter Fraud training in December 2009 and became accredited as an LCFS thereafter. Joanne Bodenham completed her Counter Fraud training in 2011 and became accredited that same year.

1.5. In total 362 Counter Fraud days were provided for Aneurin Bevan University Health Board during 2018/19. This breaks down across the standards key framework as follows: Strategic = 70 days, Inform & Involve = 99 days, Prevent & Deter = 49 days, Hold to Account = 144 days.

1.6. The aforementioned provision of Counter Fraud days was devoted to a workplan which contained 535 days spread across the key framework which were intended to be provided by 2.6 WTE LCFS's. Due to an unforeseeable and unpreventable staffing deficiency, which could not be remedied or supplemented, the LCFS provision became 1.8 WTE. Therefore the actual number of days provided by the LCFS for 2018/19 underachieved the expectation of the workplan by 173-days. The workplan itself was approved by the DoF in accordance with the legal directions and the NHS counter-fraud manual and the workplan was ratified by Audit Committee.

1.7. During the period 1st April 2018 to 31st March 2019, Aneurin Bevan University Health Board Counter Fraud team handled **thirty-seven (37)** investigations into potential fraudulent or corrupt activity, which included cases brought forward from 2017/18. These cases are listed at **Appendix 2** (index of investigations).

1.8. **Twenty-nine (29)** of those cases involved instances of staff related issues, which for the most part, the main categories were working whilst on sick leave, falsification of timesheets/expenses and dishonest retention of erroneous salary overpayments. The remainder of the cases involved alleged fraud on the part NHS primary care contractors and members of the public. For example, the LCFS conducted tape recorded interviews under caution, with a Community Pharmacist for alleged fraudulent claiming of dispensing charges and three members of GP Practice staff for fraudulent prescribing.

1.9. The aforementioned investigations have resulted in **six (6)** files of evidence being forwarded to the Crown Prosecution Service for charging decisions. The

LCFS investigations have also resulted in **ten (10)** disciplinary sanctions during 2018/19, predominately dismissal from employment with ABUHB for gross misconduct.

1.10. Furthermore, investigation numbers **(5)(16)(24)** & **(47)** are impending criminal prosecutions. Investigation numbers **(1)(4)** & **(31)** resulted in criminal convictions at court whereas investigation **(13)** resulted in a formal police caution (total 4 criminal sanctions plus 4 impending prosecutions).

1.11. Financial recoveries stemming from LCFS investigations during 2018/19 stand at **£42,622.06.**

1.12. Appendix 2 (schedule of investigations) depicts that in comparison to previous years, overpayment of salaries for personnel who have terminated employment with the organisation has reduced. The LCFS has continued to work in close liaison with NWSSP Payroll Services, NWSSP Accounts Payable staff and also ABUHB Accounts Receivable Staff from Corporate Finance. Intranet guidance has been reiterated to managers to remedy this, emphasising the crucial requirement for timely and accurate staff termination forms and staff changes forms to be disseminated to Payroll Services. To reinforce this principle, payslip messages were disseminated to all staff advising of the potential criminal liability of the wilful retention of erroneous salary overpayments, this message was promoted on the ABUHB intranet carousel. The implementation of the ABUHB Recovery of Overpayments Policy is promoted by Corporate Finance and the LCFS alike and is rigidly adhered to. All overpayments, regardless of origin, are notified to the LCFS by Corporate Finance/Payroll Services/Accounts Receivable staff. The LCFS has revamped the ABUHB Recovery of Overpayments Policy. This Policy, in conjunction with the Counter Fraud, Bribery & Corruption Policy, acts as a sanction and redress policy on behalf of the organisation. Counter Fraud guidance features throughout the Recovery of Overpayments Policy and in the action flowchart which is incorporated within the policy.

1.13. Commencing March 2018, the aforementioned system changed with the abolition of paper payslips. The LCFS will strive to implement measures to electronically monitor staff payslips which go unopened on ESR for a period of 3-months which again, could be an indicator that the staff member no longer works for the organisation yet is still being paid.

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

1.15. During year 2018/19, the ABUHB LCFS has conducted **four (4)** tape recorded interviews under caution with **four (4)** alleged offenders.

2. Strategic Governance

2.1. The NHS Counter Fraud Authority have developed standards for NHS Bodies (Wales) for fraud, bribery and corruption which were implemented in 2013/14. This was created in accordance with Minister for Health and Social Service Directions and the service agreement between the Welsh Government (WG) and the NHS Counter Fraud Service under S.83 of the Government of Wales Act 2006. This set of standards replace the former seven generic areas of work for the anti-fraud provision and they encompass a mandatory annual Quality Assurance process which is centred on the following key areas:

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

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

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

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

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

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

2.3. The policies most recently updated were the LCFS & Workforce & OD Joint Working Protocol the Counter Fraud Communication Strategy and the Internal Audit & LCFS Joint Working Protocol. These policies were updated prior to their renewal dates. The LCFS & Workforce & OD Joint Working Protocol went before the Workforce & OD Policy Group on 7th August 2018. The Internal Audit & LCFS Joint Working Protocol was updated in May 2018. All policies received Executive approval.

2.4. Furthermore, the LCFS has engaged with the Board Secretary regarding the ABUHB Standards of Business Conduct for Employees Policy. The organisation will ensure that there is evidence of compliance through outcomes. The effectiveness of the work will be evaluated as will the reduction of the risk. The awareness of the policy amongst staff has also been tested.

2.5. Since April 2011, the LCFS has acted in a consultation role to the Workforce and OD Policy Group and has received notification of all policies, terms of reference guidance notes that are subject of review by the group. This ensures that the policies are robust and 'Fraud Proofed' at concept stage. Further information is provided on this topic at paragraph 4.20 regarding the **twenty-seven (27)** policies reviewed by the LCFS during 2018/19.

2.6. With reference to the aforementioned policy entitled 'Appearing in Court' the ABUHB LCFS continues to distribute a self-designed tri-fold leaflet on this theme, which can be provided to members of ABUHB staff in the event that they become a Crown witness in a prosecution case. The information contained in the tri-fold leaflet can also be found on the Counter Fraud Web Page.

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

Evidence of recognition and appreciation of staff who are prepared to make the commitment and become crown witnesses is reflected in investigation **(1)**

on **Appendix 2**. In this instance, thirteen members of staff from a G.P. Practice (three of them Doctors) were prepared to stand up and be counted and do the right thing and become Crown witnesses in an extremely difficult case.

2.7. The Board of ABUHB has ensured that the resources invested into counter fraud work are appropriate to counter fraud, bribery and corruption. The Counter Fraud staffing level is currently under review which will have a marked impact on the Counter Fraud provision for 2019/20.

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

2.9. During 2012/13, the supply of Counter Fraud promotional memorabilia normally provided to LHB's by NHSCFA was discontinued. These products which featured under the inform and involve domain, included 'give away' products at presentations such as post-it pads, keyrings, pens etc, liveried with LCFS corporate identity and contact information. Distribution of these products serves to raise the awareness of the workforce and encourage them to report suspicions of fraudulent activity.

2.10. To supplement previously purchased presentation display boards and the Fraud Criminal Law & Procedure Manual, these 'give away' products were duly replenished during 2018/19 by ABUHB This displays further evidence of financial investment on behalf of the ABUHB Board towards tackling fraud, bribery and corruption in the NHS. The LCFS has negotiated further replenishing of the products on a rolling basis.

2.11. This also demonstrates that the Board has a clear remit to reducing losses to fraud and corruption to an absolute minimum by the appropriate application of counter fraud resources. The Counter Fraud staffing level of 2.8 WTE LCFS' remains incorporated in the LHB formal organisational structure.

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

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

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

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

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

2.15. On a reporting perspective, the LCFS customarily has monthly meetings scheduled with the DoF to appraise and update on Counter Fraud work and identify and manage risk. The LCFS met with the DoF in this capacity on the following dates: 03/04/18, 28/08/18 & 04/01/19. These meetings were supplemented by telephone and email contact maintained with the DoF, to whom, the LCFS has unrestricted access.

2.16. Furthermore, to consolidate the reporting process, the LCFS met with the Medical Director on 05/06/18 & 18/10/18 as investigations **(21)(22)** & **(23)** on Appendix 2 apply.

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

2.18. The LCFS has achieved a more effective communication flow process via the Assistant Director of Finance (Corporate) who, on behalf of the LCFS, highlights areas of concern at senior management team meetings, hosted by the Executive Leads for Operational Divisions, for cascade down through the organisations divisional structures.

2.19. Additionally, Counter Fraud reporting is a standing agenda item for the Audit Committee meetings. In compliance with NAW Legal Directions, the LCFS attended and delivered reports to 2 Audit Committees on 19th April 2018, and 17th January 2019. The LCFS also holds meetings to report to the Wales Audit Office as and when required. The most recent meeting between the LCFS and WAO Officers was on 24th January 2018.

2.20. All aspects of Counter Fraud strategic governance is incorporated in the Audit Committee Self-Assessment Checklist. There is a requirement that as part of compliance and professional probity, the LCFS has a right of direct access to the Audit Committee Chair and its independent members. This entails private, pre-Audit Committee meetings with said members. The LCFS attended such private meetings on the aforementioned dates.

2.21. With reference to further reporting, the LCFS submitted the self-review report based on the Standards for NHS Bodies (Wales) to NHSCFA on 29th March 2018.

2.22. In order to retain core skills and maintain best practice, the LCFS's have kept up to date on legislation and working practices through attendance at various training sessions. As part of continuing professional development, these included training sessions from NHSCFA on 03/10/2018 and 04/10/2018 respectively. These sessions consisted of accredited Counter Fraud Management Training.

2.23. Additionally, two LCFS attended the National Counter Fraud Conference at the QEII Centre, London, on 13/02/2019.

2.24. Furthermore, the LCFS attended the All Wales LCFS Forum on 06/03/2019.

3. Inform & Involve

3.1. The Health Board has worked with the LCFS and NHSCFA to promote an anti-fraud culture within the NHS. The LCFS's and Director of Finance (DoF),

identified target audiences for fraud awareness activities, with the following objectives:

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

3.2. Examples of work carried out to develop an Anti-Fraud Culture include:

The delivery of fraud awareness presentations to various Staff/Contractor groups and to date, **forty-nine (49)** presentations have been made during the year to an audience of **1,758** persons, and feedback forms are utilized at each and every presentation to evaluate and measure awareness. These areas are detailed below:

- Staff Corporate Induction Sessions x 36
- GP Practice sessions x 3
- LNC (Doctors) x 1
- Mental Health Team Band 5 Away Day x 1
- Managers Core Skills Lunchtime Forum x 2
- Careers Fair x 2
- HCA Conference x 1
- Specialist Community Public Health x 1
- Community Staff Band 2 & 3 Away Day x 1
- HCSW Away Day x 1

Each presentation is predominantly delivered by means of Power-Point slideshow which is preceded by the short video film entitled 'taking the U out of fraud'. Each attendee at the presentation is provided with a presentation pack, which consists of a copy of the slideshow, counter fraud trifold literature, a counter fraud referral form, a presentation feedback form and promotional giveaways, such as post-it pads, pens, bookmark, keyring each liveried with the corporate identity and contact details of the LCFS. The feedback forms are collated at the end of each presentation and feedback is assessed and evaluated.

3.3. To further promote and develop an anti-fraud culture, static Counter Fraud displays were sited in prominent positions within ABUHB Hospitals i.e. Royal Gwent, Ysbyty Ystrad Fawr, County Hospital, Nevill Hall, Ysbyty Aneurin Bevan and St Cadocs.

3.4. These displays advertised times/dates when the LCFS would be present for drop in clinics. Those clinics were held at the aforementioned locations during 2018/19.

3.5. In addition to this, with high profile displays, LCFS's were in attendance at Aneurin Bevan University Health Board's Annual HCA Conference held at Christchurch Centre at Newport on 7th December 2018 and also in attendance at the ABUHB careers fair, on 22nd & 23rd October 2018.

3.6. During 2018/19, staff fraud awareness surveys were disseminated to the following Divisions:

Community Specialist Public Health Services - 28 surveys sent out 13 returned = 46.43% return rate.

- *7.69% had never attended a LCFS fraud awareness session.*
- *92.31% had seen CF publicity.*
- *69.23% completed CF e-learning*
- *84.62% aware of CF Policy.*
- *100% know how to report fraud.*

Procurement Services - 22 surveys sent out 10 returned = 45.46% return rate.

- *60% had never attended a LCFS fraud awareness session.*
- *90% had seen CF publicity.*
- *0% completed CF e-learning.*
- *70% aware of CF Policy.*
- *80% know how to report fraud.*

Podiatry & Orthotics Services - 56 surveys sent out 13 returned = 23.21% return rate.

- *7.69% had never attended a LCFS fraud awareness session.*
- *92.31% had seen CF publicity.*
- *53.85% completed CF e-learning.*
- *100% aware of CF Policy.*
- *92.31% know how to report fraud.*

These are very positive responses which indicate a strong counter fraud, bribery and corruption culture where fraudulent and corrupt activity is not tolerated and all staff are aware of their responsibility to protect NHS funds, as well as the correct reporting procedures. A strong counter fraud, bribery and corruption culture provides the organisation with assurance that fraud is recognised and reported.

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

Examples of this are investigations listed as **(14)(31)** & **(32)** which stemmed from the 0800 National Fraud & Corruption Reporting Line. The remainder of the investigations on **Appendix 2,** were predominantly paper based anonymous fraud referrals using referral forms downloaded from the ABUHB Counter Fraud Team web-pages. This is a clear indication that all mediums are being used by 'whistleblowers' to report suspicions of fraud. The NHSCFA on-line reporting tool is also promoted by the LCFS but no referrals have been received via this medium.

Additionally, under case reference WARO/18/00082 the Counter Fraud Service Wales were referred a General Ophthalmic Services investigation by the ABUHB LCFS. This again highlights the promotional work undertaken by the ABUHB LCFS.

3.8. In addition to paragraph 3.7 above, the sheer volume of referrals received by the ABUHB LCFS is testament that the anti-fraud message is getting across and hitting the intended target audience.

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

3.10. On an all Wales basis, ABUHB personnel have consistently rated as amongst the top scoring of all NHS in Wales for having completed the fraud awareness e-learning application. This positive response has been enhanced by the fact that the fraud awareness e-learning application is a mandatory training dimension on ESR PADR for all ABUHB staff. The most recently available e-learning uptake figures is 2,283 members of staff have completed the application which equates to 17.44% of the workforce. This is currently the second highest uptake in Wales. The LCFS is now endeavouring to consolidate this figure following the placement of a reminder of this ESR mandatory learning requirement on the carousel on the ABUHB intranet homepage which took effect w/c 4th March 2019.

3.11. Fraud Awareness month (FAM) which was a national NHS initiative was customarily orchestrated/managed by NHSCFA. This initiative has been suspended by the NHS Counter Fraud Service due to funding restrictions; however the LCFS compensated for this at all ABUHB Hospitals, by means of the initiative described at paragraph 3.3 above. This initiative not only served to create an anti-fraud culture but heightened the awareness of a high footfall number of employees of all grades and the general public alike, and resulted in a great deal of staff interest generated to the LCFS.

3.12. Fraud information has been updated on the Aneurin Bevan University Health Board intranet website, which has advertised the outcomes of investigations and guidelines to staff for reporting fraud in addition to fraud notices. The ABUHB website was regularly updated and the LCFS web-pages received 406 'hits' during 2018/19. Articles placed on the organization's intranet site front page comprised of national press releases, local sanctions and general fraud awareness messages from the LCFS. The LCFS has maintained the implementation on the ABUHB website the video entitled 'Taking the U out of Fraud' on the aforementioned web-pages.

3.13. In addition to the Counter Fraud's own section of the website, the LCFS has incorporated a link tab on the ABUHB intranet homepage which provides direct access to the Counter Fraud referral form. This is with a view to encouraging users of the site to make Counter Fraud referrals.

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

3.14. The bi-annual Counter Fraud newsletter was distributed to LHB Primary Care Contractors during 2018/19 with various counter fraud articles and successful NHS fraud cases. In total there are 383 Primary Care Contractors that provide NHS services to ABUHB which consist of GP's, Optometrists, Dentists and Pharmacists. The newsletter promotes the NHS Fraud and Corruption Reporting Line and LCFS contact details. The newsletter is bespoke and topical for primary care contractors.

3.15. A staff orientated Counter Fraud Newsletter was also publicized on the ABUHB intranet during April 2018 and was accessible to the entire workforce.

3.16. The corporate identity and contact details of the LCFS is also incorporated in the Local Intelligence Network (LIN) newsletter which is accessible to the

workforce of ABUHB and which is disseminated to all GP Practices and Community Pharmacies within the LHB.

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

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

3.19. The LCFS has established a direct contact within the UK Borders Agency. This relationship has involved the sharing of information to progress investigations undertaken by both organizations.

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

3.20. Further evidence of partnership working are cases **(22)** & **(24)** on **Appendix 2** which resulted in gateway taxation requests being made by the LCFS to HMR&C and case **(12)** which necessitated Land Registry input.

3.21. The LCFS has initiated Counter Fraud awareness messages to be sent to every member of staff employed by the LHB by placing an entry on all employees' payslips highlighting the criminal liability of the willful retention of a salary overpayment.

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

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

4. Prevent & Deter

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

4.2. In order to ensure that they remain current, effective and up-to-date, the LCFS has a rolling-programme for reviewing the following polices/protocols which were initially created in 2011. These policies were extensively revamped again during 2014/15. This is necessary in order to reinforce the infrastructure of directives and the framework of organisation guidelines necessary to support the Counter Fraud provision. The LCFS & Workforce & OD Joint Working Protocol the Counter Fraud Communication Strategy and the Internal Audit & LCFS Joint Working Protocol were further reviewed ahead of their scheduled renewal dates in 2018. All policies received Executive approval and Workforce & OD Policy Group input where necessary.

- Counter Fraud Bribery & Corruption Policy
- Counter Fraud Communication Strategy
- LCFS & Workforce & OD Joint Working Protocol
- Counter Fraud Standard Operating Procedure
- Policy entitled Appearing in Court

- Counter Fraud Protocol with Internal Audit

4.3. The LCFS has worked proactively with the NHS Wales Shared Services Partnership-Primary Care Services GOS Payments Officers and the Ophthalmic Adviser. All General Ophthalmic Service payments made to Contractors are monitored and the LCFS is provided with quarterly GOS trend data for all ABUHB GOS contractors. This data is scrutinized for abnormalities in claiming patterns. Such analysis has resulted in an investigation being referred to CFS Wales by the ABUHB LCFS under WARO/18/00082.

4.4. The LCFS is linked to the Audit Committee via the DoF. The Audit Committee reviews the adequacy of the structures, processes and responsibilities for identifying and managing key risks facing the LHB. The LCFS attends Audit Committees to highlight fraud risks and to appraise the Committee of current work undertaken by the Counter Fraud Team. The Counter Fraud update report and LCFS attendance at the Audit Committee is a standing agenda item on Audit Committee agendas.

4.5. The LCFS has developed relationships with individuals whose role within the LHB has an impact on counter fraud work to identify local areas of risk. The LCFS also meets regularly with External Organizations such as the Police, Community Pharmacy Wales (CPW), NWSSP-Primary Care Services, UK Borders Agency and the Department for Work and Pensions (DWP) to gather intelligence and identify Local and National risks. The LCFS also engages with HMR&C in this capacity and has also worked with the Counter Fraud Operations Team of the HM Passport Office.

4.6. During 2018/19, as part of working in partnership with the Police, the ABUHB LCFS has provided criminal intelligence reports to Police Field Intelligence Officers (FIO's) on **three (3)** occasions, whereby the information would be deemed to be of value to law enforcement. Conversely, this information sharing practice has resulted in the LCFS being afforded access to Police held intelligence which was pertinent to the NHS.

Further evidence of partnership working with the Police are investigations **(3)(31) & (33)** on **Appendix 2,** which are collaborative investigations. Additionally investigation **(7)** is a LCFS investigation which was referred to the LCFS by the Police.

4.7. The LCFS also liaises regularly with the PPV Team and all PPV reports which form part of the standing agenda item at Audit Committee are disseminated to the LCFS. Any concerns of fraud highlighted at a PPV visit are discussed immediately with the LCFS and the appropriate action is agreed. The PPV team reports their findings directly to the DoF. The LCFS has input to a current project conducted by NWSSP-PCS PPV in relation to data set trend analysis in the General Ophthalmic Services domain designed to identify inappropriate claiming in that primary care arena.

4.8. NWSSP-Primary Care Services is responsible for registering all new patients at GP Practices in Wales. Any patients that register with another practice will automatically be removed from the patient list of their previous practice. If a person fraudulently attempts to register at a practice temporarily to obtain prescription medication or controlled drugs an alert is sent out to all GP practices in the area. The LCFS receives every drug alert that is circulated and these alerts customarily highlight prescription fraud and cases of fraudulent multiple registration at GP Practices.

4.9. Routinely, the ABUHB LCFS has utilized the NWSSP-PCS Contracts Team drug alert system to generate the LCFS's own drug alerts which contain information

and intelligence which has come to the attention of the LCFS via a variety of sources. These drug alerts can be circulated throughout an individual Health Board or clustered to a number of Health Boards or throughout all HB's in Wales if deemed necessary. The alerts are disseminated to prescribers, or dispensers or both if required.

Additionally, on **two (2)** occasions during 2018/19 the LCFS has utilized ABUHB Primary Care Team resources to alert all Gwent GP Practices of patient registration fraud and cyber fraud which was focused on the primary care GMS domain.

4.10. Fraud prevention circulars can be issued by NHSCFA under the WG directions for Countering Fraud. Any such circulars include the request for specific action to highlight and minimize any known fraud risk. These fraud prevention instructions referred to as IBURN emanate from the Central Intelligence Unit (CIU) of NHSCFA.

4.11. The ABUHB LCFS identified and correlated information from across Wales in relation to a prolific national 'hospital bed hopper' fraudster who had been utilizing services not only in ABUHB and throughout Wales but nationwide. This was a significant problem which has proved costly and disruptive to the NHS. The LCFS provided an intelligence report to the CIU of NHSCFA which resulted in the national circulation of IBURN 2019-02-02 to disrupt, deter and apprehend the offender. Information as to this type of conduct has also been made available to A & E staff to raise their awareness to this type of resource and economic sapping event.

4.12. Due to the threat level, the ABUHB LCFS has continued to focus on banking mandate and invoice fraud. During 2018, nationally within the NHS, there has been a marked resurgence on an old theme of banking mandate fraud and ABUHB has been subject to repeated attack from this type of high risk/high value fraud.

This fraud occurs when fraudsters implement changes to the banking mandate details of legitimate external suppliers/service providers, on Oracle via NHS Procurement Services (Accounts Payable) to that of the fraudsters own bank accounts. Outgoing payments are then hijacked into the fraudsters' bank accounts.

In July 2018, the LCFS established that fraudsters had successfully implemented a banking mandate change within procurement in ABUHB. Remedial measures were implemented and the fraud was intercepted prior to any payments being transacted from ABUHB. This was not before two low value payments were hijacked from two other Welsh LHB's.

It then followed that within one working week in September 2018, two NHS Healthcare organisations in England fell victim to banking mandate frauds losing £900k and £157k respectively in two individual payments.

The ABUHB LCFS reviewed and risk assessed preventative measures which had been implemented a number of years previously to discover that due to a reconfiguration of duties within NWSSP, the measures may have become diminished and weakened.

The following directives have been reinforced to mitigate this area of fraud:

- No banking mandate changes will be implemented on the receipt of an email or letter alone.

- To confirm the authenticity of the banking mandate request, the requesting supplier/service provider should be contacted (not on the contact reference on the letter but on the verified and established contact details NHS have held for them historically on file).

- A contact who is known to the NHS from within the company (with whom NHS have engaged previously) should be spoken with to and confirm the authenticity of the banking mandate request.

- To mitigate the insider threat, the NWSSP staff member who implements banking mandate changes should not be authorised to process payments on Oracle etc. This means that it would require two members of staff to collude or conspire together to transfer payments to a fraudulent bank account.

A common theme for this type of activity appears to be the targeting of civil engineering construction companies as significant outgoing payments are made by the NHS in this domain.

Particularly within ABUHB, repeated attacks have been made late in the working day on a Friday afternoon. This would appear to be an effort on the part of the fraudsters to pressurize a member of NHS accounts staff into making a snap decision (*the wrong decision*) when it comes to implementing banking mandate changes.

4.13. During 2018/19, the ABUHB LCFS responded to **four (4)** IBURN fraud circulars pertaining to banking mandate fraud and executed and actioned them accordingly (IBURN 2018-09-(01)(02)(03) & 2019-02-01 refers).

4.14. Additionally, the ABUHB LCFS generated a further **nine (9)** self-initiated alerts on banking mandate fraud throughout the Corporate Finance and Procurement communities.

4.15. The LCFS has disseminated **four (4)** scam alerts to the workforce on various issues when cybercrime was targeted at staff members.

4.16. As a consequence of an investigation which was being conducted into a primary care community pharmacy elsewhere in Wales, the ABUHB LCFS became aware of a systemic failure which enabled a pharmacy to operate a dispensing scam and inappropriately overclaim by circa £75,000.00.

This was caused by a failure on the part of authorized prescribers (Doctors) at hospital level, to adequately record the specific formulation of medication. The prescriptions made no distinction whether the medication prescribed should be in tablet/capsule form or oral solution. This enabled the pharmacy to dispense inexpensive tablet versions of medication to patients but recharge the NHS for expensive oral solution. The following schedule exemplifies the varying costs involved:-

Drug	Example liquid/ dispersible cost	Example tablet/capsule cost	Difference in cost per dispensing
Donepezil	£288.00	£2.82	£285.18
Memantine	£250.00	£5.00	£245.00
Sulfasalazine	£95.00	£7.37	£87.63
Flucloxacillin	£52.08	£1.31	£50.77
Lansoprazole	£5.50	£1.10	£4.40
Naproxen	£7.02	£2.52	£4.50

Naproxen Susp	£150.00	90p	£149.10
Omeprazole	£11.60	91p	£79.40
Prednisolone	£98.47	£1.94	£96.53

Via the ABUHB Primary Care Pharmacy Team, the LCFS instigated an immediate audit of post dispensed hospital prescription forms to determine whether this type of claiming activity was evident in Gwent. No areas of concern were identified, however; this domain will be subject of continuous monitoring.

Via the ABUHB Chief Pharmacist, instructions were disseminated to authorized prescribers to be more specific as to the formulation of medication on medical prescription forms in order to mitigate the risk of this type of exploitation.

4.17. In the past 36-months, Counter Fraud intervention has been necessary at four Gwent based G.P. Practices. Investigations listed as **(1)(16) & (30)** on Appendix 2 are examples of this. The themes were consistent at the respective practices and the areas of concern stemmed from failures in internal controls which created a platform for manipulation of the patient management systems. This facilitated the fraudulent creation of medical prescription forms by staff.

The weaknesses identified were:

- All staff using open terminals on one password logon.
- Central record kept of all staff members system passwords and usernames (including GP's).
- Staff members registered as patients at practice.
- Staff members registered on patient management system at Practice as temporary residents.
- Staff members having patient management system capacity to generate prescriptions for family members.

At the practice subject of investigation **(1)** on Appendix 2, almost every member of staff featured on the patient management system as a temporary resident. This can be a platform for fraudulent prescribing.

An additional system weakness identified is that the patient management system software allows for the creation of mock or dummy records for training purposes. These are stand-alone records which are not transmitted through to the NHS for full patient registration. Such dummy records however do have the capacity to generate medical prescription forms.

Via the ABUHB Deputy Head of Primary Care Services, the LCFS has highlighted these weaknesses for remedial action within the GMS domain.

4.18. The LCFS is a permanent attendee of the Gwent Local Intelligence Network (LIN). The Medical Director is the Accountable Officer for the LIN which has Police representation, representation from neighboring county LIN's and also representation from HoPMM, Pharmacy, GPhC, Health Inspectorate Wales, Care & Social Services Inspectorate Wales and this allows for exchanges of information. A primary function of the LIN relates to the security of and addressing risk factors attached to controlled drugs (CD's).

The LCFS has attended all LIN meetings during year 2018/19. These meetings were held on 24/04/18, 01/08/18, 06/11/18 & 22/01/19 respectively.

As a by-product of the LIN, the LCFS is named (with contact details) on the LIN Newsletters and this serves to promote the identity of the LCFS and highlight their presence to the workforce and all GP's and Community Pharmacists within the LHB.

4.19. Additionally, the LCFS was a fully appointed member of the NHS Prescription and Forms Group (Wales). This group had the capacity to implement changes to prescription forms and NHS forms in Wales. Security issues relating to NHS forms and prescription form handling were addressed by the Group which also has Welsh Government (WG) representation. The group has been dissolved however, the LCFS would be consulted prior to any major changes in prescription and NHS forms in Wales.

4.20. Since April 2011, the LCFS has acted in a consultation role to the Workforce and OD Policy Group and has received notification of all policies, terms of reference guidance notes that are subject of review by the group. This ensures that the policies are robust and 'Fraud Proofed' at concept stage.

The LCFS has reviewed and has initiated inclusions on **twenty-six (26)** documents which have been implemented by ABUHB during 2018/19. These policies are:-

- LCFS & Workforce & OD Joint working protocol
- Protocol between LCFS and Internal Audit
- Counter Fraud Communication Strategy
- Keeping Personal Records Policy
- First Aid at Work
- Fire Safety
- Volunteer Policy
- Personal Relationships at work
- Medical Gas pipeline services
- Legionella Policy/Water safety
- Accessing NHS Pension & re-engagement policy
- All Wales Menopause Policy
- All wales managing attendance policy
- Car Parking
- Catering Services & food safety
- Control of Environment
- Laundry Linen Services
- Portering Policy
- Receipt Distribution
- Security Policy
- Overtime & additional hours
- Recovery of overpayments
- H&S obligations at work for pregnant employees
- Occupational Health & Safety Policy
- Redeployment
- Alcohol Substance misuse

4.21. The LCFS monitors the pharmacy reward scheme within the LHB and is the sole countersignatory to authorize payments under the scheme. The LCFS liaises with Pharmacist and GP primary care contractors to ensure the guidelines are adhered to and that prescription fraud is reported appropriately.

4.22. The LCFS has also provided these contractors with written literature relating to the pharmacy reward rules to heighten their awareness to prescription fraud.

4.23. These rules have been distributed to all 130 Pharmacies in the LHB. During year 2018/19 ABUHB have made payment on **five (5)** Pharmacy Reward Scheme claims.

4.24. The previously mentioned Counter Fraud Newsletter, disseminated by the LCFS to all 130 Community Pharmacies within ABUHB reinforced the Pharmacy Reward Scheme.

4.25. The pharmacy reward scheme process was convoluted in so much as Pharmacists were directed to submit their claims to NWSSP-PCS, who at this point, took no part in the payment authorization process. The forms were then disseminated to the LCFS's in the respective LHB's for authorization for payment, following which, the forms were returned to NWSSP-PCS to facilitate payment. This payment process arguably delayed payment to the pharmacists and caused a delay in the LCFS's becoming aware of what was happening on their patch.

On an all Wales basis, in their former capacity of appointed member of the NHS Prescription and Forms Group (Wales) as referred to previously at paragraph 4.19, the ABUHB LCFS instigated changes to the Pharmacy Reward Scheme which essentially removed NWSSP-PCS from the initial process.

Claim forms are now sent direct to their respective LCFS's by Pharmacists. This simplifies the claim process, speeds up payments and enables the LCFS to monitor what is happening on their patch without undue delays. These changes necessitated implementing amendments to the Pharmacy Reward Scheme claim guidance and changes to the Drug Tariff itself.

4.26. A recurring issue within ABUHB is the overpayment of salaries and this is reflected in the schedule of investigations at **Appendix 2**. These overpayments occur when a member of staff erroneously continues to be paid full salary after they have reduced their working hours or after they have terminated employment with the Health Board completely.

The LCFS works in close liaison with the Accounts Receivable Team of Corporate Finance who informs the LCFS of each and every such overpayment. The LCFS is selective and identifies any suspected criminal conduct attached to the overpayments. If criminal conduct is apparent then a criminal investigation is incepted by the LCFS. If not, and the overpayment bears all the hallmarks of a civil debt, then the Accounts Receivable Team seek to recover the debt by an alternative civil legal process.

These overpayments arise as a consequence of one of two eventualities prevailing: (1) ABUHB Managers fail to submit staff changes and staff termination forms in the appropriate manner (2) NWSSP Payroll Services fail to action staff change/termination forms when the forms have actually been submitted.

This problem is not unique to ABUHB. From collaboration with counterparts in other Welsh Health Boards, it is evident to the LCFS that this is an all-Wales issue.

The LCFS has maintained a proactive role to highlight these issues to the workforce by means of a variety of mediums.

Advice to ABUHB Managers has been included on the intranet reminding Managers of their professional duty to submit staff change/termination forms in an expeditious and timely manner. This was reinforced by a payslip message sent to all employees informing them that the willful retention of and

failure to disclose an erroneous overpayment is likely to constitute a criminal offence of fraud by failing to disclose information. This staff message was also published on the ABUHB intranet.

The ABUHB LCFS also notifies their NWSSP counterpart of overpayments of salary, particularly when Payroll Services have failed to action notifications of staff changes/termination. The NWSSP LCFS reports these incidents to the DoF and Audit Committee of NWSSP with a view to improving operating systems and strengthening internal financial controls within Payroll Services.

In ABUHB, March 2018, saw the abolition of paper payslips.

Counter Fraud will strive to implement measures to electronically monitor staff payslips which go unopened or unviewed on ESR for a period of 3-months, which again, could be an indicator that the staff member no longer works for the organization yet is still being paid. It should then be a mere formality to check whether or not the individual still works for ABUHB.

4.27. The LCFS has incepted a proactive data mining exercise in relation to out of pocket expenses claimed by community pharmacies. Areas of concern have been identified within this realm. The average monthly claim for OOPE expenses would be reasonably be expected to be between £60.00 and £70.00 per pharmacy. The trend data highlighted a pharmacy within ABUHB which claimed circa £5,000 per month over 3-months. A connected pharmacy within Cardiff & Vale University Health Board featured likewise in relation to abnormal claiming.

A common feature prevails insomuch as the identified wholesaler/supplier behind the additional expenses is one and the same in both instances.

LCFS intervention was necessary at the Pharmacy as the claims amount to £44,958.61 since November 2017. This intervention has curtailed the claiming activity.

This matter remains subject of continuous monitoring and ongoing review for any indication of widespread malpractice.

4.28. The ABUHB LCFS has engaged with the Head of Engagement and Support for NWSSP on the aspect of monitoring and sharing of PPV audit data pertaining to claims by General Ophthalmic Service contractors

This has resulted in the LCFS attending all Wales PPV/LCFS meeting on 29th October 2018 chaired by the Head of Engagement and Support for NWSSP. These meeting have been reinforced by GOS trend data supplied to the LCFS which allows for proactive monitoring of claiming patterns and for any abnormal claiming activity on the part of a GOS contractor.

4.29. The LCFS frequently reports system weaknesses on the National Counter Fraud case management system 'FIRST' (Fraud Information Reporting System Toolkit) to allow for remedial national NHS system strengthening measures to be applied if considered necessary. This was the case in respect of investigations listed as **(1)(4)(5)(6)(8)(12)(15)** on **Appendix 2**.

4.30. As is every NHS Healthcare organisation, ABUHB remains under sustained attack from cyber fraud. This predominately relates to attempts of banking mandate fraud, contractor invoice fraud and attempts to illicit same day electronic money transfers.

All preventative measures and internal financial controls have defeated these attempts at fraud and remain effective. The fraudsters have become increasingly accomplished at cloning e-mail addresses of ABUHB personnel which are regularly utilized in their fraudulent efforts.

The LCFS has continued working in conjunction with NWIS who have applied system filters with a view to intercepting these cyber fraud attacks prior to them reaching their intended targets.

4.31. In order to maximise the deterrence of fraud, the LCFS has promoted successful Local and National cases to LHB staff and Contractors at every given opportunity.

4.32. A range of communication tools have been utilised to deter staff and contractors from committing fraud, including: fraud awareness presentations, newsletters, leaflets/posters, payslip messages and Counter Fraud web pages and ABUHB intranet site.

4.33. In relation to salary overpayments, a message to the workforce featured on the ABUHB intranet site advising of the criminal liability for prosecution under the Theft Act 1968 and Fraud Act 2006 of any person who knowingly retains a payment made to them in error. This message was supplemented as a payslip message.

4.34. During year 2018/19, the LCFS continued with the practice of naming individuals on the organizations website who have been successfully convicted of fraud at Court. The LCFS has also published depersonalized details of cases which resulted in staff being dismissed from the employment of ABUHB.

4.35. In total, **eighteen (18)** fraud cases (as news items) were published on the ABUHB intranet site by the LCFS.

4.36. The use of this deterrence method has been sustained by ABUHB and the LCFS as being legally permissible and proportionate under the circumstances and necessary to maximize the deterrence of fraud. This is in keeping with strategic framework of the National Assembly for Wales for tackling fraud, bribery & corruption in the NHS.

4.37. The LCFS has previously sought to exploit positive Counter Fraud reporting by utilizing media publicity in cases of fraud and corruption against the NHS to maximize deterrence against this type of conduct. This practice is ongoing.

4.38. The Counter Fraud Communication Strategy Policy developed for Aneurin Bevan University Health Board, outlines the communication methods that are utilized to promote fraud awareness.

4.39. The LCFS has continued to provide guidance to ABUHB Head of Communications that included the work of the NHS Counter Fraud Service (NHSCFA) Deterrence and Engagement Unit Media Team and the Advance Warning System adopted by that organisation. The DEU is able to support the LHB with media handling of cases that attract the attention of the press.

4.40. The Counter Fraud newsletters that were circulated during 2018/19 highlighted local and national cases of fraud against the NHS that have been successful in court. The newsletter also provided information on the correct way to report fraud and all the relevant contact details. The Newsletters sent out a clear deterrent message to readers that fraud in the NHS is unacceptable, indefensible and will not tolerated and that action will be taken against any known perpetrators.

4.41. The LCFS promotes the ABUHB Whistleblowing Policy in every instance at fraud awareness presentations and roadshows.

Feedback questionnaires are distributed at every presentation and the results of these questionnaires are retained and analysed by the LCFS. Any areas of perceived deficiency are addressed.

4.42. The proactive fraud detection exercise which was incepted by the LCFS in 2011 which centered on the audit of expenditure reports at ABUHB hospital Prescription Handling Directorates is still an ongoing rolling programme. This continuing audit of hospital prescription forms not only acts as a preventative measure but also acts as a deterrent because the LCFS publicizes the fact to prescribers that this scrutiny is taking place.

4.43. NHSCFA fraud prevention media titled 'Who pays for fraud in the NHS – we all do', features on the ABUHB intranet site. This media encompasses current NHSCFA fraud prevention leaflets.

4.44. In order to ensure the effectiveness and staff awareness of the Standards of Business Conduct for Employees Policy, the Board Secretary continues to pursue the submission of declaration of interest forms or a nil return, whichever applies.

In order to reinforce the obligation for staff to submit declarations of interest, the aspect is to be included on ESR as part of PADR in order to reach the largest audience of staff members.

5. Hold to Account

5.1. In order to prevent and detect fraud it is essential to assess potential 'gaps' in the systems of controls and carry out proactive reviews on areas of known risk.

5.2. The LCFS has highlighted that a proactive review programme helps to develop the cultural change necessary to allow the Counter Fraud Strategy to be effective.

5.3. The Audit Commission is responsible for running the National Fraud Initiative (NFI). This commenced in 1996 and runs every two years. The NFI is an exercise that matches electronic data both within and between public and private sector bodies to prevent and detect fraud. This includes the NHS, Police Authorities, Local Probation Boards, Fire and Rescue Authorities as well as Local Councils and number of private sector bodies. Since the NFI commenced, the initiative has helped to identify £1.69 billion of fraud, overpayment and error across UK public bodies. The NFI data collection operated in 2018. By the deadline date of October 2018, the LCFS facilitated the downloading of the Trade Creditors payment history and Trade Creditors standing data to the Wales Audit Office in compliance with the NFI mandate.

5.4. NHS Pension and Staff Payroll Data was also downloaded by the deadline date. This included the incorporation of fair processing notices in all staff payslips.

5.5. The data matches, were received by ABUHB in February 2019. The matches totaled 5,714 in number, of which, 5,223 related to trade creditors standing data. ABUHB has met the expectations of the Office of Auditor General as a participant in the NFI. These data matches now require investigation.

5.6. The LCFS has conducted the following proactive investigation exercises:

- Monitoring of GOS trend data pertaining to claims by GOS Contractors.
- Data mining for outliers and abnormal claiming patterns for out of pocket expenses claimed by Community Pharmacies.
- Rolling programme of monitoring the medication prescribed on Hospital Directorate medical prescription forms (Paragraph 4.42 above refers in greater detail).

5.7. The Counter Fraud team investigates all referrals of alleged fraud, bribery and/or corruption in accordance with Welsh Government Directions. The LCFS provides the DoF and the NHS Counter Fraud Service (Wales) with a concluding report on each investigation.

5.8. Investigations are anonymised in reports to the Audit Committee. Internal Audit and External Audit receive copies of the LCFS report to the Audit Committee and vice versa. Incorporated in **Appendix 2** are details of the LCFS counter fraud investigations conducted between 1st April 2018 and 31st of March 2019.

5.9. CFS Wales carry out high value complex investigations. If an investigation is linked with the area in which the LCFS operates they may be required to assist the CFS Wales by taking witness statements, assisting in the search of a premises or carrying out interview of witnesses and suspects.

5.10. The LCFS has liaised with the Information Governance Manager who is aware of the work of the LCFS. The LCFS checked the Data Protection Public Register online and established that the LHB was compliant with the data protection requirements.

5.11. The LCFS actively promotes working in partnership through collaboration and interaction with other agencies. A demonstration of this are cases listed as **(3)(31)** & **(33)** on **Appendix 2.**

5.12. Case **(3)** was in collaboration with the Police and information sharing occurred between both agencies. The LCFS provided a witness statement and documentary evidence to support a Police prosecution and conversely, the Police provided information and evidence to the LCFS to enable the LCFS to provide a further witness statement to HR for use in disciplinary proceedings. The LCFS gave evidence at this disciplinary hearing and is due to do likewise at the NMC fitness to practice hearing.

5.13. In total, the LCFS provided statements of evidence to HR to support the disciplinary process on five occasions in relation to investigations **(3)(5)(8)** & **(26)** on **Appendix 2**.

5.14. Additionally, on investigations **(2)(3)** & **(26)** on **Appendix 2** the LCFS provided evidential support the professional bodies and actually provided witness statements to the NMC, GMC & GPhC in these instances.

5.15. The LCFS is committed to pursuing every line of enquiry during an investigation and this includes employing every available investigative technique and resource. A further demonstration that the LCFS utilizes the full range of investigative resources, applies to investigation **(31)** on **Appendix 2.** This case demanded Equifax searches and financial analysis.

5.16. On four occasions previously, ABUHB has provided expenditure for handwriting forensic analysis, to progress LCFS investigations and this is yet further evidence that there is strong political and executive support for work

to counter fraud, bribery and corruption. It is apparent that the ABUHB organisation is committed to making financial investments in work to tackle fraud, bribery and corruption which is proportionate to identified risks.

5.17. During 2018/19 the ABUHB LCFS disseminated **eleven (11)** Data Protection requests to external bodies i.e. Police, DWP & UKBA, whereby information was sought by the LCFS to progress investigations.

Similarly, **three (3)** Data Protection requests were received by the LCFS from the Police & UKBA whereby information was sought by those external bodies. This resulted in the release of information by the LCFS and from probity and information governance best practice, the Head of Information Governance was party to the disclosure.

5.18. Liaison was effected with HMR&C on investigations **(22)** & **(24)** on **Appendix 2** and gateway authorities were utilized to obtain taxation records as part of these LCFS investigations.

5.19. Automated number plate recognition evidence (ANPR) was obtained from Heddlu Gwent Police in relation to investigation **(8)** on **Appendix 2**.

5.20. During 2018/19, the LCFS conducted **four (4)** interviews under caution with **four (4)** alleged offenders.

5.21. In the event that the LHB has a case of proven fraud, the next step will be to seek to apply an appropriate sanction. There are three different types of sanctions which can be followed parallel to each other. The sanctions are as follows:

- LHB Disciplinary Procedure: Applicable to NHS staff only. Contractors can be referred to the relevant professional body.
- Civil law Procedures: Applicable where the LHB needs to recover monies lost to fraud that cannot be sought through voluntary payments or the Criminal Courts.
- Criminal law Procedures: to apply an appropriate criminal penalty.

5.22. **Six (6)** investigations on **Appendix 2** have resulted in prosecution files of evidence being submitted to the Crown Prosecution Service during 2018/19 (Paragraph 1.9 above refers).

5.23. **Four (4)** of those cases **(5)(16)(24)(26)** on **Appendix 2** are transgressing through the criminal justice system. These cases are impending prosecutions.

5.24. **Ten (10)** cases **(1)(3)(4)(5)(6)(7)(10)(11)(16)(24)** on **Appendix 2** have resulted in disciplinary action. These generally pertain to dismissal for gross misconduct but include formal written warnings or where staff members have resigned prior to the conclusion of the disciplinary process.

5.25. **Four (4)** cases **(8)(26)(30) & (31)** on **Appendix 2 a**re ongoing disciplinary matters which include suspension from duty pending enquiry/investigation.

5.26. **Five (5)** cases **(3)(4)(17)(24)(26)** on **Appendix 2** have impending professional sanctions by the professional bodies the GPhC, NMC & GMC.

5.27. The LCFS has sought to maximize the deterrent value of criminal sanctions by publicizing them and exploiting media coverage of cases (Paragraph 4.37 above refers).

Two (2) cases **(1)(4)** on **Appendix 2** received extensive regional media reporting following convictions at Court. This media coverage amplified the deterrent message to any would-be NHS fraudsters.

5.28. It is important that sanctions are applied in a consistent manner according to the seriousness of the fraud, which is believed to be present. All sanctions are carried out in accordance with the NHS policy publication entitled 'Applying Appropriate Sanctions Consistently'. Full compliance is also made to Legal Directions and the NHS anti-fraud manual

5.29. The protocol between the Counter Fraud Specialist and Workforce & OD (referred to previously at paragraph 2.2 above) outlines the procedure that should be followed if a staff member is being investigated for fraud. The protocol ensures that both parties work together to ensure that any disciplinary action does not affect any criminal investigation. The implementation of the protocol by the LHB ensures consistency in working practices and will be supportive of the Counter Fraud provision and the LCFS. Consideration in this domain is also given to the NHSCFA policies on Parallel Criminal and Disciplinary Investigations.

5.30. In all cases, the LCFS, in agreement with the DoF, seeks to recover monies lost to the LHB as a result of fraud and corruption. Recoveries totalling **£42,622.06** were made against investigations listed as numbers **(1)(4)(5)(12)(13)(26)(28)** on **Appendix 2** of this report. The LCFS also seeks to maximise possible sanctions against the perpetrator. Effective recovery can benefit from other work performed by the LCFS to professionally investigate, to seek to apply sanctions and develop an anti-fraud culture.

5.31. The LCFS keeps a record of the outcome of all investigations including details of recoveries being sought. The LHB has procedures in place for recovering money lost to fraud and the recoveries policy is enforced and adhered to rigidly.

6. Counter Fraud Arrangements

6.1. CFS (Wales) the regional arm of NHSCFA, hold All-Wales bi-annual forums at which all LCFS's who work within the NHS in Wales are required to attend.

6.2. The meetings give the LCFS an opportunity to share best practice with other Counter Fraud Specialists and to receive training and updates on legislation relating to criminal investigations.

6.3. During 2018/19, such a meeting was held on 6th March 2019, in addition to which, an All-Wales lead LCFS meeting was held on 6th February 2019. The ABUHB Counter Fraud Team attended these meetings.

6.4. The Lead LCFS has regularly met/liaised with the DoF during 2018/19 to monitor the progress against the Counter Fraud workplan. The LCFS has regular interaction with the DoF relating to fraud investigations, to highlight potential fraud risks and to circulate fraud notices. These meetings are customarily scheduled on a monthly basis.

On behalf of ABUHB, the DoF is also the authority for prosecution. These meetings are scheduled at paragraph 2.15 of this report.

6.5. The Counter Fraud team consistently takes action to develop new skills for Counter Fraud, and where necessary attends the relevant training courses and workshops. NHSCFA provided training inputs at the all Wales forums referred to at paragraph 6.3 above. This training pertained to Quality Assurance.

6.6. Further to the above, the ABUHB LCFS attended accredited Fraud Management training on 3rd & 4th October 2018 and the National Fraud Conference at the QEII Centre, London, on 13th February 2019.

6.7. The Lead LCFS has ongoing liaison throughout the financial year with CFS (Wales) with regards to ongoing measures that the Counter Fraud Team has to adhere to. During 2018/19 the Counter Fraud Team has submitted quarterly statistics to CFS (Wales) which included Counter Fraud work and risks identified.

6.8. The Lead LCFS presented the Counter Fraud workplan for 2018/19 which was duly agreed by the DoF. The LCFS identified areas of greatest risk that needed addressing. The workplan is a dynamic document and is regularly updated to ensure that it is reflective of the LHB's needs.

6.9. By the submission deadline date of 30th April 2019, ABUHB Counter Fraud will submit a standards self-assessment review to NHSCFS, Quality Assurance. This review is based on the Standards for NHS Bodies (Wales) and will reflect the ABUHB Counter Fraud provision for 2018/19. The NHSCFA Quality Assurance Team scrutinise the counter fraud provision and assess for embedded counter fraud arrangements and evidence of qualitative outcomes. The resulting report will be presented to Audit Committee for its recommendations to be implemented accordingly.

6.10. Counter Fraud work is a standing item on the Aneurin Bevan University Health Board's Audit Committee meeting agenda. During 2018/19, the LHB Lead LCFS was required to attend and report at **two (2)** such Audit Committee meetings for the LHB i.e. 19th April 2018 & 17th January 2019.

6.11. During 2018/19 the LCFS referred one case to Counter Fraud Service (Wales) for investigation relating to a primary care ophthalmic contractor for potential GOS fraud.

Appendix 1

1. Reporting lines

Chief Executive	Mrs. Judith PAGET Aneurin Bevan University Health Board H.Q. St Cadocs Hospital Lodge Road Caerleon Newport NP18 3XQ Email: Judith.paget@wales.nhs.uk
Director of Finance	Mr Glyn JONES Aneurin Bevan University Health Board H.Q. St Cadocs Hospital Lodge Road Caerleon Newport NP18 3XQ Email: Glyn.Jones7@wales.nhs.uk
Head of Counter Fraud	Martyn EDWARDS Counter Fraud Aneurin Bevan University Health Board 2nd Floor, Block C, Mamhilad House Mamhilad Park Estate Pontypool NP4 0YP Email: Martyn.edwards3@wales.nhs.uk
Local Counter Fraud Specialist	Jeffrey HOWELLS Counter Fraud Aneurin Bevan University Health Board 2nd Floor, Block C, Mamhilad House Mamhilad Park Estate Pontypool NP4 0YP Email: Jeff.howells@wales.nhs.uk
Local Counter Fraud Specialist	Joanne BODENHAM Counter Fraud Aneurin Bevan University Health Board 2nd Floor, Block C, Mamhilad House Mamhilad Park Estate Pontypool NP4 0YP Email: Joanne.bodenham@wales.nhs.uk

2. Further Information\Mix of cases

Number of cases as at 31st of March 2019, including those brought forward from previous year:

Area (based on Initial reported category)	Number of Cases	Closed	Ongoing
Contractor – Pharmacy (Falsify dispensing charges)	2	0	2
Contractor – Pharmacy (Misuse of controlled drugs)	1	0	1
Contractor – GP Staff (Fraudulent prescribing)	3	1	2
Patient – (False compensation claim)	1	0	1
Member of Public - (Falsify NHS documents)	1	0	1
Staff – Doctors (Private work in NHS time)	2	0	2
Staff – Doctor (Working whilst on sick-leave)	1	0	1
Staff – Senior Manager (falsify CV to obtain post)	1	0	1
Staff – (Computer misuse)	4	2	2
Staff - (Working on sick leave)	4	0	4
Staff – (Dishonest retention of salary overpayments)	2	0	2
Staff - (Falsified expenses/timesheets)	9	1	8
Staff – (Falsification of medical records)	1	0	1
Staff – (Theft/fraud)	1	0	1
Staff – (Failing to complete contracted hours)	1	1	0
Staff – (Falsify WLI payments)	1	0	1
Staff – (Failing to disclose previous convictions)	2	1	1
Totals	**37**	**6**	**31**

3. NHS Counter Fraud Authority Website

Information about NHS Counter fraud Authority and the NHS Counter Fraud Strategy can be found at https://cfa.nhs.uk/

Appendix 2

INDEX OF LCFS INVESTIGATIONS AS AT 31st March 2019					
Case	**FIRST Ref**	**Health Body**	**Area**	**Subject**	**Status**
1.	WARO/15/00062	ABUHB	GP Practice Staff	Fraudulent prescribing.	Two defendants pleaded guilty at Newport Crown Court on 17/04/2018. They received a 12 hour Community Order to undertake 140 hours if unpaid work. They were ordered to pay £4,600.55 compensation and LCFS investigation costs. Both dismissed from employment Case closed 09/08/2018.
2.	WARO/15/00112	ABUHB	Community Pharmacist	Falsely claiming dispensing fees.	NFA on criminal aspect. Case referred to GPhC for professional sanction. Fitness to practise hearing held by GPhC on 26/10/2018. Outcome decision was registrant's fitness to practice was not impaired.
3.	WARO/16/00007	ABUHB	NHS Staff	Create false clinical history for family member to support fraudulent motor insurance personal injury claim.	Defendant convicted of fraud at Cardiff Crown Court on 29/01/16. Sentenced to 9-months imprisonment suspended for 2-years and 230 hours community order within 12-months. Dismissed from employment for gross misconduct following disciplinary hearing on 16/08/16. NMC action 12-months suspension from nursing register. Defendant appeared in Court again on 08/01/18 on fresh charges. She was found guilty by jury and sentenced to 12-months imprisonment. Further NMC referral made by LCFS. NMC fitness to practise hearing scheduled for 18/04/2019.
4.	WARO/16/00043	ABUHB	NHS Staff	Timesheet fraud.	Employee dismissed from employment with ABUHB for gross misconduct following disciplinary hearing on 10/05/17. Defendant was found guilty on 13/08/2018 at Cardiff

INDEX OF LCFS INVESTIGATIONS AS AT 31st March 2019					
Case	**FIRST Ref**	**Health Body**	**Area**	**Subject**	**Status**
					Crown Court and sentenced to 12-months imprisonment suspended for 12 months, placed on an 8pm-6am curfew for 20 weeks and forced to wear an electronic tagging device. Defendant paid £10,402.92 before her hearing and was ordered to pay a further £2,560.42 LCFS investigation costs within 15 days of hearing. NMC action ongoing.
5.	WARO/17/00053	ABUHB	NHS Staff	Falsify WLI claims.	Impending prosecution. Case progressing through criminal justice system. Employee dismissed from employment with ABUHB for gross misconduct following disciplinary hearing on 19/01/2019. Recovery of £828.41 made.
6.	WARO/17/00103	ABUHB	NHS Staff	Senior Manager falsify CV and salary claims.	Investigation ongoing. Subject resigned from ABUHB before disciplinary outcome.
7.	WARO/17/00125	ABUHB	NHS Staff	Computer misuse.	NFA on criminal aspect. Subject issued with a formal written warning as disciplinary sanction on 29/10/2018.
8.	WARO/17/00141	ABUHB	NHS Staff	Timesheet fraud.	NFA on criminal aspect. Disciplinary action ongoing.
9.	WARO/17/00159	ABUHB	NHS Staff	Fail to complete contracted hours.	NFA on criminal aspect. No disciplinary issue identified. Case closed 25/06/2018.
10	WARO/17/00163	ABUHB	NHS Staff	Computer Misuse.	NFA on criminal aspect. Written warning disciplinary sanction. Case closed 25/06/2018.
11	WARO/17/00164	ABUHB	NHS Staff	Computer Misuse.	NFA on criminal aspect. Written warning disciplinary sanction. Case closed 25/06/2018.
12	WARO/18/00013	ABUHB	NHS Staff	Dishonest retention of salary overpayment.	Insufficient evidence to incept criminal prosecution. Recovery of £12,600 made from civil recovery. Case closed 27/09/2018.
13	WARO/18/00028	ABUHB	NHS Staff	Timesheet fraud.	Subject was issued with a police caution as a criminal sanction on 16/08/2018 and a recovery of £532.35

INDEX OF LCFS INVESTIGATIONS AS AT 31st March 2019					
Case	**FIRST Ref**	**Health Body**	**Area**	**Subject**	**Status**
					was made. Case closed 20/08/2018. Defendant has been excluded from working future bank shifts with ABUHB.
14	WARO/18/00029	ABUHB	NHS Staff	Working whilst on sick leave.	Investigation ongoing.
15	WARO/18/00038	ABUHB	Student Nurse	Timesheet fraud and falsification of professional portfolio.	Investigation ongoing.
16	WARO/18/00040	ABUHB	GP Practice Staff	Fraudulent prescribing.	Impending prosecution. Case progressing through criminal justice system. Employee dismissed from employment for gross misconduct.
17	WARO/18/00048	ABUHB	Community Pharmacist	Falsely claiming pharmacy fees.	Investigation ongoing.
18	WARO/18/00064	ABUHB	NHS Staff	Fraud by abuse of position – alleged subject is not charging family members for food from canteen.	Investigation ongoing.
19	WARO/18/00067	ABUHB	NHS Staff	Timesheet fraud.	Investigation ongoing.
20	WARO/18/00069	ABUHB	NHS Patient	Compensation claim as a consequence of hospital procedure.	Investigation ongoing.
21	WARO/18/00073	ABUHB	NHS Staff	Failure to complete contracted hospital sessions.	Investigation ongoing.
22	WARO/18/00084	ABUHB	NHS Staff	Failure to complete contracted hospital sessions.	Investigation ongoing.
23	WARO/18/00102	ABUHB	NHS Staff	Fraudulently claiming mileage expenses.	NFA criminal aspect. No disciplinary issue identified. Case closed 28/12/2018.
24	WARO/18/00106	ABUHB	NHS Staff	Working elsewhere whilst on sick leave and falsification of NMC revalidation paperwork.	Impending prosecution, case progressing through criminal justice system. Subject resigned from employment with ABUHB prior to disciplinary outcome.
25	WARO/18/00119	ABUHB	NHS Staff	Failing to disclose previous convictions.	NFA on criminal aspect. No disciplinary issue identified. Case closed 27/09/2018.

INDEX OF LCFS INVESTIGATIONS AS AT 31st March 2019					
Case	**FIRST Ref**	**Health Body**	**Area**	**Subject**	**Status**
26	WARO/18/00122	ABUHB	NHS Staff	Working elsewhere whilst on sick leave.	Recovery of £3,996.43 from civil recovery. Impending prosecution, case progressing through criminal justice system. Disciplinary and professional action has also been implemented by ABUHB and GMC.
27	WARO/18/00130	ABUHB	NHS Staff	Working elsewhere whilst on sick leave.	Investigation ongoing.
28	WARO/18/00133	ABUHB	NHS Staff	Dishonest retention of salary overpayment.	Recovery of £7,100.98 from civil recovery. NFA on criminal aspect. No disciplinary issue identified.
29	WARO/18/00136	ABUHB	NHS Staff	Timesheet fraud.	Investigation ongoing.
30	WARO/18/00154	ABUHB	GP Practice Staff	Fraudulent prescribing.	Investigation ongoing.
31	WARO/18/00161	ABUHB	NHS Staff	Computer misuse.	Defendant pleaded guilty at court on 4th February 2019. Sentenced to 6-months imprisonment suspended for 12-months. Undertake 200hrs community work. Disciplinary process ongoing.
32	WARO/18/00162	ABUHB	NHS Patient	Compensation claim as a consequence of hospital procedure.	Investigation ongoing.
33	WARO/18/00169	ABUHB	Member of public	Falsification of medical history using ABUHB letter headed paper to misappropriate charity funds.	Investigation ongoing.
34	WARO/18/00173	ABUHB	NHS Staff	Falsification of expense claims.	Investigation ongoing.
35	WARO/19/00022	ABUHB	Community pharmacy	Misuse of controlled drugs.	Investigation ongoing.
36	WARO/19/00023	ABUHB	NHS Staff	Theft and misrepresentation in pre-employment disclosure.	Investigation ongoing.

INDEX OF LCFS INVESTIGATIONS AS AT 31st March 2019					
Case	**FIRST Ref**	**Health Body**	**Area**	**Subject**	**Status**
37	WARO/19/00024	ABUHB	NHS Staff	Working elsewhere whilst on sick leave.	Investigation ongoing.

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Audit Committee 3rd April 2019 Agenda Item: 3.2

3.2

Aneurin Bevan University Health Board
Annual Counter Fraud Workplan - 1st April 2019 to 31st March 2020

Executive Summary			
An executive overview has been prepared for the Aneurin Bevan University Health Board (ABUHB) Audit Committee. It highlights the Counter Fraud work which is proposed to be undertaken by the Local Counter Fraud Specialist (LCFS) for 2019/20.			
The Audit Committee is asked to: (please tick as appropriate)			
Approve the Report			
Discuss and Provide Views	√		
Receive the Report for Assurance/Compliance			
Note the Report for Information Only	√		
Executive Sponsor: Glyn Jones – Director of Finance			
Report Author: Martyn Edwards – Head of Counter Fraud			
Report Received consideration and supported by : Director of Finance			
Executive Team		**Committee of the Board [Committee Name]**	**Audit Committee**
Date of the Report: 15th March 2019			
Supplementary Papers Attached: Counter Fraud, Bribery and Corruption Work Plan 2019/20			

Purpose of the Report
The Workplan requires to be approved by the DoF and ratified by Audit Committee.

Background and Context
This document has been prepared by the Aneurin Bevan University Health Board Counter Fraud Team in order to comply with legal directions and the recommendations of the NHS Counter Fraud Authority Standards for NHS Bodies (Wales).

Assessment and Conclusion
This report will contribute towards the Quality Assurance Self-Review as evidence that the LHB has complied with the Standards for NHS Bodies (Wales). The report content and style complies with the model prescribed by the NHS Counter Fraud Authority (NHSCFA) for Quality Assurance Assessment.

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

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

COUNTER FRAUD, BRIBERY & CORRUPTION WORK-PLAN 1st APRIL 2019 to 31st MARCH 2020

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

WORKPLAN 2019-2020

1 Background

1.1 This Work-Plan provides a basis to formulate Local Counter Fraud arrangements for Aneurin Bevan University Health Board. The tasks outlined should be considered and reviewed on an annual basis. This guidance recommends the resources necessary to undertake work effectively across the areas of action outlined in NHS Counter Fraud Policy and Procedures. These recommendations are based on Standards for NHS bodies (Wales) 2019/20, which includes Quality Assurance Assessment.

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

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

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

1.5 **NHS Counter Fraud Authority Strategy**

NHS Counter Fraud Authority has published its 'Strategy for NHS Organisations' which includes 4 Key Sections of work:

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

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

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

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

1.6 NHS Counter Fraud Authority (NHSCFA) has also published its 'Standards for Providers for Fraud, Bribery and Corruption', to enable the quality of Local Counter Fraud provisions to be assessed effectively. The Health Board's 2018-19 Work-Plan for Local Counter Fraud work will therefore closely mirror the NHSCFA Standards and Providers Guidance, which in turn supports the objectives set by the Welsh Government.

1.7 The total number of suggested **Pro-Active days** to be allocated in 2019-20 is **312** (out of a total of resource of 535 workdays) this *excludes* the resource required for undertaking 'Reactive' Local Counter Fraud work (Hold to Account). This reactive resource is required to conduct detailed investigations into allegations received by the Health Board in relation to NHS Fraud, Bribery and Corruption. The total number of **Reactive days** to be allocated in the 2019-20 Work-Plan is **223** (inc proactive investigations).

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

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

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

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

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

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

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

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

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

2.5 The LCFS should have effective liaison with the Local Risk Manager and Risk Group. It is recommended that frauds that have occurred within the organisation and beyond be brought before this group to ascertain the risk to the Health Board from the same type of fraud. Once identified, the fraud can be proactively addressed.

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

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

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

3 Focusing on outcomes and not merely activity

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

Risk Assessment of Counter Fraud Arrangements

Approach

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

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

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

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

1.5 The overall risk assessment of organisational Counter Fraud Arrangements on 31st March 2019 was rated **Green** (Score- 98.04%) in all areas.

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

Suggested Response to Summary Outcomes

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

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

Summary of risk assessment outcome

1.7 The summary assessment by the ABUHB Counter Fraud Team of each Key Section at 31st March 2019 is shown in the table below:-

Key Section	Strategic Governance	Inform & Involve	Prevent & Deter	Hold to Account	Overall 'Green' risk assessment rating of Counter Fraud Arrangements (100%)
Overall risk assessment rating by generic area	**Green**	**Green**	**Green**	**Green**	**Total score across all Key Sections**
Number of red ratings by key sections	**0**	**0**	**0**	**0**	**0**
Number of amber ratings by key sections	**1**	**0**	**0**	**0**	**1**
Number of green ratings by key sections	**19**	**6**	**12**	**13**	**50**
TOTALS	**20**	**6**	**12**	**13**	**51 (98.04%)**

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

- Declaration of Interest Protocol/Form
- Standing Financial Instructions
- Counter Fraud, Bribery & Corruption Policy
- Disciplinary Policy
- Staff Code of Conduct Policy
- Whistle Blowing Policy
- Counter Fraud Communication Strategy
- Counter Fraud and HR Protocol
- Counter Fraud Standard Operating Procedure
- Counter Fraud Protocol with Internal Audit

STRATEGIC GOVERNANCE					
	Standard	**Task**	**Response**	**Expected Outcome/date**	**Planned Resource**
1.1	**A member of the executive board or equivalent body is accountable for provision of strategic management of all counter fraud, bribery and corruption work within the organisation. The accountable board member is responsible for the provision of assurance to the executive board in relation to the quality and effectiveness of all counter fraud, bribery and corruption work undertaken.**	LCFS to hold regular scheduled meetings with DoF, objectives to be reviewed and work to date evaluated. During these meetings target audiences will be identified for presentations in line with promoting counter fraud work within the organisation. The DoF to act as the link between the Audit Committee and Risk Management Group to allow key risks to be identified, managed and mitigated. The LCFS to produce the ABUHB Counter Fraud Annual Report & Workplan which is to be agreed with the DoF and ratified by the Audit Committee.	DOF in post clear reporting lines established		2 18
1.2	**The organisation's non-executive directors or lay members and board/governing level senior management are accountable for gaining assurance that sufficient control and management mechanisms in relation to counter fraud, bribery and corruption are present within the organisation. Board level evaluation of the effectiveness of counter fraud, bribery and corruption work undertaken should be documented. Where recommendations have been made by NHSCFA following an assessment, it is the responsibility of the accountable board member to**	The LCFS will hold regular one to one meetings with the Audit Committee Chairperson. In addition to this LCFS to attend pre-audit committee meetings with non-executive Audit Committee and Board Members Preparation and attendance at audit committee meetings. (including progress reports). Counter Fraud is a standing agenda item at Audit Committee. The LCFS to provide written and oral reports to this forum. The LCFS to facilitate the organisation's ongoing commitment to continue to fund promotional 'giveaway' material promoting the counter fraud			8 6 2

STRATEGIC GOVERNANCE					
	Standard	**Task**	**Response**	**Expected Outcome/date**	**Planned Resource**
	provide assurance to the board surrounding the progress of their implementation.	department to both internal and external customers. The LCFS to undertake staff surveys to evaluate the level of staff awareness of fraud, bribery and corruption across the health board, to include primary care contractors as well as staff employed directly by the health board. As a result of evaluation implement corrective/preventative measures to ensure counter fraud, bribery and corruption work continues to address organisational risks.			12
1.3	**The organisation employs one or more accredited nominated LCFSs to undertake the full range of counter fraud, bribery and corruption work, including proactive work to prevent and deter fraud, bribery and corruption and reactive work to hold those who commit fraud, bribery and corruption to account.**	ABUHB Counter Fraud Team consists of 3 team members (equates to 2.65 WTE), all are fully accredited LCFS personnel. The LCFS will undertake the full range of duties associated with the role on behalf of the organisation. All investigations will comply with all relevant legislation. All staff will continue to develop professionally, attending appropriate training sessions provided by NHSCFA to enhance their knowledge and skills as well as attending regional forums hosted by NHSCFA and NHS CFS Wales. LCFS will undertake continuing professional development opportunities associated with role. All training and development to be recorded on ESR and referenced during annual staff appraisals.			10 2

STRATEGIC GOVERNANCE					
	Standard	**Task**	**Response**	**Expected Outcome/date**	**Planned Resource**
1.4	**The organisation has carried out comprehensive risk assessment activity to identify fraud, bribery and corruption risks, and has counter fraud, bribery and corruption provision that is proportionate to the level of risk identified. Risks are recorded and managed in line with the organisation's risk management policy and are included on the appropriate risk registers. Measures to mitigate identified risks are included in an organisational work plan, progress is monitored at a senior level within the organisation and results are fed back to the audit committee.**	Undertake risk assessment of existing arrangements on a rolling programme, in all domains of the organisation, using appropriate risk assessment procedures to identify fraud, bribery and corruption risks, findings to be reported to the Audit Committee to be actioned accordingly. The Audit Committee and DoF to monitor progress to mitigate risks and ensure resources remain suitable for this purpose. LCFS to manage existing arrangements with NWSSP and local Accounts Payable to prevent mandate fraud.			5 2
1.5	**The organisation reports annually on how it has met the standards set by NHSCFA and NHS CFS Wales in relation to counter fraud, bribery and corruption work, and details corrective action where standards have not been met.**	LCFS to provide interim reports to Audit Committee at each meeting attended. These reports to include the outcomes of actions against minutes from previous meetings. Preparation for and attendance at audit committee meetings. (including progress reports) LCFS to compile the annual report at the end of the financial year for presentation at the Audit Committee alongside the counter fraud workplan for the coming year. These are to be agreed with the Director of Finance. LCFS to complete the NHSCFA Standards Self Review Tool and present to audit committee.			3 4 2

STRATEGIC GOVERNANCE					
	Standard	**Task**	**Response**	**Expected Outcome/date**	**Planned Resource**
1.6	**The organisation ensures that those carrying out counter fraud, bribery and corruption work have all the necessary tools and resources to enable them to carry out their role efficiently, effectively and promptly. This includes (but is not limited to) access to IT systems and access to secure storage.**	The LCFS maintains the appropriate standards of confidentiality and security as well as having access to the tools and resources necessary to professionally carry out their role and comply with legal requirements. LCFS to continue to have access to secure office accommodation accessible only by them. Secure storage facilities both in the office and on site to be utilised effectively for the necessary retention and storage of evidential data in line with legal requirements. Secure access to relevant IT systems is maintained including NHS Wales email addresses. Continue to maintain and supply data and statistical information to NHS CFS Wales on a quarterly basis using the designated templates supplied. Also provide ad hoc data as and when requested. Implement fraud, bribery and corruption prevention guidance as and when provided by NHS CFS Wales.			6 6 3
1.7	**The organisation ensures that there are effective lines of communication between those responsible for counter fraud, bribery and corruption work and other key staff groups and mangers within the organisation, including (but not limited to) audit, risk, finance, communications and human resources. There is evidence of positive outcomes as a result of this liaison.**	Liaison with person responsible for HB security arrangements keeping each other informed of local concerns and issues. Maintain unrestricted access to key staff groups e.g. Audit Committee, chairperson and non-executive members.			2 5

STRATEGIC GOVERNANCE					
	Standard	**Task**	**Response**	**Expected Outcome/date**	**Planned Resource**
		Continue to interact with key managers and stakeholder groups such as NWSSP payroll services, corporate finance, information governance, internal audit and HR exchanging relevant information and providing necessary support and guidance.			4
		LCFS to maintain and update existing policies and protocols with key stakeholder groups such as payroll services, PPV, HR, Corporate Finance, Internal Audit and Contractor Services.			2
		Where fraud, bribery or corruption has been identified, the LCFS will consider the full range of available sanctions – criminal, civil, disciplinary and/or regulatory in line with “Parallel Criminal and Disciplinary Investigations Policy guidelines.			2
		When requested LCFS to assist with joint operations involving internal and external departments and organisations (HR, internal audit, police forces, DWP, UKBA, HMRC).			3

INFORM & INVOLVE					
	Standard	**Task**	**Response**	**Expected Outcome/date**	**Planned Resource**
2.1	**The organisation has an ongoing programme of work to raise awareness of fraud, bribery and corruption. This should cover NHSCFA's Fraud and Corruption Reporting Line and online fraud reporting tool, and the role of the accredited counter fraud specialist. Content may be delivered through presentations, newsletters, leaflets, posters, intranet pages, induction materials for new staff, emails and other media, making use of NHSCFA's fraud awareness toolkit as appropriate. The effectiveness of the awareness programme is measured.**	Review local fraud material generated to promote the counter fraud work being undertaken by the LCFS within HB. Ensure it remains fit for purpose where necessary remove/update information accordingly. Ensure that literature developed by ABUHB contains details of the NHSCFA's Fraud and Corruption Reporting Line and online fraud reporting tool. Where appropriate utilise electronic and written information/ newspaper articles from other HBs to demonstrate the commitment to countering fraud across the Welsh Region. Include details of prosecutions etc. in both staff and contractor newsletters. The LCFS to attend all HB corporate induction training events to provide an input to new staff on the role of the Counter Fraud Department. Material to be regularly reviewed and updated to reflect any changes in legislation, policy or working practices. Evaluate feedback from all presentations, collate results, and where appropriate amend presentations as a result of feedback. Write up a report on the outcomes for the Director of Finance.			5 3 6

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

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

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

INFORM & INVOLVE					
	Standard	**Task**	**Response**	**Expected Outcome/date**	**Planned Resource**
		Undertake Local Fraud Awareness events and other initiatives across the HB. Provide a rolling program of displaying counter fraud material on a site by site basis. Promote contact details and visits by counter fraud enabling staff to discuss any concerns or issues relating to counter fraud.			65
2.2	**The organisation has a counter fraud, bribery and corruption policy that follows NHSCFA's strategic guidance, publicises the NHSCFA's Fraud and Corruption Reporting Line and online reporting tool, and has been approved by the executive body or senior management team. The policy is reviewed, evaluated and updated as required, and levels of staff awareness are measured**	Establish/review existing counter fraud bribery and corruption policy, update and amend as appropriate. **Refer to Counter Fraud, Bribery and Corruption Policy for further guidance.** LCFS to ensure effective links between the **Counter Fraud, Bribery and Corruption Policy** including 'online fraud reporting tool' and counter fraud work. Policy/reporting tool to be published on HB intranet site. Utilise staff surveys to evaluate if staff are aware of the policy and how and where to locate it. Also establish that they are aware of the correct procedures associated with reporting fraud, bribery and corruption.			1 1 1
2.3	**The organisation liaises proactively with other organisations and agencies (including local police, local authorities, regulatory and professional bodies) to assist in countering fraud, bribery and corruption.**	Work closely with the Regional and the Pharmaceutical Fraud Teams in respect of Patient GP registration fraud, and communicate ***'best practice'*** and situation updates to GP surgeries including guidance to minimise the impact of GP multiple registration fraud.			2

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

INFORM & INVOLVE					
	Standard	**Task**	**Response**	**Expected Outcome/date**	**Planned Resource**
2.4	**The organisation has a fully implemented code of conduct that includes reference to fraud, bribery and corruption and the requirements of the Bribery Act 2010. The effectiveness of the implementation of the process and staff awareness of the requirements of the code of conduct is regularly tested.**	The LCFS to actively promote to staff the organisations policy on 'Standards of Business Conduct for Employees'. A link to The Bribery Act 2010 to remain as a permanent feature on the HB intranet site's home page.			2
PREVENT AND DETER					
	Standard	**Task**	**Response**	**Expected Outcome/date**	**Planned Resource**
3.1	**The organisation reviews new and existing relevant policies and procedures, using audit reports, closure reports and guidance from NHSCFA and NHS CFS Wales, to ensure that appropriate counter fraud, bribery and corruption measures are included. This includes (but is not limited to) policies and procedures in human resources, standing orders, standing financial instructions and other finance and operational policies. The organisation evaluates the success of the measures in reducing fraud, bribery and corruption, where risks have been identified.**	The LCFS will ensure that the whistle blowing, disciplinary, standards of business conduct, declaration of interests, gifts and hospitality policies and other relevant HR policies are adequately robust to counter the risk of fraud, bribery and corruption. The LCFS will review existing and new local policies ensuring that they are fraud proofed and fit for purpose. Maintain records of these reviews for reporting purposes.			2 12

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

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

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

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

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

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

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

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

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

Appendix 1

Number of Days agreed for 2019/20	***535 Days***
Agreed/signed by	
Signature:	**Date:**
Signature:	**Date**

Appendix 2

Summary of changes to Standards for NHS Bodies 2019-2020 (Wales)

Standard	Amendment
General	When referring in the future to our system for managing fraud cases, we will simply refer to it as 'the case management system'. This primarily affects standards 4.1 and 4.2
1.1	Minor changes to headline standard.
1.2	Minor changes to headline standard and rationale.
1.4	Addition of word 'comprehensive' to standard, which changes emphasis on 'risk assessments' associated with counter fraud, bribery and corruption.
2.3	Minor changes to headline standard and rationale.
4.1	Minor changes to headline standard. System weaknesses to be recorded during the course of investigations rather than as a result of investigations.

Aneurin Bevan University Health Board

Post Payment Verification Progress Report

For the period: 1st April 2018 to 31st March 2019

Aneurin Bevan University Health Board

Issued: March 2019
Prepared by: Mrs Sara Jeremiah (PPV Location Manager)

This document has been prepared for the internal use of Aneurin Bevan University Health Board.
For any queries or further information relating to this report, please contact Mr Scott Lavender. E-mail: scott.lavender@wales.nhs.uk

1. Introduction

This report has been prepared for the Director of Finance of Aneurin Bevan University Health Board. The aim of this report is to summarise the work undertaken by the Post Payment Verification (PPV) department in accordance to the Welsh Assembly Government (WG) directions in respect of General Medical Services (GMS), General Ophthalmic Services (GOS) and General Pharmaceutical Services (GPS).

The purpose of a PPV visit to GMS contractors is to ensure that claims submitted by contractors in respect of GMS Enhanced Services are correct and in accordance with the Statement of Financial Entitlement (SFE) and service specifications set by WG and LHBs.

The purpose of a PPV visit to GOS contractors is to ensure that claims submitted by contractors in respect of GOS are correct and in accordance with the relevant NHS General Ophthalmic Services regulations and any specific LHB procedure.

The purpose of a PPV visit to GPS contractors is to ensure that claims submitted by contractors in respect of GPS are correct and in accordance with the relevant NHS General Pharmaceutical Services regulations and any specific LHB, CPW or WG procedures.

The aim of the PPV process is to ensure propriety of payments of public monies by the LHBs. The probity checks conducted during a PPV visit will provide reasonable assurance to LHBs that public money has been spent appropriately by contractors making accurate claim submissions, contractors internal protocols are clinically sound and services are being claimed for in accordance to clinical specifications.

2. Post Payment Verification process

The PPV department carry out routine visits to all General Practitioner contractors on a three year cycle. During a GMS visit, the PPV department will analyse a sample of 20 claims or 10% of the total number of claims submitted during the year prior to the visit (whichever is the greater) for each enhanced service commissioned to the Practice.

The PPV department carry out routine visits to ophthalmic contractors based on the average number of GOS3 forms submitted during the year. The following table is used in determining the GOS visit schedule in a three year cycle:

Average monthly GOS3 submissions	Number of visits within a three year cycle
Up to 200	1
201 – 400	2
401 – 600	3

During a GOS visit, the PPV department will analyse a sample of 100 claims consisting of GOS1 (Sight tests), GOS3 (Vouchers), GOS4 (Repairs and replacement) and EHEW claims.

The purpose of a GPS PPV audit is to ensure that claims submitted by Pharmacy contractors in respect of GPS are correct and in accordance with the relevant NHS General Pharmaceutical Services regulations and any specific specification set by WG, HB's and CPW.

Following a visit, an initial report is sent to the General Practitioner/ Ophthalmic contractor summarising the observations and findings of the visit and request further information from the contractor to queries that arise from the visit. The contractor is given 28 days to reply to the queries. If no response is received by the contractor, it will be assumed that they are satisfied with the report findings. If the contractor provides feedback, the PPV department will consider this information and assess if it clarifies the queries.

Taking the above into account, the report is finalised with recommended recoveries (If appropriate) and sent to the UHB Finance and Primary Care lead for approval.

If the report is approved, the PPV team will instruct the Payments department within NWSSP Primary Care Services to make the recovery against the contractor.

Where the PPV team identify a high number of claim errors for a particular service (10% for GMS, GOS & GPS), a recommendation will be made to the UHB that a more substantive review of the service needs to be carried out. If this is the case, the PPV team will carry out a revisit to the contractor within one year of the routine visit. During this visit all claims submitted by the contractor for the identified services only will be analysed for the period between the last visit and the routine visit date, usually three years.

In addition to carrying out visits, the PPV team continually monitor claims submitted by GMS, GOS and GPS contractors to assist in the identification of trends and outliers. This information is used to assist in the preparation of visit samples and also to alert the UHB and Local Counter Fraud Specialist if suspicious claiming patterns emerge.

The PPV team are also available to provide advice, support and guidance to contractors and UHBs when required.

3. Summary of findings and observations

General Medical Services

Planned visits for UHB	Completed visits	Visits on-going	Total visits carried out	Variance
47	26	21	47	0

During the period 1st April 2018 to 31st March 2019, the PPV team has visited 47 GMS contractors as per the visit plan agreed with Aneurin Bevan UHB. The PPV team have recovered £10,552.94 from completed visits to GMS contractors in the Aneurin Bevan UHB area due to errors identified in contractor's enhanced service claims. Recoveries are also to be made from on-going visits. These recoveries have not been included in the above total as they have not been authorised by the UHB. A summary of the GMS visits can be found in appendix one of this report.

The overall claim error rate for the locality was 2.18% from all claims sampled. A graphical representation of the claim error rates following GMS visits can be found in appendix two of this report.

As has been previously reported, the PPV team are still identifying GMS errors in relation to Near Patient Testing, Anti-coagulation Monitoring and Minor Surgery.

General Ophthalmic Services

Planned visits for UHB	Completed visits	Visits on-going	Total visits carried out	Variance
27	22	5	27	0

During the period 1st April 2018 to 31st March 2019, the PPV team have visited 27 GOS contractors as per the visit plan agreed with Aneurin Bevan UHB. The PPV team have recovered £6,449.95 from completed visits to GOS contractors in the Aneurin Bevan UHB area due to errors identified in contractors' GOS claims. A summary of the GOS visits can be found in appendix three of this report.

The overall claim error rate for the locality was 4.66% from all claims sampled. A graphical representation of the claim error rates following GOS visits can be found in appendix four of this report.

The majority of claim errors identified so far this financial year are consistent with previous year's findings and relate to EHEW's.

General Pharmaceutical Services

Planned visits for UHB	Completed visits	Visits on-going	Total visits carried out	Variance
43	34	9	43	0

During the period 1st April 2018 to 31st March 2019, the PPV team has visited 43 GPS contractors as per the visit plan agreed with Aneurin Bevan UHB. The PPV team have recovered £2,050.04 from completed visits to GPS contractors in the Aneurin Bevan UHB area due to errors identified in contractor's Medical Review Use claims. A summary of the GPS visits can be found in **Appendix 5** of this report.

The overall claim error rate for the Health Board was 2.43% from all claims sampled.

A summary of the PPV teams findings from visits by service can be found in **Appendix 5** of this report with a graphical representation of the error rates by service can be found in **Appendix 6**

The majority of claim errors identified so far this financial year are in relation to Medical Use Review's.

4. Conclusions and recommendations

The PPV team have been working collaboratively with the Primary Care team and governing bodies to ensure that contractors can engage with the process effectively and we are working together with contractors to build healthy relationships whilst also offering our advice and help where necessary or requested. The PPV team have been working hard to get the remote access project off the ground effectively with regard to GMS visits. We currently have a project in place that is being organised for the PPV team to undertake a presentation to GOS practice staff to help them with understanding the process. There are common themes for errors in the services that the PPV team are assisting practices to understand the rationale.

The PPV team will continue to assist the UHB in providing training, advice or informally meeting with contractors or their staff to discuss PPV related issues.

Aneurin Bevan University Health Board

Visit Plan 2019-2020

	Routine	Revisit	Extended	Visit due to HB Request	Total Visits
GMS (Medical)	21	8	1	0	**30**
GOS (Opticians)	31	6	0	0	**37**
GPS (Pharmacy)	46	1	0	1	**48**
					115

1st April 2018 to 31st March 2019

Aneurin Bevan University Health Board
GMS PPV Progress Report: 2018/19

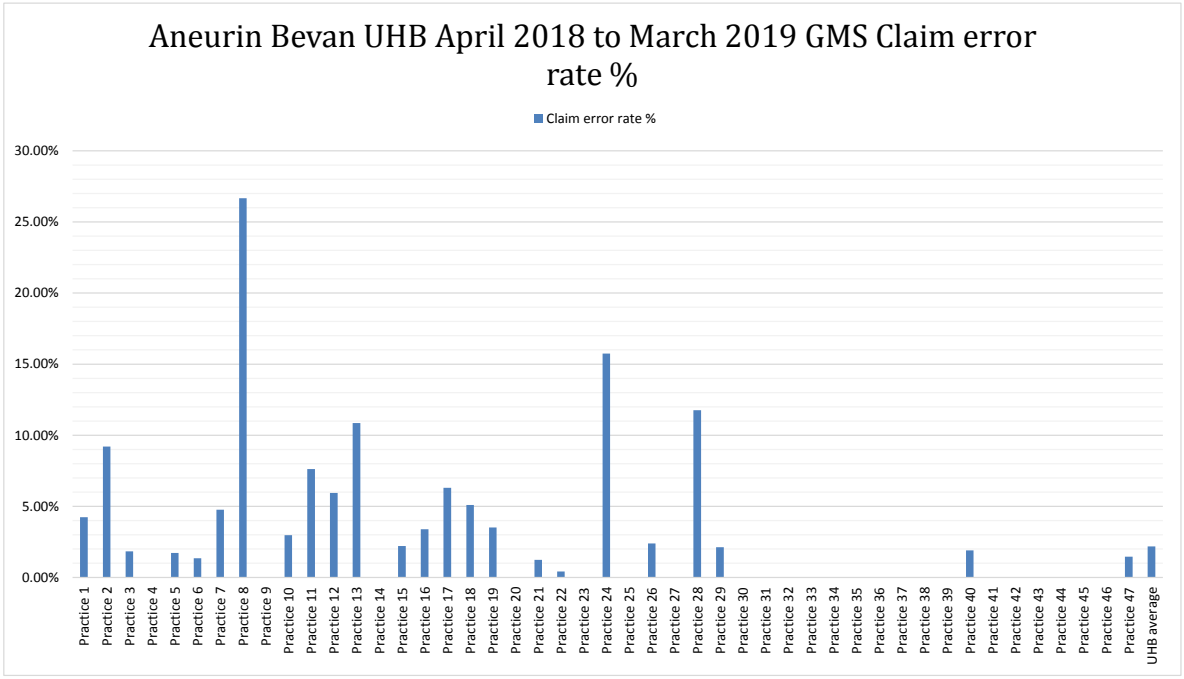
Completed GMS visits

Practice Name	Visit Status	Sample Size (numeric)	Claim errors found (numeric)	Admin error rate %	Claim error rate %	Recovery	Main error areas
Practice 1	Routine	165	7	1.21%	4.24%	£277.94	3 x Minor Surgery, 1 x Contraceptive services, 1 x Administration of Gonadorelins and 2 x Flu
Practice 2	Routine	163	15	11.66%	9.20%	£686.75	2 x Minor Surgery, 1 x Administration of Gonadorelins, 5 x Pertussis, 6 x Care Homes and 1 x Anti-coagulation monitoring
Practice 3	Routine	164	3	4.27%	1.83%	£42.47	1 x Near Patient Testing and 2 x Contraceptives
Practice 4	Revisit	1101					File in progress, initial report sent to practice
Practice 5	Routine	116	2	9.48%	1.72%	£51.68	2 x Administration of Gonadorelins
Practice 6	Routine	222	3	0.45%	1.35%	£148.05	1 x Minor Surgery and 2 x Anti-coagulation monitoring
Practice 7	Routine	147	7	38.78%	4.76%	£24.99	1 x Near Patient Testing, 1 x Minor Surgery, 5 x Flu and 1 x Denosumab
Practice 8	Revisit	15	4	0.00%	26.67%	£283.24	4 x Network Minor Surgery
Practice 9	Revisit	174					File in progress, initial report sent to practice
Practice 10	Revisit	875	26	15.09%	2.97%	£527.36	15 x Contraceptive services and 11 x Pertussis
Practice 11	Routine	131	10	5.34%	7.63%	£519.04	1 x Administration of Gonadorelins, 1 x Flu, 6 x Minor Surgery and 2 x Near Patient Testing
Practice 12	Revisit	168	10	3.57%	5.95%	£258.40	10 x Administration of Gonadorelins
Practice 13	Routine	221	24	28.96%	10.86%	£1,112.36	1 x Near Patient Testing, 7 x Anti-coagulation monitoring, 5 x Contraceptive services, 8 x Minor Surgery and 3 x Flu* (Flu recovered whole quarter due to error in claiming)
Practice 14	Revisit	2533					File in progress, initial report sent to practice
Practice 15	Routine	317	7	3.79%	2.21%	£263.66	2 x Minor Surgery, 1 x Flu, 1 x Lithium, 1 x Pertussis and 2 x Denosumab
Practice 16	Routine	177	6	15.25%	3.39%	£277.82	3 x Anti-coagulation monitoring, 2 x Minor Surgery and 1 x Near Patient Testing

Practice 17	Routine	111	7	0.90%	6.31%	£225.95	3 x Contraceptive services, 2 x Denosumab and 2 x Minor Surgery
Practice 18	Revisit	1236	63	0.65%	5.10%	£1,056.14	6 x Minor Surgery and 57 x Flu
Practice 19	Routine	199	7	0.50%	3.52%	£283.24	1 x Near Patient Testing, 1 x Lithium, 2 x Minor Surgery, 1 x Administration of Gonadorelins, 1 x Denosumab and 1 x Care Homes
Practice 20	Routine	196	0	0.00%	0.00%	£0.00	All claims were verified
Practice 21	Revisit	322	4	0.00%	1.24%	£80.92	4 x Near Patient Testing
Practice 22	Routine	237	1	4.64%	0.42%	£9.80	1 x Flu
Practice 23	Revisit	792					File in progress, initial report sent to practice
Practice 24	Revisit	775	122	0.00%	15.74%	£2,490.13	119 x Near Patient Testing, 1 x Lithium and 2 x Care Homes
Practice 25	Revisit	2293					File in progress, initial report sent to practice
Practice 26	Routine	209	5	0.00%	2.39%	£384.79	1 x Contraceptive services, 2 x Minor Surgery and 2 x Learning Disabilities
Practice 27	Routine	246	0	27.64%	0.00%	£0.00	All claims were verified
Practice 28	Revisit	238	28	0.42%	11.76%	£1,327.45	28 x Minor Surgery
Practice 29	Routine	188	4	1.60%	2.13%	£93.37	1 x Near Patient Testing, 1 x Anti-Coagulation Monitoring, 1 x Administration of Gonadorelins and 1 x Pertussis
Practice 30	Routine	184					File in progress, awaiting UHB response
Practice 31	Routine	237					File in progess, initial report sent to practice
Practice 32	Routine	182					File in progress, awaiting UHB response
Practice 33	Routine						Visit scheduled for March 2019
Practice 34	Routine	184					File in progress, awaiting UHB response
Practice 35	Routine	245					File in progress, initial report sent to practice
Practice 36	Revisit	334					File in progress, initial report sent to practice
Practice 37	Routine						Visit scheduled for March 2019
Practice 38	Routine	175					File in progress, initial report sent to practice
Practice 39	Revisit						File in progress, remote access in progress
Practice 40	Routine	209	4	2.39%	1.91%	£97.36	1 x Care Homes, 1 x Flu and 2 x MMR
Practice 41	Routine	109					File in progress, initial report sent to practice
Practice 42	Revisit	386					File in progress, awaiting UHB response
Practice 43	Revisit	456					File in progress, initial report sent to practice
Practice 44	Routine	272					File in progress, initial report sent to practice

Practice 45	Routine						File in progress, initial report sent to practice
Practice 46	Routine	204					File in progress, initial report sent to practice
Practice 47	Routine	137	2	0.00%	1.46%	£30.03	1 x Near Patient Testing and 1 x Pertussis
UHB average		**17,045**	**371**		**2.18%**	**£10,552.94**	

Practice Name	Claim error rate %
Practice 1	4.24%
Practice 2	9.20%
Practice 3	1.83%
Practice 4	
Practice 5	1.72%
Practice 6	1.35%
Practice 7	4.76%
Practice 8	26.67%
Practice 9	
Practice 10	2.97%
Practice 11	7.63%
Practice 12	5.95%
Practice 13	10.86%
Practice 14	
Practice 15	2.21%
Practice 16	3.39%
Practice 17	6.31%
Practice 18	5.10%
Practice 19	3.52%
Practice 20	0.00%
Practice 21	1.24%
Practice 22	0.42%
Practice 23	
Practice 24	15.74%
Practice 25	
Practice 26	2.39%
Practice 27	0.00%
Practice 28	11.76%
Practice 29	2.13%
Practice 30	
Practice 31	
Practice 32	
Practice 33	
Practice 34	
Practice 35	
Practice 36	
Practice 37	
Practice 38	
Practice 39	
Practice 40	1.91%
Practice 41	
Practice 42	
Practice 43	
Practice 44	
Practice 45	
Practice 46	
Practice 47	1.46%
UHB average	**2.18%**



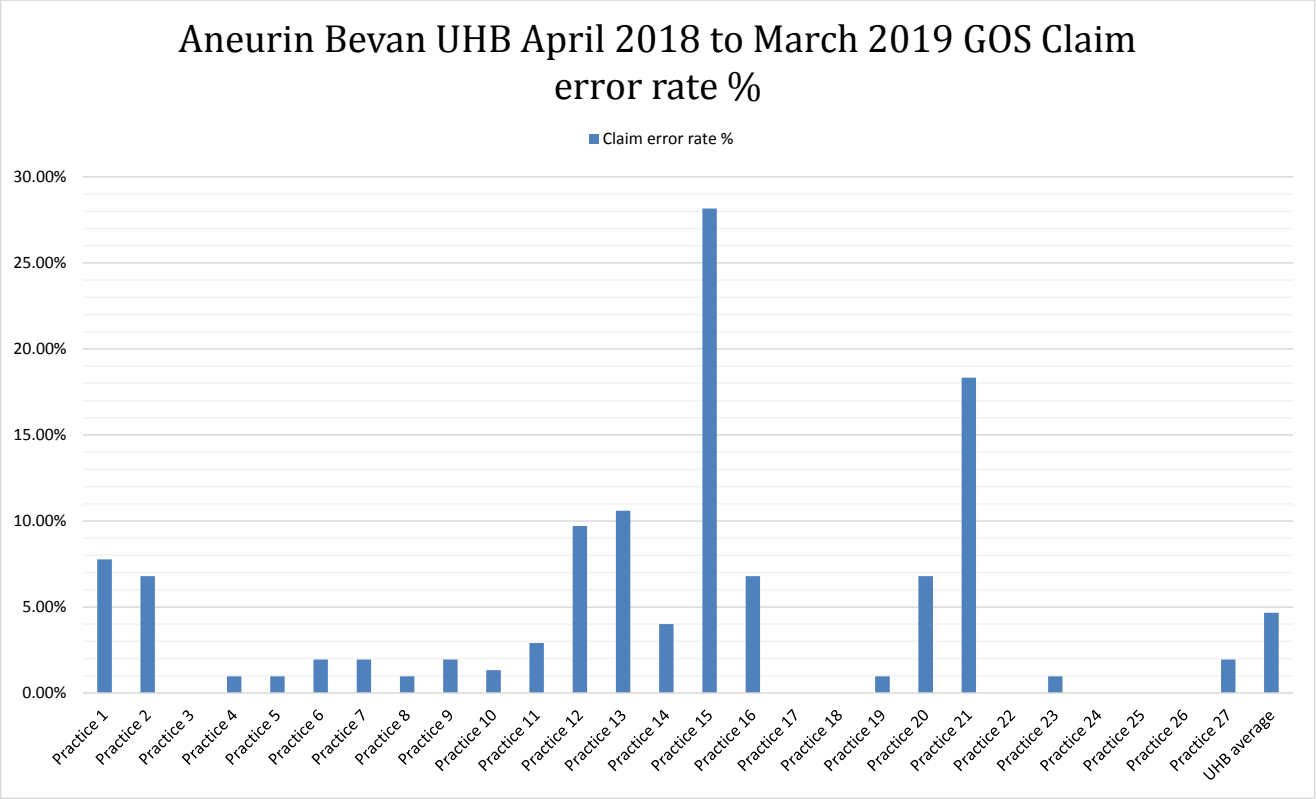
Aneurin Bevan University Health Board
GOS PPV Progress Report: 2018/19

Completed GOS visits

Practice Name	Visit Status	Sample Size (numeric)	Claim errors found (numeric)	Admin error rate %	Claim error rate %	Recovery	Main error areas
Practice 1	Routine	103	8	23.30%	7.77%	£203.40	5 x GOS 4 and 3 x EHEW
Practice 2	Routine	103	7	4.85%	6.80%	£228.20	3 x EHEW and 4 x GOS 4
Practice 3	Revisit	300					File in progress, initial report sent to practice
Practice 4	Routine	103	1	5.83%	0.97%	£40.40	1 x EHEW
Practice 5	Routine	103	1	18.44%	0.97%	£20.20	1 x EHEW
Practice 6	Routine	103	2	8.74%	1.94%	£100.00	2 x EHEW
Practice 7	Routine	103	2	14.56%	1.94%	£69.40	1 x EHEW and 1 x Tint on GOS 3
Practice 8	Routine	103	1	9.71%	0.97%	£8.80	1 x Tint on GOS 3
Practice 9	Routine	103	2	6.80%	1.94%	£80.80	2 x EHEW
Practice 10	Revisit	300	4	2.33%	1.33%	£120.00	4 x EHEW
Practice 11	Routine	103	3	4.85%	2.91%	£78.20	3 x GOS 4
Practice 12	Routine	103	10	13.59%	9.71%	£365.70	1 x GOS 3, 3 x GOS 4 & 6 x EHEW
Practice 13	Revisit	151	16	5.30%	10.60%	£743.40	16 x EHEW
Practice 14	Revisit	300	12	10.00%	4.00%	£541.20	12 x EHEW
Practice 15	Routine	103	29	23.30%	28.16%	£1,517.80	26 x EHEW & 3 x GOS 4
Practice 16	Routine	103	7	28.16%	6.80%	£189.40	3 x EHEW, 2 GOS 4 and 2 x GOS 3
Practice 17	Routine	103	0	11.65%	0.00%	£0.00	All claims were verified
Practice 18	Revisit	67					File in progress, awaiting UHB response
Practice 19	Routine	103	1	3.88%	0.97%	£39.10	1 x GOS 4
Practice 20	Routine	103	7	34.95%	6.80%	£241.90	1 x GOS 3, 4 x GOS 4 and 2 x EHEW
Practice 21	Revisit	300	55	44.33%	18.33%	£1,720.65	40 x GOS 4 and 15 x EHEW
Practice 22	Routine	100	0	15.00%	0.00%	£0.00	All claims were verified
Practice 23	Routine	103	1	0.00%	0.97%	£60.60	1 x EHEW

Practice 24	Revisit	300					File in progress, initial report sent to practice
Practice 25	Revisit						File in progress, remote access in progress
Practice 26	Routine	103					File in progress, awaiting UHB response
Practice 27	Routine	103	2	26.21%	1.94%	£80.80	2 x EHEW
UHB average		**3,672**	**171**		**4.66%**	**£6,449.95**	

Practice Name	Claim error rate %
Practice 1	7.77%
Practice 2	6.80%
Practice 3	
Practice 4	0.97%
Practice 5	0.97%
Practice 6	1.94%
Practice 7	1.94%
Practice 8	0.97%
Practice 9	1.94%
Practice 10	1.33%
Practice 11	2.91%
Practice 12	9.71%
Practice 13	10.60%
Practice 14	4.00%
Practice 15	28.16%
Practice 16	6.80%
Practice 17	0.00%
Practice 18	
Practice 19	0.97%
Practice 20	6.80%
Practice 21	18.33%
Practice 22	0.00%
Practice 23	0.97%
Practice 24	
Practice 25	
Practice 26	
Practice 27	1.94%
UHB average	**4.66%**



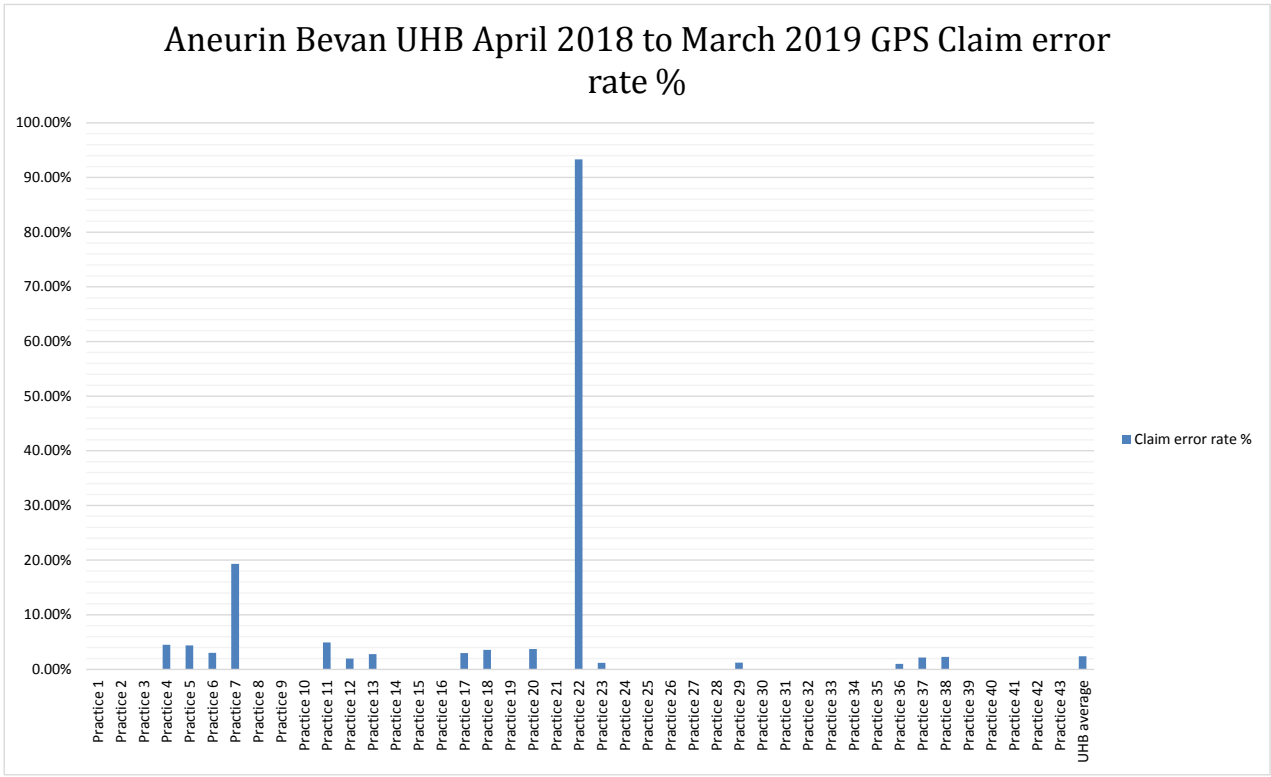
Aneurin Bevan University Health Board
GPS PPV Progress Report: 2018/19

Completed GPS visits

Practice Name	Visit Status	Sample Size (numeric)	Claim errors found (numeric)	Admin error rate %	Claim error rate %	Recovery	Main error areas
Practice 1	Routine	20	0	0.00%	0.00%	£0.00	All claims were verified
Practice 2	Routine	92	0	5.43%	0.00%	£0.00	All claims were verified
Practice 3	Routine	36	0	13.89%	0.00%	£0.00	All claims were verified
Practice 4	Routine	89	4	10.11%	4.49%	£88.10	2 x MUR & 2 x Flu
Practice 5	Routine	91	4	13.19%	4.40%	£112.00	4 x MUR
Practice 6	Routine	99	3	25.25%	3.03%	£84.00	3 x MUR
Practice 7	Revisit	145	28	65.52%	19.31%	£784.00	28 x MUR
Practice 8	Routine	52	0	0.00%	0.00%	£0.00	All claims were verified
Practice 9	Routine	100	0	0.00%	0.00%	£0.00	All claims were verified
Practice 10	Routine	20	0	0.00%	0.00%	£0.00	All claims were verified
Practice 11	Routine	101	5	18.81%	4.95%	£116.10	3 x MUR & 2 X Flu
Practice 12	Routine	100	2	6.00%	2.00%	£32.10	2 x Flu
Practice 13	Routine	72	2	6.94%	2.78%	£56.00	2 x MUR
Practice 14	Routine	2	0	0.00%	0.00%	£0.00	All claims were verified
Practice 15	Routine	100	0	20.00%	0.00%	£0.00	All claims were verified
Practice 16	Routine	86	0	12.79%	0.00%	£0.00	All claims were verified
Practice 17	Routine	67	2	13.43%	2.99%	£56.00	2 x MUR
Practice 18	Revisit	28	1	0.00%	3.57%	£15.96	1 x Flu
Practice 19	Routine	77	0	16.88%	0.00%	£0.00	All claims were verified
Practice 20	Routine	80	3	6.25%	3.75%	£84.00	3 x MUR
Practice 21	Routine	100	0	7.02%	0.00%	£0.00	All claims were verified
Practice 22	Routine	92	23	43.89%	93.33%	£425.78	6 x MUR & 17 x Flu
Practice 23	Revisit	82	1	20.73%	1.22%	£28.00	1 x MUR
Practice 24	Routine	86	0	49.12%	0.00%	£0.00	All claims were verified
Practice 25	Routine	87	0	17.19%	0.00%	£0.00	All claims were verified

Practice 26	Routine	80	0	17.50%	0.00%	£0.00	All claims were verified
Practice 27	Routine	84	0	22.50%	0.00%	£0.00	All claims were verified
Practice 28	Routine	84	0	20.94%	0.00%	£0.00	All claims were verified
Practice 29	Routine	80	1	8.75%	1.25%	£28.00	1 x MUR
Practice 30	Routine	100	0	6.00%	0.00%	£0.00	All claims were verified
Practice 31	Routine	24					File in progress, initial report sent to practice
Practice 32	Routine	100	0	22.00%	0.00%	£0.00	All claims were verified
Practice 33	Routine	412					File in progress, initial report sent to practice
Practice 34	Routine	94					File in progress, initial report sent to practice
Practice 35	Routine						Visit scheduled for March 2019
Practice 36	Routine	100	1	3.00%	1.00%	£28.00	1 x MUR
Practice 37	Routine	92	2	4.35%	2.17%	£56.00	2 x MUR
Practice 38	Routine	87	2	4.60%	2.30%	£56.00	2 x MUR
Practice 39	Routine						Visit scheduled for March 2019
Practice 40	Routine						Visit scheduled for March 2019
Practice 41	Routine	77					File in progress, initial report sent to practice
Practice 42	Routine	77					File in progress, initial report sent to practice
Practice 43	Routine	65					File in progress, initial report sent to practice
UHB average		**3,460**	**84**		**2.43%**	**£2,050.04**	

Practice Name	Claim error rate %
Practice 1	0.00%
Practice 2	0.00%
Practice 3	0.00%
Practice 4	4.49%
Practice 5	4.40%
Practice 6	3.03%
Practice 7	19.31%
Practice 8	0.00%
Practice 9	0.00%
Practice 10	0.00%
Practice 11	4.95%
Practice 12	2.00%
Practice 13	2.78%
Practice 14	0.00%
Practice 15	0.00%
Practice 16	0.00%
Practice 17	2.99%
Practice 18	3.57%
Practice 19	0.00%
Practice 20	3.75%
Practice 21	0.00%
Practice 22	93.33%
Practice 23	1.22%
Practice 24	0.00%
Practice 25	0.00%
Practice 26	0.00%
Practice 27	0.00%
Practice 28	0.00%
Practice 29	1.25%
Practice 30	0.00%
Practice 31	
Practice 32	0.00%
Practice 33	
Practice 34	
Practice 35	
Practice 36	1.00%
Practice 37	2.17%
Practice 38	2.30%
Practice 39	
Practice 40	
Practice 41	
Practice 42	
Practice 43	
UHB average	**2.43%**



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SWYDDFA ARCHWILIO CYMRU

Archwilydd Cyffredinol Cymru
Auditor General for Wales

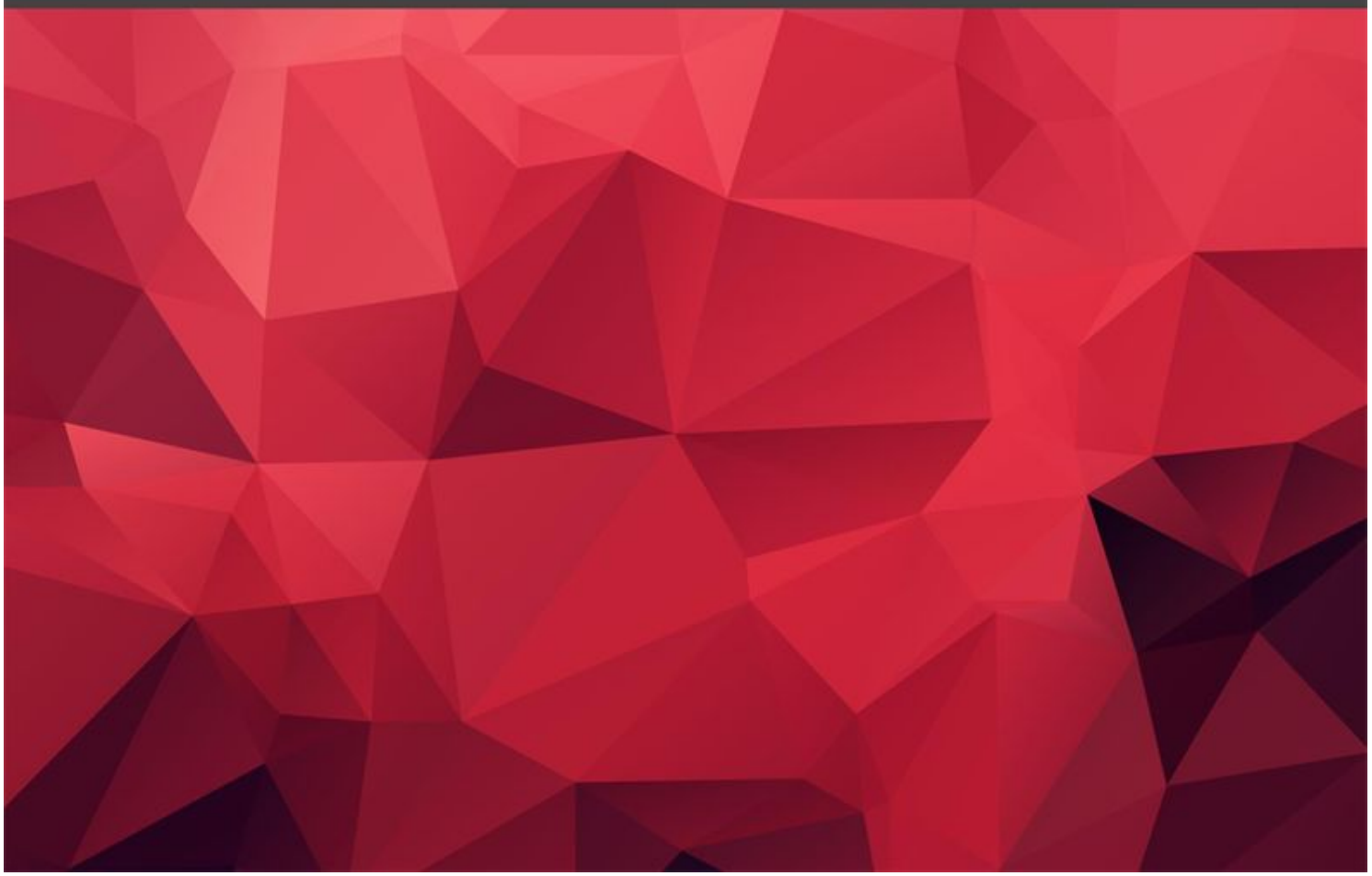
4.1

External Audit Progress Report – **Aneurin Bevan University Health Board**

Audit Committee Meeting – April 3, 2019

Date issued: March 19, 2019

Reference: 648A2018-19



This document was prepared by Terry Lewis and Gabrielle Smith.

Contents

About this document

1 This document is intended to help the Audit Committee of Aneurin Bevan University Health Board to monitor the progress of external audit work. All finalised reports are presented to the Committee for information and consideration.

2 Progress in relation to both financial and performance audit work is presented, as well as information on the Auditor General's planned programme of NHS related studies and publications.

Progress against previous audit plans

3 Exhibit 1 provides an update on progress against the performance audit projects identified in the 2017 and 2018 audit plans, which are either complete or ongoing.

Exhibit 1: progress against previous audit plans

Topic	Details	Status	Executive lead
2017 performance audits			
Primary Care Services	The audit examined the extent to which the Health Board has implemented the Welsh Government's three-year plan for primary care	**Complete** and on the agenda for the meeting on 3rd April 2019	Nick Wood
2018 financial and performance audits			
Annual Audit Report	This report will summarise our financial and performance audit work during 2019.	**Complete** – on the agenda to note as the report is to be considered by the Board at its meeting on 27th March	
Structured Assessment	Our annual Structured Assessment work assessed the robustness of the Health Board's arrangements for corporate and financial	**Complete** – on the agenda to note as the report is to be considered by the Board at its meeting on 27th March	Judith Paget

Topic	Details	Status	Executive lead
	governance, as well as progress in addressing areas for improvement identified previously.		
Clinical coding: follow-up review	This work considered the extent to which the Health Boards has made progress to address areas for improvement and recommendations made in our 2014 report.	Draft report being prepared for clearance process to start end of March	Glyn Jones
Orthopaedics - follow-up review	This work will consider the extent to which the Health Board has made progress to address areas for improvement and recommendations made in our 2015 report.	Terms of reference issued February 2019 and data collection underway in March	Claire Birchall
Follow-up work against previous recommendations	This work will track progress made by the Health Board to address our recommendations on: • District nursing services (2014/2015) • Medicines management in acute hospitals (2015) • GP out-of-hours services (2017)	Terms of reference issued; data collection scheduled to get underway in March	Awaiting confirmation

Progress against the 2019 audit plan

4 Exhibit 2 provides an update on progress against the 2019 audit plan with most audit work not yet underway.

Exhibit 2: progress against the 2019 audit plan

Topic	Details	Status	Executive lead
Financial audits			
2019 Audit Plan	The plan sets out the financial and performance audit work to be carried out in 2019-20.	Complete – to be presented to the Audit Committee on 3rd April 2019.	Glyn Jones
Financial accounts audit work	Our interim work on the Financial Statements is virtually complete. The draft financial statements are due to be presented for audit on 29 April 2019 and our audit will commence immediately.	Work in progress	Glyn Jones
Financial Accounts Audit Report (ISA 260)	This report will be presented to the Committee at its meeting in May 2019.	Not started	Glyn Jones
Opinion on Financial Statements	The AGW will give his audit opinion on the financial statements in early June 2019 shortly after approval by the Board.	Not started	Glyn Jones
Charitable Funds	Our work on the Charitable Funds is scheduled for August/September 2019.	Not started	Glyn Jones
2019 Annual Audit Report	This report will summarise our financial and performance audit work during 2019.	Not started	To be confirmed

Topic	Details	Status	Executive lead
Performance audits			
Structured Assessment	Structured Assessment will continue to assess the robustness of the arrangements for corporate and financial governance, as well as progress against previous issues and recommendations.	Not started	To be confirmed
Thematic review - quality governance arrangements	This audit will consider the Health Board's quality governance arrangements and reporting how these underpin the work of the Quality and Patient Safety Committee.	Not started	To be confirmed
Thematic review - Well Being of Future Generations (Wales) Act 2015	This work will consider the Health Board's overall corporate approach to applying the 'Sustainable Development Principle' and 'Five Ways of Working'.	Terms of reference issued	Sarah Aitken
Locally focused audit project	The precise focus of this work is yet to be agreed but will be reflected in regular updates to the Committee.	Not started	To be confirmed

NHS-related national reports and Good Practice Exchange events

5 Exhibit 3 provides information on national value for money studies and other publications directly relevant to NHS organisations published by the Auditor General since the Committee last met or which he intends to publish in the coming year. Any recommendations arising from national studies (or related reports by the National Assembly's Public Accounts Committee) that are relevant to the Health Board will be reported to the Committee where appropriate.

6 Our Good Practice Exchange (GPX) helps public services improve by sharing knowledge and good practice. Events are held where knowledge can be exchanged face to face or via webinars and podcasts. The main areas of work relate to financial management, public sector staff and governance. Future events include a let's talk cyber security webinar, 26 March 2019.

Exhibit 3: NHS-related national reports

Report topic	Publication date
Expenditure on agency staff by NHS Wales This is a 'facts only report', which sets out the key information about the use of agency staff by NHS bodies in Wales. It identifies two key challenges to improving the management of agency staffing expenditure. Firstly, NHS Wales needs consistent and comparable data at an all-Wales level to track the volume, nature and cost of agency staff used and the impact of changes in agency spend on other temporary staffing costs, such as overtime and internal staff banks. Secondly, future projects to manage agency and other temporary staffing spend will need strong leadership and the capacity to drive change in a timely manner, to deal consistently with difficult decisions. A data-tool developed by Wales Audit Office staff enables readers to conduct their own analysis of agency expenditure.	January 2019
A review of the Integrated Care Fund	Spring 2019
Primary Care Services in Wales	Spring 2019

The Auditor General has also commenced a programme of work looking at the arrangements that the devolved public sector in Wales, including all NHS bodies, is putting in place to prepare for, and respond to, Britain's exit from the European Union. In autumn 2018, he issued a call for evidence to compile a baseline of arrangements being put in place. On 19 February, he issued a report, Preparations in Wales for a 'no deal' Brexit. This will be followed up by further audit fieldwork during the rest of 2019.

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Auditor General for Wales

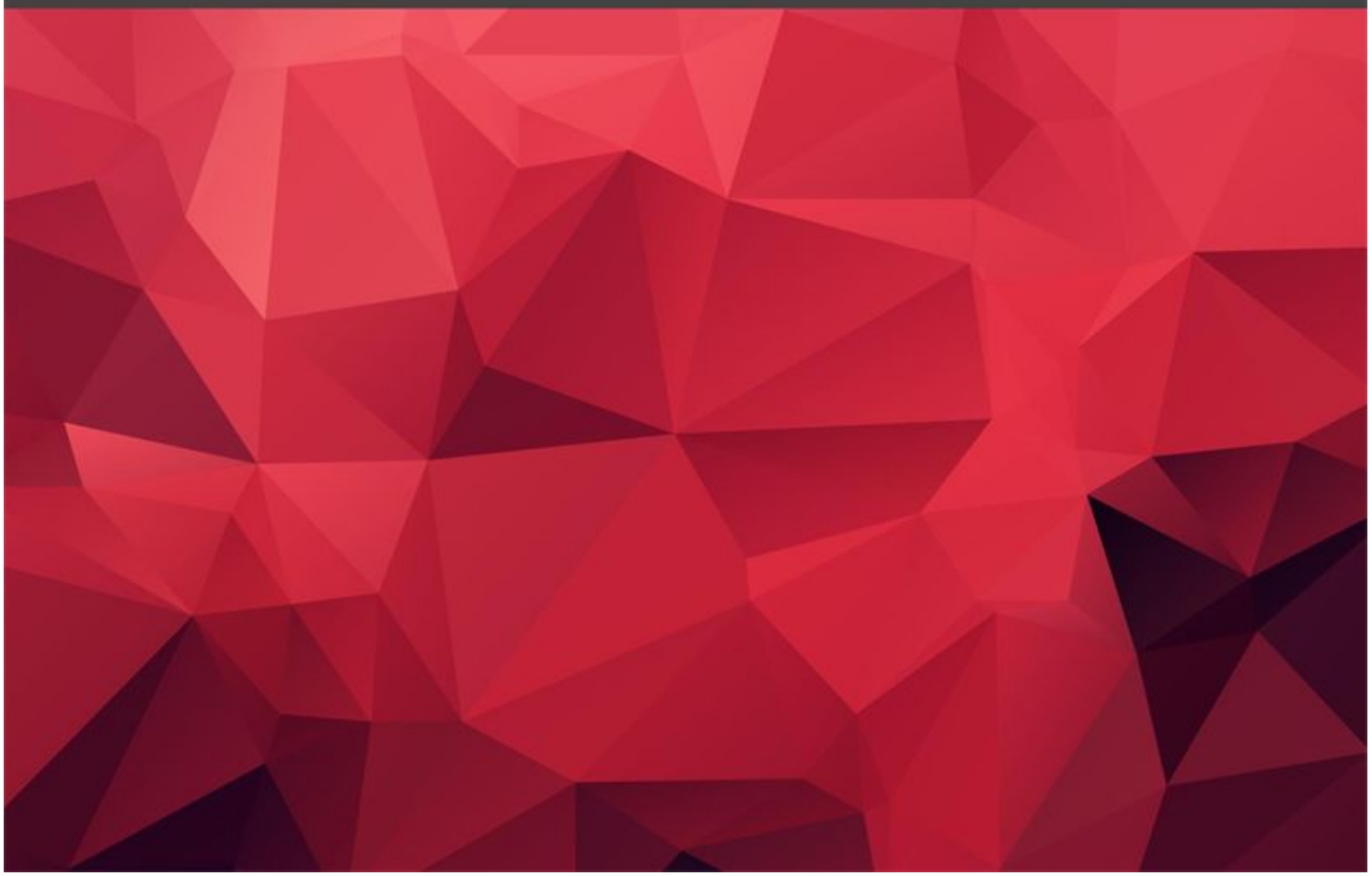
4.2

2019 Audit Plan – Aneurin Bevan University Health Board

Audit year: 2019

Date issued: March 2019

Document reference: 1075A2019-20



This document has been prepared as part of work performed in accordance with statutory functions. Further information on this is provided in in Appendix 1.

No responsibility is taken by the Auditor General, the staff of the Wales Audit Office or, where applicable, the appointed auditor in relation to any member, director, officer or other employee in their individual capacity, or to any third party.

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

We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay.

This document is also available in Welsh.

This document was produced by Richard Harries on behalf of the Auditor General for Wales.

Contents

2019 Audit Plan

Summary

1 As your external auditor, my objective is to carry out an audit which discharges my statutory duties as Auditor General and fulfils my obligations under the Code of Audit Practice, namely to:

- examine and certify whether your financial statements are 'true and fair' and lay them before the National Assembly together with any report that I make on them;
- satisfy myself that the expenditure and income reported in your accounts have been incurred or received lawfully and in accordance with the authorities which govern them; and
- assess whether you have made proper arrangements for securing economy, efficiency and effectiveness in the use of resources.

2 The purpose of this plan is to set out my proposed work, when it will be undertaken, how much it will cost and who will undertake it.

3 There have been no limitations imposed on me in planning the scope of this audit.

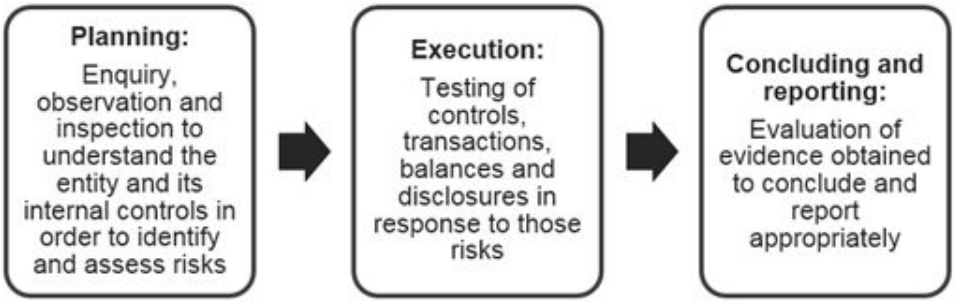
4 My responsibilities, along with those of management and those charged with governance, are set out in Appendix 1.

Financial audit

5 It is my responsibility to issue a certificate and report on the financial statements which includes an opinion on their 'truth and fairness' and the regularity of the expenditure and income within them. Appendix 1 sets out my responsibilities in full.

6 The audit work we undertake to fulfil our responsibilities responds to our assessment of risks. This understanding allows us to develop an audit approach which focuses on addressing specific risks whilst providing assurance for the financial statements as a whole. Our audit approach consists of three phases as set out in Exhibit 1.

Exhibit 1: my financial audit approach



7 The risks of material misstatement which I consider to be significant, and which therefore require special audit consideration, are set out in Exhibit 2 along with the work I intend to undertake to address them.

Exhibit 2: financial audit risks

Financial audit risks	Proposed audit response
Significant risks	
The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.31-33].	My audit team will: • test the appropriateness of journal entries and other adjustments made in preparing the financial statements; • review accounting estimates for biases; and • evaluate the rationale for any significant transactions outside the normal course of business.
There is a risk that the Health Board will fail to meet its first financial duty to break even over a three-year period. Whilst the Health Board is currently predicting a year-end surplus, there are a number of risks to this position with a 'worst case' financial risk of £1m which could push the Health Board into deficit. Where the Health Board fails this financial duty, I will place a substantive report on the financial statements highlighting the failure. The current financial pressures on the Health Board increase the risk that management judgements and estimates	My audit team will: - monitor the Health Board's financial position for the 2018-19 financial year; and - focus its testing on areas of the financial statements which could contain reporting bias.

Financial audit risks	Proposed audit response
could be biased in an effort to achieve the financial duty.	
Other areas of audit attention	
New accounting standards IFRS 9 financial instruments applies from 1 April 2018 and brings in a new principles-based approach for the classification and measurement of financial assets. It also introduces a new impairment methodology for financial assets based on expected losses rather than incurred losses. This will result in earlier recognition of expected credit losses and will impact on how the Health Board calculates its bad debt provision. IFRS 15 revenue from contracts with customers introduces a principles-based five-step model for recognising revenue arising from contracts with customers. It is based on a core principle requiring revenue recognition to depict the transfer of promised goods or services to the customer in an amount that reflects the consideration the body expects to be entitled to, in exchange for those goods or services. It will also require more extensive disclosures than are currently required.	My audit team will assess the likely impacts of the new IFRSs and undertake work to respond to any identified risks of material misstatement.

8 I do not seek to obtain absolute assurance on the truth, fairness and regularity of the financial statements and related notes but adopt a concept of materiality. My aim is to identify material misstatements, that is, those that might result in a reader of the accounts being misled. The level of materiality will be calculated once the draft financial statements are received, but it is expected to be around £12.5m.

9 For reporting purposes, we will treat any misstatements below a 'trivial' level (set at 5% of materiality) as not requiring consideration by those charged with governance and therefore we will not report them.

10 My fees and planned timescales for completion of the audit are based on the following assumptions:

- the financial statements are provided in accordance with the agreed timescales, to the quality expected and have been subject to a robust quality assurance review;

- information provided to support the financial statements is in accordance with the agreed audit deliverables document[1];
- appropriate accommodation and facilities are provided to enable my audit team to deliver our audit in an efficient manner;
- all appropriate officials will be available during the audit;
- you have all the necessary controls and checks in place to enable the Accountable Officer to provide all the assurances that I require in the Letter of Representation addressed to me; and
- Internal Audit's planned programme of work is complete, and management has responded to issues that may have affected the financial statements.

11 I am also responsible for the audit of Health Board's charitable funds accounts. The audit will be undertaken in accordance with the timescales agreed with the Health Board and the Charity Commission.

Performance audit

12 It is my responsibility to satisfy myself that the audited body has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. I do this by undertaking an appropriate programme of performance work each year.

13 I set out in this section, the programme of performance audit work to be undertaken at the Health Board. The content of the programme is informed by an ongoing analysis of the risks and challenges facing NHS Wales as a whole, as well as consideration of issues and risks that are specific to the Health Board. I have also taken account of the work programme of Healthcare Inspectorate Wales (HIW)[2] [3].

14 The topics I plan to examine as part of my 2019 performance audit work are summarised in Exhibit 3.

[1] The agreed audit deliverables document sets out the expected working paper requirements to support the financial statements and include timescales and responsibilities

[2] An operational protocol between HIW and the Auditor General sets out how the two organisations will work together. March 2015

[3] Wales Audit Office, **Working Together to Provide Assurance** describes the collective arrangements the Auditor General and HIW make use of to review governance arrangements in the NHS, November 2016

Exhibit 3: contents of my 2019 performance audit work programme

Theme	Approach/key areas of focus
NHS Structured Assessment	Structured Assessment will continue to form the basis of the work I do at each NHS body to examine the existence of proper arrangements for the efficient, effective and economical use of resources. Building on previous years' work, I will seek to describe the progress that is being made in embedding sound arrangements for corporate governance and financial management, alongside other key processes such as strategic planning, workforce management, procurement and asset management.
All Wales Thematic Reviews	**Quality Governance arrangements** As an extension of my structured assessment work, I plan to undertake a specific thematic review of quality governance arrangements and how these underpin the work of quality and safety committees. In recent years my structured assessment work across Wales has pointed to various challenges with such governance arrangements. I therefore intend to undertake a review that will allow my team to undertake a more detailed examination of factors underpinning quality governance such as strategy, structures and processes, information flows and reporting. I shall scope this work in discussion with NHS bodies, and Healthcare Inspectorate Wales. In designing this work, I will also seek to build in an ability to compare approaches to quality governance across NHS bodies. **Well Being of Future Generations (Wales) Act 2015** The Well-being of Future Generations (Wales) Act 2015 became law in April 2016. The Act requires me to report every five years to the National Assembly on how public bodies apply the sustainability principles. During the first half of 2019, I plan to undertake work at the Health Board that will inform the report I must prepare for the National Assembly by May 2020. My work will consider the Health Board overall corporate approach to applying the "Sustainable Development Principle" and "Five Ways of Working". My team will also seek to examine one of the Health Board's well-being objectives in more detail, reviewing the steps that have been taken to achieve that objective. When selecting which well-being objectives to review, I will aim to do so in such a way that maximises my ability to compare approaches across NHS bodies.
Locally focused work	I will also undertake thematic performance audit work that reflects issues specific to the Health Board. The precise focus of this work will be agreed with executive officers and shared with the Audit Committee and will be reflected in the regular updates that are produced for the Audit Committee.

Theme	Approach/key areas of focus
Implementing previous audit recommendations	The examination of governance arrangements I undertake as part of my structured assessment work includes a review of the arrangements that the Health Board has in place to track progress against my previous audit recommendations. This allows my team to obtain assurance that the necessary progress is being made in addressing areas for improvement identified in previous audit work. It also enables me to more explicitly measure the impact my work is having.

15 The performance audit projects included in last year's audit plan, which are either still underway or which have been substituted for alternative projects in agreement with the Health Board, are set out in Appendix 2.

Fee, audit team and timetable

Fee

16 Your estimated fee for 2019 is set out in Exhibit 4. There have been some small changes to my fees rates for 2019, however my audit team will continue to drive efficiency in their audits to ensure any resulting increases will not be passed onto you. This figure represents a 2% decrease compared to the fee set out in the 2018 annual audit plan.

Exhibit 4: audit fee

Audit area	Proposed fee for 2019 (£)[4]	Actual fee for 2018 (£)
Financial accounts work	249,154	254,154
Performance audit work:		
• Structured Assessment	69,512	66,696
• All-Wales thematic reviews[5]	64,605	66,432
• Local project	18,873	19,863
Performance audit work total	152,992	152,992
Total fee	402,146	407,146

[4] The fees shown in this document are exclusive of VAT, which is no longer charged to you.

[5] As detailed in the respective audit plans.

17 Planning will be ongoing, and changes to my programme of audit work and therefore my fee, may be required if any key new risks emerge. I shall make no changes without first discussing them with the Director of Finance.

18 Further information on my fee scales and fee setting can be found on our website.

Audit team

19 The main members of my local audit team, together with their contact details, are summarised in Exhibit 5.

Exhibit 5: my local audit team

Name	Role	Contact number	E-mail address
Richard Harries	Engagement Director and Engagement Lead – Financial Audit	029 20320640	Richard.Harries@audit.wales
Dave Thomas	Engagement Lead – Performance Audit	029 20320604	Dave.Thomas@audit.wales
Terry Lewis	Financial Audit Manager	029 20320641	Terry.Lewis@audit.wales
Gabrielle Smith	Performance Audit Lead	029 20320608	Gabrielle.Smith@audit.wales
Gareth Rees	Financial Audit Team Leader	029 20829300	Gareth.Rees@audit.wales
Deborah Woods	Financial Audit Team Leader	029 20320621	Deborah.Woods@audit.wales

20 I can confirm that my team members are all independent of the Health Board and your officers. There is one potential conflict of interest which I need to bring to your attention. Gabrielle Smith's husband is Clinical Director of the University Dental Hospital, Cardiff and Vale University Health Board. The University Dental Hospital is contracted to provide Restorative Dental Services to the Health Board. Our Law and Ethics team has undertaken a detailed review and concluded that the possibility of this relationship affecting the audit work that Gabrielle undertakes to be remote. However, we have taken steps to ensure that Gabrielle is not involved in any work we may do that covers the contracts for Restorative Dental Services at the Health Board.

Staff secondment

21 A trainee accountant employed by the Wales Audit Office has been 'seconded' to the Health Board for the period December 2018 to June 2019. This secondment is

part of an initiative funded by the Welsh Consolidated Fund designed to allow trainee accountants to broaden their skills and to gain experience of working across different parts of the Welsh public sector.

22 In order to safeguard against any potential threats to auditor independence and objectivity, the Wales Audit Office and the Health Board have agreed the following arrangements:

- secondees will not perform duties prohibited by the FRC's Revised Ethical Standard 2016 and will not be able to exercise discretionary authority to commit the Health Board to a particular position or accounting treatment;
- the secondee will undertake tasks at a relatively junior level, will be properly supervised and will not undertake a management role or be involved in the decision taking of the Health Board; and
- the secondment will be for a period of time within the meaning of the FRC's Revised Ethical Standard 2016.

Timetable

23 I will provide reports, or other outputs as agreed, to the Health Board covering the areas of work identified in this document. My key milestones are set out in Exhibit 6.

Exhibit 6: timetable

Planned output	Work undertaken	Report finalised
2019 Audit Plan	November 2018 to January 2019	February 2019
Financial accounts work: • Audit of Financial Statements Report • Opinion on Financial Statements	January to May 2019	May 2019 June 2019
Performance work: • Structured Assessment • Governance arrangements underpinning quality and safety committees • Implementing the Well Being of Future Generations Act • Local project work	Timescales for individual projects will be discussed with the Health Board and detailed within the specific project briefings produced for each study.	
Annual Audit Report for 2019	November to December 2019	December 2019
2020 Audit Plan	December 2019 to January 2020	February / March 2020

Future developments to my audit work

24 Details of other future developments, including forthcoming changes to key International Financial Reporting Standards (IFRS) [for charitable funds, future changes to UK Generally Accepted Accounting Practice (UK GAAP)], the Wales Audit Office's Good Practice Exchange seminars and my planned work on the readiness of the Welsh public sector for Brexit, are set out in Appendix 3. This appendix also contains relevant information on data protection legislation.

Appendix 1

Respective responsibilities

My powers and duty to undertake your financial audit are set out in the Public Audit (Wales) Act 2004. It is my responsibility to issue a certificate and report on the financial statements which includes an opinion on:

- their 'truth and fairness', providing assurance that they:
  - are free from material misstatement, whether caused by fraud or error;
  - comply with the statutory and other applicable requirements; and
  - comply with all relevant requirements for accounting presentation and disclosure.
- whether the remuneration report is properly prepared.
- the regularity of the expenditure and income.
- the consistency of other information presented with the financial statements.

It must also state by exception if the Annual Governance Statement does not comply with requirements, if proper accounting records have not been kept, if disclosures required for remuneration and other transactions have not been made or if I have not received all the information and explanations I require.

In addition, I may place a substantive report on the financial statements if I wish to make additional observations on any matters within them.

My powers to undertake performance audit work at the Health Board are set out in the Government of Wales Acts 1998 and 2006 and this work also discharges my duty under the Public Audit (Wales) Act 2004 to satisfy myself that the body has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

My audit work does not relieve management and those charged with governance of their responsibilities which include:

- the preparation of the financial statements and annual report in accordance with applicable accounting standards and guidance;
- the keeping of proper accounting records;
- ensuring the regularity of financial transactions; and
- securing value for money in the use of resources.

Appendix 2

Performance audit work in last year's audit plan still in progress

Exhibit 7: 2018 performance audit work still in progress

Performance audit project	Status	Comment
Orthopaedic Services (Follow up)	Commencing data collection	Data collection has started, and analysis will inform onsite fieldwork which is due to commence in April 2019.
Clinical Coding (Follow up)	Reporting	Fieldwork complete, reporting expected in March 2019.
Local project to follow up previous recommendations	Commencing data collection	Data collection will inform onsite fieldwork planned for late Spring 2019.

Appendix 3

Other future developments

Forthcoming key IFRS changes

Exhibit 8: changes to IFRS standards

Standard	Effective date	Further details
IFRS 16 Leases	Expected in 2020-21	IFRS 16 will replace the current leases standard IAS 17. The key change is that it largely removes the distinction between operating and finance leases for lessees by introducing a single lessee accounting model that requires a lessee to recognise assets and liabilities for all leases with a term of more than 12 months, unless the underlying asset is of low value. It will lead to all leases being recognised on balance sheet as an asset based on a 'right of use' principle with a corresponding liability for future rentals. This is a significant change in lessee accounting.

Future changes to UK GAAP (charitable funds accounts)

Following the introduction of the new UK GAAP accounting regime in 2015-16, and the replacement of the Financial Reporting Standard for Smaller Entities (FRSSE) by Section 1A of FRS 102 in 2016-17, there will be no substantive changes to FRS 102 until 2019-20. Any changes made then are expected to be limited in nature.

More significant amendments are expected from 2022-23, reflecting recent changes in International Financial Reporting Standards, including accounting for financial instrument and leases.

Good Practice Exchange (GPX)

The Wales Audit Office's GPX helps public services improve by sharing knowledge and practices that work. Events are held where knowledge can be exchanged face to face and resources shared on line. Further information, including details of forthcoming GPX events and outputs from past seminars, is available on our website.

Brexit: preparations for the United Kingdom's departure from membership of the European Union

In accordance with Article 50 of the Treaty of Rome, on 29 March 2019 the United Kingdom will cease to be a member of the European Union. Negotiations are continuing, and it currently remains unclear whether agreement will be reached on a transition period to 31 December 2020, or whether a 'no deal' immediate exit will take place next March.

The Auditor General has commenced a programme of work looking at the arrangements that the devolved public sector in Wales, including all NHS bodies, is putting in place to prepare for, and respond to, Britain's exit from the European Union. This will take the form of a high-level overview to establish what is being put in place across the Welsh public sector, and what the key issues are from the perspectives of different parts of the Welsh public service.

The Auditor General intends to carry out this initial work in two tranches. In autumn 2018, he issued a call for evidence to compile a baseline summary of arrangements being put in place. On 19 February, the Auditor General issued a report Preparations in Wales for a 'no deal' Brexit. This will be followed up by further audit fieldwork during the rest of 2019.

Data Protection Legislation

Data protection legislation, including the Data Protection Act 2018 (DPA) and the General Data Protection Regulation (GDPR) has introduced updated requirements for processing personal data.

The Auditor General for Wales' (AGW's) access rights are not affected by the new data protection legislation or the Digital Economy Act, which also grants data sharing powers. Information about the AGW's access rights is available in the Guide to Legislation, as well as the shorter Access Rights leaflet which can be found on our website.

Fair Processing (Privacy) Notices provided to your employees, contractors and service users should include reference to the collecting and sharing of data with the AGW in connection with his audit work and studies.

Our own general fair processing notice is available on our website and, where appropriate, we shall provide further fair processing notices in connection with our work.

Where it is necessary to transfer information, we ask that this is done securely, through suitable methods such as hand to hand transfer of data using memory sticks or other secure means. We can accept password protected files if the password protection is strong, and the password is communicated to us separately and by a different means to the information, such as SMS text message.

If you would like to discuss any of the matters raised above, our Data Protection Officer can be contacted at martin.peters@audit.wales

4.2

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WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

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Auditor General for Wales

4.3

Primary care services – **Aneurin Bevan University Health Board**

Audit year: 2017-18

Date issued: March 2019

Document reference: 863A2018-19

This document has been prepared as part of work performed in accordance with statutory functions.

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

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

The people who delivered the work were Elaine Matthews and Emily Owen

Contents

The Health Board has comprehensive plans for primary and community care and is making steady progress towards implementing the key elements of the national vision. While performance levels are above average for many indicators, growing workforce pressures are challenging the sustainability of core GP services in some areas.

Summary report

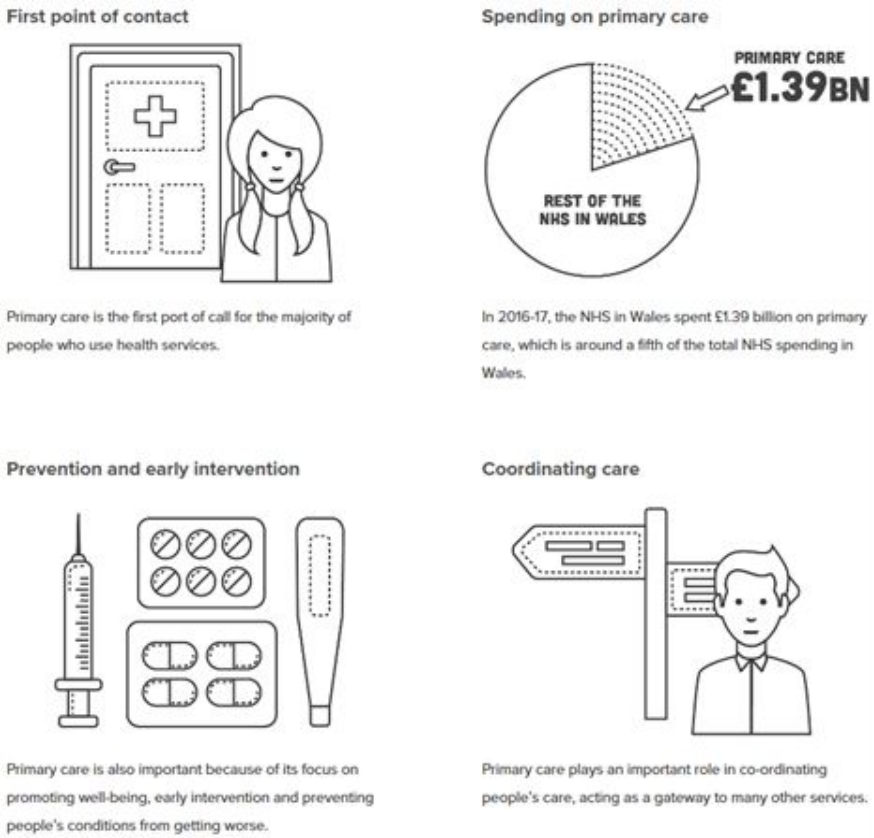
Background

1 The national primary care plan[1] defines primary care as follows:

‘Primary care is about those services which provide the first point of care, day or night for more than 90% of people’s contact with the NHS in Wales. General practice is a core element of primary care: it is not the only element – primary care encompasses many more health services, including, pharmacy, dentistry, and optometry. It is also – importantly – about coordinating access for people to the wide range of services in the local community to help meet their health and wellbeing needs.’

2 Exhibit 1 shows the important role that primary care plays in Wales.

Exhibit 1: why is primary care important in Wales?



[1] Our plan for a primary care service for Wales up to March 2018. Welsh Government. February 2015.

Source: Wales Audit Office. Note: Primary care expenditure is not consistently categorised by health boards. As such, it is likely that the £1.39bn figure from the NHS accounts does not represent the totality of primary care expenditure.

3 Wales has had plans for many years that stress the importance of primary care. The plans aim to rebalance the system of care by moving resources from secondary care towards primary and community care. The national primary care plan aims for a 'social model' that promotes physical, mental and social wellbeing, rather than just an absence of ill health. The core principles in the plan are: planning care locally; improving access and quality; equitable access; a skilled local workforce; and strong leadership.

4 The national primary care plan and the NHS Wales planning framework place an expectation on health boards to set out plans for primary care as part of their integrated medium term plan. Each plan should explain how the health board will develop the capacity and capability of primary care services.

5 To support the implementation of the national plan, NHS Wales issued a workforce plan[2] . Health boards are expected to put in place actions to secure, manage and support a sustainable primary care workforce shaped by local population needs and by prudent healthcare principles.

6 Primary care clusters are the main mechanism for planning services at a community level and were established in 2009[3]. Clusters are groups of neighbouring GP practices, other primary care services and partner organisations such as the ambulance service, councils and the third sector. There are 64 clusters (also known as neighbourhood care networks) in Wales. Their role is to plan and provide services for their local populations. The national primary care plan requires health boards to prioritise the rapid development of the clusters in their area.

7 To support the national primary care plan and encourage innovation, the Welsh Government introduced the national primary care fund in 2015-16. And in 2016-17, the fund totalled £41 million. Cluster development was provided with £10 million and health boards were allocated £3.8 million for pathfinder and pacesetter projects, which aimed to test elements of the primary care plan. The projects funded in this way have produced some new ways of working that have been collated into the Transformational Model of Primary and Community Care[4].

8 Since the national primary care plan was published in 2014, there have been a number of developments. In October 2017, the National Assembly's Health, Social

[2] NHS Wales. Planned Primary Care Workforce for Wales: Approach and development actions to be taken in support of the plan for a primary care service in Wales up to 2018. July 2015.

[3] Welsh Government. Setting the Direction Primary & Community Services Strategic Delivery Programme. 2009.

[4] http://www.primarycareone.wales.nhs.uk/pacesetters

Care and Sport Committee published a report following an inquiry into clusters[5]. The report noted impressive examples of progress but said that a step-change is required if clusters are to have a significant impact. The Welsh Government has continued to support the cluster approach through its programme for government[6].

9 However, at the same time as health boards are introducing new ways of working in primary care, there have been difficulties with recruitment and retention of GPs and other professionals. While there have been recent successes in recruiting GP trainees[7], in many areas more GP partners are retiring and there are particular difficulties in recruitment in rural areas.

10 The Welsh Government is planning to respond to the Parliamentary Review of Health and Social Care in Wales[8] with a £100 million transformation fund. It will be used to improve population health, drive integration of health and care services, build primary care, provide care closer to home, and transform hospital services.

11 It is therefore timely for the Auditor General to review primary care services in Wales. We have published two national reports on primary care this year. In April 2018, we published **A picture of primary care in Wales**. This provides a factual snapshot of primary care in Wales and contains background information that is not detailed in this report. And in July 2018, we published **GP out-of-hours services**.

12 To complement those national reports, this report summarises the findings of our work in Aneurin Bevan University Health Board (the Health Board), carried out between March and May 2018. We considered whether the Health Board is well placed to deliver the national vision for primary care as set out in the national plan. Appendix 1 shows our methods. The work focused specifically on areas:

- **Strategic planning**: Is the Health Board effectively driving implementation of the national primary care plan at a local level?
- **Investment**: Is the Health Board managing its finances to support transformation in primary care?
- **Workforce**: Is the Health Board well placed to deliver key aspects of the national primary care workforce plan?
- **Oversight**: Does the Health Board have effective arrangements for oversight and leadership that support transformation in primary care?
- **Performance**: Is the Health Board effectively monitoring its performance and progress in implementing its primary care plan?

[5] National Assembly for Wales, Health, Social Care and Sport Committee. Inquiry into Primary Care: Clusters. October 2017.

[6] Welsh Government. Prosperity for All: the national strategy. September 2017.

[7] The Welsh Government reported that 91% of Wales' GP training places were filled in 2017. 16 October 2017. http://gov.wales/newsroom/health-and-social-services/2017/gprecruitnew/?lang=en

[8] The Parliamentary Review of Health and Social Care in Wales. A Revolution from Within: Transforming Health and Care in Wales. Final Report. January 2018.

Key findings

13 Our overall conclusion is: **The Health Board has comprehensive plans for primary and community care and is making steady progress towards implementing the key elements of the national vision. While performance levels are above average for many indicators, growing workforce pressures are challenging the sustainability of core GP services in some areas.** Exhibit 2 sets out our key findings in more detail.

Exhibit 2: our main findings

Table detailing our main findings.

Our main findings
Strategic planning: The Health Board has comprehensive primary care plans that align with the national vision. The plans are informed by Neighbourhood Care Network plans but these networks are not yet fully mature. • The Health Board is collaborating with partners and has built on strong planning foundations to incorporate the key elements of the national vision within its primary care plans. • All Neighbourhood Care Networks (NCNs) have plans that support the Health Board's vision and network leads are generally satisfied with the Health Board's support, although the networks are not yet fully mature.
Investment: The Health Board has some clear examples of resources shifting closer to home and aims to increase investment in primary care but the available data make it difficult to accurately calculate the overall investment in primary care. • The Health Board's annual accounts suggest a real terms decrease in investment in primary care but the format of the accounts makes it difficult to say with any certainty. • The Health Board can point to specific examples of shifting resources towards primary and community care and is strengthening the way it monitors and evidences such shifts. • The Health Board routinely monitors NCN spending but not all NCN leads agreed they have sufficient financial autonomy. • The Health Board does not yet have a primary care estates strategy but is using a prioritisation process to guide investment in primary care buildings.
Workforce: Workforce challenges threaten the sustainability of some practices. The Health Board has assessed these challenges and is in the early stages of testing solutions. • The Health Board has mapped its current workforce and is facing challenges including increasing list sizes, an ageing workforce and a shortfall in GPs. • There are growing challenges to the sustainability of GP practices and the Health Board is having to directly manage an increasing number of practices for extended periods. • The Health Board is in the early stages of implementing the national vision of multi-professional primary care teams.
Oversight: The Health Board has strong leadership arrangements but current performance indicators do not allow oversight of all areas of primary care and there is scope for more Board-level focus on primary care

Our main findings
• The Chief Executive and Vice Chair are strong advocates for primary care transformation although there is scope to for more Board time to be focused on primary care. • Monitoring of primary care performance at Board and committees is hampered by a lack of data on some key areas of primary care. • GPs provide leadership of most of the NCNs and the leads gave positive views about the Health Board's support.
Performance: The Health Board is making steady progress in delivering its plans and performance compares well with the rest of Wales but a number of difficult challenges remain • Many aspects of the Health Board's primary care performance are better than the Welsh average although they are not all on target. • The Health Board is making steady progress delivering its plans for primary and community care but a number of difficult challenges remain.

Recommendations

14 As a result of this work, we have made a number of recommendations which are set out in Exhibit 3.

Exhibit 3: recommendations

Table outlining our recommendations to the Health Board.

Recommendations
Investment in primary care R1 While the Health Board recognises that it needs to shift resources from secondary to primary and community settings, it cannot demonstrate that this shift is happening. The Health Board should: a. Calculate a baseline position for its current investment and resource use in primary and community care. b. Review and report, at least annually, its investment in primary and community care, to assess progress since the baseline position and to monitor the extent to which it is succeeding in shifting resources towards primary and community care.
Oversight of primary care R2 We found scope to raise the profile of primary care in the Health Board, particularly at Board and committee level. The Health Board should develop an action plan for raising the profile of primary care in the Health Board. Actions could include ensuring a standing item on Board agendas regarding primary care, and publishing an annual report on primary care. R3 We found scope to improve the way in which primary care performance is monitored and reported at Board and committee level. The Health Board should: a. Review the contents of its Board and committee performance reports to ensure sufficient attention is paid to primary care.

Recommendations
b. Review the frequency with which Board and committees receive performance reports regarding primary care. c. Review the way it currently reports to Board and committees on its progress in delivering its plans for primary care, and importantly, how it is reporting on improved outcomes for patients in primary care.
New ways of working R4 Whilst the Health Board is taking steps towards implementing some new ways of working, more progress is required to evaluate the effectiveness of these new models and to mainstream their funding. The Health Board should: a. Work with the NCNs to agree a specific framework for evaluating new ways of working, to provide evidence of beneficial outcomes and inform decisions on whether to expand these models. b. Centrally collate evaluations of new ways of working and share the learning by publicising the key messages across all NCNs. c. Subject to positive evaluation, begin to fund these new models from mainstream funding, rather than from the Primary Care Development Fund. d. Work with the public to promote successful new ways of working, particularly new alternative first points of contact in primary care that have the potential to reduce demand for GP appointments.
Neighbourhood Care Networks (NCNs) R5 We found variation in the maturity of the NCNs, and scope to improve leadership. The Health Board should: a. Review the relative maturity of the NCNs, to develop and implement a plan to strengthen its support where necessary. b. Review the membership of the NCNs and attendance at NCN meetings to assess whether there is a need to increase representation from local authorities, third sector, lay representatives and other stakeholder groups. c. Clarify and publicise the governance and leadership arrangements for NCNs, to ensure better understanding of the responsibilities for decision-making. d. Ensure all NCN leads attend the Confident Primary Care Leaders course. e. Consider introducing a locum NCN lead post, to work across all NCNs providing additional capacity and backfill for leads. The post could also be valuable in sharing learning across NCNs.

Detailed report

Strategic planning: The Health Board has comprehensive primary care plans that align with the national vision. The plans are informed by Neighbourhood Care Network plans but these networks are not yet fully mature

The Health Board is collaborating with partners and has built on strong planning foundations to incorporate the key elements of the national vision within its primary care plans

Primary care transformation is a prominent aspect of the Health Board's overall strategy and planning intentions

15 The Health Board's overall strategic direction is set out in the Clinical Futures Programme, which has been running since 2004. This programme promotes services in or closer to the home, along with high quality hospital services. The programme is built around 12 Neighbourhood Care Networks (NCNs)[9].

16 While the Health Board has had a primary care strategy for many years, the national primary care plan became the focus of the Health Board's strategy in the integrated medium term plan (IMTP) starting in 2015-16[10]. That IMTP acknowledged that the focus had historically been on secondary care and aims to move resources towards primary care.

17 The 2015-16 IMTP contained a number of service change plans (SCPs) related to primary care. The SCP 3 - Primary Care Services (Independent Contractors) set out a vision for general practice, optometry practices, general dental practices and community pharmacies. The SCP was based on the five principles from the national plan and clearly articulated the need for sustainable general medical services, to address UK-wide challenges relating to increasing workload, managing patients with more complex conditions and recruitment and retention issues. The plan also set out the need for a sustainable estate, and improved use of information and technology. Other developments affecting primary and community care were set out in a number of other SCPs related to reducing health inequalities, bringing care closer to home and managing chronic conditions.

18 The Health Board is working with the five local authorities as part of the Greater Gwent Health, Social Care & Wellbeing Partnership (the Regional Partnership

[9] Aneurin Bevan Health Board, Neighbourhood Care Network Strategic Plan 2013 – 2018.

[10] Aneurin Bevan University Health Board. 2015/16 – 2017/18 Integrated Medium Term Plan Technical Plan. March 2015.

Board). The Regional Partnership Board finalised the Care Closer to Home Strategy in 2017[11], which represents level 1 of the Health Board's Clinical Futures Strategy. This strategy responds to the findings of the Parliamentary Review into Health and Social Care although at the time of our audit work, the strategy had not yet been approved by the Board.

19 The Health Board's IMTP for 2018-19 onwards[12] sets out updated plans for primary care under SCP 2 – Delivering an Integrated System of Health, Care and Wellbeing. The plan states that NCNs are continuing to mature and play a key role in the development of future models of integrated health, care and well-being services.

20 The primary and community care divisional plan for 2018-19 onwards[13] articulates in detail how the Health Board will address the challenges of an ageing population, health inequalities and workforce deficits. The intention is to re-model services over five years to reduce unnecessary complexity and deliver a more integrated, inter-professional way of working across health, social care and the third sector. The plan also states that new model of service provision will require the development of 'hubs', both physical and virtual, at key locations in each borough. While the locations are not yet agreed, these health and well-being hubs will provide a wide range of integrated services relevant for the local population.

The Health Board's primary and community care divisional plan aligns well with most of the key aspects of the national primary care plan

21 We reviewed the divisional plan to assess whether it contained key elements of the national primary care plan and Transformational Model. We found that the plan was well developed in the majority of areas, although there were a small number of areas where further development is required. Strong areas of the plan include:

- Integration with other relevant Health Board strategies;
- Plans to shift resources from hospitals to community settings;
- Workforce plans for primary and community care;
- The use of clinical triage systems and multi-professional teams;
- The role of primary care support units in sustaining GP practices; and
- Arrangements for leadership of transformation.

22 The areas of the plan that require further development are set out in Exhibit 4.

[11] Greater Gwent Health, Social Care and Well-being Partnership Board. Care Closer to Home: Gwent Health and Wellbeing strategy. 2017.

[12] Aneurin Bevan University Health Board. Integrated Medium Term Plan 2018/19 – 2020/21. March 2018.

[13] Aneurin Bevan University Health Board, Primary Care & Community Services Division. IMTP Divisional Plan 2018/19 – 2020/21. February 2018.

Exhibit 4: areas of the primary and community care divisional plan that require further development

Area of plan	Division's progress to date	Further development needed
An estate strategy based on evidence of service needs.	The Division has an estates group, which is taking forward development of an estates strategy across all primary and community estates.	Estates strategy required to ensure future capital investment is appropriated targeted.
How modern technology will be used effectively.	The Division's IT group will take forward work to improve the use of IT in GP practices.	Innovative of technology can provide solutions to challenges facing primary care such as triage.
Evaluation of how improved primary care will be measured and reported, including tracking the shift of resources.	The Division is mapping existing spend across primary and secondary care and benchmarking it with other Health Boards. It has produced a framework and created a group of Divisional Directors to take forward this work. The Division also has plans to report on the impact of new extended roles.	Evaluation is important in order to determine where investment has worked or not worked. Some projects have been evaluated but not reported in a consistent way.
Evaluation of the impact of any primary care service changes.	The evaluations that have been completed so far are of individual projects so do not show the impact on patients of changes across primary care.	Going beyond the evaluation of individual developments, the impact of changes to primary care on patients should be evaluated.

Source: Wales Audit Office review of the Health Board's Primary Care and Community Services Division, IMTP Divisional Plan 2018-19 – 2020-21

The Health Board can provide examples of good engagement and collaboration with stakeholders in developing its primary care plans

23 It is important for health boards to collaborate with stakeholders in developing their plans. The Health Board consulted formally on Clinical Futures in 2014. This was followed by a series of listening events and an engagement strategy in 2015[14]. The Health Board then carried out extensive engagement on Clinical Futures and co-produced the Care Closer to Home strategy with the public and third sector.

24 Other positive examples of engagement and collaboration on primary care include:

[14] Aneurin Bevan University Health Board. Engagement Strategy. Board, 28 January 2015.

- Talk Health events and locality fora in each of the five boroughs;[15]
- Engagement with local politicians about transforming primary care;
- Various engagement activities described in NCN plans; and
- Specific engagement activities with the public when potential closures and changes to local primary care services are proposed.

25 The Community Health Council representative told us that they have regular discussions with the Director of Primary and Community Care where the Community Health Council is informed of primary care strategies and developments that the Health Board plans to introduce and are then able to offer suggestions into the strategy going forward.

26 The Health Board can demonstrate some examples of positive engagement with primary care professionals, including:

- workshops with NCN leads to determine key priorities for the IMTP;
- positive relationships with the Gwent Local Medical Committee (LMC) although the LMC representative expressed some frustration that ideas from LMC members are not always taken forward; and
- successful delivery of service changes through collaboration with the South East Wales Regional Optometric Committee.

All Neighbourhood Care Networks have plans that support the Health Board's vision and network leads are generally satisfied with the Health Board's support, although the networks are not yet fully mature

27 We looked at the way that the Health Board provides support to NCNs in developing local needs assessments and NCN plans. Our NCN lead survey found:

- all seven respondents agreed that they had received helpful guidance from the Health Board when it was developing its cluster plan;
- all seven respondents agreed that they had received support from the Health Board to develop a needs analysis of their local population; and
- six respondents agreed that "the Health Board listens to my cluster when it is developing Health Board-level priorities for primary care".

28 Exhibit 5 shows the views of NCN and cluster leads on the level of maturity within their NCN or cluster. At the Health Board, six respondents said their NCN was 'stable and starting to deliver' and one respondent said their NCN was 'developmental'. Aneurin Bevan is the only health board where no leads rated their cluster as mature.

[15] Aneurin Bevan University Health Board Engages. Board, 27 September 2017.

Exhibit 5: cluster and NCN leads' views on the level of their organisation's development

The table provides the number of clusters at each of three levels of maturity.

	1 = Developmental	2 = Stable and starting to deliver	3 = Mature
Abertawe Bro Morgannwg	1	4	2
Aneurin Bevan	1	6	0
Betsi Cadwaladr	2	5	1
Cwm Taf	0	5	2
Cardiff and Vale	1	5	2
Hywel Dda	0	4	1
Powys	1	1	1
Wales	6	30	9

Note:
1 = Developmental: still at early stages of development with significant support required; not all cluster members fully engaged.
2 = Stable and starting to deliver: Starting to deliver some benefits but still early days, ongoing support required and full potential yet to be reached.
3 = Mature: all cluster members fully engaged; delivering across a number of areas in line with the cluster plan.
Source: Wales Audit Office survey of cluster leads, April 2018

29 The Division provides support to the NCNs through dedicated teams of staff. There are partnership managers, network managers and support officers at NCN level and teams of staff to support each of the professional contracts.

30 The NCN support teams help to interpret national guidance and draw together themes from the Practice Development Plans submitted by individual GP practices. Support teams also oversee NCN expenditure, co-ordinate NCN forums, represent the NCN at meetings and help to implement projects on behalf of the NCNs. NCN members are also encouraged to take part in training provided by the Health Board, including the 1000 Lives Wales Improving Quality Together (IQT) at silver level.

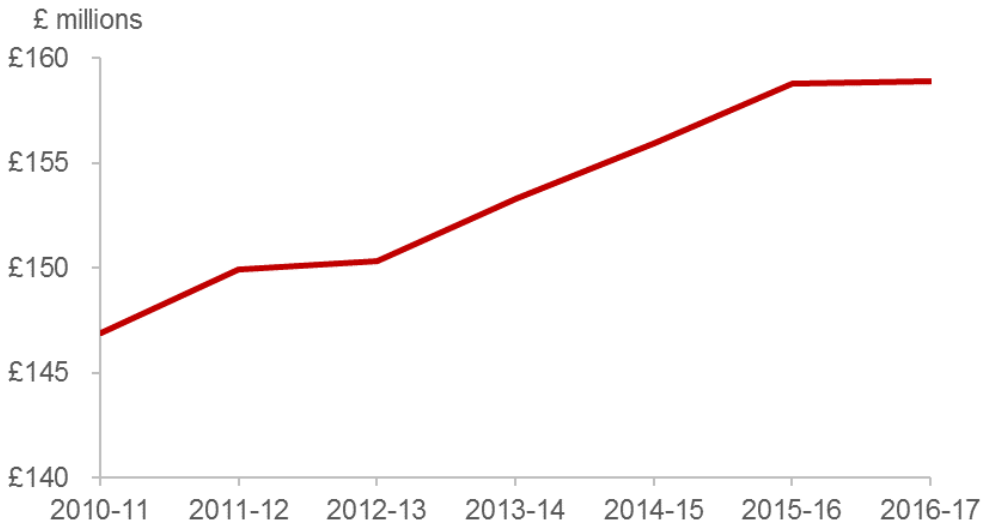
31 Division staff told us that the Health Board's initial light touch approach to supporting NCNs had resulted in too much variation between NCNs in their ability to plan and deliver transformational change. Staff also told us that whilst all NCNs were becoming stronger organisations, there was more work required to ensure all NCNs are able to plan and deliver service change.

Investment: The Health Board has some clear examples of resources shifting closer to home and aims to increase investment in primary care but the available data make it difficult to accurately calculate the overall investment in primary care

The Health Board's annual accounts suggest a real terms decrease in investment in primary care but the format of the accounts makes it difficult to say with any certainty

32 Exhibit 6 is based on data from the Health Board's annual accounts and sets out the long-term expenditure on primary care. The total includes spending on General Medical Services (GMS), Pharmaceutical Services, General Dental Services (GDS), General Ophthalmic Services (GOS) and 'Other Primary Health Care' expenditure[16]. The exhibit shows that the Health Board spent £158.9 million on these primary care services in 2016-17, up from £146.9 million in 2010-11.

Exhibit 6: the Health Board's spending on primary care services



Note: The y-axis does not begin at zero. We have excluded expenditure on 'Prescribed drugs and appliances' due to variable nature of this expenditure,

[16] Excludes spending of £95 million on 'Prescribed drugs and appliances'.

partly as a result of drug price fluctuations. 'Other Primary Health Care' is a gather-all category in the accounts, used to record spending on numerous primary care items that do not fit into the other categories.

Source: LHBs' Annual Accounts

33 The trend in Exhibit 6 shows a steady increase in spending from 2010-11 to 2016-17. The Division explained that over this period, expenditure increased in dental, optometry and 'Other' primary care. However, there was a reduction in GMS expenditure between 2015-16 and 2016-17 because a review by the Valuation Office Agency reassessed the business rates due for GP practices based on a lower valuation over a number of years. This resulted in a reduced budget allocation for GMS in 2016-17.

34 After taking into account the effect of inflation, the Health Board's overall spending on primary care decreased by 1% in real terms between 2010-11 and 2016-17, which is not enough to keep pace with inflation.

35 Across Wales we found issues with the way that primary care expenditure is recorded in the accounts. Spending is not consistently categorised by health boards and the figures recorded in the accounts often do not represent the totality of primary care expenditure. The Health Board told us that they receive additional funding for primary care from the Welsh Government, which is not included in the above figures. In 2016-17, the Health Board received an additional £8.4 million which it allocated in the following ways:

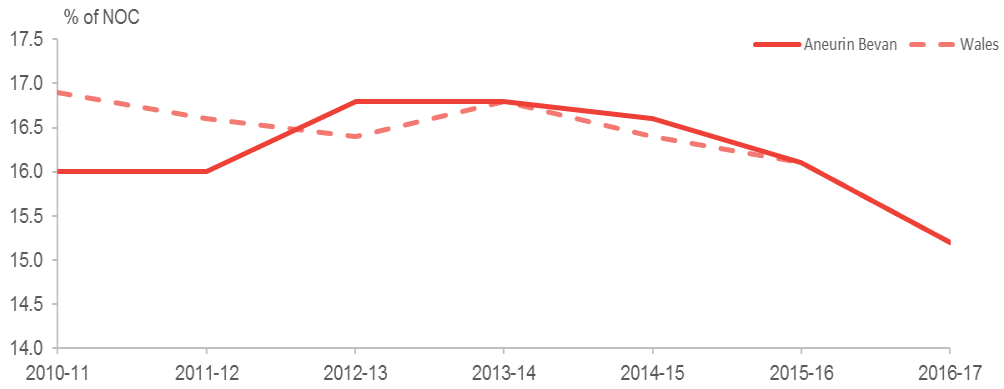
- £4.4 million for 12 projects to transform services across primary, community services and mental health (eg primary care support team, anticoagulation service transformation, Living Well, Living Longer);
- £1.88 million for the NCNs to develop new activities based on their own plans;
- £1.236 million for the pathfinder and pacesetter projects (A is for Access, wet AMD, OTDC/glaucoma, cardiovascular inverse care law);
- £0.67 million to support the primary care workforce (eg. development of pharmaceutical support in care homes, primary care nurse led childhood immunisation team); and
- £0.225 million for other projects (e.g. development of occupational health services for GPs).

The Health Board can point to specific examples of shifting resources towards primary and community care and is strengthening the way it monitors and evidences such shifts

36 For many years, the NHS in Wales has planned to shift resources towards primary care, to reverse the 'relative under-development of primary care'[17]. However, issues with the format of NHS accounts makes it difficult to say whether health boards have secured such shifts.

37 Exhibit 7 shows the Health Board's expenditure on primary care as a percentage of its total expenditure. The figures exclude expenditure on prescribed drugs and appliances. The exhibit shows that despite national priorities for shifting resources towards primary care, across Wales as a whole, primary care spending has not kept pace with health boards' total spending. The trend for the Health Board is similar to that of Wales with a peak in 2013-14 followed by year on year reductions.

Exhibit 7: the Health Board's expenditure on primary care as a percentage of its total expenditure (Net Operating Cost, 2010-11 to 2016-17)



Note: The y-axis does not begin at zero.

Source: LHBs' Annual Accounts

38 We asked whether health boards are taking specific actions to achieve a shift in resources towards primary care. We found that none of the health boards has set targets for moving resources towards primary care and none of the health boards has quantified the total amount of resource moved towards primary care since the inception of the national primary care plan in 2014.

39 The Health Board understands that it needs to be able to provide evidence of money and services shifting from secondary to primary care. To achieve this, the

[17] Welsh Government. Improving Health in Wales: The Future of Primary Care. July 2001.

Health Board has recently developed a framework to support the shift of services from secondary to primary care settings, based on developing a clear business case for each service that they want to change[18].

40 The bullet points below show some specific examples from the Health Board where services and resources have shifted from hospitals towards primary and community care:

- Ophthalmic Diagnostic Treatment Centres: Due to long waiting lists for hospital based ophthalmology services, the Health Board has developed assessment and treatment services for wet age-related macular degeneration (wet AMD) and glaucoma in high street opticians in each borough. The Welsh Government provided pathfinder funding of £240,000 for three years. In 2018-19 annual funding of £161,000 will come from the Health Board's secondary care budget.
- Primary Care Anticoagulation Service: the Welsh Government provided funding of £763,500 a year to pump-prime the transfer of INR testing[19] from hospital to primary care. Uptake of INR testing in primary care practices has been good and performance measures already show a reduction in tests in hospital and fewer emergency admissions for complications. It is also more convenient for patients. At the time of the audit, the Health Board was investigating how to fund this service in the longer term.

41 The Health Board has plans to shift a range of other services to primary care including extended skin surgery, specialist orthodontics services and support for chronic conditions such as diabetes and chronic obstructive pulmonary disease.

The Health Board routinely monitors NCN spending but not all NCN leads agreed they have sufficient financial autonomy

42 Health boards need to strike the right balance of giving autonomy to clusters whilst at the same time overseeing their spending. The Health Board's approach to overseeing NCN spending is to produce monthly monitoring data on each NCN's financial position. The Health Board holds regular discussions with the NCNs regarding how much of their allocation is still available to spend, and what their plans are for spending the money. The overall financial position is reported at NCN Clinical Leads meetings.

[18] Aneurin Bevan University Health Board, Division of Primary and Community Care. Improving value through allocative and technical efficiency financial framework to support secondary acute services shift to community/primary service delivery.

[19] Anticoagulant medicines, such as warfarin, are often prescribed for people who've had a condition caused by a blood clot, such as a stroke. The international normalised ratio (INR) is a measure of how long it takes blood to clot and is used to determine the required dose of warfarin [NHS Choices].

43 In our survey of NCN leads, we found that all seven respondents agreed that the Health Board effectively monitors the NCNs' expenditure. All seven respondents to our survey agreed that "the cluster spends all the funding it receives" and six out of seven respondents agreed that the "cluster is able to spend its funding quickly once it has decided how to allocate its funding". Only three respondents agreed that "the health board gives my cluster sufficient financial autonomy". The other four respondents said they 'neither agreed nor disagreed' with this statement.

The Health Board does not yet have a primary care estates strategy but is using a prioritisation process to guide investment in primary care buildings

44 The Health Board's IMTP in 2015-16 recognises that many primary care buildings are not fit for purpose and do not support extending the range of services envisaged in its plans for primary care. While the Health Board does not have a primary care estates strategy, it takes a considered approach to investing in primary care premises. Each year it undertakes a prioritisation process to identify which schemes it wants to progress through Welsh Government funding.

45 The Health Board opened a new primary care centre in Brynmawr in June 2018 and plans to open another centre in Llanbradach in spring 2019. These developments involve third party developers and are funded by Health Board revenue monies. In 2017, the Welsh Government announced support to develop health and wellbeing centres with a capital value of around £68 million across Wales[20]. The development of centres at Tredegar and Newport were part of this announcement.

46 Health Board also provides around £300,000 a year in improvement grants to support primary care infrastructure[21]. These grants support compliance with the Equality Act 2010, increased clinical space and better infection control. The Health Board's expectation is that estates planning will move to the NCNs at borough level supported by the Health Board's planning team.

47 The NHS Wales Informatics Service leads on most primary care IT developments but the Health Board provided funding of £320,000 in 2016-17 for equipment such as receptionist headsets and computer screens.

48 Some NCN plans include IT developments including the roll out of My Health Online for booking appointments and repeat prescriptions, and mobile devices for

[20] Welsh Government. Plans for 19 new health and care centres across Wales announced by Vaughan Gething. 6 December 2017.

[21] The National Health Service (General Medical Services - Premises Costs) (Wales) Directions 2015 (2015 No.9)

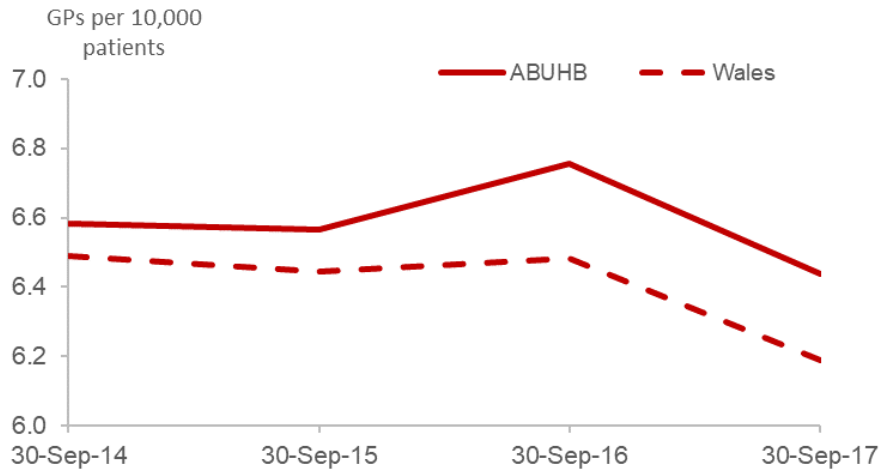
district nurses. In addition, some GP practices in Gwent are piloting Skype for consultations[22].

Workforce: Workforce challenges threaten the sustainability of some practices. The Health Board has assessed these challenges and is in the early stages of testing solutions

The Health Board has mapped its current workforce and is facing challenges including increasing list sizes, an ageing workforce and a shortfall in GPs

49 The Health Board has a slightly higher number of GPs per 10,000 population (6.44) than average in Wales (6.19) (Exhibit 8). However, the number of GP partnerships has reduced from 88 in September 2014 to 78 at the time of our audit, and the percentage of partnerships with just one partner (13%) is slightly higher than the Wales average (11%).

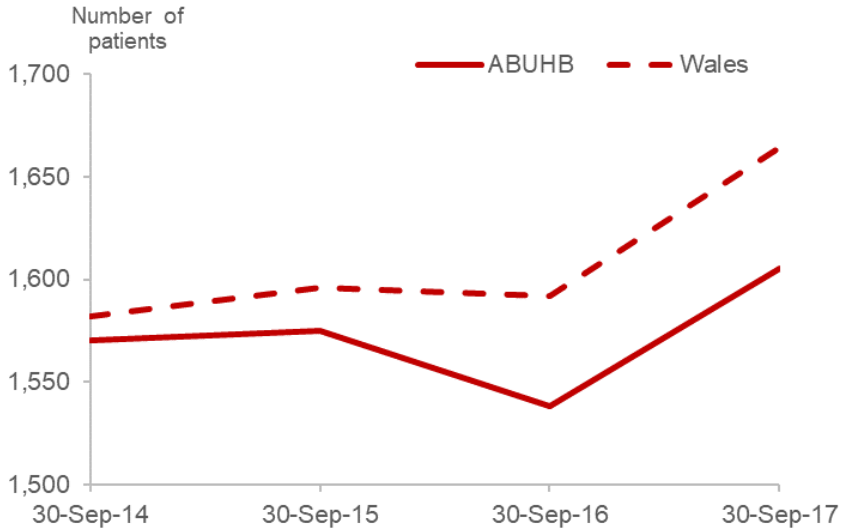
Exhibit 8: number of GPs per 10,000 population



[22] www.publictechnology.net/articles/features/how-skype-ending-isolation-nhs-staff-wales

50 As shown in Exhibit 9, the average list size per GP in the Health Board has increased although it is lower than the Wales average.

Exhibit 9: average list size per GP



Source: Welsh Government, September 2017

51 Exhibit 10 shows that the proportion of GPs that are female is higher in the Health Board than the Wales average, while the proportion of GPs aged over 55 is similar to the Wales average.

Exhibit 10: demographics of GPs by age and gender

	Aneurin Bevan University Health Board	Wales
• Aged over 55	22%	23%
• Female	58%	54%

Source: Welsh Government, 30 September 2017

52 The number of dentists and optometrists offering NHS care is increasing. The Health Board had 309 General Dental Services contractors in 2017, up from 285 in 2014. Optometrist numbers also increased, from 149 in 2014 to 159 in 2017.

53 The national primary care plan requires health boards to map its workforce. The Health Board has a Primary Care Workforce Group which reviews the workforce data, develops recruitment plans and considers alternative roles/models. They have analysed the age, gender and employment status of the workforce at each GMS practice, including GPs and all non-medical clinical staff employed directly by the practices or NCNs.

54 The Health Board has also reviewed the age profile of primary and community staff directly employed across the Division. Nearly 40% of the Division's workforce are aged over 50, and a further 20% are aged over 55.

55 The Division has compared its models of care with those across the rest of the UK to assess opportunities to adjust the skill mix. Using this intelligence, the Health Board conducted modelling to predict the numbers of GPs and other extended roles needed in Gwent to sustain services in future. This model shows the Health Board has a shortfall of 35 substantive GPs when compared to its chosen benchmark of 1 full time equivalent GP per 1,800 population. The following section comments on the Health Board's approach to creating a more stable and sustainable primary care workforce.

There are growing challenges to the sustainability of GP practices and the Health Board is having to directly manage an increasing number of practices for extended periods

56 The Health Board reports that over the last year or so it is experiencing increasing numbers of GP partners retiring, which is threatening the sustainability of practices. In November 2017, the Division produced a thorough report on general practice sustainability. The report stated that the challenges to sustainability in the past five years are greater than those in the preceding 65 years. The report contains 32 recommendations to support the design and delivery of modern and resilient services to meet population need in the short, medium and long term. They have a detailed action plan and have established a primary care sustainability board to oversee the implementation of the recommendations.

57 To identify practices at risk of closure, the Division is using the revised GP sustainability framework[23] at all practices in Gwent. The Division identified 14 practices at high risk, 22 at medium risk and 43 at low risk. The areas with the highest numbers of practices at risk are in Blaenau Gwent and Caerphilly North. The Division is working closely with GPs to design solutions for a targeted programme of support for high and medium risk practices.

58 Many health boards have developed Primary Care Support Units (although the names of these vary across Wales) to support GP practices. The Health Board has a Primary Care Operational Support Team (PCOST). PCOST staff work alongside

[23] Welsh Government. Revised GP Sustainability Assessment Framework: 2017/18. 21 April 2017.

practice staff in a range of clinical and managerial roles. The Health Board has successfully recruited clinical leads to the PCOST but the LMC has expressed concern that the successful applicants were recruited from the existing pool of GPs, which affects the sustainability of the practices in which they had been working.

59 The Health Board is directly managing four practices. Practices have been handed over to the Health Board because GP partners have retired and the Health Board has not been able to find replacements to take over the GMS contract. Factors contributing to these retirements include high numbers of patients with complex conditions placing a greater demand on clinical time, and the poor condition of practice premises.

60 Sometimes practices are handed back to the Health Board with as little as three months' notice. In the past, directly managing a practice was a temporary measure and the Health Board only had one at a time, but increasingly it is proving difficult to return managed practices to a GMS contract holder despite advertising widely and providing new premises. One practice has now been directly managed by the Health Board for three years.

61 GP partners are increasingly choosing to merge practices as they recognise the limitations of small practices. The Health Board has also closed seven branch surgeries in recent years because of difficulties in providing enough staff to cover these branches.

62 The Health Board received funding from Welsh Government of just over a £1 million in 2016-17 and 2017-18 to run the PCOST. Expenditure on managed practices has also increased. The Division estimates that the cost of a managed practice is £200,000 a year more than through GMS because managed practices are reliant on higher-cost locums.

63 The Division is aware of the risks of moving additional services to already stretched GP practices.

The Health Board is in the early stages of implementing the national vision of multi-professional primary care teams

64 The national plan says that in future, the role of GPs will be to provide overarching leadership of multi-professional teams. These teams would include pharmacists, therapists, optometrists, paramedics, advanced practice nurses and others. The national workforce plan says that health boards must find opportunities for these professionals to improve access by providing the first point of contact for patients.

65 The Division's IMTP sets out three models that it is exploring for new ways of working in primary and community care:

- primary care model: this model assumes that if a practice is short by one GP, then an advanced nurse could do 50% of a GP's work, a pharmacist could do 25% and other professionals could do the remaining 25%.

- graduated care model: the Health Board is closing community beds on two wards and GPs could lead the replacement services. The Buurtzorg principles[24] will be applied to a community nursing pilot to inform a new model of community nursing.
- integrated model: to deliver the Care Closer to Home strategy, the Division is developing its five year plan to provide primary and community services via the NCNs through its existing workforce working at the top of their skills and employing additional staff from a wide range of disciplines in new roles.

66 The main area of activity funded by the NCNs has been the appointment of 16.60 whole time equivalent practice based pharmacists over the past two years. Some practices have also employed their own pharmacists. The initial findings of a Health Board evaluation of practice-based pharmacists are that when compared to GPs, pharmacists can spend twice as long with patients, but the cost is lower and the quality of the medicines review is better.

67 The bullet points below describe other new roles introduced in NCNs:

- social prescribing in Torfaen is jointly funded by NCNs and the local authority. The social prescriber enables patients to access information about local legal and benefits services. A survey of primary care practitioners found that most respondents said social prescribers had reduced demand for, and resulted in more appropriate use of, primary care consultations[25].
- eleven practice-based social workers were appointed by NCNs in Caerphilly, funded through the Integrated Care Fund, social services and other sources. The NCNs have assessed these social workers as working well within the practice multi-disciplinary teams and agreed to maintain funding for 2017-18. However, the Health Board has withdrawn its funding due to the high cost. The NCN leads told us they were unhappy about this as they rated the social workers as a success.

68 The Health Board is also recruiting two physician associates to work in primary care. While NHS Wales has a governance framework for employing physician associates, they are not yet fully regulated by an organisation like the General Medical Council. It is important to provide good supervision and ongoing evaluation of their impact.[26]

[24] The Buurtzorg model of district nursing started in the Netherlands and has taken off around the world. Each Buurtzorg nursing team stands alone, is self-determining and made up of entirely registered nurses Each nurse works to design and implement the most appropriate and effective care plan based on an individual's needs.

[25] Social Prescribing in Torfaen: A Partnership between North & South Torfaen Neighbourhood Care Networks (NCN's), Our Learning so Far: October 2015-March 2017. www.primarycareone.wales.nhs.uk/sitesplus/documents/1191/Social%20Prescribing%20in%20Torfaen%20Oct%2015%20-%20Mar%2017.pdf

[26] www.gpone.wales.nhs.uk/opendoc/293958

69 The Transformational Model highlights the importance of enhanced multi-disciplinary teams providing a shared resource for all practices in a cluster. To implement this model, the Health Board is recruiting occupational therapists, advanced nurse practitioners and advanced paramedics. However, there are complications because of competing recruitment from organisations like the Welsh Ambulance Services NHS Trust.

70 The Health Board is planning to use one managed practice in Brynmawr, Blaenau Gwent East to test out the Transformational Model and has asked the Welsh Government for funding to pursue this. The Blaen y Cwm practice moved to new premises in June 2018. The new resource centre will provide services including General Medical Services, Community Dental Services, District Nursing, Reproductive and Sexual Health, Mental Health Services, Diabetic Retinopathy Screening and Pharmacy.

71 The Transformational Model highlights the need for shared systems of triage for members of the primary care team. The Health Board is currently trialling electronic triage systems in some practices. However, as GP practices do not currently report to the Health Board on which practitioners see the patients, the Health Board expressed concerns that it is difficult to assess how well triage is working in practice.

72 The Community Health Council representative stated that the new multi-professional primary care team model (known as the Prestatyn model) is having a positive impact on the current GP sustainability issues. The Community Health Council would like to see this model delivered further within primary care but stated that it is imperative that patients understand why they are being asked to see a different primary care professional instead of their GP. It is important that the Health Board ensures that the public understand this approach and raises awareness to increase public support for these new ways of working.

73 The Health Board is taking every opportunity to address the challenges it is facing with GP recruitment and retention. It also recognises the benefits of providing improved access to a wide range of services in primary care. It is important that the Health Board ensures that the public understand this approach and raises awareness to increase public support for these new ways of working.

Oversight: The Health Board has strong leadership arrangements but current performance indicators do not allow oversight of all areas of primary care and there is scope for more Board-level focus on primary care

The Chief Executive and Vice Chair are strong advocates for primary care transformation although there is scope for more Board time to be focused time on primary care

74 To transform primary care, health boards need clear and effective arrangements for oversight and senior leadership. The vice chairs of health boards have a specific responsibility for championing primary care. The Vice Chair chairs the Public Partnerships and Wellbeing Committee and the Regional Partnership Board, which is the main driver for the development of the Care Closer to Home strategy, including primary care modernisation in Gwent. He attends all NCN lead meetings and locality meetings to reduce the gap between the Board and primary care practitioners. His term ended in June 2018 although he will continue for another year with the Health Board as a special advisor.

75 The Chief Executive has a strong grip on primary care and is the lead executive on the National Primary Care Board. The Health Board merged primary care and community services into one Division in 2018. There is a strong team in the Division and support for the Transformational Model from the Chief Operating Officer, Divisional Director of Primary Care and Community Services, Head of Primary Care, Director of Public Health and Assistant Medical Director. They are working closely with divisional business managers for HR, planning, performance and finance to support the NCNs and the implementation of their plans.

76 The Chief Operating Officer is the Health Board's Executive Lead for primary care, a role he does alongside community care, mental health and learning disabilities as well as leading on delivery of planned and unscheduled care. He also chairs the Primary Care and Network Development Board. While this is a broad portfolio it does provide clear leadership for the whole primary and community care transformation agenda.

77 The Assistant Medical Director engages regularly with primary care professionals. He line manages the NCN leads and monitors contracts with over 300 independent contractors. He recognises the importance of good relationship management in a complex environment.

78 However, only three out of seven respondents to our NCN lead survey agreed that the Health Board gives a sufficiently high priority to transforming primary care. Concerns were raised that despite the Health Board's clear determination to strengthen primary and community care there was more focus on developing the

specialist and critical care centre. There were also concerns that the pace of change is not sufficient to address primary care recruitment problems. In addition, the LMC was critical that primary care did not have a stronger voice at Board level. While it is clear that the Health Board is committed to transforming primary care it could do more to raise the profile of primary care at Board level.

Monitoring of primary care performance at Board and committees is hampered by a lack of data on some key areas of primary care

79 At Board level, the Executive Team Report provides updates on developments in primary and community care at each meeting. There are also Board papers on primary care practice developments and closures and on NCN plans and achievements. There is an increasing focus on primary care through reports on progress with implementing the strategic change plans and the development of the Care Closer to Home Strategy. However, the main focus of Board business is Clinical Futures and secondary care.

80 The Board and the Finance and Performance Committee review the Integrated Performance Report every month on progress against Welsh Government National Outcomes and Performance Framework. The measures related to primary care include childhood immunisation and flu vaccinations, smoking cessation, access to GP appointments, GP out-of-hours services, NHS primary dental care and prescribing indicators. However, the main focus of the framework is secondary care targets. Moreover, there are no primary care indicators reported in the high-level dashboard seen at Board. In May 2018, the Board recognised this shortcoming and agreed to redesign the Integrated Performance Report to increase the prominence of primary and community care services.

81 The Health Board's Public Partnerships and Wellbeing Committee's terms of reference were updated in 2017 to include a specific reference to primary care. While the committee's agendas focus on public health and the wider developments by the Regional Partnership Board and five Public Services Boards, over the last year there has been good, regular coverage of primary care through a range of reports including an annual report on primary care. However, there are no reports on performance of primary care services by GPs and other primary care staff nor how the NCNs are progressing with their projects. This lack of activity data is hampering their ability to plan and develop new services in primary care. In addition, the primary care annual report was not provided to the full Board, which missed the opportunity to share progress in transforming primary care more widely.

82 The Health Board produces more detailed reports on primary care performance at divisional level. Each month the Division reviews a balanced scorecard, which is aligned to the IMTP. The scorecard covers 60 indicators but most of these indicators relate to community services and few of them relate to primary care.

83 At the NCN level, each NCN receives a monthly performance report containing key indicators relating to their strategic aims of population health, access, planned care, urgent care and clinical governance. These reports provide a good range of indicators to support the implementation of actions for the NCNs but are not reported to any forum in the Health Board.

GPs provide leadership of most of the NCNs and the leads gave positive views about the Health Board's support

84 Exhibit 11 sets out the professional backgrounds of the cluster and NCN leads across Wales. In the Health Board, the NCN leads are mostly GPs. The three other professionals that lead NCNs are a nurse practitioner, a pharmacist, and a public health consultant.

Exhibit 11: professional background of the cluster and NCN leads

The table provides the numbers of cluster and NCN leads who are GPs and the number of cluster leads who are other professionals in each Health Board

Health Board	Number of clusters leads: GPs	Number of clusters leads: other professionals	Total number of clusters
Abertawe Bro Morgannwg	11	0	11
Aneurin Bevan	9	3	12
Betsi Cadwaladr	12	2	14
Cwm Taf	5	6	8
Cardiff and Vale	9	0	9
Hywel Dda	6	1	7
Powys	2	1	3
Wales	54	13	64

Note: While the total number of clusters is 64, the total number of cluster leads is 67 because Cwm Taf has both GP and other professional leads for its clusters.

Source: Wales Audit Office, Health Board self-assessment returns.

85 Public Health Wales' Primary and Community Care Development and Innovation Hub has developed a Confident Leaders Programme, which has been attended by 40 cluster and NCN leads who continue to learn from each other through a

community of practice. Our survey found that five NCN leads had attended the programme, with four agreeing it had helped them improve as an NCN lead.

86 All NCN leads that responded to our survey agreed that the Health Board provides them with effective support to undertake their role. However, only three respondents agreed with the statement 'I have enough time in my day to focus on cluster development'.

87 The Health Board recognises that local delivery of the Transformational Model is dependent on effective leadership, professional engagement, community involvement and a workforce committed to new ways of working. Further investment in leadership development in the NCNs will be critical to the delivery of their plans to transform primary care.

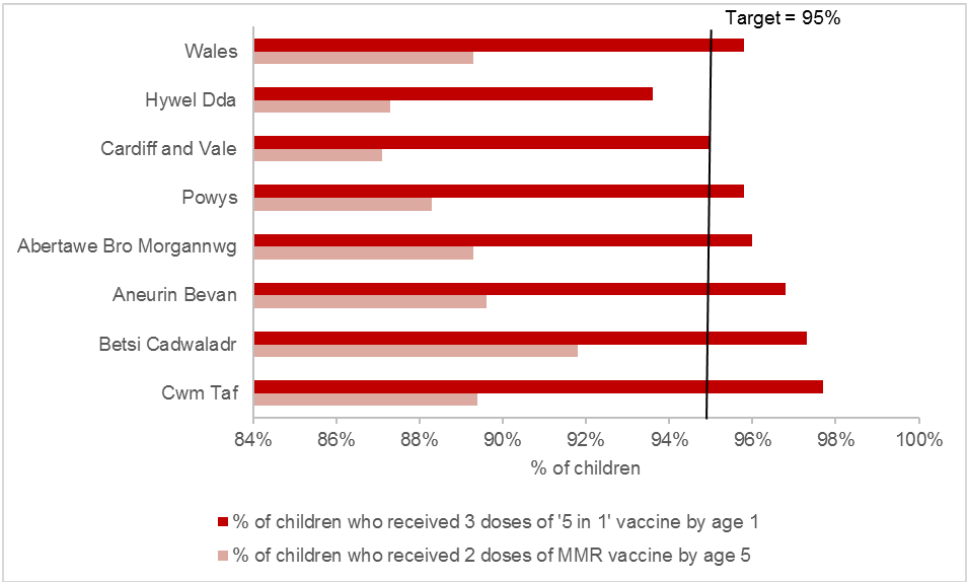
Performance: The Health Board is making steady progress in delivering its plans and performance compares well with the rest of Wales but a number of difficult challenges remain

Many aspects of the Health Board's primary care performance are better than the Welsh average although they are not all on target

88 In this section of the report we summarise the Health Board's performance against some of the Welsh Government's Outcome and Performance Measures, as described in the Health Board's monthly Integrated Performance Report.

89 Exhibit 12 [27] shows that the Health Board's childhood immunisation rate is higher than the Welsh average for two key vaccines. The Health Board is meeting the target for '5 in 1' vaccines at age 1, and is the third best performing health board. However, it is under target for the MMR vaccine.

Exhibit 12: childhood immunisation rates for the quarter January to March 2018



Note: '5 in 1' vaccine protects against diphtheria, tetanus, pertussis (whooping cough), polio and hib infection. MMR protects against measles, mumps and rubella infections.

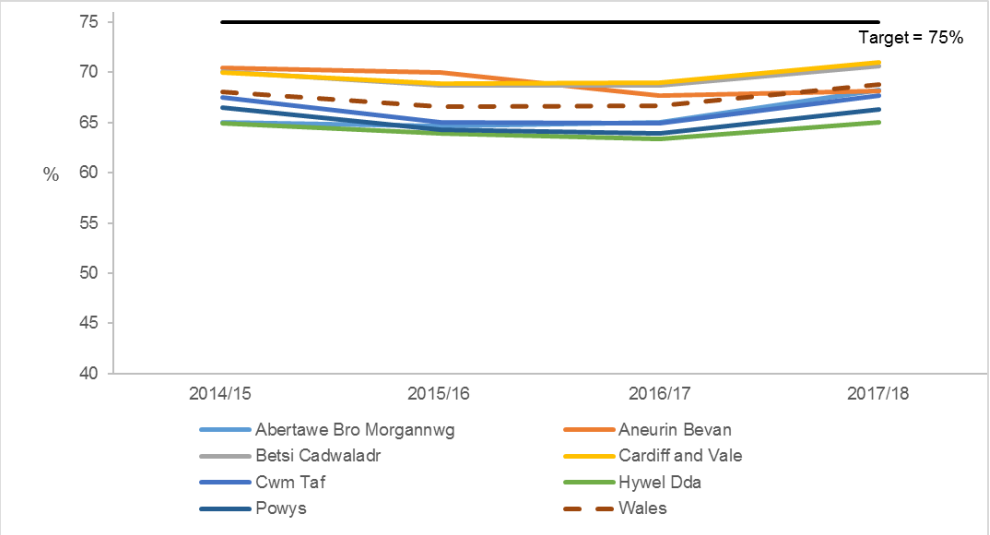
[27] www.wales.nhs.uk/sites3/page.cfm?orgid=457&pid=54124

These results are for children living in the Health Board area in March 2018 and who reached their first and fifth birthdays during the quarter 1 January - 31 March 2018.

Source: Public Health Wales

90 For adults, flu vaccinations are recommended for people aged 65 and over, as well as people with other risk factors such as asthma. The target for both groups is for 75% of those populations to receive the vaccination each year. Exhibit 13 and Exhibit 14 show that the rates of flu vaccinations at the Health Board have fallen in recent years and have never met the target of 75% coverage[28].

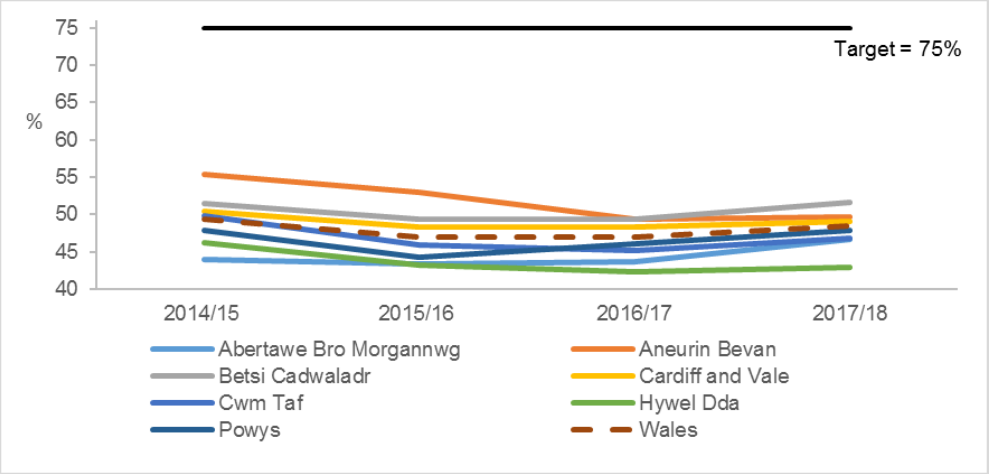
Exhibit 13: trends in uptake of flu vaccination 2014/15 to 2017/18: Uptake in patients aged 65 years and older



Source: Public Health Wales

[28] www2.nphs.wales.nhs.uk:8080/CommunitySurveillanceDocs.nsf/($All)/AC9851271F3475FD80258160004CF724/$File/Seasonal%20influenza%20in%20Wales%20201617_v1a.pdf

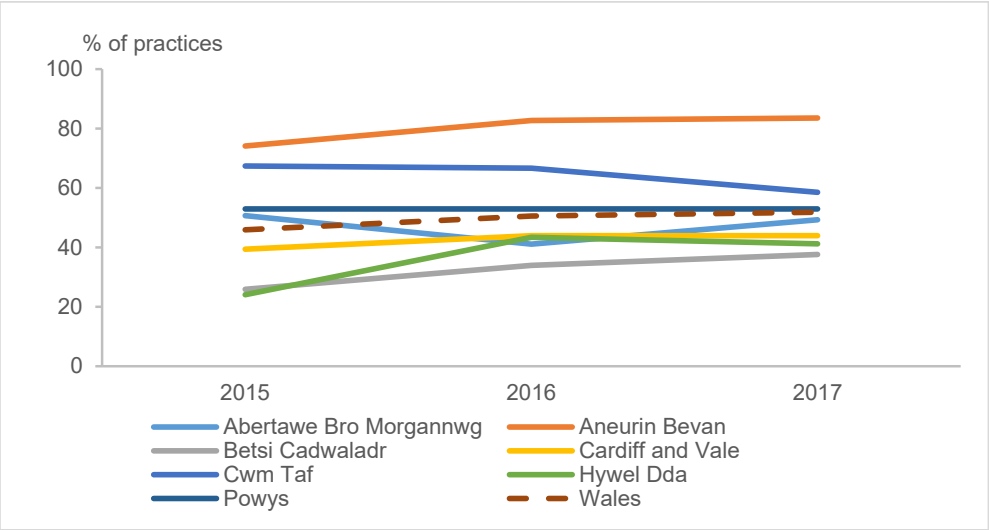
Exhibit 14: trends in uptake of flu vaccination 2014/15 to 2017/18: Uptake in patients younger than 65 who are at risk



Source: Public Health Wales

91 In relation to access to GPs, the percentage of GP practices that remained open all day in 2017 was 84% (Exhibit 15). This is the highest in Wales and is the best performing health board in Wales and well above the all Wales average of 51%.

Exhibit 15: percentage of practices open for 100% or more of weekly total core hours, by Health Board, 2017

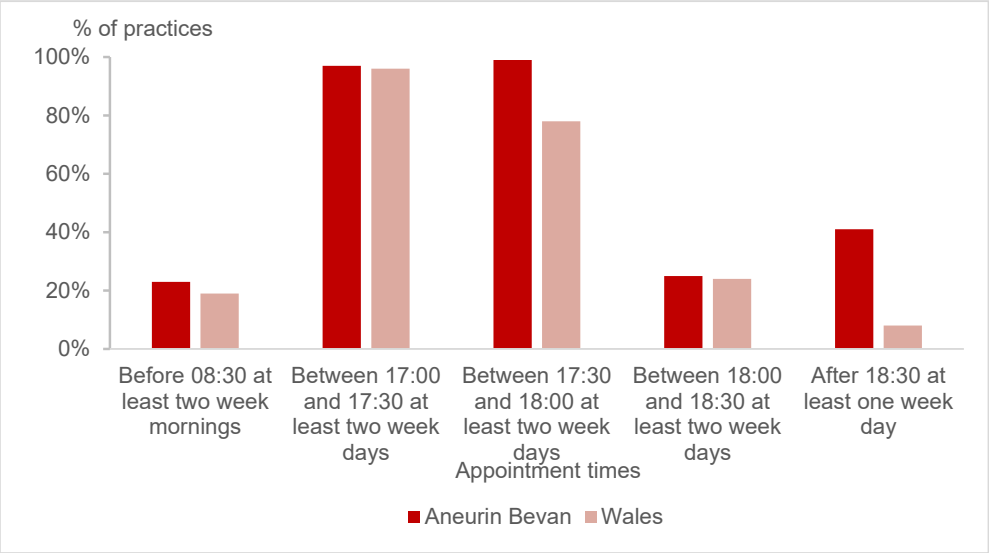


Note: Total weekly core hours equals 52 hours and 30 minutes.

Source: Welsh Government

92 Exhibit 16 shows that in all measures related to the provision of GP appointments at different times of the day, the Health Board performs better than the Wales average.

Exhibit 16: extended appointment times at GP practices, 2017



Source: Welsh Government

93 Exhibit 17 shows that in all measures related to the provision of GP appointments at different times of the day, the Health Board has the highest proportion of practices offering appointments between 18:00 and 18:30 and is one of only two areas where GPs offer appointments after 18:30.

Exhibit 17: extended appointment times at GP practices, 2017

Percentage of practices offering appointments.

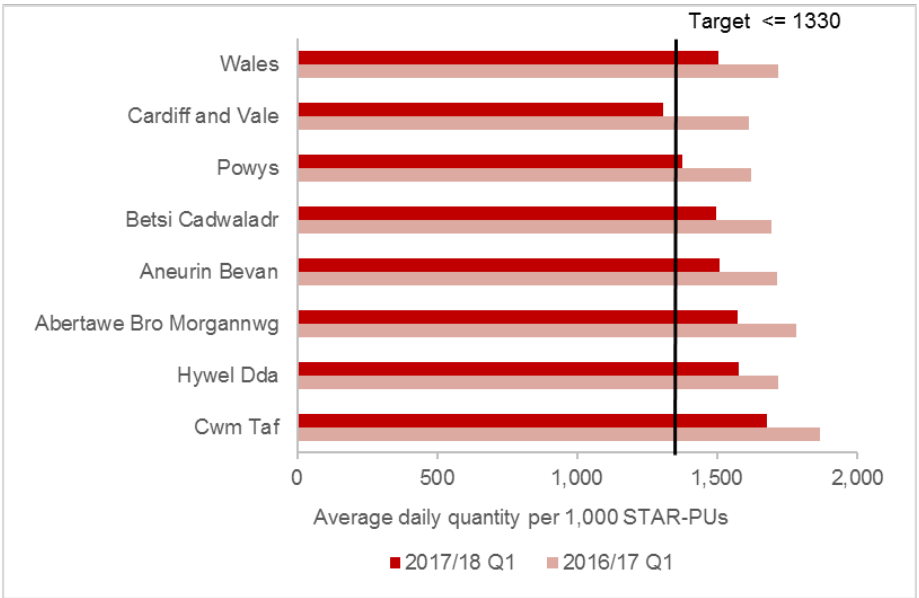
Health Board	Before 08:30 at least 2 week mornings	Between 17:00 and 17:30 at least 2 week days	Between 17:30 and 18:00 at least 2 week days	Between 18:00 and 18:30 at least 2 week days	After 18:30 at least 1 day a week
Abertawe Bro Morgannwg	14%	93%	77%	22%	0%
Aneurin Bevan	23%	97%	99%	25%	41%
Betsi Cadwaladr	15%	94%	56%	11%	0%
Cardiff and Vale	23%	95%	74%	12%	0%
Cwm Taf	12%	100%	100%	66%	0%
Hywel Dda	31%	98%	80%	37%	10%
Powys	12%	100%	76%	18%	0%
Wales	19%	96%	78%	24%	8%

Source: Welsh Government

94 Welsh Government set a national prescribing indicator in 2017-18 for GPs to reduce the use of painkillers like ibuprofen, known as non-steroidal anti-inflammatory drugs (NSAIDs), to reduce the risk of complications. Exhibit 18 shows the Health Board reduced its prescribing in the previous 12 months by 12.1%. The Health Board's performance is similar to the Welsh average, which has decreased at a similar rate. This is a positive direction of travel towards a challenging target.

Exhibit 18: prescribing levels of NSAIDs in primary care, first quarter 2016-17 and 2017-18

Prescribing levels in average daily quantity per 1,000 STAR-PUs (specific therapeutic group age-sex prescribing units).

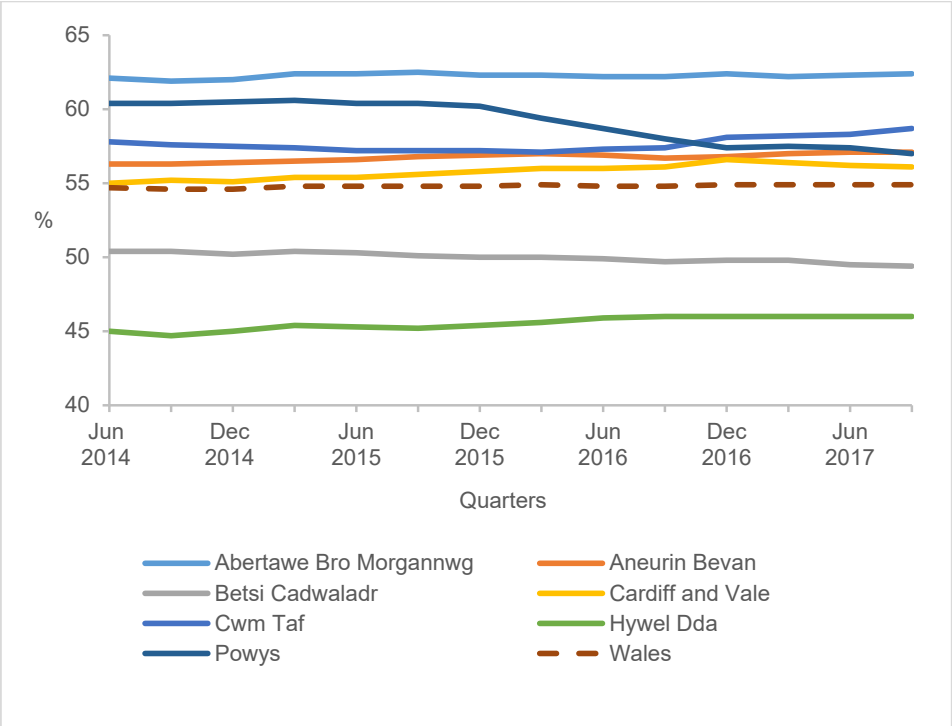


Target = <1,330

Source: Welsh Analytical Prescribing Support Unit

95 Exhibit 19 shows the percentage of population regularly accessing NHS primary dental care in the previous 24 months as at 30 September 2017. The target is for annual improvement, which the Health Board has achieved, rising steadily from 56.3% to 57.1%. They are ranked at third out of seven health boards.

Exhibit 19: percentage of residents treated at a dental practice in the previous 24 months



Target = annual improvement

Source: Dental activity forms, Welsh Government

The Health Board is making steady progress delivering its plans for primary and community care but a number of difficult challenges remain

96 The Division's monthly assurance report aims to provide assurance to the Division and Executive Team that services are being delivered effectively, while also seeking to improve performance. The report covers 60 indicators across primary and community care that are organised into four domains. Each indicator has a target and a tolerance level based on reaching national targets or achieving local improvement objectives targets set by the division. Scoring is allocated as follows:

- Green, 3 points – met target;
- Amber, 2 points – within the agreed tolerance;
- Red, 1 point – outside tolerance.

97 The scores are aggregated to make up an overall scorecard. Exhibit 20 shows that in February 2018 the overall score for the Division was 1.90. This rates

performance as red and 'outside tolerance'. Three out of four domains are rated red with only finance rated as amber. These scores illustrate the challenges that the Division continues to face in delivering its primary and community service plan.

Exhibit 20: scorecard setting out the high level position on the Division's performance

Domains	Denom.	Green	Amber	Red	Aggregate Score	Final score
Operational	24	7	7	10	45	1.88
Quality & Patient Safety	20	5	8	7	38	1.90
Workforce	11	4	2	5	21	1.91
Finance	5	2	1	2	10	2.00
Total	60	18	18	24	114	1.90

Red	<2
Amber	≥2 - <2.4
Green	≥2.4

Source: Aneurin Bevan University Health Board, Divisional Assurance Report February 2018.

98 The Division reports annually on progress delivering its work programme. Exhibit 21 summarises the extent of progress in 2016-17. Whilst some of the actions that have been marked as completed are in reality ongoing, overall the report demonstrates steady progress across all the contractor professions while recognising the sustainability issues facing GMS services.

Exhibit 21. progress against primary care work programme, 2016-17

	Priority areas set out in the work programme	Progress against priorities
General Medical Services	GMS sustainability, access including the 5 A's for Access, My Health Online roll out, Quality and Outcomes Framework indicators, progress delivering enhanced services; and contractual governance and assurance.	7 completed 8 ongoing
General Dental Services	Governance arrangements, assurance processes, general/personal dental services, orthodontic dental services, domiciliary dental care, minor oral surgery, and local oral health action plan.	6 completed 6 ongoing
Community Pharmacy	Governance arrangements, assurance processes, essential services, access, and enhanced services.	11 completed 4 ongoing
Community Optometry	Governance arrangements, assurance processes, enhanced services and the glaucoma service.	3 completed 2 ongoing

	Priority areas set out in the work programme	Progress against priorities
Primary care estates	Progress in current major development schemes, minor improvement grants, and store and scan service development.	1 completed 5 ongoing

Source: Primary Care Team Annual Report 2016-17

99 We asked the Health Board what the main barriers were to transforming primary care. Exhibit 22 shows that the Division recognises issues with a reduced supply of doctors and increasing demand from patients, as well as a need to find ways to deal with increasing complexity and provide more support for primary care.

Exhibit 22: the Division's view on the main barriers to transforming primary care

Barriers	What needs to be done to remove the barriers
Recruitment and retention of GPs	Remodelling the workforce, redirecting demand, embracing technology.
Increasing patient need and demand	Remodelling services, moving resources into primary care, embracing technology.
Increased complexity of the system	Greater collaboration to facilitate innovation and change.
Greater scrutiny	Developing a supportive mechanism across primary care to support changes.

Source: Wales Audit Office, Health Board self-assessment returns.

100 We sought views from the NCN leads on the successes of NCNs and main challenges facing primary care in their area. Exhibit 23 shows that the NCN leads feel their main successes are the employment of staff such as pharmacists, social prescribers and social workers. They also note progress with increased integration between services.

Exhibit 23: successes described by NCN leads in our survey

Successes	Number of NCNs
Practice based pharmacists	6
Integration of primary and secondary care planning	3
Social prescribing	3
Direct access physiotherapy	3
Social workers	2
Support for practice	1
Integration with community services	1

Source: Wales Audit Office survey of cluster leads, April 2018

101 As shown in Exhibit 24, the concerns raised by NCN leads are similar to those raised by the Division, namely problems with the supply of doctors at a time of increased demand. Other challenges are financial pressures and deprivation.

Exhibit 24: challenges described by NCN leads in our survey

Challenges	Number of NCNs
Sustainability of GP practices	5
GP recruitment and retention	4
Financial pressures	3
Community service issues	3
Deprivation and rurality	2
Increased demand	2
Slow pace of change among GP practices	1

Source: Wales Audit Office survey of cluster leads, April 2018

Appendix 1

Methods

Method	Detail
Health Board self-assessment	The self-assessment was the main source of corporate-level data that we requested from the Health Board in February 2018. This tool also incorporated a document request.
Survey of cluster leads	We sent an online survey to all cluster leads in Wales in April 2018. The overall response rate was 63% (45/67). The response rate for the Health Board was 58% (7/12).
Interviews	We interviewed a number of staff including the following with responsibility for primary care: • Vice Chair • Executive Director responsible for primary care • Medical Director • Assistant/Deputy Medical Director • Finance lead • Workforce lead • Planning and Performance lead • Operational Managers • Community Health Council representative
Review of the Health Board's Integrated Medium Term Plan	We reviewed the Health Board's medium term plan to assess the extent to which primary care is considered.
Use of existing data	We used existing sources of data wherever possible such as Welsh Government and Public Health Wales statistics.

Appendix 2

Management Response

Completion date: 8 February 2019

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R1a	Calculate a baseline position for its current investment and resource use in primary and community care.	To establish a baseline from which to measure the resource shift towards primary care.		Yes	Work has been undertaken within the Health Board to develop a mechanism to demonstrate resource/activity shift in line with the WHC from July 2018.	Being presented to Board in December 2018 for consideration.	Rob Holcombe
R1b	Review and report, at least annually, its investment in primary and community care, to assess progress since the baseline position and to monitor the extent to which it is succeeding in shifting resources towards primary and community care.	To understand progress made in moving resources from secondary to primary care.		Yes	As above, this would be reported through the divisional and organisation governance framework reporting to Board quarterly through Public Partnership and Wellbeing Committee.	On going	Nick Wood

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R2	The Health Board should develop an action plan for raising the profile of primary care in the Health Board. Actions could include ensuring a standing item on Board agendas regarding primary care, and publishing an annual report on primary care.	To increase the Board's understanding of primary care performance	Yes	Yes	A change at Health Board executive level has resulted in an executive lead for Primary Care and Mental Health. As such will be a standing item/discussion at Executive Board.	Complete	
R3a	Review the contents of its Board and committee performance reports to ensure sufficient attention is paid to primary care.	To increase the Board's understanding of primary care performance	Yes	Yes	As above.	Complete	
R3b	Review the frequency with which Board and committees receive performance reports regarding primary care.	To increase the Board's understanding of primary care performance	Yes	Yes	Monthly reports are submitted via the assurance meetings. The Division also reports for both mid and full year reviews.	On going	

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R3c	Review the way it currently reports to Board and committees on its progress in delivering its plans for primary care, and importantly, how it is reporting on improved outcomes for patients in primary care.	To raise Board awareness of the impact of primary care transformation on patients.	Yes	Yes	The Division has monthly assurance meetings with their Executive Director. The Division also provides information at mid and full year to the Board.	On going	
R4a	Work with the NCNs to agree a specific framework for evaluating new ways of working, to provide evidence of beneficial outcomes and inform decisions on whether to expand these models.	To support NCNs to evaluate initiatives and understand whether it would be beneficial to carry on and expand or stop.	Yes	Yes	A review has been undertaken via a workshop with the NCNs to look at current and planned investments and to determine and support decisions to withdraw and continue funding.	Complete	S Millar
R4b	Centrally collate evaluations of new ways of working and share the learning by publicising the key messages across all NCNs.	To provide a mechanism for NCNs to learn from each others initiatives.	Yes	Yes	The Division has a dashboard which captures activity and performance which is shared with the NCNs.	On going	Clinical Directors

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R4c	Subject to positive evaluation, begin to fund these new models from mainstream funding, rather than from the Primary Care Development Fund.	To ensure that new ways of working are embedded and sustainable.			Work has already begun and services such as Wet AMD for ophthalmology and extended skin are now funded as a core service which was initially established through pace setters.		
R4d	Work with the public to promote successful new ways of working, particularly new alternative first points of contact in primary care that have the potential to reduce demand for GP appointments.	To educate the public about alternative first points of contact available.	Yes	Yes	We are establishing the roles of care co-ordinators within primary care to support discussions within practice. Care Navigation training is being rolled out across Gwent to support reception staff to undertaken an alternative discussion with patients.	On going	NCN Leads/Heads of Service

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R5a	Review the relative maturity of NCNs, to develop and implement a plan to strengthen its support where necessary.	To strengthen and target NCN development support.	Yes	Yes	NCN Leads have been supported to undertake the competent leader programme to support the wider maturity of the NCNs.	On going	Associate Medical Director for Primary Care
R5b	Review the membership of NCNs and attendance at NCN meetings to assess whether there is a need to increase representation from local authorities, third sector, lay representatives and other stakeholder groups.	To ensure NCNs have the right representation.			The governance of NCNs is being reviewed. There remains differing levels of engagement at the local NCN meetings and this will be reviewed with the governance.	On going	NCN Leads
R5c	Clarify and publicise the governance and leadership arrangements for NCNs, to ensure better understanding of the responsibilities for decision-making.	To strengthen NCN governance.			As above.		
R5d	Ensure all NCN leads attend the Confident Primary Care Leaders course.	To strengthen NCN leadership.			This is on going. Recent appointments have been made to	On going	Associate Medical Director

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
					NCN leads and they will be accessing this development.		
R5e	Consider introducing a locum NCN lead post, to work across all NCNs providing additional capacity and backfill for leads. The post could also be valuable in sharing learning across NCNs.	To increase support to NCNs.			This recommendation needs to be reviewed in line with the governance review.		

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4.4

Structured Assessment 2018 – **Aneurin Bevan University Health Board**

Audit year: 2018

Date issued: March 2019

Document reference: 990A2018-19

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The team who delivered the work comprised David Wilson, Nathan Couch, Terry Lewis and Andrew Strong.

Contents

About this report

1 This report sets out the findings from the Auditor General's 2018 structured assessment work at Aneurin Bevan University Health Board (the Health Board). The work has been undertaken to help discharge the Auditor General's statutory requirement, under section 61 of the Public Audit (Wales) Act 2014, to be satisfied that NHS bodies have made proper arrangements to secure economy, efficiency and effectiveness in their use of resources.

2 Our 2018 structured assessment work has included interviews with officers and Independent Members, observations at board and committee and reviews of relevant documents, performance and financial data. We also conducted a survey of board members across all health boards and NHS trusts. Seventeen of the 23 (74%) board members invited to take part at the Health Board responded.

3 This year's structured assessment work follows similar themes to previous years' work, although we have broadened the scope to include commentary on arrangements relating to procurement, asset management and improving efficiency and productivity. The report groups our findings under three themes – the Health Board's governance arrangements, its approach to strategic planning and the wider arrangements that support the efficient, effective and economical use of resources. The report concludes with our recommendations.

4 Appendix 1 summarises the action that the Health Board has taken to address previous year's structured assessment recommendations. Appendix 2 sets out the Health Board's response to the recommendations arising from our 2018 work.

Background

5 During 2017-18, the Health Board remained on routine monitoring under the NHS Wales Escalation and Intervention Framework[1]. It once again achieved a break-even financial position in 2017-18 and reported a £246,000 surplus at the year-end. It also secured an approved Integrated Medium-Term Plan (IMTP)[2] for 2018-2022 within the timeframe required by the Welsh Government.

6 The Health Board is at a key stage of implementing its Clinical Futures Strategy. This is a major transformation programme that covers the period to and beyond opening the Grange University Hospital. The Clinical Futures Strategy will affect both hospital-based services and those provided within the community. The Health Board secured funding for the Grange University Hospital in October 2016 and building work is well underway. In the meantime, the Health Board is committed to planning and implementing significant changes to the way health care is provided in the region. The next year is therefore critical in completing planning and initiating service change.

7 Our 2017 Structured Assessment concluded that the Health Board has a clear ambition and commitment to improving healthcare across South East Wales but will need to further strengthen some aspects of governance, risk management, estates management and workforce planning. We also highlighted several areas of good practice around the Health Board's approaches to financial

[1] Joint Escalation and Intervention Arrangements

[2] Aneurin Bevan University Health Board - Integrated Medium-Term Plan 2018/19 - 2020/21

savings, its clear vision and long-standing governance arrangements and its management of resources, such as assets, workforce and information technology.

8 This report provides a commentary on key aspects of progress and issues arising since our last structured assessment review. This report should be read with consideration to our previous review.

Main conclusions

9 **The Health Board has effective planning processes, but there is more to do to strengthen governance arrangements and performance against some key targets**.

10 The following sections consider the findings underpinning these conclusions in more detail. The Health Board has made some progress against our previous structured assessment recommendations, but more work is needed to address them in full. This is highlighted throughout the report and cross-referenced with a summary of overall progress against recommendations in Appendix 1.

Governance

11 As in previous years, our structured assessment work has examined the Health Board's governance arrangements. We comment on the way in which the Board and its sub-committees conduct their business, and the extent to which organisational structures are supporting good governance and clear accountabilities. We also looked at the information the Board and its sub committees receive to help it oversee and challenge performance and monitor how it achieves organisational objectives. We have drawn on results from our board member survey, interviews with board members and a review of key documents to help understand where things are working well, and where there is scope to strengthen arrangements.

12 We found that **whilst the Health Board has established the necessary arrangements to support good governance, there is more to do to ensure they are operating as intended.**

Conducting business effectively

13 We looked at how the Board organises itself to support the effective conduct of business. We found that **arrangements to support board and committee effectiveness are generally good with ongoing work to strengthen team working at the board.**

14 Sound governance arrangements are fundamental to help provide strategic direction, challenge the effectiveness of delivery and ensure that corrective actions resolve issues where they arise. The Board and committees have a good 'cycle of business' and operate effectively ensuring coverage of key issues. Board meeting administration is good. There is also clarity in decision making and recording. The Board and committees review their effectiveness annually. Three-fifths (60%) of board members completed the Board's most recent self-assessment in 2018, with the proportion responding lower than usual. Due to the turnover of Independent Members and changes to committee membership during 2018, the Board collectively assessed committee effectiveness, apart from the Audit Committee. The Audit Committee completed its own self-assessment based on the NHS Wales Committee Handbook. The Board discussed the self-assessment findings at one of its board development sessions and agreed a plan to address areas of learning and improvement.

15 During 2018, Independent Members continued to settle into their new roles and to develop relationships with each other and executive officers, relationships that are essential for an effective and cohesive board. The Board's self-assessment of its effectiveness found positive working relationships between Independent Members and Executive Directors, which is also reflected in our survey findings with 14 of the 17 (82%) board members reporting a mostly constructive relationship between executive officers and Independent Members. However, the Board's self-assessment also identified team working as a theme for improvement, which it is working to address.

16 Independent Members have been able to access the national induction programme and the Health Board is providing a range of training opportunities for Independent Members itself, including an induction programme to help new members get an understanding about the organisation, the complexity of the operational environment and their role in ensuring the organisation succeeds in achieving its objectives. Independent Members responding to our board member survey had mixed views about the induction programme, the training and support given to discharge their responsibilities and the programme of board development. Our survey found that:

- three of the nine (33%) Independent Members were satisfied or very satisfied with the induction programme for new board members compared with 65% of Independent Members across Wales;
- four of the nine (44%) Independent Members were satisfied or very satisfied with training and support given to discharge their responsibilities compared with 83% of Independent Members across Wales; and
- six of the nine (67%) Independent Members were satisfied or very satisfied with the programme of board development to support effective Board working compared with 85% of Independent Members across Wales.

17 The Chair appraises Independent Members to set personal objectives and to identify training and development needs. The Health Board is developing a new board training and development programme to address learning needs.

18 Since our last review, the Health Board has rebalanced the workload and portfolios amongst the executive team and established two new roles of Director of Operations and Director of Primary, Community and Mental Health. In addition, development opportunities have been provided for the executive team by rotating the role of Deputy Chief Executive.

19 We observed several Board and committee meetings and noted that they operated effectively. For example, we found effective administration and management of the meeting, good quality of debate, scrutiny and challenges with significant contribution from Independent Members and Executives. There were also good arrangements in place to escalate concerns to the Board. We observed that some committees often focus on similar issues or agenda items, although from a different perspective in line with the committees' terms of reference. We observed good communication and flows of information between the Quality and Patient Safety Committee and the Mental Health and Learning Disabilities Committee. However, some board members told us that such communication is not always systematic between committees. The Board's self-assessment of effectiveness also indicated a lack of understanding among board members about committee roles and responsibilities, leading to perceptions of duplication of work, which the Health Board is working to address.

Managing risks to achieving strategic priorities

20 We looked at the Board's approach to assuring itself that it is managing risks to achieving priorities. We found **the Health Board is making progress to develop a board assurance framework, and work is underway to improve and strengthen risk management arrangements**.

21 A board assurance framework[3] (BAF) supported by an effective risk management system is critical for focusing the Board's attention on the risks to achieving strategic priorities. The Health Board is developing its BAF with support from the Audit and Assurance team.[4] The draft BAF was presented to the Audit Committee in October 2018 for comment. The Board planned to discuss the next iteration of the BAF at its February 2019 briefing session, so that it could consider any further information arising from the external review of its approach to risk management. There is ongoing work to map the strategic risks and the required sources of assurance within the BAF. The BAF is only in draft, and therefore, we have not formally reviewed it. Fifteen of the 17 (88%) board members responding to our survey agreed or strongly agreed that they were involved in identifying the strategic risks, which is comparable with the all Wales average (91%).

22 The Health Board's strategic risk management arrangements are generally fit for purpose and responses to our board member survey were mostly positive about them. We asked board members to what extent they agreed or disagreed with several statements about managing strategic risks. Our survey found that:

- 16 out of 17 (90%) board members agreed or strongly agreed that they understood the risks to achieving strategic objectives and how they were being managed (Wales average 91%);
- 14 out of 17 (80%) board members agreed or strongly agreed that the information presented to the Board allowed members to effectively scrutinise actions taken to mitigate risks (Wales average 77%); and
- 14 out of 17 (80%) board members agreed or strongly agreed that they were clear how risks are both managed and escalated to Board and committees (Wales average 86%).

23 The Health Board maintains a corporate risk register and routinely presents it to the Committees and the Board. In our 2017 Structured Assessment, we recommended the Health Board should review risk management arrangements to ensure corporate risks were appropriately escalated and managed (Recommendation 3, 2017). The Audit and Assurance team's report on the divisional risk management arrangements dated February 2018 provided reasonable assurance. The Audit and Assurance team identified several areas of good practice, such as effective communication of the risk management strategy, good control over major project and health and safety risks, effective reporting and discussion of risks in meetings throughout the organisation and senior officer and staff awareness of their responsibilities for managing risks. The Audit and Assurance team also made recommendations to improve the management of risk. This includes one high priority recommendation to introduce an 'action plan and priorities for the year' where the Executive Team and Board agree the

[3] For the purposes of this report, the BAF is the key document used to record and report the Health Board's key strategic objectives, risks, controls and assurances to the Board.

[4] The NHS Wales Shared Services Partnership (NWSSP) – Audit and Assurance Service provides bilingual internal audit, specialist audit and consultancy services to the whole of the NHS in Wales.

developments required over risk management and resources and timescales are set and monitored to ensure their achievement.

24 We also found improvements in risk reporting. For example, the quarterly risk dashboard reports generated from the Corporate Risk Register provide a summary of the risks to make it more accessible to the Board. The Corporate Risk Dashboard Report is comprehensive and easy to understand and provides a good overview of the strategic risks of the Health Board. Eleven of the 29 risks set out in the Corporate Risk Dashboard Report presented to the Board in January 2019, were first captured on the corporate risk register in 2016 (1 risk only) and 2017. The Health Board reports that mitigating actions for managing risks are regularly reviewed for effectiveness, which is clear from the change in risks scores for several risks, including one identified in 2017.

25 The Health Board's current Risk Management Strategy sets out the definitions and principles underpinning its risk appetite in relation to ten core business areas, such as patient safety and finance. However, comments from board members responding to our survey indicate concerns about how the extent to which the risk appetite applies throughout the organisation and whether there is common understanding of the risk statement. These concerns should be addressed as part of the Health Board's plans to redevelop its risk appetite statement when the BAF has been finalised and populated with the strategic risks.

26 The Health Board recognises that it needs to strengthen risk management arrangements and has identified additional capacity and resources to complete a risk review, which is to fully report in March 2019. The Health Board has not clarified roles for collating and monitoring corporate and clinical risks or assessed whether it has sufficient capacity to oversee and improve risk management across the organisation.

Embedding a sound system of assurance

27 We also examined whether the Health Board has an effective system of internal control to support board assurance. We found that **internal controls are in place and the Health Board is continuing to strengthen aspects of its clinical audit arrangements**.

28 Health Board business is conducted in accordance with Standing Financial Instructions, Standing Orders and a Scheme of Delegation, which set out roles, responsibilities and levels of authority. The Health Board uses the latest all-Wales version of Standing Financial Instructions[5] and Standing Orders[6] (dated 2014) which are reviewed annually by Audit Committee. A proposal to review existing Standing Financial Instructions was agreed at the all-Wales Directors of Finance meeting in November 2016. This work is ongoing and any changes to the model Standing Financial Instructions have yet to be formally agreed.

29 The Health Board has an up-to-date Scheme of Delegation (March 2018) and continues to raise awareness of the importance of completing the Register of Gifts, Hospitality and Sponsorships and Declarations of Interest.

30 The Audit Committee oversees and monitors compliance with Standing Financial Instructions, Standing Orders and a Scheme of Delegation. It regularly reviews reports on Governance, Financial

[5] Standing Financial Instructions for Health Boards - March 2014

[6] Standing Orders & Reservation and Delegation of Powers - March 2014

Control Procedures, Technical Accounting Issues, Single Tender Actions; and Payments over £100,000. The Audit Committee also formally reviews both the Register of Gifts, Hospitality and Sponsorships and Declarations of Interest each year with the latest reviews in March and April 2018.

31 The Board and Finance and Performance Committee routinely monitor both financial and operational performance. Performance management arrangements are robust and the Health Board takes action to address poor performance. Our review of the Health Board's Integrated Performance Reports found the quality of the information presented to be sufficient. The Health Board monitors performance against the IMTP with a focus on delivery against key national targets included in the Performance Dashboard. There are highlight reports for each of the seven service change plans underpinning the IMTP, which identify key achievements, areas of concern or risk and key actions for the next quarter. The Performance Dashboard is appended to the report and it identifies trends in performance and highlights areas of risk.

32 The Health Board procured a business intelligence system, Qlik Sense, in March 2018, which will be implemented over the next three years. We understand that the Qlik Sense system will enable the Health Board to combine data sources into a single view allowing users to analyse and interrogate relationships in the data. The Health Board anticipates that it will bring many benefits, including dynamic reports, real-time information, automation of performance dashboards, ability to link data with other key systems and a single location for reporting. The Health Board informed us that it has started to roll out the application for the Quality Dashboard, Accident and Emergency activity analysis, radiology referrals and activity, single cancer pathway monitoring and Vitalpac[7]. It plans further applications for inclusion by the end of December 2018.

33 Nine of the 17 (53%) board members responding to our survey indicated that the Board had agreed the information it needed for effective oversight and scrutiny compared with 75% of board members across Wales. Comments from a few board members responding to our survey indicate that the Board is still working to agree what type of information and the level of detail needed for scrutiny and assurance. Nonetheless, board members were generally positive about the information they received but were less positive about the balance between strategic and operational issues. Of the 17 respondents:

- 16 (94%) felt confident that the Board receives sufficient information to inform decision making;
- 15 (89%) felt confident that information received by the Board is sufficient to gain assurance on organisational risk and performance;
- 13 (77%) felt confident that information received by the Board covers the breadth of the organisation's business or functions, that information received by the Board covers all strategic issues and that information supports effective scrutiny;
- 11 (69%) felt confident in the quality and accuracy of information presented to the Board; and
- nine (53%) felt confident that the Board receives an appropriate balance between strategic and operational issues.

34 Our 2017 structured assessment work found that the volume of Board and committee papers was often several hundred pages and the duration of some meetings sometimes lasted up to five hours.

[7] Vitalpac is a mobile clinical system that monitors and analyses patients' vital signs to identify deteriorating conditions and provide risk scores to trigger the need for further necessary care.

The Health Board has introduced a new board and committee report format, which includes hyperlinks to additional background papers. The new format has helped to reduce the pack of papers and to focus on the key information needed for decision making. Board papers for the September 2018 meeting were 182 pages in length and the meeting lasted around three hours. The Health Board with its committee chairs is working to roll out these arrangement to the committees (Recommendation 2, 2017).

35 It is important that board members understand and assess organisational performance from patients' and service users' perspectives. The Health Board has developed a draft Quality Assurance and Improvement Framework[8] setting out how it will achieve this. The document covers quality assurance, professional regulation, patient experience, and quality improvement. Performance is monitored by the Quality and Patient Safety Committee at its bi-monthly meetings.

36 The Board considers a patient story at each of its meetings. In the past, patient stories were not always balanced to show both positive and negative aspects of care. However, the Health Board has done work during the year to address this and now link patient stories to key agenda items for each board meeting.

37 The Health Board has a schedule of quarterly Independent Member walkabouts where they can see and hear first-hand from staff about any safety concerns that they may have. These walkabouts promote a safety-oriented culture and ensure board members visibly demonstrate their commitment to safety by listening to and supporting staff when issues are raised. Independent Members provide written feedback on their visits to the Chair with information also provided to the Quality and Patient Safety Committee and Board. Just over half (55%) the Independent Members responding to our survey were satisfied or very satisfied with opportunities to meet staff and visit services and wards compared with two-thirds (65%) of Independent Members across Wales. We were informed that some Independent Members have been carrying out unscheduled walkabouts to clinical areas, which we understand has sometimes been disruptive to patient care. However, feedback from unscheduled visits is not formalised.

38 The Public Services Ombudsman for Wales (PSOW) report[9] identified an increase in complaints about the Health Board, from 90 to 121 (34%) between 2016-17 and 2017-18. The latest information reported to the Quality and Patient Safety Committee shows complaints continue to rise with the PSOW receiving 121 complaints about the Health Board between April 2018 and January 2019.

39 Health Board data on complaints and serious incidents between April and December 2018 indicate that:

- the total number of formal complaints received is reducing compared with the same period in 2017 but performance against the 30-day response target is also reducing. At December 2018, only 41% of complainants received a response within 30 days; and
- compliance with the 60-day closure for serious incidents is deteriorating; in November 2018 compliance was 63% in November 2018 and 29% in December 2018.

40 The Health Board's 'Putting Things Right' team deals with complaints, as well as serious incidents and PSOW cases. At this stage it is unclear whether the increase in complaints arise because there is

[8] Aneurin Bevan University Health Board - Draft Quality Assurance and Improvement Framework

[9] Public Services Ombudsman for Wales - Annual Report and Accounts 2017/18

easier access to the complaints procedure, poor investigation and resolution of complaints or a reflection on the quality of complaint handling. The Health Board is working to address areas of improvement identified by the PSOW as part of its 'Putting Things Right' service improvement programme, which aims to improve performance and the quality of complaint and incident handling.

41 In May 2017, the Audit and Assurance team provided limited assurance on the Health Board's clinical audit arrangements. At that time, the Audit and Assurance team found that the Health Board did not maintain a programme of local clinical audits, there was an inconsistent process for following up clinical audit results, an ineffective mechanism for collating and reporting on directorate level clinical audit activity and no mechanism to identify clinical audit training and development opportunities for relevant staff. The Medical Director presented a position paper on clinical audit to the Audit Committee in February 2018, indicating that the Health Board had made significant progress to address the previous audit recommendations. At the time our audit, the Health Board was continuing its work on a clinical audit assurance map and developing the clinical audit strategy, with an update on progress provided to the Audit Committee in January 2019. The Health Board's draft Quality Assurance and Improvement Framework outlines its intention to improve the outcomes from National Clinical Audits year on year. Where the National Clinical Audit reports identify key issues for the Health Board, it will agree and develop actions to address the issues within three months of the report's publication. (Recommendation 4, 2017). However, the Quality Assurance and Improvement Framework makes no reference to local clinical audit.

42 The Audit Committee oversees progress against our recommendations and recommendations made by the Audit and Assurance team. Our review of the Audit Recommendation Tracker showed that many deadlines for completion against open recommendations date back to 2015, 2016 and 2017. Some recommendations had no target implementation date. The Health Board undertook work to address these outstanding recommendations and the Audit Committee received a report on the review of the audit tracker at its meeting in July 2018. This report indicated that significant progress had been made to address outstanding recommendations and the Executive Team recommended closing 58 of the 84 high-level recommendations, which the Audit Committee was satisfied were complete. At that time, there were no high priority (red) recommendations, but there were 23 medium priority (amber) recommendations. These were discussed at Executive Team and further work is underway to ensure actions are now completed. There is ongoing work to ensure recommendations are addressed in a timely way. At the time of our audit, the Health Board was developing a process to track progress against recommendations made by other regulators and inspectors, such as Healthcare Inspectorate Wales, for oversight by the Quality and Patient Safety Committee. Since our audit work, the Audit Committee was assured at its January 2019 meeting that the new tracking system had been introduced.

Detecting and preventing fraud and overpayments

43 The National Fraud Initiative (NFI) is a biennial data-matching exercise that helps detect fraud and overpayments by matching data across organisations and systems to help public bodies identify potentially fraudulent or erroneous claims and transactions. It is a highly effective tool in detecting and preventing fraud and overpayments and helping organisations to strengthen their anti-fraud and corruption arrangements. We found that **the Health Board has generally made effective use of NFI**

as a component of its counter-fraud arrangements but has yet to review all recommended data matches.

44 In January 2017, the Health Board received 7,989 data-matches as part of the most recent biennial exercise. The data-matches highlight anomalies which when reviewed can help to identify fraud and error. Whilst we would not expect participants to review all data-matches, some of the matches are categorised as 'recommended matches'. These are matches considered to be of high risk and therefore recommended to be prioritised for early review. The Health Board received 458 recommended matches. In our 2016-17 Annual Audit Report, we reported that as at 20 November 2017 the Health Board had made good progress in reviewing the data-matches but had not reviewed three-way data-matches between payroll, creditor payments and Companies House. These are high-risk matches because they can identify undeclared staff interests and possible corrupt practices.

45 We recently carried out a further review of the Health Board's progress in reviewing the NFI data-matches. As at 30 November 2018, the Health Board has reviewed 336 data-matches. We consider that the Health Board has generally made effective use of NFI as a component of its counter-fraud arrangements. However, the NFI web application shows that whilst reviews of the recommended three-way data-matches between payroll, creditor payments and Companies House commenced in early 2018, it does not record that these reviews have been completed and matters arising resolved. It is essential that the Health Board ensures the review of these matches is completed as a matter as urgency. This is particularly important given that the reviewer notes within the NFI web application record instances where staff members had interests in companies that had not been declared to the Health Board.

46 To ensure that the Health Board continues to make effective use of NFI going forward, we recommend it puts in place an action plan to ensure that the matches it receives in January 2019, as part of the next NFI exercise, are prioritised for review and where necessary investigated in a timely manner.

Ensuring a sound framework for information governance and cyber security

47 We found **the Health Board is working to strengthen cyber security and to achieve full compliance with response times for statutory information requests**.

48 Compliance with information governance training is improving and is currently 89% but it is still below the all-Wales target of 95%. In 2017, the Health Board's performance for staff compliance with its information governance training programme was reported at 83%.

49 The Health Board provided additional staff resources for its information governance unit from mid-2018 to strengthen the information confidentiality arrangements and work towards full GDPR compliance (Recommendation 5, 2017). The Health Board needs to ensure that it provides a timely response to statutory information requests in relation to the Freedom of Information (FOI) and Data Protection Acts. The Health Board is expected to respond to FOI requests within 20 working days and subject access requests in relation to the Data Protection Act within one month. The Health Board reports that the volume of FOI requests is growing and that it deals with on average 50 requests each month. Although response times to FOI requests started to improve towards the end of 2018 overall compliance was 73% for the year compared with 84% in 2017. Performance in relation to response times to data subject access requests began to improve towards the end of 2018 having fluctuated between 83% and 89% for much of the year. Overall compliance with data subject access requests for 2018 was 88% compared with 96% in relation in 2017.

50 In early 2018, an external review of information governance and information security was undertaken at the Health Board as part of a broader programme of work across NHS Wales. The Health Board has had an external cyber security assessment in 2018 which identified improvement actions. The Health Board is developing a cyber security action plan to respond to these recommendations and in doing so updating security patches and replacing unsupported software and hardware. At the time of our audit work, the Health Board was working to strengthen cyber security arrangements and planned to establish a specialist team to strengthen controls, resilience and incident response plans. Since our audit work, the Health Board has advised us that it is now implementing plans to strengthen cyber security. The Health Board needs to ensure that it updates its ICT disaster recovery plans and tests them following recent changes to the ICT infrastructure.

Strategic planning

51 Our work examined how the Board sets strategic objectives for the organisation and how well the Health Board plans for the delivery of its objectives within the resources that it has or can make available. We also wanted to know if the Health Board is monitoring progress with these plans effectively. We found that **the Health Board has a clear vision supported by effective planning processes, and work is continuing to update plans for service re-design.**

Setting the strategic direction

52 We looked at how the Board goes about setting its priorities in engagement with key stakeholders and whether it defines agreed objectives clearly in strategic plans. We found **the Health Board has an effective approach for engaging with stakeholders to inform strategy development**.

53 The Health Boards Clinical Futures Strategy clearly sets out the Health Board's aim to deliver a refreshed clinical model. The Board worked collectively to agree the strategic objectives and structured its IMTP into seven Service Change Plans (SCPs). The SCPs are aligned to the Health Board's priority areas and address the importance of the five ways of working required by the Well-being of Future Generations Act; drawing these work programmes from clinical service strategies, Divisional IMTPs and national programmes and priorities.

54 The Health Board's Engagement Strategy (2015)[10] recognises the need for effective engagement and communication with service-users and patients to be equal partners with professionals in decisions about healthcare and outcomes they want from services they use. In 2017, we recommended that the Health Board review, refresh and update the Engagement Strategy as it was out of date in some areas. The Health Board has indicated that the revised Engagement Strategy will be presented to the Board for approval at its March 2019 meeting.

55 In 2018, the Health Board set up a specific workstream on Workforce and Organisational Development/Staff Engagement as part of its Clinical Futures Programme. At the time of our audit it was consulting with staff groups and the Trade Union Partnership Forum on a new Employee Experience Framework (Recommendation 7, 2017).

[10] Aneurin Bevan University Health Board - Engagement Strategy

56 The Health Board engages formally with stakeholders when seeking views on its strategic aims and priorities, and the shape of clinical services. The Health Board uses various methods, such as workshops and public forums to engage with stakeholders, and as part of the Clinical Futures Programme, it also established a workstream on Communications and Engagement, which is led by the Board Secretary. We also noted the frequent use of social media by the Health Board and the Chief Executive in particular to communicate and promote IMTP planning sessions and the Clinical Futures Strategy.

57 The Health Board is a member of the Greater Gwent Regional Partnership Board and five Public Service Boards, which ensures alignment between the IMTP and the Greater Gwent Area and Well-being plans. Our board member survey found that 15 of the 17 (88%) individuals responding felt that the organisation effectively engages with statutory partners and the third sector when developing and setting its strategic objectives. The Health Board's Public Partnership and Well-being Committee oversees partnership engagement and the Independent Chair of the Regional Partnership Board attends this committee meeting to provide updates. Minutes of the Regional Partnership Board and Public Service Boards meetings are also presented to the Public Partnership and Well-being Committee for information. The Public Partnership and Well-being Committee is responsible for oversight and scrutiny of the Health Board's contribution to the delivery of the Area and Well-being plans.[11]

Developing strategic plans

58 We considered the Health Board's approach to developing the strategic plan and whether it is underpinned by appropriate strategies and plans that are based on cost, resource and savings analysis. We found **the Health Board has a strong planning approach underpinned by an analysis of demand and capacity with ongoing work to update service models underpinning the Clinical Futures Strategy.**

59 The Health Board has a clear and agreed planning approach, which enabled it to co-ordinate the development of the IMTP. The Health Board's IMTP Business Planning Guidance sets out the approach for developing divisional IMTPs and implementing the overarching IMTP between 2018 and 2021. The Health Board's divisions are encouraged to look beyond the three-year planning cycle to align the local IMTPs with the Clinical Futures Strategy. The divisional IMTP planning templates set out headings for the core business over the planning period, which are then populated within service areas. These are also profiled for delivery against the Welsh Government Delivery and Outcomes Framework.

60 The Health Board has invested in extra capacity within the Planning Team introducing a lead planner for each division mirroring the business partner model for finance and workforce. The Health Board's IMTP planning approach is also informed by learning and evaluation. The Planning Team seeks views from across the organisation and the Welsh Government and uses learning from other Health Boards to develop the planning guidance for the following year.

[11] Each local authority and health board is required to prepare and publish a regional area plan setting out the range and level of services they propose to provide or arrange to be provided in response to an assessment of need. Each local authority is required to develop a wellbeing plan, outlining objectives for improving wellbeing in its communities and meeting its duties under the Future Generations Act (2015).

61 Analysis of demand and capacity supports strategic planning. The IMTP planning templates require the Divisions to outline their approach for demand and capacity planning and to show how it contributes to development of the organisation-wide IMTP. Demand and capacity planning is not consistent across all areas of the Health Board, for example it is not as strong in primary care, frailty and district nursing than in other parts of the organisation.

62 The IMTP is underpinned by the Health Board's Clinical Futures Strategy, which aims to deliver a refreshed clinical model. The Health Board is working to produce an overarching workforce plan by the end of March 2019 to support the Clinical Futures Strategy and the timely opening of the Grange University Hospital. In order to complete the overarching workforce plan, the Health Board agreed an ambitious timetable to update the 54 clinical service models by the end of December 2018. At the time of our audit, the Health Board's own risk assessment indicated that not all service plans would be completed on time. Since our audit work, the Health Board has advised that it has completed work on the clinical service models and that further work is underway to assess their impact and commence implementation.

Monitoring delivery of the strategic plan

63 Finally, we looked at whether the Health Board is effectively monitoring and reporting on progress with implementing strategic plans and supporting strategic change programmes. We found **the Health Board has arrangements for monitoring and reporting on delivery of the IMTP and the Clinical Futures Strategy**.

64 As part of our review we considered the scrutiny and challenge on IMTP delivery as well as the content of the plans. The Planning and Performance Team reports progress against IMTP delivery to both the Finance and Performance Committee and the Board on a quarterly basis, while the Executive Team also reviews performance against all parts of the IMTP.

65 The Health Board has approved its IMTP Delivery Framework in July 2018, which sets out how the organisation ensures delivery of the strategic objectives. The IMTP Delivery Framework reinforces the importance of performance at individual, team, division and organisational level. This enables the Board to assess progress, learn from its performance and act where necessary. Our board member survey found that all members responding agreed that the information they receive gives them a good understanding of how well the organisation performs against its IMTP.

66 The Health Board recognises that it needs robust governance arrangements to ensure its delivery of the Clinical Futures Strategy. The Chief Executive chairs the Delivery Board and is the Senior Responsible Officer (SRO) for the programme. Members of the Executive Team chair the seven subgroups responsible for delivering specific workstreams, which are: Service Re-design; Workforce and Organisational Design; Strategic Capital and Estates; Communication and Engagement; Supporting Infrastructure; Information Technology; and the Grange University Hospital Build. The Health Board has appointed a Programme Director and set up a project timeline to support delivery of the strategy.

67 The Director of Planning and Performance reports progress against delivery of the Clinical Futures Strategy to both the Planning and Strategic Change Committee and the Board. We reviewed the content of the Clinical Futures progress reports and found them to provide enough information to enable effective monitoring of progress, risks and issues. Our board member survey found that 16 of

the 17 (94%) individuals responding agreed that the information they receive gives them a good understanding of how well the organisation performs against strategic change programme delivery.

68 The Health Board continually self-assesses its overall progress in delivering the Clinical Futures Strategy. During our fieldwork this was rated as 'Amber' indicating that some progress is being made with delivery to date in most but not all areas and there are some risks with mitigation plans, requiring the Health Board to monitor or take action. The Amber rating broadly reflects the ratings for individual workstreams, except for the workstreams for the Grange University Hospital Build and Communication and Engagement which are both 'Green'. The Welsh Government Gateway review[12] completed in July 2018 further reinforces this assessment by giving an overall delivery confidence assessment of 'Amber' and outlines recommendations to ensure success. We have seen evidence that an action plan is in place and formed part of the discussion at the Clinical Futures Delivery Board meeting in September 2018.

Wider arrangements that support the efficient, effective and economical use of resources

69 Efficient, effective and economical use of resources largely depends on the arrangements the organisation has for managing its workforce, its finances and other physical assets. In this section we comment on those arrangements, and on the action the Health Board is taking to maximise efficiency and productivity. We also examine if the Health Board is procuring goods and services well.

70 We found that **the Health Board has a track record in managing resources effectively and a good developing approach to improving productivity, although some aspects are not always sufficiently strategic or detailed and performance against some key targets needs to improve**.

Managing the workforce

71 The workforce is the Health Board's biggest asset, not least because pay represents such a significant proportion of expenditure. It is important the workforce is well managed and productive because staff are critical for day-to-day service delivery and for delivering efficiency savings and quality improvements. We found that **the Health Board is actively managing workforce issues, but sickness absence rates remain above the Welsh Government target and compliance with statutory and mandatory training, the appraisal process and consultant job planning need to improve**.

72 The following table shows how the Health Board is performing on some key measures compared to the Wales average. Exhibit 1 shows the Health Board compares more favourably against the Wales average across two measures and less favourably with the Wales average across three measures.

[12] The OGC Gateway Process examines programmes and projects at key decision points in their lifecycle. It looks ahead to provide assurance that they can progress successfully to the next stage; the process is best practice in central civil government, the health sector, local government and Defence.

Exhibit 1: performance against key workforce measures[13]

Workforce measures	Health board	Wales average
Sickness absence	5.2%	5.3%
Turnover	7.8%	6.9%
Vacancy	3.4%	2.6%
Appraisals	74%	67%
Statutory and mandatory training	67%	73%

Source: NHS Wales Workforce Dashboard, Health Education and Improvement Wales, July 2018

Sickness absence

73 Exhibit 1 shows the Health Board's performance on sickness absence is marginally better than the Wales average. Although the Health Board has arrangements in place to manage sickness absence, the rolling 12-month average has not changed, fluctuating around 5.2%, which is slightly above the Health Board's target of 5%. The monthly figures reported to the Board shows that the monthly rate reduced below 5% between April and August 2018 but this reduction has not been sustained. Its arrangements include management coaching for divisional managers and enabling staff to complete alternative duties to encourage an earlier return to work. Divisions use monthly scorecards to monitor sickness absence, and at assurance meetings managers identify themes, hotspot areas and innovative models for reducing sickness. The Health Board has a Sickness Task and Finish Group that develops tools and engages with staff to promote better sickness absence management. The Audit and Assurance Service's review of sickness absence management provided reasonable assurance (May 2018) and identified several areas of good practice.

Turnover

74 Exhibit 1 shows that the Health Board's turnover rate is higher than the Wales average and is experiencing difficulties maintaining low levels of turnover. Turnover amongst nursing and midwifery staff is largely related to retirement.

75 To support staff retention, the Health Board developed an Employee Experience Framework, which has been finalised, ready for implementation in February 2019. The Employee Experience Framework outlines six components for positive engagement and wellbeing and provides detail on current practice and what improving and ambitious progress would look like. The Health Board is actively introducing arrangements to retain staff and understand the reasons for them leaving. It runs monthly sessions aimed at staff approaching retirement to provide information on flexible working choices to enable them to continue working for the organisation if they want to. The Health Board has introduced an

[13] Sickness: rolling 12-month average at July 2018; Turnover: 12-month period July 2017 to June 2018; Vacancy: advertised vacancies at July 2018; Appraisal: preceding 12 months at July 2018; Statutory and mandatory training: at July 2018.

online exit questionnaire for all staff, although the response rate is reported to be low. The Health Board is working to encourage better completion. The Health Board is implementing an 18-point nurse retention plan, which is monitored by the Workforce and Organisational Development Team and Strategic Nursing Group.

Vacancies

76 Exhibit 1 above shows that the vacancy rate in July 2018, based on posts advertised, was 3.4% compared to the Wales average (2.6.%). Our analysis of the NHS Wales Workforce, Education and Development Service (WEDs) data shows that the overall number of vacancies has remained consistent since the same period in 2017. The Health Board is tackling recruitment across all staff groups with some success. The latest Workforce Performance Update Report (dated October 2018) highlighted the significant work underway. For example, the Health Board is reviewing recruitment advertising and branding, developing medical recruitment timeline key performance indicators (KPIs), recruiting doctors from India and holding events for overseas-trained nurses living in the UK.

77 The Health Board is involved in the national programme for the recruitment streamlining process for newly qualified nurses and it has introduced successful apprenticeship schemes and support for administrative staff to become Healthcare Support Workers. The Health Board is also introducing alternative staffing models to encourage cross professional working and to help minimise risks from vacancies, such as appointing physicians associates to paediatric services, frailty services, unscheduled care and primary care, extending nursing roles to deliver enhanced services and blended therapy roles and therapy assistant practitioner support roles.

78 Performance against the recruitment target, that is the time from a manager requesting a vacancy to an unconditional offer, exceeded the 71 day target every month from April 2018. The Health Board has introduced improvement plans with managers telling us they are starting to see improvements and in December the average time taken to recruit was 67.9 days.

79 The Health Board is seeking to reduce its reliance on agency and locum staff, for example, by increasing the use of its nurse bank staff. The latest Workforce Performance Update Report (dated October 2018) shows that the Health Board had some success. It has reduced spending on agency and medical agency staff and increased its bank spend between July and August 2018. Although, we noted a decrease in the use of medical agency staff costs (locums), the Health Board does not expect to achieve the Welsh Government savings target. Expenditure on Agency (including Locums) at premium rates was 3.9% of total pay in April 2018, and whilst it fluctuates through the year (falling to 3.2% in August 2018) it is estimated to increase to 4.6% of total pay by March 2019. The Health Board is piloting a new Medical Locum Bank system called 'Patchwork'[14]. The main aim of introducing the system is to increase the numbers of staff on the Medical Locum Bank to maximise fill rates during the winter, which will also help to reduce medical agency spend.

80 The Health Board has put arrangements in place to meet the requirements of the Nurse Staffing (Wales) Act 2016.[15] However, continuing challenges remain to ensure sufficient levels of nurse staffing, because of shortfalls of available staff and increased service demand.

[14] https://patchwork.health/

[15] Nurse Staffing Levels (Wales) Act - Legislation

Appraisals

81 Compliance with the appraisal process, Personal Annual Development Reviews (PADR) is improving. Exhibit 1 shows that three-quarters of the Health Board's staff (74%) had had an appraisal and development review in the last 12 months, which is better than the Wales average but still below the all-Wales target of 85%. The Health Board has one of the highest compliance rates across Wales. The Audit and Assurance Service review of the Health Board's PADR arrangements provided limited assurance (dated 24 May 2018) and it identified the quality and completion as areas for improvement. The Health Board is taking urgent action by including a PADR module in the middle management development programme. Other actions include introducing a medical appraisal process into secondary care (Workforce Performance Update Report, October 2018). However, according to a report presented to Board on Medical Appraisals and Revalidation in September 2018, the Health Board still needs to introduce a way of offering more support to locum doctors to ensure they can and do access timely appraisal.

82 The Health Board's People Plan sets out objectives linked to training and development linking to IMTP priorities. The Health Board uses PADRs to identify individual training and development needs. It has also introduced a development programme for managers and supervisors focusing on developing people management skills and to support the Clinical Futures Transformational Change Programme. The Director of Workforce and Organisational Development reports on progress against the training and development plan to the Finance and Performance Committee as part of the Workforce Performance Update. We also found various subcommittees receive progress reports against the People Plan.

83 We found improvements in the proportion of consultants completing the job planning process from 58% in April 2018 to 79% in December 2018, although compliance is still well below the 100% target. The Health Board is working to improve performance. It is replicating the escalation process used for medical revalidation and appraisal, where the Medical Director issues reminder letters to consultants prompting them to complete their job plans.

Statutory and mandatory training

84 A continuing challenge for the Health Board is to improve compliance with statutory and mandatory training. Exhibit 1 shows the Health Board's performance (67%) is below the Wales average (73%) and well below target (85%). Staff that we met told us that some groups of staff are unwilling to complete the training or prioritise the requirements of professional bodies or other regulators over statutory and mandatory training. Also, issues with IT systems limit the overall clinical workforce's access to Statutory and Mandatory training modules resulting in introducing group/face-to-face training in some areas.

Staff engagement and wellbeing

85 The Health Board uses results from the NHS Staff Survey, custom-made surveys and face-to-face interventions to understand staff views. The 2018 NHS staff survey results show continued improvement in 2018 from the 2013 and 2016 NHS staff surveys results. Improvements include overall staff engagement and staff advocacy. It highlights some areas where the Health Board needs to improve, including bullying and harassment from patients and colleagues, and staff confidence in

delivering services in Welsh. The Health Board is addressing these areas. The Health Board is committed to improving staff safety and wellbeing by encouraging staff to access services, such as online counselling, employee wellbeing listening service and wellbeing initiatives like the Chill-Out Chapel at the Royal Gwent Hospital. Meanwhile, the Mental Health and Learning Disability Division is developing a wellbeing programme for its staff that focuses on effective stress management and promoting wellbeing.

Managing the finances

86 We considered financial and budget management, financial controls, and operational support and processes. We found that **in general, the financial management of the Health Board is strong and improving; nevertheless, there are challenges in managing financial risks.**

87 The Health Board met its financial duties in each of the last three financial years by achieving 'break-even' and has made a small surplus each year.

88 The IMTP submitted to the Welsh Government in March 2018 identified a financial risk of £14 million for 2018-19 made up as follows:

- Underlying deficit £19 million
- Cost pressures £45 million
- Identified savings £19 million
- Additional allocation funding £31 million

89 The position at the end of November 2018 (after month 8) was as follows:

- Additional identified savings £9 million
- Accountancy gains £3 million
- Cost revisions £5 million
- Reduced brokerage £3 million

90 The net effect of each of the above adjustments produces a forecast break-even position at the end of 2018-19. The securing of the additional funding is subject to a range of targets being met so the Health Board considers that an estimated £4 million is 'at risk' if key targets are not met by the end of the year. The Health Board currently has £4.197 million funding held in reserve, of this only £0.151 million is not committed. The remaining reserve supports Health Board provisions including the Welsh Risk Pool (£1.5 million), remaining pension auto enrolment commitments, Treatment Fund and NICE TA implementation (£1.66 million) and other remaining smaller IMTP commitments.

91 At the end of November, the discretionary capital expenditure programme was broadly in line with plans submitted to the Welsh Government with a cumulative underspend of £0.5 million due to 'slippage' on a number of schemes. This is offset by a current forecast overspend against the Grange Hospital Scheme of around £0.5 million. The current forecast spend is £32.884 million for the project as a whole compared to the approved funding allocation of £32.404 million.

92 Our 2017 structured assessment work provided detailed information on the Health Board's arrangements for planning and delivering cost improvements and financial savings. We found that the Health Board had effective arrangements, but Executive team and Independent Members needed more detailed information on progress against savings schemes/plans. The Finance Team now provides more summary information, more detail in Board reports, has adjusted the risk ratings of

savings plans to reduce ambiguity and also now places more emphasis on the delivery of savings plans. Savings plans are also discussed in more detail at divisional finance assurance meetings (Recommendation 1, 2017).

93 The Health Board is starting to move away from traditional cost improvement programmes, although there is still some reliance on transactional savings. It has developed a framework that aligns performance and cost drivers to efficiency. However, the Health Board estimates that it could save up to £22 million by reducing levels of sickness absence, temporary staffing costs and lengths of stay to benchmark levels. It has already acted to make more effective use of bank services and reduce reliance on agency staff referred to above. However, this remains a challenge and the Health Board is not realising the full potential benefits because of staffing shortages, particularly in key service areas.

94 Our annual accounts audit work has found the Health Board has good financial management and control arrangements in place. This enables the Auditor General to certify each year's accounts as materially 'true and fair'.

95 Procurement is undertaken by the NWSSP - Procurement Service (Procurement team),[16] on the Health Board's behalf. There is an all-Wales Procurement Strategy, underpinned by an all Wales business plan but there is no overall Health Board procurement plan. In common with other NHS bodies, the Health Board has a service level agreement with the Shared Services Partnership. The Health Board also uses its SFIs to guide procurement practice. The Audit and Assurance Service's review of Non-Pay Expenditure provided reasonable assurance (dated 18 May 2018). The report identified the lack of a detailed service level agreement, out-of-date policies and procedures and non-compliance with the Financial Control procedure. We understand that the Procurement team is drafting a new set of policies and procedures on behalf of the Health Board.

96 The Health Board has recently secured a fully established procurement team with sufficient resources in place and evidence of training and development that should help deliver an effective service. The Health Board employs two procurement officers and commissions the remaining procurement function through the Shared Service. The Procurement team uses a business partner approach and procurement leads are based within each division to work with service managers and suppliers to secure value for money and in doing so improve patient outcomes.

97 Our board member survey found that nine of the 17 (53%) individuals responding were either not sure or not confident that the way procurement is managed within the organisation achieves value for money. The Health Board identifies the level of procurement savings it plans to make at the start of the financial year. The NHS Wales Shared Services Partnership performance summary report shows that the Health Board had secured procurement savings totalling £4.2 million between April and September 2018, more than double the planned target (£1.8 million) for the year. There are regular meetings between the Head of Procurement and Director of Finance and an annual procurement report is presented to the Board. There is also evidence to suggest that information on procurement risk is shared effectively between NWSSP and the Health Board.

[16] The NHS Wales Shared Services Partnership (NWSSP) is an independent organisation, owned and directed by NHS Wales. NWSSP supports NHS Wales through the provision of a comprehensive range of high-quality, customer-focused support functions and services.

Performance, Efficiency and Productivity

98 We looked at what the organisation is doing to improve performance, efficiency and productivity. We found the **Health Board is not delivering against all key access targets, but it is actively improving its arrangements to secure efficiency and productivity.**

Key waiting time targets

99 The Health Board has had a challenging year, and **while performance has improved in some areas, others such as meeting waiting time targets in Scheduled and Unscheduled Care remain a significant challenge.**

100 Exhibit 2 shows targets and comparative performance for November 2017 and November 2018. There have been improvements in waiting times for scheduled care but a deterioration in waiting times performance related to emergency care. However, performance against all the measures is outside the IMTP planned performance profile and national targets.

Exhibit 2: Comparison of Scheduled and Unscheduled Care Performance between November 2017 and November 2018

Measure	National Target	IMTP Target	November 2017	November 2018
Referral to Treatment				
Patients waiting less than 26 weeks for treatment	95%	86%	89.5%	91.1%
Patients waiting more than 36 weeks for treatment	0	0	1539	280
Patients waiting more than eight weeks for a specified diagnostic	0	0	1675	5
Emergency Department				
Number of ambulance handovers over one hour	0	83	309	495
Percentage of patients waiting less than four hours in A&E	95%	88.7%	84.9%	74.8%
Number of patients waiting more than 12 hours in A&E	0	0	393	470

Source: Aneurin Bevan University Health Board Integrated Performance Dashboard Report dated December 2018

101 Performance in relation to the number of patients whose follow-up outpatient appointment was delayed remains a concern. The number of delayed follow-up outpatient appointments is largely unchanged during 2018. Reducing the number of delayed follow-up appointments is a key part of the Health Board's work to transform and improve services. However, the Health Board indicates that since September 2018, in some clinical specialties work has focused on reducing referral waiting times rather than reducing delayed follow-up appointments.

Improving Patient Flow, Managing Demand for Diagnostic Services and Improving Access to Services

102 Our work this year has considered the Health Board's approach to improving patient flow, managing demand for diagnostic services and improving access to services. Our findings show **the Health Board is investing resources to address areas of underperformance and achieve some positive outcomes.**

103 The Aneurin Bevan Continuous Improvement Team (ABCi)[17] is helping to improve productivity, efficiency and patient flow through improvement collaboratives.[18] Its work on preventing pressure ulcers and the patient flow re-alignment programme within the Health Board's Unscheduled Care Division has led to some notable improvements, including:

- between September 2017 and May 2018, more than 50 pressure ulcers were prevented across the six wards taking part in the collaborative. This is a reduction in the number of pressure sores by almost 50% compared to the year before the collaborative started. The Health Board is confident that this means safer care for patients and it estimates that it has saved £309,119.
- the Integrated Performance Report to the Board (dated January 2018) shows the Unscheduled Care Collaborative continues to see reductions in length of stay (LOS) and early discharges.

The Health Board is actively scaling up both projects to maximise the benefit across more wards and departments.

104 The Health Board is also acting to improve patient flow and reports success by:

- transferring patient flow staff from the corporate management teams to the Royal Gwent Hospital (RGH) and Nevill Hall Hospital (NHH) resulting in flow improvements at both sites;
- expanding its Frailty Unit at RGH to prevent avoidable admissions by assessing out patients at the 'front door' of A&E;
- developing business cases to secure permanent discharge co-ordinators and a transfer team at RGH; and
- Therapy Services now remind patients of clinic appointments by text message.

[17] The Aneurin Bevan Continuous Improvement team (ABCi) was established in 2013 with the aim of supporting staff by helping them to improve the services they provide. It uses improvement methodologies and creates space for innovation by bringing organisations and professionals together to co-create solutions.

[18] ABCi Improvement Collaboratives

105 The Audit and Assurance review of the Health Board's arrangements for Scheduled Care Diagnostics within Radiology provided reasonable assurance and identified several areas of good practice in relation to the department's processes and its approach to addressing waiting list times.

Productivity and efficiency

106 Our work this year has considered the Health Board's efficiency and productivity arrangements. Our findings show the **Health Board has embraced prudent and value-based healthcare and its benchmarking approach identifies notable savings through efficiency opportunities**.

107 The Health Board has developed a value-based healthcare programme that aligns with the Clinical Futures Strategy and its IMTP, and delivery through the SCPs. The approach allows the Health Board to: review costs and outcomes across care pathways: identify where and how to reallocate resources to make better use of them; and to deliver improved outcomes and quality for patients. The programme brief provides a detailed description of the programme, its objectives, desired outcomes, output benefits, risks, dependencies, costs and timescales. The infrastructure supporting the programme consists of Executive level support from the Medical Director and Director of Finance, a dedicated Value Team, Assistant Medical Directors and the Finance/Benchmarking Team. The Health Board's organisation-level approach resulted in nomination for the values-based healthcare prize during 2018.

108 The Health Board is progressing 24 value-based healthcare workstreams, which are at various stages of maturity, and operational and strategic oversight is provided by the Executive Team Quality and Patient Safety Committee, and the Board. Managers described some notable successes in its work around mental health and follow-up outpatients. The Health Board's IMTP sets out how it is applying values-based healthcare principles to workforce configuration for re-designing the vascular pathway, treating paediatric constipation and tele-dermatology with GP minor surgery, which should result in a fall of inappropriate demand and cost. The Value Team is assessing each workstream to understand its success and aims to apply learning to forthcoming work on diabetes. A report to the Quality and Patient Safety Committee during November 2017 highlighted the need to improve in-house IT capability and capacity to further improve the values-based healthcare programme.

109 The Health Board actively participates in benchmarking activities. It has a dedicated benchmarking team and is a member of CHKS[19] and the NHS Benchmarking club. Its participation in benchmarking has helped it to identify some notable savings through efficiency opportunities. As already mentioned in paragraph 90 above, the Health Board's Finance and Performance Report (dated September 2018) indicates that its savings plans include £5 million of deliverable efficiency opportunities and benchmarking intelligence has identified further potential savings totalling £22 million by:

- reducing lengths of stay, readmissions and the incidence of falls;
- improving theatre productivity and the use of outpatients;
- reducing staff sickness levels; and
- reducing the use of medical and nursing agency staff.

[19] http://www.chks.co.uk/

110 Our board member survey found that 12 of the 17 (70%) individuals responding were clear about the actions the organisation is taking to make cost improvements and improve service efficiency.

Use of informatics to support service delivery

111 We assessed the Health Board's arrangements to utilise technology to support service delivery. We found that **there is a good strategic approach in the informatics service, but it needs focused investment and stronger oversight of the impact of national IT system risks**.

112 The Health Board agreed a five-year informatics strategic outline programme (SOP), which was first produced in late 2016. The SOP is now subject to revision and reprioritisation as part of a wider digital transformation strategy in line with the Health Board's priorities and budget availability. The Health Board plans to consult on, complete and approve the digital transformation strategy by the end of December 2019. It has set up a Transformation to Digital Delivery Board to oversee the delivery of the digital programme.

113 Transformation projects, enabled by digital technology, have the potential to improve productivity and deliver efficiencies. Delivery of the Digital Strategy and investments in new digital technologies, for example, diagnostics modernisation, tele-health, e-Pharmacy and patient flow initiatives will rely on a modern and resilient ICT infrastructure to support it.

114 Overall, informatics funding was provided in 2017-18 for ICT infrastructure and technology upgrades. Despite this additional investment, several risks remain in relation to the availability of and delays in implementing national IT systems. For example, the delay of the Welsh Community Care Information System presents a lost opportunity because of the lack of reliable community-based service and productivity information.

115 There are several positive local initiatives and pilot projects that use technology to support improved patient flow and tele-health. An Information Communications Technology (ICT) department structure is in place but continued constraints on resources (Recommendation 5, 2017) may limit the extent to which ICT can support the existing IT infrastructure and service change through enabling digital technologies. This may also present business continuity and resilience risks because of ageing ICT infrastructure.

116 For the past year, the Information Governance Committee has scrutinised the work of the Informatics Department. However, to be more effective, it should strengthen its focus on overseeing delivery of the information governance and technology strategic plans rather than operational matters.

Managing the estate and other physical assets

117 Finally, we considered how the Health Board is managing its estate and physical assets. We found that **the Health Board's management of assets, particularly medical equipment devices, needs to be more rigorous and strategic**.

118 In last year's Structured Assessment, we recommended that the Health Board develop an Estates Strategy that reflected the current condition of its buildings and supports delivery of the Clinical

Futures Strategy. This year the Health Board recently completed its 6-facet survey[20] of the estate it owns, and is incorporating this in its draft Estates Strategy. The Health Board presented the Estates Strategy to the Board for approval at its January 2019 meeting (Recommendation 6, 2017). The Health Board's IMTP sets out the strategic intent for the Estates function and there is also a Capital Programme, which details the capital spend required over the next year.

119 The Audit and Assurance report on the Health Board's Medical Devices and Equipment (dated January 2018) provided limited assurance. There are arrangements for risk assessing medical equipment operationally, but the Audit and Assurance team raised concerns around the monitoring of medical equipment incidents reported on the Datix system. No serious medical equipment risks were brought to our attention during our fieldwork. However, we note that the Audit and Assurance report was presented to both the Audit Committee and the Quality and Patient Safety Committee with medical equipment risks and issues being discussed specifically at the latter.

120 Roles and responsibilities for estates management are clear. The Executive Director of Operations has overall strategic responsibility for estates and facilities while operational responsibility sits with the Divisional Director of Estates and Facilities. The Director of Planning and Performance is responsible for Capital Planning and the capital programme and chairs the Health Board's Strategic Capital and Estates Group and the Capital Programme Group.

121 The Health Board has clear rules and procedures governing how it manages acquisitions, disposals and other property matters and the Maintenance Policy sets out performance management standards for response times. More guidance is available in the Health Board's Standing Orders and in Estatecode[21].

122 The Health Board uses MICAD and e-PIMS (electronic Property Information Mapping Service) to store estate information and manage its property. However, the Audit and Assurance review of Medical Equipment and Devices found that the Health Board does not have an overarching asset register for its medical devices and equipment. Our structured assessment audit found that the Health Board had made limited progress to address Audit and Assurance recommendations, although we were informed that some work had been completed around hospital beds and ultrasound equipment resulting in better asset tagging.

123 Thirteen of the 17 (76%) individuals responding to our board member survey were either not sure, or not confident that the way assets are managed within the organisation achieves value for money. The Health Board has robust risk management arrangements for Estates with estates risks captured on either the Corporate Health and Safety Risk Register or Divisional risk registers. The Board receives the Strategic Risk Dashboard, which includes corporate estates risks. The Divisional Board reviews the estates and facilities risk report at its six-monthly meetings held in December and June. The Capital Group escalate any risks not dealt with at the Divisional meeting to the Board. There are adequate performance management arrangements of the Estates team. Monthly Estates and Facilities

[20] A facet survey is an external condition review of the NHS estate; the number of facets relates to the scope or elements reviewed.

[21] Estatecode is a user manual for NHS organisations managing the healthcare estate for current and future use. It includes advice on a broad range of estates topics, including land transactions, town planning issues and guidance on baseline assessments of the condition of the estate, as part of corporate planning and investment decision making processes and procedures.

divisional meeting reports contain financial and workforce performance information but nothing on estates performance, for example, completion of capital works, performance against backlog maintenance, compliance with statutory compliance inspections and customer satisfaction with estates. We understand that the Health Board is developing a performance dashboard which will improve performance reporting around estates functions, which might improve board members' confidence that assets are well managed.

Recommendations

Exhibit 3: 2018 recommendations

The following table sets out the recommendations arising from the 2018 Structured Assessment. Exhibit 4 sets out the progress made against recommendations made in our 2017 Structured Assessment report. We will continue to monitor implementation where these are shown as 'in progress' and have therefore sought not to repeat them in Exhibit 3.

2018 recommendations
Governance R1 The Health Board should: • ensure board member induction and training meets the needs of Independent Members; • explore the reasons for the increase in complaints from patients and service users as part of its Putting Things Right Service Improvement plan; and • clarify perceptions around interoperability of the Board committees.
National Fraud Initiative R2 The Health Board should put in place an action plan to ensure that the matches it receives in future NFI exercises are reviewed and where necessary investigated in a timely manner. We expect the Health Board to: • commence review of the data-matches as soon as possible following the release of the next NFI matches in January 2019; • in addition to reviewing all the high priority matches recommended for review, carry out a review of a sample of the remaining data matches; and • ensure that where data-matches have been reviewed, the NFI web application is updated to clearly record how matches were reviewed and the outcomes of those reviews.
Information Governance 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%; • improving performance against information access targets for the Freedom of Information Act and Data Protection Act to reach the statutory targets; and • strengthening the focus of the Information Governance Committee to scrutinise delivery of informatics strategic plans rather than operational matters.

2018 recommendations
Informatics R4 The Health Board should address areas for improvement in relation to informatics, specifically: • assessing resource needs within the Informatics Department to improve the resilience of the ICT infrastructure and replace ageing hardware and software; • completing and approving the digital transformation strategy by the end of 2019; • oversight of national system risks and scrutiny of the delivery of these services and their impact on the organisation; • completing the implementation of plans to strengthen cyber security control arrangements; and • updating ICT disaster recovery plans and test these to ensure they work as intended.
Asset Management R5 The Health Board should take steps to improve the management of its non-estate assets by: • agreeing an Asset Strategy; and • ensuring there are suitable asset registers to support the management of assets.

Appendix 1

Progress implementing previous recommendations

Exhibit 4: The Health Board's self-reported progress against the 2017 recommendations

Recommendation	Action taken in response	Completed
Savings schemes monitoring and reporting R1 The Health Board should provide more detail to Executives and Independent Members in respect of progress against savings schemes. This should help them to provide sufficient scrutiny and challenge to schemes which are off target.	The Health Board continues to provide summary information on savings plans and achievability. The Health Board has adjusted its financial plan to ensure financial balance and this has been summarised in Board and Committee reporting. In addition, the Health Board has adjusted its risk rating to reduce ambiguity for savings schemes previously rated as 'amber'. There will be more emphasis on achievability of the financial savings requirement and therefore detail of off-target schemes will be highlighted. In addition, Divisional financial assurance meetings continue to discuss savings plans in more detail.	In progress
Board and committee papers R2 The Health Board should ensure that Board and Committee Members receive appropriate information to help them make sound decisions and effectively scrutinise by: a. ensuring adequate time to consider agenda items during meetings; b. ensuring that reports include information relevant to the Board's or committees' remit;	The Health Board has introduced a new Board and committee report format, which requires summary information with reference to the Well-being of Future Generations Act five ways of working. The report format includes key information and hyperlinks to facilitate access to additional background papers. This has reduced agenda pack size and focused on the essential information to support decision making.	Complete

Recommendation	Action taken in response	Completed
c. provide access to additional or background information; and d. ensure that agenda reports are of a reasonable length that members can reasonably be expected to read before the meeting.	Board Members have commented positively on the reduction in agenda pack size, quality of the papers and the summary information provided. The length of board meetings has reduced and further work is being undertaken to enable Committees to adopt similar approaches.	
Risk management R3 The Health Board should review risk management arrangements to ensure that corporate risks are appropriately escalated and managed by: a. developing upon its current risk reports to ensure that the context of the risk and progress in managing it are clearly set out; and b. revising the risk rating based on the mitigating actions.	The Health Board has fully reviewed its Corporate Risk Register and has updated its Risk Reporting arrangements. A Health Board wide risk diagnostic is underway to further inform this improvement work by streamlining and standardising risk management activity. A new Board Assurance Framework is being finalised, which includes one risk per page reporting. This is focused on the risk of non-delivery of the IMTP and is built around the Service Change Plans (SCPs) and the Health Board's stated priorities.	In progress
Internal control R4 The Health Board should ensure that clinical audits provide assurance within an assurance framework, linked to the organisation's strategic objectives.	The Medical Director has presented updated work on the Management and Reporting of Clinical Audit to the Audit Committee and Quality and Patient Safety Committee. The Deputy Director of Therapies and Health Science is leading work with Executive Team colleagues to create a Quality and Safety Assurance Framework in which clinical audit will play a key role,	In progress

Recommendation	Action taken in response	Completed
	aiming to bring a proposal for consideration by the QPSC by January 2019.	
Information technology and information management R5 The Health Board should ensure resources allocated to information technology and information management provide sufficient capacity to meet the Health Board's plans.	The Strategic Outline Plan (SOP) was prepared for and submitted to the Welsh Government in October 2016. Whilst it was recognised by the Welsh Government there was no approval process agreed. The IMTP process incorporates the SOP and the Health Board is currently consulting on its digital transformation strategy and aims to finalise it by the end of December 2018. In the intervening period the Health Board has funded a core ICT business case resulting in an investment of £600,000 starting with £300,000 in 2018-19. An external review of cyber security has resulted in recruitment of 14 staff, including cybersecurity specialists, systems management; and Help Desk staff. The Health Board acknowledges that it is just beginning to address the findings of the 2017 recommendations following the significant investment in staff. The Health Board acknowledges that compliance with GDPR is a key part of its governance framework. Therefore, a further investment to recruit additional staff members was agreed.	In progress

Recommendation	Action taken in response	Completed
	The Health Board has also invested in Qlik Sense Business Intelligence software and is currently engaged in deployment and planning. The Health Board remains committed to the WCCIS programme and the informatics directorate also hosts two national IT programmes – National Electronic Patient Flow and Technology Enabled Care Services.	
Estate Management R6 The Health Board should develop an Estates Strategy that reflects the current condition of its buildings and supports delivery of the Clinical Futures Strategy.	The 6-facet estate survey has been completed at all premises owned by the Health Board and incorporated into Estates Strategy that was presented to the Board for approval at its meeting in January 2019.	Completed
Engagement R7 The Health Board should review, refresh and update the Engagement Strategy – 'Hearing and acting upon the voice of our staff and citizens'.	At the time of our audit, the Health Board's revised Engagement Strategy was being scrutinised through the usual governance process. The Health Board intends to present the Engagement Strategy, which is aligned to the Clinical Futures Strategy and the Health Board's Patient Experience approach, to the Board for approval in March 2019. The Health Board has also established a couple of specific workstreams in support of the Clinical Futures Strategy programme of work, which are the Workforce and OD/Staff Engagement and Communications and Engagement.	In progress

Appendix 2

Health Board's response to this year's recommendations

Exhibit 5: management response to 2018 recommendations

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R1	**Governance** The Health Board should: • ensure board member induction and training meets the needs of Independent Members;	Decision making will be improved.	Yes	Yes	The Health Board has already introduced a new Induction and training programme for 2018/2019. Several elements of this have been completed. The programme will be completed during 2019. The Health Board is also participating in the redesign of the national NHS Wales Induction Programme.	December 2019	Richard Bevan, Board Secretary
	• explore the reasons for the increase in complaints from patients and service users as part of the service improvement plan for Putting Things Right; and		Yes	Yes	The Health Board has appointed new leadership for the Putting Things Right Team. The Health Board has undertaken a thematic review of the reasons for the increase in formal complaints and developed an improvement plan. Progress is being closely monitored by the Executive Team and the Quality Patient Safety Committee.	December 2019	Martine Price, Acting Director of Nursing

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
	• Clarify perceptions around interoperability of the Board committees.	Improved decision making and taking	Yes	Yes	The Health Board is in the process of completing a full review of its Committees and their terms of reference to support further interoperability and avoid any duplication.	May 2019	Richard Bevan, Board Secretary
R2	**National Fraud Initiative** The Health Board should put in place an action plan to ensure that the matches it receives in future NFI exercises are reviewed and where necessary investigated in a timely manner. We expect the Health Board to: • commence review of the data-matches as soon as possible following the release of the next NFI matches in January 2019; • in addition to reviewing all the high priority matches recommended for review, carry out a review of a sample of the remaining data-matches; and	Better controls over potential fraud.	Yes	Yes	High priority matches are reviewed first. For last year, these were reviewed and actioned in February 2018. All high priority 3-way data matches were actioned in February 2018.	March 2019	Glyn Jones, Director of Finance

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
	• ensure that where data-matches have been reviewed, the NFI web application is updated to clearly record how matches were reviewed and the outcomes of those reviews.				High priority actions completed and updated. Other matches being updated. The process for 2018/2019 will be completed by the end of March 2019.		
R3	**Information Governance** 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%;	More effective framework for information governance arrangements.	Yes	Yes	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.	March 2020	Nicola Prygodzicz, Director of Planning, Digital and IT

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
	• improving performance against information access targets for the Freedom of Information Act and Data Protection Act to reach the statutory targets; and	More effective framework for information governance arrangements.	Yes	Yes	The Health Board during 2018/19 has already improved its compliance with statutory targets and will continue with this focus for 2019/2020.	March 2020	Richard Bevan, Board Secretary and Richard Howells, Head of IG
	• strengthening the focus of the Information Governance Committee to overseeing delivery of informatics strategic plans rather than operational matters.	More effective framework for information governance arrangements.	Yes	Yes	The Information Governance Committee agenda is focused on strategic plans around informatics and is evidenced by agenda items. This will also be highlighted in the revised Terms of Reference.	March 2020	Nicola Prygodzicz, Director of Planning, Digital and IT
R4	**Informatics** The Health Board should address weakness in its use of informatics, specifically concerning: • the resource constraints within the Informatics Department to improve the resilience of the ICT infrastructure and replace ageing hardware and software;	Improved resources and strategic focus for digitally enabled transformation projects. Better controls over cyber security arrangements and resilience of the IT infrastructure. Improved resources and strategic focus for digitally enabled transformation projects. Better controls over cyber security arrangements and resilience of the IT infrastructure.	Yes	Yes	A business case was approved in 2017 and resource was prioritised against cyber security and NISD. The Directorate has now appointed to the positions of: • Cyber Security Team Leader • X2 Cyber Security Officers • X2 System Engineers This team has the focus to deliver a policy and underlying service that keeps ICT assets secure and up to date as well as informing future plans.	Recruitment Completed	Nicola Prygodzicz, Director of Planning, Digital and IT

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
	• completing and approving the digital transformation strategy by the end of 2019;		Yes	Yes	Further work was undertaken to align with the IMTP, an updated version has now been drafted and Health Board approval will be sought.	December 2019	Nicola Prygodzicz, Director of Planning, Digital and IT
	• oversight of national system risks and their impact on the organisation;		Yes	Yes	ABUHB continues to engage with both Welsh Government and NHS Wales Informatics Service. Welsh Government have conducted a review of governance following the Wales Audit Office report. The Health Board is actively engaged in this and other resultant actions including an architecture review.	December 2019	Nicola Prygodzicz, Director of Planning, Digital and IT
	• strengthening cyber security control arrangements and resourcing by establishing a specialist team, resilience and incident response plans; and		Yes	Yes	As stated above key appointments have now been made against a number of positions relating to cyber security. Work is being completed on key personnel polices plans and underlying services.	September 2019	Nicola Prygodzicz, Director of Planning, Digital and IT
	• updating its ICT disaster recovery plans and test these to ensure they work as intended.		Yes	Yes	Work is ongoing with the newly recruited team in compliance with NISD. A Task and Finish group is currently prioritising and planning continuity arrangements led by the Emergency Planning Team.	March 2020	Nicola Prygodzicz, Director of Planning, Digital and IT

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R5	**Asset Management** The Health Board should take steps to improve the management of its non-estate assets by: • agreeing an asset strategy; and • ensuring there are suitable asset registers to support the management of assets.	Better controls over the use of assets	Yes	Yes	Under GDPR organisations must hold an Information Asset Register. IT holds an Asset Register linked to all IT equipment held by ABUHB. The Information Governance unit holds the information asset register, within the asset register we collect the following: • Patient/Personal Identifiable Information • Staff Records • Non patient/personal identifiable information System used throughout the health board	Reviewed every three months – Annual review March 2020	Nicola Prygodzicz, Director of Planning, Digital and IT

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4.5

Annual Audit Report 2018 – **Aneurin Bevan University Health Board**

Audit year: 2018

Date issued: March 2019

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg. This document is also available in Welsh.

This report was prepared for the Auditor General by David Wilson, Terry Lewis, Nathan Couch, Dave Thomas and Richard Harries.

Contents

Summary report

About this report

1 This report summarises the findings from the audit work I have undertaken at Aneurin Bevan University Health Board (the Health Board) during 2018. I did that work to carry out my responsibilities under the Public Audit (Wales) Act 2004. That Act requires me to:

a) examine and certify the accounts submitted to me by the Health Board, and to lay them before the National Assembly;

b) satisfy myself that the expenditure and income to which the accounts relate have been applied to the purposes intended and in accordance with the authorities which govern it; and

c) satisfy myself that the Health Board has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

2 I have reported my findings under the following headings:

- Key messages
- Audit of accounts
- Arrangements for securing economy, efficiency and effectiveness in the use of resources

3 I have issued several reports to the Health Board this year. This annual audit report is a summary of the issues presented in these more detailed reports, a list of which is included in Appendix 1.

4 Appendix 2 presents the latest estimate on the audit fee that I will need to charge to cover the actual costs of undertaking my work at the Health Board, alongside the original fee that was set out in the 2018 Audit Plan.

5 Appendix 3 sets out the significant financial audit risks highlighted in my 2018 Audit Plan and how they were addressed through the audit.

6 The Chief Executive and the Director of Finance have agreed this report is factually accurate. The report has been shared with members of the Audit Committee and will be presented to the Board on 27 March 2019. We strongly encourage the Health Board to arrange wider publication of this report. We will make the report available to the public on the Wales Audit Office website after the Board has considered it.

7 I would like to thank the Health Board's staff and members for their help and co-operation during the audit work my team has undertaken over the last 12 months.

Key messages

Audit of accounts

8 I have issued an unqualified opinion on the 2017-18 financial statements of the Health Board, concluding that the accounts were properly prepared and materially accurate.

9 My work did not identify any material weaknesses in the Health Board's internal controls relevant to my audit of the accounts.

10 The Health Board achieved financial balance for the three-year period ending 31 March 2018 and so I have issued an unqualified opinion on the regularity of the financial transactions within its 2017-18 accounts.

Arrangements for securing efficiency, effectiveness and economy in the use of resources

11 My 2018 structured assessment work at the Health Board has found that:

- whilst the Health Board has established the necessary arrangements to support good governance, there is more to do to ensure they are operating as intended;
- the Health Board has a clear vision supported by an effective planning process, and work is continuing to update plans for service re-design; and
- the Health Board has a track record in managing resources effectively and a good developing approach to improving productivity, although some aspects are not always sufficiently strategic or detailed and performance against some key targets needs to improve.

12 Reviews of primary care services, estates management and regional working around the Integrated Care Fund have found some aspects of good practice as well as opportunities to strengthen arrangements for securing efficient, effective and economical use of resources.

13 The Health Board has made broadly effective use of National Fraud Initiative (NFI) as a component of its counter-fraud arrangements but has yet to review all the recommended data matches. This is particularly important given the NFI web application record instances where staff members had interests in companies that had not been declared to the Health Board.

14 These findings are considered further in the following sections.

Detailed report

Audit of accounts

15 This section of the report summarises the findings from my audit of the Health Board's financial statements for 2017-18. These statements are how the organisation shows its financial performance and sets out its net operating costs, recognised gains and losses, and cash flows. Preparing the statements is an essential element in demonstrating appropriate stewardship of public money.

16 In examining the Health Board's financial statements, I must give an opinion on:

- whether they give a true and fair view of the financial position of the Health Board and of its income and expenditure for the period in question;
- whether they are prepared in accordance with statutory and other requirements, and meet the relevant requirements for accounting presentation and disclosure;
- whether that part of the remuneration report to be audited is properly prepared;
- whether the other information provided with the financial statements (usually the annual report) is consistent with them; and
- the regularity of the expenditure and income in the financial statements.

17 In giving this opinion, I have complied with my Code of Audit Practice and the International Standards on Auditing (ISAs).

I have issued an unqualified opinion on the accuracy and proper preparation of the 2017-18 financial statements of the Health Board

18 I issued an unqualified opinion on the Health Board's 2017-18 financial statements, concluding that they were properly prepared and materially accurate. My work did not identify any material weaknesses in the Health Board's internal controls relevant to my audit of the accounts.

19 We have no concerns about the qualitative aspects of your accounting practices and financial reporting. We found the information provided to be relevant, reliable, comparable, material and easy to understand. We concluded that accounting policies and estimates are appropriate and financial statement disclosures unbiased, fair and clear.

20 We did not encounter any significant difficulties during the audit. As in previous years, the accounts and audit process ran smoothly with excellent engagement. We received information in a timely and helpful manner and were not restricted in our work. We met the Health Board's Finance Team regularly during the final audit to review progress and clear any issues arising promptly. We also continued to develop our audit approach and carried out early audit testing of 'in-year' transactions wherever possible. The Finance Team prepared a detailed closedown plan for

2017-18 which incorporated our audit requirements and details of the supporting papers. This approach continued to strengthen the financial statements production process and helped to meet the tight clearance timetable. We will continue to work closely with the Health Board to review the process and experiences this year to identify any areas where we can further develop and refine the procedures and to ensure any lessons learned can be carried forward to 2018-19.

21 I reviewed those internal controls that I considered to be relevant to the audit to help me identify, assess and respond to the risks of material misstatement in the accounts. I did not consider them for the purposes of expressing an opinion on the operating effectiveness of internal control. My review did not identify any significant deficiencies in the Health Board's internal controls.

22 I must report issues arising from my work to those charged with governance before I issue my audit opinion on the accounts. My Financial Audit Engagement Lead reported these issues to the Health Board's Audit Committee on 29 May 2018. Exhibit 1 summarises the key issues set out in that report.

Exhibit 1: issues identified in the Audit of Financial Statements Report

The following table summarises and provides comments on the key issues identified.

Issue	Auditors' comments
Uncorrected misstatements	There were no misstatements identified in the financial statements, which remained uncorrected.
Corrected misstatements	There were a number of misstatements that have been corrected by management. However, we did not consider that they needed to be drawn to your attention as part of your responsibilities over the financial reporting process. As well as a few additional disclosures, the financial corrections were relatively minor and have not impacted on the reported surplus.
Other significant issues	Whilst there were no significant difficulties, we did note that Internal Audit have reported on a number of system weaknesses which require management action.

23 As part of my financial audit, I also undertook a review of the Whole of Government Accounts return. I concluded that the counterparty consolidation information was consistent with the financial position of the Health Board at 31 March 2018 and the return was prepared in accordance with the Treasury's instructions.

24 My separate audit of the charitable funds financial statements was carried out during September 2018. I presented my Audit of Financial Statements Report to the Health Board on 28 November 2018. I issued an unqualified audit opinion and there were no significant issues to report.

I also issued an unqualified audit opinion on the regularity of the financial transactions within the financial statements of the Health Board

The Health Board achieved financial balance for the three-year period ending 31 March 2018 and so I have issued an unqualified opinion on the regularity of the financial transactions within its 2017-18 accounts

25 The Health Board's financial transactions must be in accordance with authorities that govern them. It must have the powers to receive the income and incur the expenditure that it has. Our work reviews these powers and tests that there are no material elements of income or expenditure which the Health Board does not have the powers to receive or incur.

As the Health Board achieved its financial balance duty and has an approved three-year plan in place and there were no other issues which warranted highlighting, no substantive report was placed on the Health Board's accounts

26 I have the power to place a substantive report on the Health Board's accounts alongside my opinions where I want to highlight issues. As the Health Board met both of its financial duties: to achieve financial balance (as set out above) and to have an approved three-year plan in place; and there were no other issues warranting report, I did not issue a substantive report on the accounts.

27 As detailed above, the Health Board has met its financial duty to break even over the three years 2015-16 to 2017-18 and reported a retained surplus of £509,000 for this period.

Arrangements for securing efficiency, effectiveness and economy in the use of resources

28 I have a statutory requirement to satisfy myself that NHS bodies have proper arrangements in place to secure efficiency, effectiveness and economy in the use of their resources. I have undertaken a range of performance audit work at the Health Board over the last 12 months to help me discharge that responsibility. This work has involved:

- assessing the effectiveness of the Health Board's governance and assurance arrangements;
- reviewing the Health Board's approach to strategic planning;
- examining the arrangements in place for managing the Health Board's finances, workforce, assets and procurement;

- specific use of resources work on the Primary Care service, Estates and regional partnership working;
- reviewing the Health Board's arrangements for tracking progress against external audit recommendations; and
- assessing the application of data-matching as part of the National Fraud Initiative (NFI).

29 My conclusions based on this work are set out below.

Whilst the Health Board has established the necessary arrangements to support good governance, there is more to do to ensure they are operating as intended

30 My structured assessment work examined the Health Board's governance arrangements, the way in which the Board and its sub-committees conduct their business, and the extent to which organisational structures are supporting good governance and clear accountabilities. I also looked at the information that the Board and its committees receive to help them oversee and challenge performance and monitor the achievement of organisational objectives. I found the following.

31 **Arrangements to support board and committee effectiveness are generally good with ongoing work to strengthen team working at the board.** My work found that the Health Board reviews its Board and committee effectiveness annually and used this year's survey results as part of a board development session and developed an action plan to inform a development programme.

32 Since my 2017 Structured Assessment, the Health Board has experienced a turnover of independent members and during 2018, they have been settling into their new roles and developing relationships that will be essential to make the Health Board's governance arrangements fully effective. Independent Members have been able to access the national induction programme and the Health Board is providing a range of training opportunities for independent members itself including an induction programme, all-Wales board member training and the Health Board's own board development sessions. However, independent members responding to our board member survey had mixed opinions about their induction programme, the training and support given to discharge their responsibilities and the programme of board development.

33 The Chair appraises independent members to set personal objectives and to identify training and development needs. The Health Board is developing a new board training and development programme to address learning needs. Health Board committees perform effectively, with good arrangements in place to escalate issues to the Board. However, there is scope to ensure systematic communication between committees and improve understanding amongst board members about committee roles and responsibilities.

34 **The Health Board is making progress to develop a board assurance framework, and work is underway to improve and strengthen risk management arrangements**. The Health Board is developing its Board Assurance Framework with support from the Audit and Assurance team[1]. Work continues to map strategic risks and the required sources of assurance within the BAF, as well as redevelopment of the risk appetite statement once the BAF is finalised. I found that the strategic risk management arrangements are generally fit for purpose and work is in progress to strengthen them further. There are improvements to risk reporting but I note that the Health Board is yet to clarify the roles for collating and monitoring corporate and clinical risks and ensure it has sufficient resources and capacity to oversee risk management across the organisation.

35 **Internal controls are in place and the Health Board is continuing to strengthen aspects of its clinical audit arrangements**. The Health Board business is conducted in accordance with the latest Standing Financial Instructions[2], Standing Orders[3] and an up-to-date Scheme of Delegation, which sets out roles, responsibilities and levels of authority. The Audit Committee oversees and monitors compliance against them. The Health Board is also continuing to raise awareness of its Register of Gifts, Hospitality and Sponsorships. The Health Board routinely monitors both financial and operational performance. Its performance management arrangements are robust, and it takes action to address poor performance. The Health Board has developed a draft Quality Assurance and Improvement Framework[4], but my work did identify some ways that its quality governance arrangements could be improved such as around patient stories, independent member walkabouts, complaints and clinical audit.

36 The Audit Committee oversees progress against recommendations made by Internal and External Audit. My work found that the Health Board has made significant progress to address outstanding recommendations with ongoing work to ensure recommendations are addressed in a timely way. I also found tha the Health Board has implemented a new process to track recommendations made by other regulators and inspectors such as Health Inspectorate Wales to enable the Quality and Patient Safety Committee to monitor progress.

37 **The Health Board is working to strengthen cyber security and to achieve full compliance with response times for statutory information requests**. I found that compliance with information governance training is improving and is currently 89%, but it is still below the all-Wales target of 95%. The Health Board provided additional resources to its information governance unit from mid-2018 to strengthen

[1] The NHS Shared Services Partnership Audit and Assurance service provides bilingual internal audit, specialist audit and consultancy services to the whole of the NHS in Wales.

[2] Standing Financial Instructions for Health Boards – March 2014

[3] Standing Orders & Reservation and Delegation of Powers – March 2014

[4] Aneurin Bevan University Health Board – Draft Quality Assurance and Improvement Framework

the information confidentiality arrangements and work towards full GDPR compliance. The Health Board reports that the volume of FOI requests is growing and that it deals with on average 50 requests each month. Although response times to FOI requests started to improve towards the end of 2018 overall compliance was 73% for the year compared with 84% in 2017. Performance in relation to response times to data subject access requests began to improve towards the end of 2018 having fluctuated between 83% and 89% for much of the year. Overall compliance with data subject access requests for 2018 was 88% compared with 96% in relation to 2017. An external review of information governance and information security was undertaken in early 2018 and the Health Board is working to address areas for improvement and to strengthen cyber security arrangements and capacity by establishing a specialist team to bolster controls, resilience and manage incidents.

The Health Board has a clear vision supported by an effective planning process, and work is continuing to update plans for service re-design

38 My work examined how the Board engages partners and sets the strategic direction for the organisation. I also assessed how well the Health Board plans the delivery of its objectives and how it monitors progress in delivering the plans. My findings are set out below.

39 **The Health Board has an effective approach for engaging with stakeholders to inform strategy development**. My work found that the Health Board's strategy development is supported by effective internal and external engagement. It is also continuing to improve its engagement approach and has established workstreams on Workforce and Organisational Development/Staff Engagement and Communication and Engagement as part of its Clinical Futures Programme. The Health Board is a member of the Greater Gwent Regional Partnership Board and five Public Service Boards, ensuring alignment between the IMTP and the Greater Gwent Area and Well-being plans. The Health Board's Public Partnership and Well-being Committee effectively oversees partnership engagement and the Independent Chair of the Regional Partnership Board attends this meeting to provide updates.

40 **The Health Board has a strong planning approach underpinned by an analysis of demand and capacity with ongoing work to update service models underpinning the Clinical Futures Strategy.** Throughout 2017-18, the Health Board has had a clear and agreed planning approach. It has invested in extra capacity within the Planning Team, introducing a lead planner for each division mirroring the business partner model for finance and workforce. I also found evidence that the Health Board's IMTP planning approach is informed by learning and evaluation. The Health Board's analysis of demand and capacity supports strategic planning, but my 2018 Structured Assessment work found that

whilst it is developing its approach to demand and capacity analysis, it is not as strong in primary care, frailty and district nursing, as in other parts of the organisation. I found that the Health Board is working to produce an overarching workforce plan to support the Clinical Futures Strategy and the timely opening of the Grange University Hospital in 2020.

41 **The Health Board has arrangements for monitoring and reporting on delivery of the IMTP and the Clinical Futures Strategy.** The Board, Executive Team and Finance and Performance Committee regularly reviews and monitors IMTP performance and evidence indicates that actions are taken to address poor performance. However, we found that the Health Board is not consistently achieving some of its IMTP performance targets. The Health Board has approved its IMTP Delivery Framework, which sets out how the organisation ensures delivery and reinforces the importance of performance at individual, team, directorate and organisational level. This enables the Health Board to assess progress, learn from its performance and act where necessary. The Health Board recognises that it needs robust governance arrangements to support delivery of the Clinical Futures Strategy with Executive Member involvement at a Delivery Board and sub-group level which are responsible for delivering specific workstreams. The Health Board has appointed a Programme Director and set up a project timeline to support delivery of the strategy. My review of the content of the Clinical Futures progress reports found them to provide enough information to enable effective monitoring of progress, risks and issues. Both the Health Board and Welsh Government assessment of progress in delivering the Clinical Futures Strategy is reported to be broadly on target.

The Health Board has a track record in managing resources effectively and a good developing approach to improving productivity, although some aspects are not always sufficiently strategic or detailed and performance against some key targets needs to improve

42 My structured assessment work examined the Health Board's arrangements for managing its workforce, its finances and other physical assets to support the efficient, effective and economical use of resources. I also considered the arrangements for procuring goods and services, and the action being taken to maximise efficiency and productivity. My findings are set out below.

43 **The Health Board is actively managing workforce issues, but sickness absence rates remain above the Welsh Government target and compliance with statutory and mandatory training, the appraisal process and consultant job planning needs to improve.** The Health Board is proactively addressing workforce issues particularly around sickness absence, turnover, vacancies and appraisals resulting in improvement in key performance indicators. The Health

Board must meet requirements of the Nurse Staffing (Wales) Act 2016[5] and while it has put arrangements in place, nursing staff shortfalls present ongoing challenges. The Health Board is taking a proactive approach for staff engagement and wellbeing. For example, it has developed an Employee Experience Framework although this is still being approved by the Executive Team. The 2018 NHS staff survey results show continued improvement particularly around overall staff engagement and staff advocacy. It highlights some areas to improve, including bullying and harassment from patients and colleagues, and staff confidence in delivering services in Welsh. The Health Board is addressing these areas. The organisation commits to staff safety and wellbeing by encouraging staff access to services and wellbeing initiatives, and its Mental Health and Learning Disabilities Division is developing a wellbeing programme for its staff focusing on effective stress management and promoting wellbeing.

44 **In general, the financial management of the Health Board is strong and improving; nevertheless, there are challenges in managing financial risks.** The Health Board met its financial duties in each of the last three financial years by achieving 'break-even' and has made a small surplus each year. It is forecasting a 'break-even' position in the current financial year despite managing significant challenges and must meet many targets, to either secure existing funding or to attract extra funding for service improvements. The Health Board considers that during 2018-19 a total of £5 million is 'at risk' within its IMTP either because targets are not met to secure additional funding, or savings plans do not fully deliver. The Health Board is starting to move away from traditional cost improvement programmes although there is still some reliance on transactional savings. It has developed a framework that aligns performance and cost drivers to efficiency. However, the Health Board estimates that it could save up to £22 million by reducing sickness levels, temporary staffing costs and lengths of stay, to benchmark levels. It has already acted to secure a reduced reliance on bank services and agency staff, however, this remains a challenge given staffing shortages in a number of key service areas.

45 Procurement is undertaken by the NWSSP Procurement Service (Procurement team), on the Health Board's behalf. There is an all-Wales Procurement Strategy, underpinned by an all-Wales business plan but there is no overall Health Board procurement plan. In common with other NHS bodies, the Health Board has a service level agreement with the Shared Services Partnership. The Health Board uses its SFIs to guide procurement practice. Internal Audit's review of Non-Pay Expenditure provided reasonable assurance (dated 18 May 2018). The report did, however, identify the lack of a detailed service level agreement, out-of-date policies and procedures and non-compliance with the Financial Control procedure. We understand that the Procurement team is drafting a new set of policies and procedures on behalf of the Health Board.

[5] Nurse Staffing Levels (Wales) Act – Legislation

46 The Procurement team uses a business partner approach and procurement leads are based within each division to work with service managers and suppliers to secure value for money and in doing so improve patient outcomes. However, our interviews suggest further scope for engagement with some clinical areas and Work and Estates to understand whether there are potential opportunities to drive better value from key contracts.

47 **The Health Board is not delivering against all key access targets, but it is actively improving its arrangements to secure efficiency and productivity.** I found that some performance continues to be a matter of concern particularly with four-hour and 12-hour Accident & Emergency (A&E) waiting times, the number of ambulance handovers taking over one hour and achieving the Welsh Government target to deliver zero 36-week and eight-week diagnostic breaches by the end of December 2018.

48 The Health Board is investing resources to address areas of underperformance and achieve some positive outcomes. For example, it has embraced prudent and value-based healthcare and its benchmarking approach identifies notable savings through efficiency opportunities.

49 **There is a good strategic approach in the informatics service, but it needs focused investment and stronger oversight of the impact of national IT system risks.** The Health Board agreed a five-year informatics strategic outline programme (SOP), which was first produced in late 2016. Additional funding of £500,000 was provided for infrastructure and technology updates in 2017-18. Despite this additional investment, capital investment is required to replace an ageing IT network and infrastructure. Several risks remain concerning availability and delays in implementing national IT systems. For example, the delay of the Welsh Community Care Information System presents a lost opportunity, because of the lack of reliable community-based service and productivity information.

50 **The Health Board's management of assets, particularly medical equipment devices, needs to be more rigorous and strategic.** I identified some concerns around the Health Board's arrangements to manage medical equipment and devices specifically around the Health Board's monitoring of medical equipment incidents reported through Datix and the lack of an overarching asset register.

My wider programme of work indicates that the Health Board is responding to risks and opportunities, but continues to face several challenges

The Health Board has comprehensive plans for primary and community care and is making steady progress towards implementing the key elements of the national vision. While performance levels are above average for many indicators, growing workforce pressures are challenging the sustainability of core GP services in some areas

51 I found that the Health Board has comprehensive primary care plans that align with the national vision and are informed by Neighbourhood Care Network plans although these networks are not yet fully mature. The Health Board is making steady progress in delivering its plans and performance compares well with the rest of Wales, but a number of difficult challenges remain.

52 In respect of resources, the Health Board has some clear examples of resources shifting closer to home and aims to increase investment in primary care but the available data makes it difficult to accurately calculate the overall investment in primary care. Workforce challenges threaten the sustainability of some practices which the Health Board has assessed and is in the early stages of testing solutions.

53 The Health Board has strong leadership arrangements but current performance indicators do not allow oversight of all areas of primary care and there is scope for more Board-level focus on primary care.

The Health Board is taking positive steps to improve estate management but would benefit from introducing a strategic plan, which reflects its vision for future healthcare provision

54 I found the Estates Team is involved in strategic planning through the Integrated Medium Term Planning process, but the Health Board lacks an agreed Estates Strategy. It is piloting a new approach to assessment and reporting of its estate, but this is taking longer than initially expected to complete.

55 In respect of the management of estates, there is clarity around accountability, roles and responsibilities for Estate Management and systems are in place to record asset data and to support maintenance.

56 The Health Board continues to improve its management of Estates and Facilities in key areas. It performs well against national indicators compared to the All Wales averages and there are clear systems for managing performance although there is scope to make better use of service user feedback and post-work inspections.

57 The Health Board spends a high proportion of its maintenance budget on reactive repairs which reflects the age and condition of the current estate. It has a clear policy for the disposal of an asset once it has become redundant and it uses national and local guidance to dispose of assets.

58 The Health Board is aware of risks and prioritises actions using feedback from users. It actively ensures that staff and contractors have the skills and behaviours required to deliver an effective service, and management is taking positive steps to improve staff satisfaction and sickness absence levels.

My emerging findings on the Integrated Care Fund are showing some challenges

59 I have completed the fieldwork for my cross-sector Integrated Care Fund review. I intend to prepare a national summary report early in 2019, setting out my all-Wales findings. My audit team has already presented local findings to Regional Partnership Boards. The key messages for the Greater Gwent Regional Partnership Board are:

- the Integrated Care Fund (the fund) has had a positive impact in bringing organisations together across the Greater Gwent Region, but there is scope to further clarify and improve links between the Regional Partnership Board and the five Public Service Boards on an ongoing and regular basis.
- due to the annual nature of the fund, the region recognises that it has not always used the fund strategically to develop services based on need, with scope to strengthen aspects of project management for the projects supported by the fund.
- decisions surrounding the use of the fund are delegated to sub-groups of the regional partnership board, with the Strategic Partnership Boards responsible for developing business cases for proposed ICF projects. This approach appears to be working effectively, but the Strategic Partnership Board lacks third sector representation, which limits their involvement in developing ICF projects. Furthermore, the level of understanding within partner organisations of the work of the Greater Gwent Regional Partnership Board and its sub-groups, including what the fund is being used for and its impact, needs to improve.
- there is general agreement that the fund is supporting the right projects and having a positive impact on service users, but like other regional partnership boards across Wales, very few projects are being mainstreamed into core services. The Greater Gwent region is attempting to demonstrate outcomes more clearly, but this presents an ongoing challenge.

The Health Board has generally made effective use of NFI as a component of its counter-fraud arrangements but has yet to review all recommended data matches

60 The National Fraud Initiative (NFI) is a biennial data-matching exercise that helps detect fraud and overpayments by matching data across organisations and systems to help public bodies identify potentially fraudulent or erroneous claims and transactions. It is a highly effective tool in detecting and preventing fraud and

overpayments and helping organisations to strengthen their anti-fraud and corruption arrangements.

61 The Health Board received the outcomes from the 2016 data-matching exercise in January 2017 which included 7,989 data-matches, 458 of which were 'recommended matches'. In last year's Annual Audit Report, I noted that the Health Board had made good progress in reviewing the data-matches but has not reviewed three-way data-matches between payroll, creditor payments and Companies House. These are high risk matches because they can identify undeclared staff interests and possible corrupt practices.

62 In October 2018, participating bodies submitted data for the next data-matching exercise. The Health Board has reviewed 336 data-matches. We consider that the Health Board has generally made effective use of the NFI as a component of its counter-fraud arrangements. However, the NFI web application shows that whilst reviews of the recommended three-way data-matches between payroll, creditor payments and Companies House commenced in early 2018, it does not record that these reviews have been completed and matters arising resolved. It is essential that the Health Board ensures the review of these matches is completed as a matter as urgency. This is particularly important given that the reviewer notes within the NFI web application record instances where staff members had interests in companies that had not been declared to the Health Board. The outcomes of this exercise will be available early in 2019.

Appendix 1

Reports issued since my last annual audit report

Exhibit 2: reports issued since my last annual audit report

The following table lists the reports issued to the Health Board in 2018.

Report	Date
Financial audit reports	
Audit of Financial Statements Report	May 2018
Opinion on the Financial Statements	June 2018
Performance audit reports	
Structured Assessment 2018	December 2018
Primary Care	September 2018
Review of Estates	November 2018
Other reports	
2018 Audit Plan	January 2018

Exhibit 3: performance audit work still underway

There are also a number of performance audits that are still underway at the Health Board. These are shown in the following table, with the estimated dates for completion of the work.

Report	Estimated completion date
Clinical coding	March 2019
Orthopaedics	October 2019
Local follow-up work to track progress against recommendations related to district nursing, medicines management in acute hospitals and GP out-of-hours services	July 2019

Appendix 2

Audit fee

The 2018 Audit Plan set out the proposed audit fee of £407,146 (excluding VAT). My latest estimate of the actual fee, on the basis that some work remains in progress, is in keeping with the fee set out in the outline.

Appendix 3

Significant audit risks

Exhibit 4: significant audit risks

My 2018 Audit Plan set out the significant audit risks for 2018. The table below lists these risks and sets out how they were addressed as part of the audit.

Significant audit risk	Proposed audit response	Work done and outcome
The Health Board has a duty to ensure that robust accounting records and internal controls are in place to ensure the regularity and lawfulness of transactions.	My audit team will test accounting records and internal controls relevant to the audit to ensure accuracy, regularity and lawfulness of transactions.	Accounting records and internal controls tested as planned and found to be robust. No evidence found of irregular or unlawful transactions.
The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk.	My audit team will: • test the appropriateness of journal entries and other adjustments made in preparing the financial statements; • review accounting estimates for biases; and • evaluate the rationale for any significant transactions outside the normal course of business.	Audit work carried out as planned and no evidence found of management override of controls.
There is a risk of material misstatement due to fraud in revenue recognition and as such is treated as a significant risk.	My audit team will consider the Health Board's income streams and assess whether there is a risk of material misstatement due to fraud related to revenue recognition. Where we determine that such risks do exist we will undertake specific testing.	Audit work carried out as planned and no evidence found of misstatement due to fraud in revenue recognition.

Significant audit risk	Proposed audit response	Work done and outcome
There is a significant risk that the Board will fail to meet its first financial duty to break even over a three-year period. The position at the end of December shows an improved position with a year to date surplus of £0.676 million. This is a significant improvement from early in the year when there was a predicted deficit of £15 million, although the full extent of Welsh Government funding was unclear at that time. Whilst the Board does not have a cumulative deficit from prior years, risks still remain in the delivery of plans as they are based on the following: the current savings and cost avoidance plans deliver the anticipated reductions in costs; the full extent of operational financial pressures are contained for the remainder of the year; service delivery is improved to meet agreed targets linked to additional funding and the additional costs are within the funding envelope; and the costs associated with NICE remain consistent within the forecast financial position. Where the Board fails this financial duty I will place a substantive report on the financial statements highlighting the failure. The current financial pressures on the Board increase the risk that management judgements and estimates could be biased in an effort to achieve the financial duty.	My audit team will continue to monitor the Health Board's financial position for the 2017-18 financial year. If the Health Board fails to meet the three-year resource limits for revenue and/or capital, I would expect to qualify my regularity opinion on the 2017-18 financial statements. I would also expect to place a substantive report on the statements to explain the basis of the qualification and the circumstances under which it had arisen. My audit team will also focus its testing on areas of the financial statements which could contain reporting bias.	Audit work confirmed that the Health Board met its annual revenue resource allocation and its financial target to break even.
The current financial pressures on the Health Board, around its revenue and capital expenditure, and cash spend, increase the risk that management judgements and estimates could be biased in an effort to report within the financial limits put in place by the Welsh Government.	My audit team will identify those areas of the financial statements that they judge to be prone to reporting bias, and undertake focused audit testing where appropriate.	Focused audit testing carried out as planned and no evidence found of reporting bias.

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INTERNAL AUDIT PROGRESS REPORT 2018/2019

5.1

3 April 2019 Audit Committee

NHS Wales Shared Services Partnership

Audit and Assurance Service

1. INTRODUCTION

1.1 The purpose of this report is to highlight progress against the 2018/19 Internal Audit Plan at 28 March 2019 to the Audit Committee, together with an overview of other activity undertaken since the previous meeting.

2. PROGRESS AGAINST THE 2018/19 INTERNAL AUDIT PLAN

Number of audits in plan	36*
Of which:	
Number of audits reported as final	17
Number of audits reported in draft	10
Number of audits in progress	9

* Total excludes AGS and G&A Module.

2.1 The following reports from the 2018/19 Internal Audit Plan have been issued since the previous meeting of the Audit Committee:

AUDIT ASSIGNMENT	ASSURANCE RATING
Clinical Futures – Service Redesign	Reasonable
Nurse Staffing Levels (Wales) Act 2016	Reasonable
Falls Prevention	Reasonable
Clinical Audit – Follow-up	Limited
Health and Care Standards	Reasonable
Equality, Diversity and Inclusion	Reasonable

2.2 Appendix A details progress in respect of each of the reviews in the 2018/19 Internal Audit Plan.

3. SUMMARY OF FINDINGS

3.1 Limited assurance reports are considered by the Audit Committee in detail. The following summary provides the Audit Committee with the main messages from the reasonable assurance reports issued since the last meeting in January 2019:

Clinical Futures – Service Redesign

3.2 This audit focussed on the process for the redesign of clinical pathways with the Service Redesign work stream of the Clinical Futures Programme. Success of the work stream is critical to the delivery of the overall Clinical Futures Programme, of which the introduction of the Grange University Hospital is only part.

3.3 We reviewed the process for ten clinical models. We reported reasonable assurance overall and found the challenge and support process to be generally well designed and operated effectively.

3.4 However, at the time of reporting, major decisions remained to be made in order for the Health Board could have a complete picture of the performance, financial, workforce and operational requirements. We reported that it is vital that these decisions are made as part of a robust governance process and not compromised now that the Challenge and Support process has ceased. We noted that this would prove extremely challenging under the pressure that exists to move on to the implementation stage.

Nurse Staffing Levels (Wales) Act 2016

3.5 This audit assessed the extent to which the Health Board is compliant with the Nurse Staffing Levels (Wales) Act 2016. We reported reasonable assurance overall with two medium priority recommendations regarding the need for all ward rosters to be updated for recalculated staffing levels and reporting deficits to planned rosters more accurately.

Falls Prevention

3.6 The objective of this audit was to evaluate and determine the adequacy and effectiveness of the arrangements in place within the Health Board to reduce inpatient falls, including monitoring the effects of changes to the environment and working practices, and whether policies and procedures are being complied with.

3.7 We reported reasonable assurance overall with two medium priority recommendations and one low priory recommendation. The medium priority recommendations were in respect of the need to remind ward staff to correctly complete the required Multi-factorial Risk Assessment and the process for disseminating good practice. We noted a number of areas of good practice during this review.

Health and Care Standards

3.8 This audit focussed on the process within the Health Board for overseeing and reporting on compliance with the Health and Care Standards. We undertake an audit in this area every year and noted that there has been improvement from the previous year.

3.9 We reported reasonable assurance overall and made three medium priority recommendations regarding the need to update guidance, attendance at the Health and Care Standards Group and the completion of driver diagrams.

Equality, Diversity and Inclusion

3.10 This audit sought to provide assurance that the Health Board has effective mechanisms in place to ensure that the requirements of Section 149 of the Equality Act 2010 are being complied with.

3.11 We reported reasonable assurance overall, identifying four medium priority recommendations regarding consistency of Equality Impact Assessments, completeness of ESR data, compliance rates for mandatory training and the link with Health and Care Standards monitoring processes.

4. CONTINGENCY

4.1 There is a contingency element in the 2018/19 Internal Audit Plan. These days will be utilised in discussion with the Health Board in response to emerging risks.

5. MANAGEMENT RESPONSES

5.1 We highlighted to the Audit Committee at its October 2018 meeting that we were experiencing delays in receiving management responses to our reports. This position is not improving and the matter has been escalated to the Board Secretary and Chief Executive.

6. ENGAGEMENT

ADDITIONAL MEETINGS HELD AND COMMITTEES ATTENDED DURING THE REPORTING PERIOD

6.1 Board/Sub Committee/other events

- Board;
- Quality & Patient Safety Committee;
- Information Governance Committee; and
- Finance & Performance Committee.

6.2 Meetings

- regular update meetings regarding the Clinical Futures Programme;
- planning meetings for the 2019/20 audit programme;

- Executive Team to discuss 2019/20 audit programme;
- audit scoping and debrief meetings;
- Chief Executive quarterly;
- Board Secretary bi-weekly;
- Assistant Director of Finance (Corporate Finance) monthly;
- Audit Committee Chair quarterly;
- Chair bi-annually;
- Well-being of Future Generations Act Steering Group; and
- Wales Audit Office, Health Inspectorate Wales and Ombudsman quarterly.

Additional activity

6.3 We have continued to liaise and consult with the Health Board on a range of audit matters and risks identified. For example, during March 2019 we continued to support the process for the improvement of the quality of PADRs by:

- attending and observing the March 2019 PADR Strategic Development Group meeting;
- reviewing the supporting papers presented at the above meeting; and
- undertaking discussions with members of the Group.

6.4 Overall, we found that the PADR Strategic Development Group could be an effective forum to drive forward improvement on the quality of PADR form completion with some areas for improvement which we will continue to monitor prior to the completion of the planned follow up audit in 2019/20.

6.5 In addition, we continue to advise at the Health and Care Standards Group meetings and support the development of the Board Assurance Framework.

7. RECOMMENDATION

7.1 The Audit Committee is invited to approve the proposed change and note the above.

Planned output	Outline timing	Status	Assurance
Corporate Governance, Risk and Regulatory Compliance			
Governance, Leadership and Accountability (Health and Care Standards)	Q4		
Annual Governance Statement	Q4		
Risk Management and Assurance	Q4	Work in progress	
Board Assurance (Advisory)	Q3	Work in progress	
Health and Care Standards	Q4	Final report	Reasonable
Corporate Legislative Compliance – Well-being of Future Generations Act	Q3	Draft report	Reasonable
Strategic Planning, Performance Management and Reporting			
Clinical Futures – Service Redesign	Q2, Q3	Final report	Reasonable
Clinical Futures – Progress Following Gateway Review	Q4	Work in progress	
Financial Governance and Management			
Budgetary Control Including Cost Improvement	Q3	Final report	Reasonable
Management of Balance Sheet Assets	Q2	Final report	Reasonable
Private and Overseas Patients Follow-up	Q2	Draft report	Reasonable

Planned output	Outline timing	Status	Assurance
Clinical Governance, Quality and Safety			
Annual Quality Statement	Q1	Final report	Reasonable
Learning Lessons from Incidents and Reports	Q2	Work in progress	
Patient Experience and Outcomes	Q2	Work in progress	
Patient Discharge Process	Q2	Final report	Limited
Nurse Staffing Levels (Wales) Act 2016	Q4	Final report	Reasonable
Falls Prevention	Q2	Final report	Reasonable
Clinical Audit Follow-up	Q3	Final report	Limited
Information Governance and Security			
Cyber Security	Q4	Work in progress	
Global Data Protection Regulations (GDPR)	Q3	Draft report	Reasonable
Digitisation of Medical Records	Q1	Final report	Reasonable
Clinical Futures - IT Work stream	Q3	Draft report	Reasonable
Use of Digital Technology – Fit for the Future (Advisory)	Q2	Draft report	N/a

Planned output	Outline timing	Status	Assurance
Operational Service and Functional Management			
Divisional Review - Facilities	Q4	Final report	Reasonable
Unscheduled Care Wards – Follow-up	Q1	Final report	Reasonable
Royal Gwent – Site Review	Q2	Final report	Reasonable
Nevill Hall – Site Review	Q2	Final report	Reasonable
Workforce Management			
Project Implementation of Absence Drop Down into ESR	Q3	Deferred	
Organisational Development and Training	Q3	Work in progress	
Flexible Working (Advisory)	Q4	Work in progress	
Equality, Diversity and Inclusion	Q4	Final report	Reasonable
Medical Staffing	Q2	Draft report	Limited
Capital & Estates			
Carbon Reduction Commitment	Q2	Final report	N/a
Environmental Sustainability Report	Q2	Final report	N/a
Major Capital Projects	Q4	Draft report	Reasonable
Capital Systems	Q4	Draft report	Reasonable
Estates Assurance	Q4	Work in progress	
Grange University Hospital – Open Book Audit	Separate Plan	Draft report	Reasonable

Planned output	Outline timing	Status	Assurance
Grange University Hospital – Project Audit	Separate Plan	Draft report	Substantial

Indicator	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2018/19		19 April 2016	By 30 April	Not agreed	Draft plan	Final plan
Report turnaround: time from fieldwork completion to draft reporting [10 days]		23 of 23	*80%*	v>20%	10%<v< 20%	v<10%
Report turnaround: time taken for management response to draft report [15 days]		8 of 14	*80%*	v>20%	10%<v< 20%	v<10%
Report turnaround: time from management response to issue of final report [10 days]		14 of 14	*80%*	v>20%	10%<v< 20%	v<10%

Audit Assurance Ratings

RATING	INDICATOR	DEFINITION
Substantial assurance	 - + Green	The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.
Reasonable assurance	 - + Yellow	The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact on residual risk** exposure until resolved.
Limited assurance	 - + Amber	The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.
No assurance	 - + Red	The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved.

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5.2

Aneurin Bevan University Health Board

Internal Audit Plan 2019/20

March 2019

NHS Wales Shared Services Partnership
Audit and Assurance Services

Contents

1. Introduction

This document sets out the Internal Audit Plan for 2019/20 ('the Plan') detailing the audits to be undertaken and an analysis of the corresponding resources. It also contains the Internal Audit Charter which defines the over-arching purpose, authority and responsibility of Internal Audit and the key performance indicators for the service.

As a reminder, the Accountable Officer (the Health Board's Chief Executive) is required to certify in the Annual Governance Statement that they have reviewed the effectiveness of the organisation's governance arrangements, including the internal control systems, and provide confirmation that these arrangements have been effective, with any qualifications as necessary including required developments and improvement to address any issues identified.

The purpose of Internal Audit is to provide the Accountable Officer and the Board, through the Audit Committee, with an independent and objective annual opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control. The opinion should be used to inform the Annual Governance Statement.

Additionally, the findings and recommendations from internal audit reviews may be used by Health Board management to improve governance, risk management, and control within their operational areas.

The Public Sector Internal Audit Standards require that "The risk-based plan must take into account the requirement to produce an annual internal audit opinion and the assurance framework. It must incorporate or be linked to a strategic or high-level statement of how the internal audit service will be delivered in accordance with the internal audit charter and how it links to the organisational objectives and priorities."

Accordingly this document sets out the risk based approach and the Plan for 2019/20. The Plan will be delivered in accordance with the Internal Audit Charter. All internal audit activity will be provided by Audit & Assurance Services, a division of NHS Wales Shared Services Partnership.

2. Developing the Internal Audit Plan

2.1 Link to the Public Sector Internal Audit Standards

The Plan has been developed in accordance with Public Sector Internal Audit Standard 2010 – Planning, to enable the Head of Internal Audit to meet the following key objectives:

- the need to establish risk-based plans to determine the priorities of the internal audit activity, consistent with the organisation's goals;
- provision to the Accountable Officer of an overall independent and objective annual opinion on the organisation's governance, risk management, and control, which will in turn support the preparation of the Annual Governance Statement;
- audits of the organisation's governance, risk management, and control arrangements which afford suitable priority to the organisation's objectives and risks;
- improvement of the organisation's governance, risk management, and control arrangements by providing line management with recommendations arising from audit work;
- quantification of the audit resources required to deliver the Internal Audit Plan;
- effective co-operation with external auditors and other review bodies functioning in the organisation; and
- provision of both assurance (opinion based) and consulting engagements by Internal Audit.

2.2 Risk based internal audit planning approach

Our risk based planning approach recognises the need for the prioritisation of audit coverage to provide assurance on the management of key areas of risk, and our approach addresses this by considering the:

- organisation's risk assessment and maturity;
- coverage of the audit domains;
- previous years' internal audit activities; and
- audit resources required to provide a balanced and comprehensive view.

Our planning also takes into account the NHS Wales Planning Framework 2019/22 and is also mindful of significant national changes that are taking place. In addition, the Plan aims to reflect the significant local changes occurring as identified through the Integrated Medium Term Plan (IMTP), the developing Clinical Futures Programme

and other changes within the organisation, assurance needs, identified concerns from our discussions with management, and emerging risks.

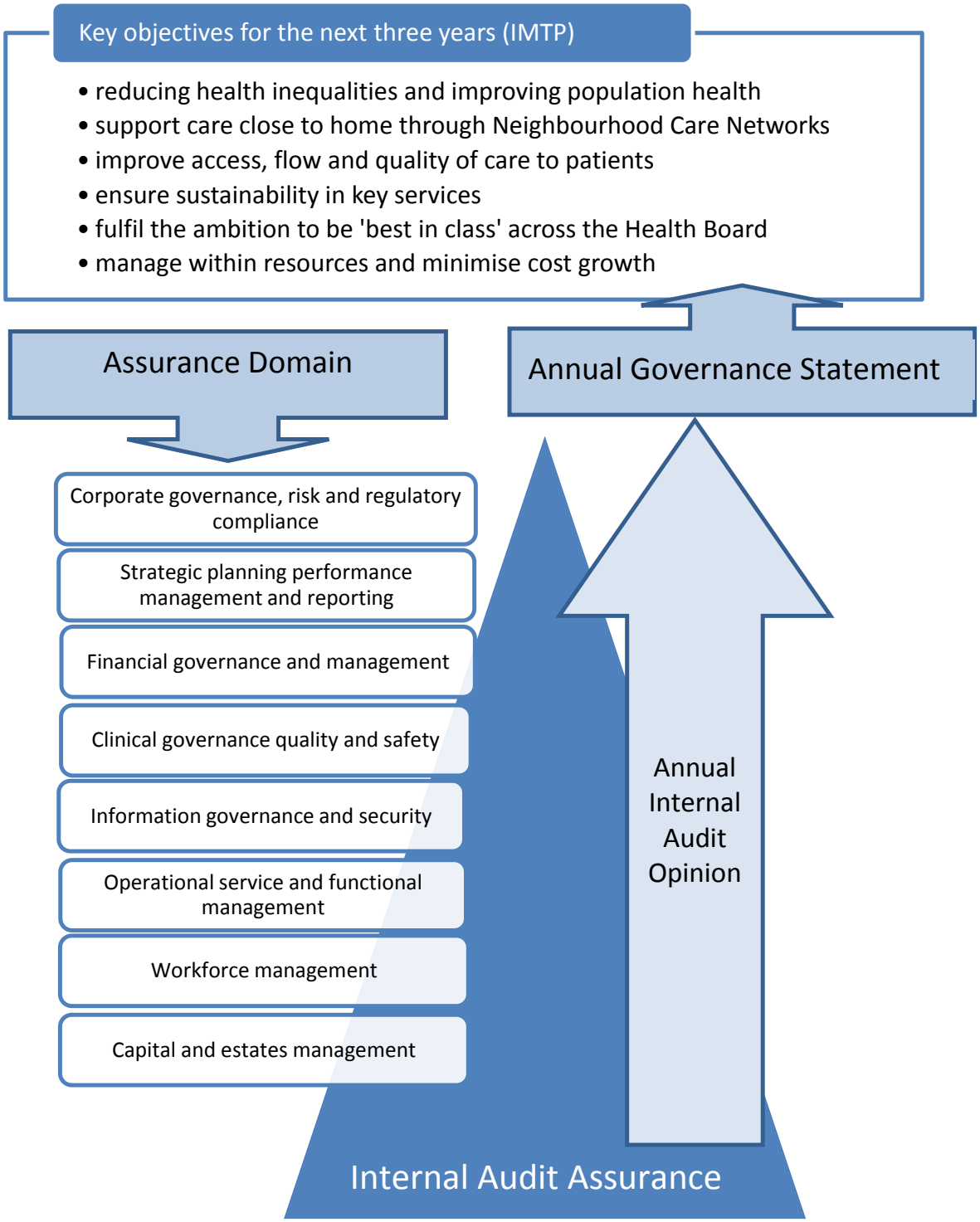
We will ensure that the Plan remains fit for purpose by reacting to any emerging issues throughout the year. Any necessary updates will be reported to the Audit Committee in line with the Internal Audit Charter.

While some areas of governance, risk management and control require annual review, and some work is mandated by Welsh Government, our risk based planning approach recognises that it is not possible to audit every area of an organisation's activities every year. Therefore, our approach identifies auditable areas (the audit universe), categorised into eight assurance domains. The risk associated with each domain is assessed and this determines the appropriate frequency for review. As part of this approach we also develop and maintain a 3-year audit strategy to identify when audit areas will be audited.

The eight audit domains are shown in figure 1, which also shows how the cumulative internal audit coverage of them contributes to the Annual Internal Audit Opinion, which in turn feeds into the Annual Governance Statement and the achievement of the key objectives for the organisation.

The mapping of the Plan to the eight assurance domains is designed to give balance to the overall annual audit opinion, which supports the Annual Governance Statement.

Figure 1 Internal Audit assurance on the domains



2.3 Link to the Health Board's systems of assurance

The risk based internal audit planning approach integrates with the Health Board's systems of assurance; thus we have considered the following:

- a review of the Board's vision, values and forward priorities as outlined in the Annual Plan and three year Integrated Medium Term Plan (IMTP);
- an assessment of the Health Board's governance and assurance arrangements and the contents of the Corporate Risk Register;
- risks identified in papers to the Board and its Committees (in particular the Audit Committee, Quality & Patient Safety Committee and Finance & Performance Committee);
- key strategic risks identified within the Corporate Risk Register and assurance processes;
- discussions with Executive Directors regarding risks and assurance needs in areas of corporate responsibility;
- cumulative internal audit knowledge of governance, risk management, and control arrangements (including a consideration of past internal audit opinions);
- new developments and service changes;
- legislative requirements to which the organisation is required to comply;
- other assurance processes including planned audit coverage of systems and processes now provided through NHS Wales Shared Services Partnership (NWSSP) and, where appropriate, WHSSC, EASC and NWIS;
- work undertaken by other assurance bodies including the Health Board's Local Counter-Fraud Services (LCFS) and the Post-Payment Verification Team (PPV);
- work undertaken by other review bodies including Wales Audit Office (WAO) and Health Inspection Wales (HIW); and
- coverage necessary to provide reasonable assurance to the Accountable Officer in support of the Annual Governance Statement.

2.4 Audit planning meetings

In developing the Plan, in addition to consideration of the above, the Head of Internal Audit has met with a number of Health Board Executives and Independent Members to discuss current areas of risk and related assurance needs.

Meetings have been held with the following key personnel during the planning process:

- Chief Executive Officer;
- Medical Director;
- Director of Finance and Performance;
- Director of Operations;
- Director of Planning, Digital & IT;
- Director of Workforce & Organisational Development;
- Acting Director of Nursing;
- Director of Therapies & Health Science;
- Director of Public Health and Strategic Partnerships;
- Board Secretary; and
- Chair of Audit Committee.

The draft Plan was then discussed with the full Executive Team to ensure that internal audit effort was best targeted to areas of risk.

3. Audit risk assessment

The prioritisation of audit coverage across the audit universe is based on the organisation's assessment of risk and assurance requirements as defined in the Board Assurance Framework.

The maturity of these risk and assurance systems allows us to consider both inherent risk (impact and likelihood) and mitigation (adequacy and effectiveness of internal control). Our assessment also takes into account corporate risk, materiality or significance, system complexity, previous audit findings, potential for fraud and sensitivity.

4. Planned internal audit coverage

4.1 Internal Audit Plan 2019/20

The Plan is set out in Appendix A and identifies the audit assignment, lead executive officer, outline scope, and proposed timing.

Where appropriate the Plan makes cross reference to key strategic risks identified within the corporate risk register and related systems of assurance together with the proposed audit response within the outline scope.

The scope objectives and audit resource requirements and timing will be refined in each area when developing the audit scope in discussion with the responsible executive director(s) and operational management.

The scheduling takes account of the optimum timing for the performance of specific assignments in discussion with management and WAO requirements if appropriate.

The Audit Committee will be kept appraised of performance in delivery of the Plan, and any required changes, through routine progress reports to each Audit Committee meeting.

Specialist audit coverage in terms of capital audit and estates assurance and information technology audit will be delivered by our Specialist Services Unit. Given the specialist nature of this work and the assurance link with the all-Wales capital programme we will need to refine with management the scope and coverage on specific schemes. The Plan will then be updated accordingly to integrate this tailored coverage. Note a separate plan has been agreed for the Grange University Hospital.

4.2 Keeping the plan under review

Our risk assessment and resulting Plan is limited to matters emerging from the planning processes indicated above. We will review and update the risk assessment and rolling 3-year audit plan annually giving definition to the upcoming operational year and extending the strategic view outward.

Audit & Assurance Services is committed to ensuring its service focuses on priority risk areas, business critical systems, and the provision of assurance to management across the medium term and in the operational year ahead. Hence, the Plan will be kept under review and may be subject to change to ensure it remains fit for purpose. In particular the Plan will need to be periodically reviewed to ensure alignment with the developing systems of assurance.

Consistent with previous years and in accordance with best professional practice an unallocated contingency provision has been retained in the Plan to enable internal audit to respond to emerging risks and priorities identified by the Executive Management Team and endorsed by the Audit Committee. Any changes to the Plan will be based upon consideration of risk and need and will be presented to the Audit Committee for approval.

Regular liaison with the Wales Audit Office as your External Auditor and other regulators will take place to coordinate planned coverage and ensure optimum benefit is derived from the total audit resource.

5. Resource needs assessment

The Plan indicates an indicative resource requirement of 865 days to provide balanced assurance reports to the Chief Executive as Accountable Officer in accordance with the Public Sector Internal Audit Standards.

This assessment is based upon an estimate of the audit resource required to review the design and operation of controls in review areas for the purpose of sizing the overall resource needs for the Plan. Provision has also been made for other essential audit work including planning, management, reporting and follow-up.

This total resource allocation covers the servicing of the local audit plan (865 days). The top-slice funding passed to NWSSP is sufficient to meet these audit resource needs. The inclusive internal provision through NWSSP Audit & Assurance Services represents best value for NHS Wales in comparison with external commercial rates for the equivalent provision of these professional services.

The audit plan for the Grange University Hospital is addressed outside of this Internal Audit Plan although certain aspects of the implications of the Grange University Hospital are incorporated into the outline scope of the planned reviews.

The Public Sector Internal Audit Standards enable internal audit to provide consulting services to management provided that independence of internal audit is not compromised. The commissioning of these additional services by the Health Board is discretionary and therefore not included in the Plan. Accordingly, any requirements to service management consulting requests would be additional to the Plan and will need to be negotiated separately.

6. Action required

The Audit Committee is invited to consider the Internal Audit Plan for 2019/20 and:

- approve the Internal Audit Plan for 2019/20;
- approve the Internal Audit Charter; and
- note the associated internal audit resource requirements and key performance indicators.

James Quance
Head of Internal Audit (Aneurin Bevan University Health Board)
Audit & Assurance Services
NHS Wales Shared Services Partnership

Planned Output	Audit Ref	Corporate Risk Register	Outline Scope	Indicative Audit days	Executive Lead	Outline timing
Corporate governance, risk and regulatory compliance						
Governance, Leadership and Accountability	AB19/20 -01		To provide a commentary on the process that has been adopted and evidence supporting the self-assessment.	5 days	Chief Executive/ Board Secretary	Q4
Annual Governance Statement	AB19/20 -02		To provide a commentary on key aspects of Board Governance to underpin the completion of the Statement.	5 days	Chief Executive/ Board Secretary	Q4
Risk Management	AB19/20 -03	CRR1	To provide an opinion on the effectiveness of the risk management arrangements in place within the Health Board in order to ensure that strategic objectives are achieved.	15 days	Chief Executive/ Board Secretary	Q4
Welsh Language Standards	AB19/20 -04	CRR15	To assess the arrangements that the Health Board has in place to ensure compliance with the Standards.	20 days	Director of Workforce and Organisational Development	Q2

Planned Output	Audit Ref	Corporate Risk Register	Outline Scope	Indicative Audit days	Executive Lead	Outline timing
Health and Care Standards	AB19/20 -05	CRR12 CRR15	To assess the processes adopted by the Health Board to support declaration against the Health and Care Standards and addressing areas where improvement against the Standards is required.	15 days	Interim Director of Nursing/ Medical Director	Q4
Health and Safety Management and Fire Safety Follow-up	AB19/20 -06	CRR5 CRR7 CRR15	To assess progress made against the limited assurance reports issued in 2017/18.	15 days	Director of Therapies and Health Science	Q1
Corporate governance, risk and regulatory compliance domain sub-total				**75 days**		
Strategic planning performance management and reporting						
Clinical Futures – Staff Engagement	AB19/20 -07	CRR12 CRR15 CRR46	To review whether effective arrangements are in place to ensure that the workforce of the Health Board are sufficiently engaged and prepared for the changes taking place within the Clinical Futures Programme.	20 days	Director of Planning, Digital and IT	Q2
Clinical Futures – Operational Commissioning Planning	AB19/20 -08	CRR12 CRR15 CRR46	To review the effectiveness of project management arrangements in order to ensure that operational commissioning for the Grange	30 days	Director of Planning, Digital and IT	Q3

Planned Output	Audit Ref	Corporate Risk Register	Outline Scope	Indicative Audit days	Executive Lead	Outline timing
		CRR51	University Hospital is proceeding in accordance with plan.			
Clinical Futures – Critical Path	AB19/20 -09	CRR15 CRR46	To review key aspects of the delivery programme that are critical to overall delivery of Clinical Futures, for example patient transport.	30 days	Director of Planning, Digital and IT	Q4
Service Change Plan 2	AB19/20 -10	CRR10 CRR24 CRR25 CRR34	To review the progress in developing a seamless system of Health, Care and Wellbeing with partners, including remodelling of primary care, effectiveness of NCN hubs and delivery of SCP1 'Improving Population Health and Wellbeing.'	30 days	Director of Primary, Community and Mental Health	Q3
Dashboard Reporting	AB19/20 -11	CRR1	To review the controls in place to ensure that performance data being reported through developing dashboards is accurate and complete.	15 days	Director of Finance and Performance	Q3
Strategic planning performance management and reporting domain sub-total				**125 days**		
Financial governance and management						
Financial Planning and Budgetary Control	AB19/20 -12	CRR1 CRR53	To review the key budgetary control processes and compliance with Financial Control Procedures and the process for financial planning including the development and	20 days	Director of Finance and Performance	Q3

Planned Output	Audit Ref	Corporate Risk Register	Outline Scope	Indicative Audit days	Executive Lead	Outline timing
			monitoring of savings programmes required for financial sustainability and the delivery of the Clinical Futures programme.			
Losses and Special Payments	AB19/20 -13	CRR53	To review compliance against the Financial Control Procedure in accordance with rotational internal audit coverage.	10 days	Director of Finance and Performance	Q4
Business Case Scrutiny Arrangements	AB19/20 -14	CRR1 CRR53	To review the effectiveness of the process for scrutinising and approving business cases and whether effective post evaluation and scrutiny are being undertaken.	20 days	Director of Finance and Performance	Q2
Procurement	AB19/20 -15	CRR1 CRR53	To review whether the Health Board is complying with required procurement procedures and ensuring value for money in its procurement activities by, for example, reducing variation in use of clinical supplies.	25 days	Director of Finance and Performance	Q1
Charitable Funds	AB19/20 -16	CRR1	To review whether operational procedure is compliant with policies of the Health Board as trustee in accordance with rotational internal audit coverage.	15 days	Director of Finance and Performance	Q3

Planned Output	Audit Ref	Corporate Risk Register	Outline Scope	Indicative Audit days	Executive Lead	Outline timing
Patients Monies	AB19/20-17	CRR1	To review compliance against the Financial Control Procedure in accordance with rotational internal audit coverage.	15 days	Director of Finance and Performance	Q1
Financial governance and management domain sub-total				**105 days**		
Clinical governance quality & safety						
Annual Quality Statement	AB19/20-18	CRR15	The Board must assure itself that the information published is both accurate and representative. To provide an opinion on the process that has been adopted and the evidence recorded supports data sources.	10 days	Medical Director	Q1
Medical Equipment and Devices Follow-up	AB19/20-19	CRR12	To assess progress made against the limited assurance report issued in 2017/18.	10 days	Medical Director	Q1
Maternity Services	AB19/20-20	CRR15	To review clinical governance arrangements in place within maternity services in order to ensure that performance is being monitored effectively and risks are managed appropriately.	20 days	Acting Director of Nursing	Q3
Discharge Planning Follow-up	AB19/20-21	CRR12	To assess progress made against the limited assurance report issued in 2018/19.	5 days	Director of Operations	Q1

Planned Output	Audit Ref	Corporate Risk Register	Outline Scope	Indicative Audit days	Executive Lead	Outline timing
Putting Things Right	AB19/20 -22	CRR15	To review the controls to ensure that the Health Board complies with standards for the handling of complaints both in terms of quality and content and that changes are made as a result of issues identified.	20 days	Interim Director of Nursing	Q4
Clinical Audit Follow-up	AB19/20 -23	CRR15	To assess progress made against the limited assurance report issued in 2018/19.	5 days	Medical Director	Q3
Clinical governance quality & safety domain sub-total				**70 days**		
Information governance and security						
111 Service	AB19/20 -24	CRR1 CRR40	To assess whether risks associated with the 111 Service established by the Health Board are being managed effectively.	20 days	Medical Director	Q4
Freedom of Information Requests	AB19/20 -25	CRR1	To assess the effectiveness of the Health Board's controls to ensure compliance with the Freedom of Information Act.	15 days	Board Secretary	Q1

Planned Output	Audit Ref	Corporate Risk Register	Outline Scope	Indicative Audit days	Executive Lead	Outline timing
IT Service Management Follow-up	AB19/20-26	CRR1	To assess progress made against the limited assurance report issued in 2017/18.	10 days	Director of Planning, Digital and IT	Q3
IT Business Continuity/Disaster Recovery	AB19/20-27	CRR17 CRR44 CRR54	To review the arrangements in place within the Health Board to ensure that IT systems are maintained in the event of significant disruption and data is not lost.	15 days	Director of Planning, Digital and IT	Q3
Information governance and security domain sub-total				**60 days**		
Operational service and functional management						
Job Planning	AB19/20-28	CRR12 CRR15	To review whether Health Board procedures for job planning are being followed and clear job plans are in place and monitored where required.	20 days	Director of Operations	Q1
Outpatients	AB19/20-29	CRR15 CRR18	To review compliance with procedures for the booking and scheduling of outpatient appointments to support required improvements in management of outpatient demand.	20 days	Director of Operations	Q2
Escalation Policy	AB19/20-30	CRR12 CRR15	To review whether the new policy is operating as intended and is being complied with.	15 days	Director of Operations	Q2
Divisional Review – Scheduled Care	AB19/20-31	CRR15	To undertake an audit of compliance with policies and procedures and the	30 days	Director of Operations	Q2

Planned Output	Audit Ref	Corporate Risk Register	Outline Scope	Indicative Audit days	Executive Lead	Outline timing
			management of risk within the Scheduled Care Division.			
Theatres	AB19/20 -32	CRR12 CRR15	To review whether anticipated savings from the introduction of Omnicell are being realised and whether controls are operating effectively.	20 days	Director of Operations	Q4
Operational service and functional management domain sub-total				**105 days**		
Workforce management						
Staff Experience Framework	AB19/20 -33	CRR1 CRR15 CRR29	To review actions being undertaken by the Health Board to improve staff experience, including in response to the 2018 NHS Wales Staff Survey.	20 days	Director of Workforce and Organisational Development	Q4
Pay Incentives	AB19/20 -34	CRR12 CRR15 CRR29	To review whether pay incentives intended to fill shifts and for additional activity are being applied as intended, including both internally generated initiatives and Waiting List Initiative.	25 days	Medical Director	Q1
PADR Follow-up	AB19/20 -35	CRR15 CRR29	To assess progress made against the limited assurance report issued in 2017/18.	10 days	Director of Workforce and Organisational Development	Q2

Planned Output	Audit Ref	Corporate Risk Register	Outline Scope	Indicative Audit days	Executive Lead	Outline timing
Healthcare Support Workers Delegation Framework	AB19/20 -36	CRR15 CRR29	To review the framework for delegation to Healthcare Support Workers in order to ensure it is designed and operating effectively.	15 days	Director of Workforce and Organisational Development/ Interim Director of Nursing	Q3
Workforce management domain sub-total				**70 days**		
Capital and Estates						
Carbon Reduction Commitment	AB19/20 -37		An audit to check compliance with the reporting requirements in the final year of the CRC scheme.	15 days	Director of Public Health and Strategic Partnerships	Q1
Environmental Sustainability Report	AB19/20 -38		To provide an opinion on the statement regarding compliance with guidance and quality of reported information.	10 days	Director of Public Health and Strategic Partnerships	Q1
Major Capital Projects	AB19/20 -39	CRR1 CRR5	To audit a specific major project to observe compliance with local internal controls. The specific project will be agreed with management.	20 days	Director of Planning, Digital and IT	Q3
Anti-fraud Capital Systems	AB19/20 -40	CRR1 CRR5	To review arrangements for the management of capital, focussing on whether systems and controls are sufficiently robust to protect the Health Board from fraud.	20 days	Director of Planning, Digital and IT	Q3

Planned Output	Audit Ref	Corporate Risk Register	Outline Scope	Indicative Audit days	Executive Lead	Outline timing
Estates Assurance	AB19/20 -41	CRR1 CRR5	To audit compliance of an area of estates assurance e.g. Asbestos Management, Legionella Management etc.	20 days	Director of Operations	Q2
The Grange University Hospital	AB19/20 -42	CRR1 CRR51	Separate plan agreed.	See separate plan	Director of Planning, Digital and IT	Ongoing
Capital and Estates domain sub-total				**85 days**		
Audit Contingency				**50 days**		
Audit Management and Reporting						
Audit planning, reporting and management			Ongoing work.	**70 days**		
Liaison with WAO and HIW			Ongoing work.	**5 days**		
Attendance at Board, committee and other meetings and provision of ongoing advice and support			Ongoing work.	**30 days**		
Audit Committee preparation and attendance			Incorporating preparation and attendance at Audit Committee.	**10 days**		
Head of Internal Audit Annual Report			Mandatory requirement to comply with the Public Sector Internal Audit	**5 days**		

Planned Output	Audit Ref	Corporate Risk Register	Outline Scope	Indicative Audit days	Executive Lead	Outline timing
			Standards for the NHS in Wales and the Annual Governance Statement.			
Total audit management and reporting				**120 days**		
			Indicative Total Days 2019/20	**865 days**		

The KPIs reported monthly for Internal Audit are:

KPI	SLA required	Target 2019/20
Audit plan 2019/20 agreed/in draft by 30 April	✓	100%
Audit opinion 2018/19 delivered by 31 May	✓	100%
Audits reported vs. total planned audits	✓	varies
% of audit outputs in progress	No	varies
Report turnaround fieldwork to draft reporting [10 days]	✓	80%
Report turnaround management response to draft report [15 days]	✓	80%
Report turnaround draft response to final reporting [10 days]	✓	80%

Aneurin Bevan University Health Board

INTERNAL AUDIT CHARTER

March 2019

Contents

1 Introduction

1.1 This Charter is produced and updated regularly to comply with the Public Sector Internal Audit Standards. The Charter is complementary to the relevant provisions included in the organisation's own Standing Orders and Standing Financial Instructions.

1.2 The terms 'board' and 'senior management' are required to be defined under the Standards and therefore have the following meaning in this Charter:

- Board means the Board of Aneurin Bevan University Health Board with responsibility to direct and oversee the activities and management of the organisation. The Board has delegated authority to the Audit Committee in terms of providing a reporting interface with internal audit activity; and
- Senior Management means the Chief Executive as being the designated Accountable Officer for Aneurin Bevan University Health Board. The Chief Executive has made arrangements within this Charter for an operational interface with internal audit activity through the Board Secretary.

2 Purpose and responsibility

2.1 Internal audit is an independent, objective assurance and advisory function designed to add value and improve the operations of Aneurin Bevan University Health Board. Internal audit helps the organisation accomplish its objectives by bringing a systematic and disciplined approach to evaluate and improve the effectiveness of governance, risk management and control processes. Its mission is to enhance and protect organisational value by providing risk-based and objective assurance, advice and insight.

2.2 Internal Audit is responsible for providing an independent and objective assurance opinion to the Accountable Officer, the Board and the Audit committee on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control[1]. In addition, internal audit's findings and recommendations are beneficial to management in securing improvement in the audited areas.

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[1] *Audit work designed to deliver an audit opinion on the risk management, control, and governance arrangements is referred to in this Internal Audit Charter as Assurance Work because management use the audit opinion to derive assurance about the effectiveness of their controls*

2.3 The organisation's risk management, internal control and governance arrangements comprise:

- the policies, procedures and operations established by the organisation to ensure the achievement of objectives;
- the appropriate assessment and management of risk, and the related system of assurance;
- the arrangements to monitor performance and secure value for money in the use of resources;
- the reliability of internal and external reporting and accountability processes and the safeguarding of assets;
- compliance with applicable laws and regulations; and
- compliance with the behavioural and ethical standards set out for the organisation.

2.4 Internal audit also provides an independent and objective advisory service specifically to help management improve the organisations risk management, control and governance arrangements. The service applies the professional skills of internal audit through a systematic and disciplined evaluation of the policies, procedures and operations that management have put in place to ensure the achievement of the organisations objectives, and through recommendations for improvement. Such advisory work contributes to the opinion which internal audit provides on risk management control and governance.

3 Independence and Objectivity

3.1 Independence as described in the Public Sector Internal Audit Standards is the freedom from conditions that threaten the ability of the internal audit activity to carry out internal audit responsibilities in an unbiased manner. To achieve the degree of independence necessary to effectively carry out the responsibilities of the internal audit activity, the Head of Internal Audit will have direct and unrestricted access to the Board and Senior Management, in particular the Chair of the Audit Committee and Accountable Officer.

3.2 Organisational independence is effectively achieved when the auditor reports functionally to the Audit Committee on behalf of the Board. Such functional reporting includes the Audit Committee:

- approving the internal audit charter;
- approving the risk based internal audit plan;
- approving the internal audit budget and resource plan;
- receiving outcomes of all internal audit work together with the assurance rating; and
- reporting on internal audit activity's performance relative to its plan.

3.3 Whilst maintaining effective liaison and communication with the organisation, as provided in this Charter, all internal audit activities shall remain free of untoward influence by any element in the organisation, including matters of audit selection, scope, procedures, frequency, timing, or report content to permit maintenance of an independent and objective attitude necessary in rendering reports.

3.4 Internal Auditors shall have no executive or direct operational responsibility or authority over any of the activities they review. Accordingly, they shall not develop nor install systems or procedures, prepare records, or engage in any other activity which would normally be audited.

3.5 This Charter makes appropriate arrangements to secure the objectivity and independence of internal audit as required under the standards. In addition, the shared service model of provision in NHS Wales through NWSSP provides further organisational independence.

3.6 In terms of avoiding conflicts of interest in relation to non-audit activities, Audit & Assurance has produced a Consulting Protocol that includes all of the steps to be undertaken to ensure compliance with the relevant Public Sector Internal Audit Standards that apply to non-audit activities.

4 Authority and Accountability

4.1 Internal Audit derives its authority from the Board, the Accountable Officer and Audit Committee. These authorities are established in Standing Orders and Standing Financial Instructions adopted by the Board.

4.2 The Minister for Health has determined that internal audit will be provided to all health organisations by the NHS Wales Shared Services Partnership (NWSSP). The service provision will be in accordance with the Service Level Agreement agreed by the Shared Services Partnership Committee and in which the organisation has permanent membership.

4.3 The Director of Audit & Assurance leads the NWSSP Audit and Assurance Services and after due consultation will assign a named Head of Internal Audit to the organisation. For line management (e.g. individual performance) and professional quality purposes (e.g. compliance with the Public sector Internal Audit Standards), the Head of Internal Audit reports to the Director of Audit & Assurance.

4.4 The Head of Internal Audit reports on a functional basis to the Accountable Officer and to the Audit Committee on behalf of the Board. Accordingly the Head of Internal Audit has a direct right of access to the Accountable

Officer the Chair of the Audit Committee and the Chair of the organisation if deemed necessary.

4.5 The Audit Committee approves all Internal Audit plans and may review any aspect of its work. The Audit Committee also has regular private meetings with the Head of Internal Audit.

4.6 In order to facilitate its assessment of governance within the organisation, Internal Audit is granted access to attend any committee or sub-committee of the Board charged with aspects of governance e.g. Quality & Patient Safety Committee, and the Information Governance Committee.

5 Relationships

5.1 In terms of normal business the Accountable Officer has determined that the Board Secretary will be the nominated executive lead for internal audit. Accordingly, the Head of Internal Audit will maintain functional liaison with this officer.

5.2 In order to maximise its contribution to the Board's overall system of assurance, Internal Audit will work closely with the organisation's Board Secretary in planning its work programme.

5.3 Co-operative relationships with management enhance the ability of internal audit to achieve its objectives effectively. Audit work will be planned in conjunction with management, particularly in respect of the timing of audit work.

5.4 Internal Audit will meet regularly with the external auditor to consult on audit plans, discuss matters of mutual interest, discuss common understanding of audit techniques, method and terminology, and to seek opportunities for co-operation in the conduct of audit work. In particular, internal audit will make available their working files to the external auditor for them to place reliance upon the work of Internal Audit where appropriate.

5.5 The Head of Internal Audit will establish a means to gain an overview of other assurance providers' approaches and output as part of the establishment of an integrated assurance framework.

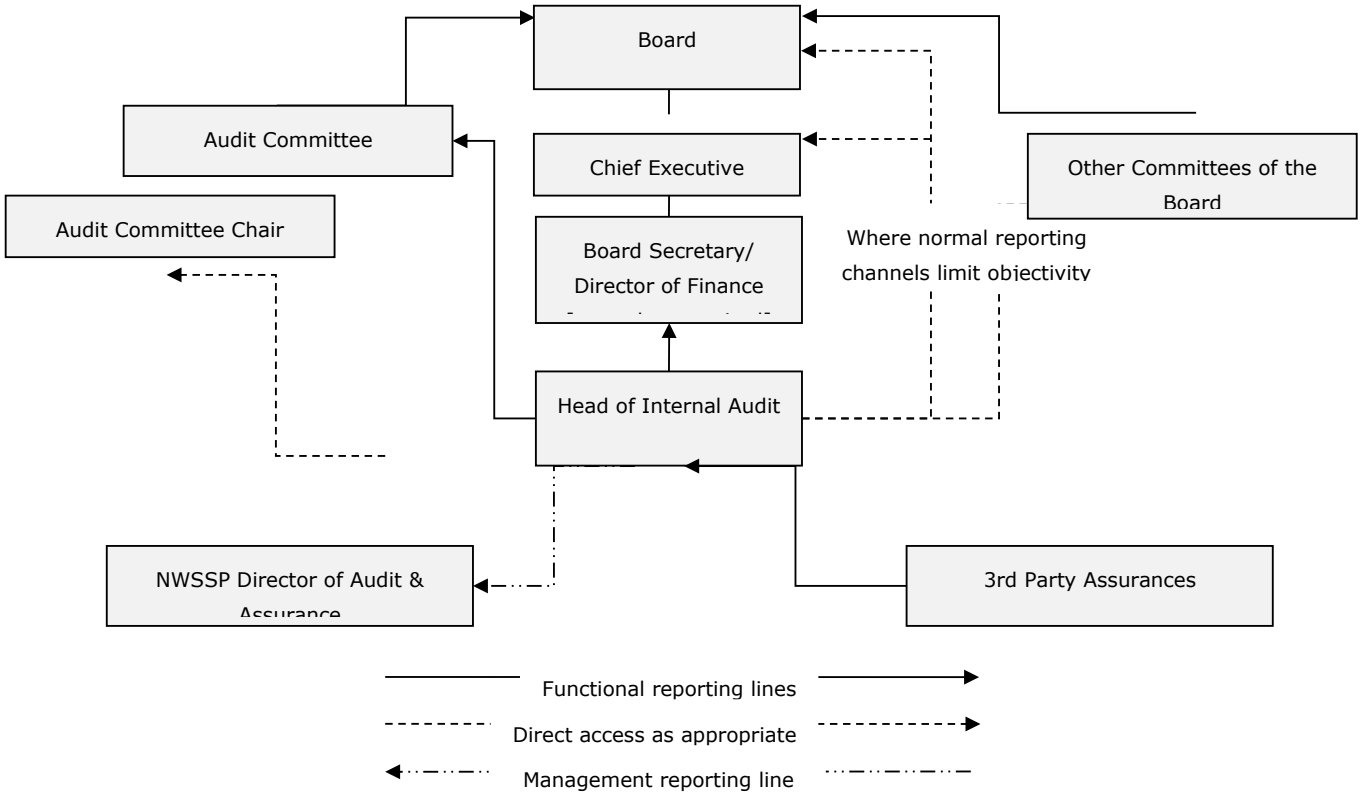
5.6 The Head of Internal Audit will take account of key systems being operated by organisation's outside of the remit of the Accountable Officer, or through a shared or joint arrangement, e.g. the NHS Wales Shared Services Partnership, WHSSC, EASC and NWIS.

5.7 Internal Audit strives to add value to the organisation's processes and help improve its systems and services. To support this Internal Audit will obtain an understanding of the organisation and its activities, encourage two way

communications between internal audit and operational staff, discuss the audit approach and seek feedback on work undertaken.

5.8 The key organisational reporting lines for Internal Audit are summarised in Figure 1 overleaf. As part of this, the Audit Committee may determine that another Committee of the organisation is a more appropriate forum to receive and action individual audit reports. However, the Audit Committee will remain the final reporting line for all reports.

Figure 1 Audit reporting lines



6 Standards, Ethics and Performance

6.1 Internal Audit must comply with the Definition of Internal Auditing, the Core Principles, Public Sector Internal Audit Standards and the professional Code of Ethics, as published on the NHS Wales e-governance website.

6.2 Internal Audit will operate in accordance with the Service Level Agreement (updated 2018) and associated performance standards agreed with the Audit Committee and the Shared Services Partnership Committee. The

Service Level Agreement includes a number of Key Performance Indicators and we will agree with each Audit Committee which of these they want reported to them and how often.

7 Scope

7.1 The scope of Internal Audit encompasses the examination and evaluation of the adequacy and effectiveness of the organisation's governance, risk management arrangements, system of internal control, and the quality of performance in carrying out assigned responsibilities to achieve the organisation's stated goals and objectives. It includes but is not limited to:

- reviewing the reliability and integrity of financial and operating information and the means used to identify measure, classify, and report such information;
- reviewing the systems established to ensure compliance with those policies, plans, procedures, laws, and regulations which could have a significant impact on operations, and reports on whether the organisation is in compliance;
- reviewing the means of safeguarding assets and, as appropriate, verifying the existence of such assets;
- reviewing and appraising the economy and efficiency with which resources are employed, this may include benchmarking and sharing of best practice;
- reviewing operations or programmes to ascertain whether results are consistent with the organisation’s objectives and goals and whether the operations or programmes are being carried out as planned;
- reviewing specific operations at the request of the Audit Committee or management, this may include areas of concern identified in the corporate risk register;
- monitoring and evaluating the effectiveness of the organisation's risk management arrangements and the overall system of assurance;
- reviewing arrangements for demonstrating compliance with the Health and Care Standards;
- ensuring effective co-ordination, as appropriate, with external auditors; and

- reviewing the Governance and Accountability modular assessment and the Annual Governance Statement prepared by senior management.

7.2 Internal Audit will devote particular attention to any aspects of the risk management, internal control and governance arrangements affected by material changes to the organisation's risk environment.

7.3 If the Head of Internal Audit or the Audit Committee consider that the level of audit resources or the Charter in any way limit the scope of internal audit, or prejudice the ability of internal audit to deliver a services consistent with the definition of internal auditing, they will advise the Accountable Officer and Board accordingly.

7.4 The scope of the audit coverage will take into account and include any hosted body.

8 Approach

8.1 To ensure delivery of its scope and objectives in accordance with the Charter and Standards Internal Audit has produced an Audit Manual (called the Quality Manual). The Quality Manual includes arrangements for planning the audit work. These audit planning arrangements are organised into a hierarchy as illustrated in Figure 2 overleaf.

Figure 2 Audit planning hierarchy

NHS Wales Level	NWSSP overall audit strategy	Arrangements for provision of internal audit services across NHS Wales to meet
Organisation Level	Entity strategic 3-year audit plan	Entity level medium term audit plan linked to organisational objectives
	Entity annual internal audit plan	Annual internal audit plan detailing audit engagements to be completed in year ahead leading to the overall HIA opinion
Business Unit Level	Assignment plans	Assignment plans detail the scope and objectives for each audit engagement within the annual operational plan

8.2 NWSSP Audit & Assurance Services has developed an overall audit strategy which sets out the strategic approach to the delivery of audit services to all health organisations in NHS Wales. The strategy also includes arrangements for securing assurance on the national transaction processing systems including those operated by NWSSP on behalf of NHS Wales.

8.3 The main purpose of the Strategic 3-year Audit Plan is to enable the Head of Internal Audit to plan over the medium term on how the assurance needs of the organisation will be met as required by the Public sector Internal Audit Standards and facilitate:

- the provision to the Accountable Officer and the Audit Committee of an overall opinion each year on the organisation's risk management, control and governance, to support the preparation of the Annual Governance Statement;
- audit of the organisation's risk management, control and governance through periodic audit plans in a way that affords suitable priority to the organisations objectives and risks;
- improvement of the organisation's risk management, control and governance by providing management with constructive recommendations arising from audit work;
- an assessment of audit needs in terms of those audit resources which "are appropriate, sufficient and effectively deployed to achieve the approved plan";
- effective co-operation with external auditors and other review bodies functioning in the organisation; and
- the allocation of resources between assurance and consulting work.

8.4 The Strategic 3-year Audit Plan will be largely based on the Board Assurance Framework where it is sufficiently mature, together with the organisation-wide risk assessment.

8.5 An Annual Internal Audit Plan will be prepared each year drawn from the Strategic 3-year Audit Plan and other information, and outlining the scope and timing of audit assignments to be completed during the year ahead.

8.6 The strategic 3-year and annual internal audit plans shall be prepared to support the audit opinion to the Accountable Officer on the risk management, internal control and governance arrangements within the organisation.

8.7 The annual internal audit plan will be developed in discussion with executive management and approved by the Audit Committee on behalf of the Board.

8.8 The NWSSP Audit Strategy is expanded in the form of a Quality Manual and a Consulting Protocol which together define the audit approach applied to the provision of internal audit and consulting services.

8.9 During the planning of audit assignments, an assignment brief will be prepared for discussion with the nominated operational manager. The brief will contain the proposed scope of the review along with the relevant objectives and risks to be covered. In order to ensure the scope of the review is appropriate it will require agreement by the relevant Executive Director or their nominated lead, and will also be copied to the Board Secretary. The key stages in this risk based audit approach are illustrated in figure 3 below.

Figure 3 Risk based audit approach

9 Reporting

9.1 Internal Audit will report formally to the Audit Committee through the following:

- An annual report will be presented to confirm completion of the audit plan and will include the Head of Internal Audit opinion provided for the Accountable Officer that will support the Annual Governance Statement. The process for arriving at the appropriate assurance level for each Head of Internal Audit opinion was subject to a review process during 2013/14, which led to the creation of a set of criteria for forming the judgement that was adopted and used for 2013/14 opinions onwards;

- The Head of Internal Audit opinion will:

a) State the overall adequacy and effectiveness of the organisation's risk management, control and governance processes, with reference to compliance with the Health and Care Standards;
b) Disclose any qualification to that opinion, together with the reasons for the qualification;

c) Present a summary of the audit work undertaken to formulate the opinion, including reliance placed on work by other assurance bodies;
d) Draw attention to any issues Internal Audit judge as being particularly relevant to the preparation of the Annual Governance Statement;
e) Compare work actually undertaken with the work which was planned and summarise performance of the internal audit function against its performance measurement criteria; and
f) Provide a statement of conformity in terms of compliance with the Public Sector Internal Audit Standards and associated internal quality assurance arrangements.

- For each Audit Committee meeting a progress report will be presented to summarise progress against the plan. The progress report will highlight any slippage and changes in the programme. The findings arising from individual audit reviews will be reported in accordance with Audit Committee requirements; and

- The Audit Committee will be provided with copies of individual audit reports for each assignment undertaken unless the Head of Internal Audit is advised otherwise. The reports will include an action plan on any recommendations for improvement agreed with management including target dates for completion.

9.2 The process for audit reporting is summarised below and presented in flowchart format in Appendix A:

- Following the closure of fieldwork and the resolution of any queries, Internal Audit will discuss findings with operational managers to confirm understanding and shape the reporting stage;
- Operational management will receive draft reports which will include any proposed recommendations for improvement within 10 working days following the discussion of findings. A copy of the draft report will also be provided to the relevant Executive Director;
- The draft report will give an assurance opinion on the area reviewed in line with the criteria at Appendix B. The draft report will also indicate priority ratings for individual report findings and recommendations;
- Operational management will be required to respond to the draft report in consultation with the relevant Executive Director within 15 working days of issue, stating their agreement or otherwise to the content of the report, identifying actions, identifying staff with responsibility for implementation and the dates by which action will be taken;

- The Head of Internal Audit will seek to resolve any disagreement with management in the clearance of the draft report. However, where the management response is deemed inadequate or disagreement remains then the matter will be escalated to the Board Secretary. The Head of Internal Audit may present the draft report to the Audit Committee where the management response is inadequate or where disagreement remains unresolved. The Head of Internal Audit may also escalate this directly to the Audit Committee Chair to ensure that the issues raised in the report are addressed appropriately;
- Reminder correspondence will be issued after the set response date where no management response has been received. Where no reply is received within 5 working days of the reminder, the matter will be escalated to the Board Secretary. The Head of Internal Audit may present the draft report to the Audit Committee where no management response is forthcoming;
- Final reports inclusive of management comments will be issued by Internal Audit to the relevant Executive Director within 10 working days of management responses being received; and
- The final report will be copied to the Accountable Officer and Board Secretary and placed on the agenda for the next available Audit Committee.

9.3 Internal Audit will make provision to review the implementation of agreed action within the agreed timescales. However, where there are issues of particular concern provision maybe made for a follow up review within the same financial year. Issue and clearance of follow up reports shall be as for other assignments referred to above.

10 Access and Confidentiality

10.1 Internal Audit shall have the authority to access all the organisation's information, documents, records, assets, personnel and premises that it considers necessary to fulfil its role. This shall extend to the resources of the third parties that provide services on behalf of the organisation.

10.2 All information obtained during the course of a review will be regarded as strictly confidential to the organisation and shall not be divulged to any third party without the prior permission of the Accountable Officer. However, open access shall be granted to the organisation's external auditors.

10.3 Where there is a request to share information amongst the NHS bodies in Wales, for example to promote good practice and learning, then permission will be sought from the Accountable Officer before any information is shared.

11 Irregularities, Fraud & Corruption

11.1 It is the responsibility of management to maintain systems that ensure the organisation's resources are utilised in the manner and on activities intended. This includes the responsibility for the prevention and detection of fraud and other illegal acts.

11.2 Internal Audit shall not be relied upon to detect fraud or other irregularities. However, Internal Audit will give due regard to the possibility of fraud and other irregularities in work undertaken. Additionally, Internal Audit shall seek to identify weaknesses in control that could permit fraud or irregularity.

11.3 If Internal Audit discovers suspicion or evidence of fraud or irregularity, this will immediately be reported to the organisation's Local Counter Fraud Service (LCFS) in accordance with the organisation's Counter Fraud Policy & Fraud Response Plan and the agreed Internal Audit and Counter Fraud Protocol.

12 Quality Assurance

12.1 The work of internal audit is controlled at each level of operation to ensure that a continuously effective level of performance, compliant with the Public Sector Internal Audit Standards, is being achieved.

12.2 The Director of Audit & Assurance will establish a quality assurance programme designed to give assurance through internal and external review that the work of Internal Audit is compliant with the Public Sector Internal Audit Standards and to achieve its objectives. A commentary on compliance against the Standards will be provided in the Annual Audit Report to Audit Committee.

12.3 The Director of Audit & Assurance will monitor the performance of the internal audit provision in terms of meeting the service performance standards set out in the NWSSP Service Level Agreement. The Head of Internal Audit will periodically report service performance to the Audit Committee through the reporting mechanisms outlined in Section 9.

13 Resolving Concerns

13.1 NWSSP Audit & Assurance was established for the collective benefit of NHS Wales and as such needs to meet the expectations of client partners. Any questions or concerns about the audit service should be raised initially with the Head of Internal Audit assigned to the organisation. In addition any matter may be escalated to the Director of Audit & Assurance. NWSSP Audit & Assurance will seek to resolve any issues and find a way forward.

13.2 Any formal complaints will be handled in accordance with the NWSSP complaint handling procedure. Where any concerns relate to the conduct of the Director of Audit & Assurance, the NHS organisation will have access to the Director of Shared Services.

14 Review of the Internal Audit Charter

14.1 This Internal Audit Charter shall be reviewed annually and approved by the Board, taking account of advice from the Audit Committee.

Simon Cookson
Director of Audit & Assurance - NHS Wales Shared Services Partnership
March 2019

Appendix A Audit Reporting Process

Audit fieldwork completed and debrief with management.	Following closure of audit fieldwork and management review audit findings are shared with management to check accuracy of understanding and shape recommendations for improvement to address any control deficiencies identified.
A draft report is issued within 10 working days of fieldwork completion and the resolution of any queries.	Draft reports issued with an assurance opinion and recommendations within 10 days of fieldwork completion to Operational Management, and copied to Executive Leads.
Management responses are provided on behalf of the Executive Lead within 15 working days of receipt of the draft report.	A report clearance meeting may prove helpful in finalising the report between management and auditors. A response, including a fully populated action plan, with assigned management responsibility and timeframe is required within 15 days of receipt of the Draft report.
Outstanding responses are chased for 5 further days.	Where management responses are still awaited after the 15 day deadline, a reminder will be sent. Continued non-compliance will be escalated to Executive management after 5 further days.
Report finalised by Internal Audit within 10 days of management response.	Internal Audit issues a Final report to Executive Director, within 10 working days of receipt of complete management response. All Final reports are copied to the Chief Executive.
Individual audit reports received by Audit Committee.	Final reports are received by the Audit Committee at next available meeting and discussed if applicable. For reports with "green/ yellow" assurance ratings, Executive Summaries are received for noting. For those with "red/ amber" ratings, the full reports are received for discussion. The Audit Committee identifies their priority areas for Internal Audit to follow up.

Appendix B Audit Assurance Ratings

RATING	INDICATOR	DEFINITION
Substantial assurance	 - + Green	The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.
Reasonable assurance	 - + Yellow	The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact on residual risk** exposure until resolved.
Limited assurance	 - + Amber	The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.
No assurance	 - + Red	The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved.

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

5.2

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Clinical Audit Follow-up

Internal Audit Report

5.3

2018/19

Aneurin Bevan University Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Service

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1. Introduction and Background

The follow-up review of 'Clinical Audit and Assurance' was completed in line with the 2018/19 Internal Audit Plan.

In April 2017, as part of the 2016/17 Internal Audit Plan, we undertook a review of Clinical Audit and Assurance within Aneurin Bevan University Health Board (the 'Health Board').This resulted in a limited assurance report being issued, identifying that the Health Board did not have the necessary resources, governance arrangements and organisational structure to efficiently and effectively engage in a clinical audit process that addressed major quality and patient safety risks and aided quality improvement.

In the 2016/17 report, management set out implementation timescales of between six to 18 months to fully implement our recommendations. Therefore, we agreed the follow-up review would be undertaken in quarter three of the 2018/19 Internal Audit Plan, allowing sufficient time for the recommendations to be implemented and embedded.

2. Scope and Objectives

The purpose of the follow-up review was to assess whether the Health Board has implemented the Internal Audit recommendations made following the Clinical Audit and Assurance review in 2016/17. The recommendations made in the 2016/2017 audit and the current audit findings are set out in Appendix A.

The scope of this follow-up review does not aim to provide assurance against the full review scope and objectives of the original audit. The 'follow-up review opinion' provides an assurance level against the implementation of the agreed action plan only.

The follow-up review was completed in the context of the wider quality and patient safety assurance framework within the Health Board.

3. Associated Risks

The overall risk to be considered in the follow-up review is failure to implement agreed audit recommendations and, therefore:

- management control frameworks continue to exhibit weaknesses;
- management do not have processes in place to review and action agreed audit recommendations (and consequential risk mitigation); and
- management do not have adequate recording systems to inform whether requisite actions have been undertaken and, therefore, are unable to evidence actions.

Risks specific to the Clinical Audit process are:

- clinical risks are not identified and mitigated to an acceptable level;
- inappropriate governance structure/arrangements in place;
- a clinical audit plan or progress therein is not developed or monitored;
- failure to have a documented and agreed reporting pathway for clinical audit results; and
- key staff are unaware of the Clinical Audit Strategy (or alternative) resulting in poor quality clinical audit work.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

The current review considers all recommendations made (high, medium or low priority). This report **does not** provide assurance against the full review scope and objective of the original audit. The 'follow-up review opinion' provides the assurance level against the implementation of the agreed action plan only. Considering the progress made against the action plan the follow-up review opinion is **Limited Assurance**.

RATING	INDICATOR	DEFINITION
Limited Assurance		The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

Some progress has been made towards addressing the findings of the original audit. However, this progress has been insufficient to reduce the risks associated with the area under review to an acceptable level.

Progress against implementing our previous recommendations can be seen in Appendix A.

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5. Assurance Summary

The following table summarises the extent to which the original recommendations have been implemented and provides classification of current risks:

Area		Classification 2016/17 audit	Direction of travel	Classification 2018/19 audit
1	Clinical Audit Approach	High	Some progress made, but insufficient to reduce risk to an acceptable level.	High
2	National Clinical Audits	High	Some progress made, but insufficient to reduce risk to an acceptable level.	High
3	Follow-up of Clinical Audit Results	High	No progress made.	High
4	Clinical Audit Activity	Medium	Some progress made, but insufficient to reduce risk to an acceptable level.	Medium
5	Training & Development	Medium	Progress made, sufficient to reduce the level of risk.	Low

6. Summary of Audit Findings

Clinical audit and the wider quality improvement agenda

The Healthcare Quality Improvement Partnership ('HQIP') defines clinical audit as "a quality improvement cycle that involves measurement of healthcare against agreed and proven standards for high quality, and taking action to bring practice in line with these standards so as to improve the quality of care and health outcomes". Clinical audit is one of a range of quality improvement methodologies in use within the healthcare sector, functioning best as part of a planned programme of quality improvement (HQIP 2016 Best Practice in Clinical Audit).

The Health Board has a number of quality improvement methodologies and activities ongoing throughout the organisation, including clinical audit, ABC*i*, Value Based Healthcare and 1,000 Lives.

Standard 3.3 of the Health and Care Standards 2015 requires healthcare organisations to engage in continuous improvement activities, including clinical audit.

To the Welsh Government, clinical audit is one of the main priorities to improve patient care in Wales. All health boards and trusts are required to participate in the annual National Clinical Audit and Outcomes Review ('NCAOR') plan where they provide the relevant service and to ensure that the necessary resources, governance and organisational structures are in place to support complete engagement in the national audits, reviews and national registers.

Alongside participation in the NCAOR plan, the NHS Wales Governance eManual states that "all organisations should have annual clinical audit programmes in place which include both national and local audits that address their priorities".

Overview of progress in implementing previous recommendations

In our previous audit we identified that the Health Board did not have the necessary resources, governance arrangements and organisational structure to efficiently and effectively engage in a clinical audit process that addressed major quality and patient safety risks and aided quality improvement. Not all applicable National Clinical Audits ('NCAs') were participated in, monitoring and recording of the NCA process was not being completed consistently, feedback of results from the NCAs was not always taking place and insufficient allocated resource levels resulted in delayed completion of audits. Additionally, the Health Board was not maintaining a programme of local clinical audits and had not undertaken an assurance mapping exercise to determine if clinical risks were being addressed.

Some progress has been made in addressing some of these issues, including:

- development of a Clinical Audit Strategy and Policy (currently in draft and, therefore, not yet approved);
- a three-tiered approach to clinical audit has been devised, including national, Health Board wide and divisional clinical audits, although there are significant gaps in the governance and reporting arrangements within this approach;
- appointments have been made within the Medical Director Support Team ('MDST'), including a new positing to lead on the NCAOR (the Quality & Patient Safety Lead for National Clinical Audits). However, the MDST is responsible for more than just clinical audit and there is no dedicated clinical audit team within the Health Board;
- NCA reports are a standing agenda item at the Quality & Patient Safety Operational Group ('QPSOG') and the Quality & Patient Safety Committee ('QPSC') receives one NCA report at each meeting; and

- the Assistant Director of Quality & Patient Safety ('QPS') presents an annual NCAOR report to the QPSOG and QPSC, although this report did not clearly show progress against the NCAOR Programme.

However, insufficient progress has been made to reduce the risks associated with this area to an acceptable level. Key actions that remain outstanding include:

- the Health Board has not completed an assurance mapping exercise against its major clinical risks and, therefore, is unable to determine if the level of clinical audit being carried out is adequate to address these risks as part of the wider quality improvement work within the Health Board;
- the Health Board is still not participating in three major NCAs (Ophthalmology, Major Trauma and Inflammatory Bowel Disease), despite stating in the previous report that it would prioritise participation in the Ophthalmology NCA. Additionally, there is a backlog in data entry for some other NCAs that is not being formally monitored and progress against the annual NCAOR plan is not being reported; and
- there are significant gaps in the governance and reporting process of the newly designed clinical audit approach, including the Clinical Audit Plan not having been approved by the QPSC and a lack of oversight over clinical audit within the divisions.

Full details of the progress made in addressing our previous recommendations can be seen in Appendix A.

Action plan

In order to provide the Health Board with clear direction to address the outstanding actions, we have formulated a new action plan, which incorporates all of our original recommendations that have not yet been implemented. The action plan can be seen in Appendix B and is linked to HQIP's Best Practice in Clinical Audit prerequisites to maximise the impact of clinical audit in Appendix C.

The action plan contains three **high** priority recommendations:

1. Quality & Patient Safety Assurance Framework

Clinical audit functions best when part of a planned quality improvement programme. Whilst the Health Board has a number of quality improvement initiatives ongoing, it does not have an overarching quality improvement programme in place. Therefore, there is no overall coordination of the quality improvement work within the Health Board (clinical audit, ABC*i*, Value Based Healthcare, 1,000 lives, etc) and it is not possible to assess whether these initiatives are efficiently and

effectively addressing major QPS risks. For example, our review of the 2018/19 NCAOR and Value Based Healthcare programme identified seven areas of overlap. We were unable to identify gaps in the risks addressed because clinical risks are not set out.

We have not audited the other quality improvement initiatives. It is for management to determine whether the Health Board's clinical audit activity is sufficient in the context of the wider quality and patient safety agenda within the organisation. Therefore, we have recommended that the Health Board develops a QPS Improvement Strategy and Assurance Framework, based upon a review of its approach to clinical audit and other QPS assurance mechanisms. This exercise will allow the Health Board to determine the level of clinical audit required throughout the organisation and the resource needed to support this.

2. Clinical Audit Framework

The Health Board is required to participate in a certain level of clinical audit throughout the organisation. In order to maximize the effectiveness of clinical audit, the Health Board needs to address the gaps in the governance and reporting arrangements over its clinical audit programme, including:

- bringing the top two tiers of the audit programme (national and Health Board wide) together into one plan that receives approval from the QPSC;
- implementing governance mechanisms to regularly monitor the delivery of the audit plan, to ensure dissemination and escalation of results and to provide assurance that the divisions are taking action to implement recommendations;
- reporting action plans for known issues with the delivery of the NCAOR, including the three NCAs that the Health Board are still not participating in (Major Trauma, National Ophthalmology and Inflammatory Bowel Disease); and
- the provision of clinical audit training upon request for relevant staff within the divisions.

We have further recommended that the Clinical Audit Strategy & Policy be updated to reflect the recommendations raised in this review.

3. Divisional Clinical Audit

There is a no mechanism within the divisional clinical audit process for holding the divisions to account in developing and delivering a divisional clinical audit programme, or to ensure that actions are taken to address significant issues arising. Therefore, the divisions should:

- Produce an annual workplan of assurance against their major clinical risks, including, but not limited to, clinical audit; and
- Provide regular updates to the QPSOG against this workplan, highlighting significant issues arising and the action being taken to address them.

A high level summary of the above should be included within the QPS report produced by the Assistant Director of QPS.

Additionally, we have recommended improvements to the Health Board's Clinical Audit Registration Form and Checklist, including ensuring that consideration is given as to whether clinical audit is the most appropriate quality improvement methodology for a specific area or matter. The form and checklist should be used for all divisional clinical audits.

7. Summary of Recommendations

The current recommendations are detailed in Appendix B together with the management action plan and implementation timetable.

A summary of these recommendations is outlined below.

Priority	H	M	L	Total
Number of recommendations	**3**	**-**	**-**	**3**

Previous Finding 1 Clinical Audit Approach (Design)

Original Recommendation (Priority Rating: High)

An assurance mapping exercise should be completed across the Health Board to identify service areas / assurance providers that are currently providing assurance on clinical risks in order to:

- identify gaps and overlaps in clinical audit coverage;
- minimise duplication in clinical audit work;
- promote collaboration and opportunities for reliance on the work of other assurance providers; and
- provide effective assurance over the organisations major clinical risks.

The Health Board should consider whether the Medical Director's Support Team should co-ordinate or manage and undertake a range of local clinical audit work, in conjunction with the national clinical audit work already required. This should ensure that major clinical risks are identified and mitigated to an acceptable level.

If this approach is agreed then it should be formalised via a strategic document, specific to the Health Board which outlines the following elements relating to both local and national clinical audit:

- the governance structure;
- a programme methodology for identifying clinical audits to undertake;
- reporting/monitoring of audits;
- process for following up audit results;
- clear communication pathway direct to Board; and
- the procedure to follow for adverse results.

This document should be reviewed and approved by the Board or a nominated sub-committee.

An annual clinical audit plan should be produced which incorporates a range of local Health Board wide and national clinical audits to be completed. This should be based on available resources within the Medical Director's Support Team, high clinical risk areas identified, via the risk management process and discussions with key stakeholders throughout the Health Board e.g. Executives, Assistant Medical Directors etc.

Progress against the plan should be reported to and reviewed periodically by the Quality and Patient Safety Committee.

Guidance (published 2016) on how to develop a Clinical Audit Policy, Strategy and Programme is available on the Healthcare Quality Improvement Partnership website, for reference, if required.

Original Management Response

The need for a Clinical Audit Programme to address clinical issues that are important across the whole health board has been recognised and some resource identified within the Medical Director's Support Team to complete a small number of high level Health Board wide clinical audits in 2017-18. *Assistant Director – Quality and Patient Safety, Initiate Programme May 17*

Strategic documents for Clinical Audit will be developed for the Health Board and agreed through the Clinical Effectiveness Group and Quality and Patient Safety Committee. *Assistant Director – Quality and Patient Safety, Nov 17*

Over the next 12-18 months, the Health Board will complete a review of assurance mechanisms to clarify where and how assurance is provided on clinical risks in the Health Board. This will include consideration of how the Health Board moves towards an assurance plan marrying together traditional assurance with real time data from the outcomes and values work. *Assistant Director – Quality and Patient Safety, Sept 18*

Current Findings

Assurance mapping

Current Status of Implementation: Partially Implemented

The Health Board is in the process of developing a Board Assurance Framework ('BAF'), which includes assurance mapping against principal risks as expressed in the IMTP. The BAF, risk assessment and assurance mapping is due to be completed by, and presented to the Board in, early 2019. However, the BAF focuses on high level corporate risks and will not be sufficient identify the gaps in assurance over the organisation's clinical risks.

There is a Quality & Patient Safety ('QPS') committee structure diagram, referred to as the QPS Corporate "Assurance Framework", which maps out the sub-groups that report into the QPS Committee ('QPSC'). However, this document is out of date (the Clinical Effectiveness Sub-Committee no longer meets, for example) and does not identify sources of assurance within the quality and patient safety domain. Therefore, it is not possible to assess whether major clinical risks are being addressed, or whether there are areas of inefficiency and overlap between QPS assurance sources. For example, our review of the 2018/19 NCAOR plan and Value Based Healthcare programme highlighted that there are seven areas of overlap. This is work that could potentially be complimentary. However, without appropriate assurance mapping, planning and communication, this could result in duplication of effort and potentially leave other risk areas unaddressed. We were unable to identify gaps in the risks addressed because clinical risks are not set out.

Clinical Audit Strategy and Policy

At the time of our fieldwork, the Clinical Audit Strategy and Policy were in the process of being finalised for presentation to the QPS Operational Group ('QPSOG') and, therefore, have not been formally approved.

The Strategy and Policy cover the strategic aims and objectives of clinical audit, key leadership and committee roles and responsibilities in clinical audit and the processes for agreeing, carrying out and reporting clinical audits. However, our review of the individual elements of these documents highlighted gaps within the governance and reporting processes, which are highlighted under the 'Local Clinical Audit Programme' section below.

Local Clinical Audit Programme

The Clinical Audit Strategy sets out a three-tiered approach to clinical audit:

1. National Clinical Audits: participation in the National Clinical Audits ('NCAs') that are mandated as part of the National Clinical Audit and Outcomes Review ('NCAOR') Programme;
2. Health Board Wide Clinical Audit: a small programme of Health Board clinical audits on issues that have an impact across a large part of the Health Board and, therefore, involve several directorates or divisions; and
3. Divisional Clinical Audit: local programmes of clinical audit determined and carried out by directorates/specialties.

Whilst the Clinical Audit Strategy requires that clinical audit plans are in place for each of the three tiers, these plans are individual, stand-alone documents, rather than being brought together into one overall clinical audit plan for the Health Board.

National Clinical Audit

Participation in the NCAs is led by the QPS Lead for NCA who sits within the Medical Director Support Team ('MDST'). This is the subject of previous finding 2 and, as such, has not been covered further here.

Health Board Wide Clinical Audit

A 2018/19 Health Board Wide Programme of six clinical audits has recently been developed by the MDST through discussions with individuals and a review of learning themes from incidents, complaints and mortality reviews and the clinical risk issues highlighted by the divisions at the QPSOG meetings. Our review of the 2018/19 Health Board Wide Programme document identified that it covered areas that would be considered a clinical risk, such as consent and clinical records. However, the link between the programme and the organisation's clinical risks is not explicit within the document and we were unable to identify any gaps within the programme because the organisation's clinical risks are not clearly set out and defined..

The 2018/19 programme identifies which Health Board Committee or Group each clinical audit will be reported to. However, there is no mechanism in place to ensure the results are reported centrally to either the QPSOG or QPSC.

At the time of our audit, the Health Board Wide Programme had not been formally approved by either the QPSOG or the QPSC, although QPSOG members had received a copy of the Programme via email and were asked for comments. No progress reports had been presented. The Assistant Director of QPS confirmed that three of the six audits in the 2018/19 programme had been completed thus far.

Divisional Clinical Audit

This tier of the Health Board's Clinical Audit Strategy should be overseen by the divisions. There is no oversight mechanism to ensure that the local plans adequately address the main clinical risks, that plans are being delivered on a timely basis or that action is taken to implement recommendations. There is also no mechanism to ensure that the QPSC receives regular updates on the divisional clinical audits or approves the annual divisional clinical audit plan. On the basis that the oversight and governance arrangements are inadequate, we have not undertaken any detailed testing on the divisional clinical audits.

Clinical Audit Resource

Appointments have been made within the MDST, including a new position – QPS Lead for NCAs. However, the MDST is responsible for more than just clinical audit and there is no dedicated clinical audit team within the Health Board. This is inconsistent with other quality improvement initiatives within the Health Board (for example, ABC*i* and Value Based Healthcare) and clinical audit functions within other Health Boards. It opens up the risk that the Health Board may not obtain maximum value from the clinical audit programme.

Additionally, clinical audit planning, governance and reporting to QPSOG/QPSC is heavily dependent on the Assistant Director of QPS. In their absence, there is a risk that clinical audit will not progress or be appropriately reported. For example, we identified that on three occasions within the past six months, no papers on the NCAOR or NCAs have been presented to the QPSOG due to the absence of the Assistant Director of QPS (all for genuine reasons).

Conclusion	Priority Level
Progress has been made in implementing a risk based clinical audit programme for the Health Board. However, gaps in the governance and reporting arrangements and a lack of clarity on what clinical risks are being addressed continue to leave the Health Board at risk of having an ineffective clinical audit programme that does not adequately address major clinical risks. The Health Board also needs to ensure that clinical audit receives sufficient, regular attention at Board level (via the QPSOG and QPSC, or another function), including when the Assistant Director of QPS is unable to attend.	**High**

Therefore, further work is required to address these issues and to ensure that the Health Board gains maximum value from the clinical audit programme. See Appendix B for the management action plan.	

Previous Finding 2 National Clinical Audits (Operation)

Original Recommendation (Priority Rating: High)

In conjunction with recommendation 1, management should:

- ensure that the necessary resources, governance and organisational structures are in place to support engagement with national audits and registers that are included within the NHS Wales National Clinical Audit and Outcomes Review Plan;
- continue to implement effective monitoring controls (i.e. new spreadsheet) for the completion of national clinical audit work. This record should be reviewed on a regular basis to identify potential issues with completion of work so timely and effective action can be taken to address it; and
- ensure that progress against the plan is reported to and reviewed periodically by the Quality and Patient Safety Committee.

Original Management Response

Additional resources have been made available to the MDST and the posts have been filled and staff are currently being trained. The MDST will co-ordinate, facilitate and monitor the participation in and response to the approximately 40 National Clinical Audits (NCAs) in the National Clinical Audit and Outcome Review (NCAOR) Plan, but the bulk of the data entry and the implementation of change relies upon a partnership with the Directorates and Clinical Leads, as the majority of the resource is within the service. *Assistant Director – Quality and Patient Safety, July 2017*

A new spreadsheet for NCAs in the NCAOR Plan has been developed to monitor participation in audits, review and dissemination of findings and identification of actions based on findings. *Assistant Director – Quality and Patient Safety, Nov 17*

As we roll out the programme, we will prioritise the Ophthalmology NCA.

An Annual Report on Clinical Audit in ABUHB will be presented to the QPSC annually.

Current Findings

In April 2017, the MDST appointed a QPS Lead for NCA to provide support for the NCA Clinical Leads and MDST staff in all aspects of the NCA process, to continually monitor participation in audits, to review the NCA reports as they are published and to disseminate the results to the relevant divisions. They also responsible for ensuring that both the Part A and Part B returns are submitted to Welsh Government on a timely basis.

Current Status of Implementation: Partially Implemented

A member of the MDST is assigned to each NCA in order to support the clinicians throughout the Health Board in carrying out these audits on a timely basis. The directorates and clinical leads are responsible for the data entry.

The MDST maintains a database (spreadsheet) of all NCAOR work. For each NCA, this identifies the ABUHB Clinical Lead, the MDST Lead, a link to the most recent published report, whether local data is available in the results, a link to the dataset, the date the Welsh Government Part A response is due and national support details. The database does not identify progress made against each NCA nor does it highlight any issues with timely delivery.

Due to the previous vacancies and capacity issues within the MDST there is a backlog of data entry and reporting to Welsh Government for some of the NCAs. There is no formal action plan in place to monitor or reduce the backlogs, therefore we were unable to ascertain the gravity of this issue.

Our review of clinical audit reports from across NHS Wales highlighted that four of the seven Health Boards appear to be fully participating in the NCAOR (to the extent the NCAs are relevant) and three (including ABUHB) are not, to varying degrees. The Health Board is still not participating in the following 2018/19 NCAs:

- National Ophthalmology Audit: This NCA was identified as a priority by management in our previous report. However, the Health Board is not participating because it still does not have the software required to complete this audit. We understand that Cardiff & Vale UHB is currently developing software, which the Health Board may use once completed.
- Major Trauma Audit ('TARN'): the data entry requirements for TARN are significant and the clinicians do not have sufficient time available to undertake this themselves. Other health boards have employed and trained a Band 5 to undertake the data entry.
- Inflammatory Bowel Disease ('IBD'): the Health Board is not currently submitting data due to "transitional issues with IBD Registry". We understand that the MDST is working closely with service providers to re-commence participation.

There is no formal action plan in place to monitor and report on progress towards participation in these NCAs.

Each member of the MDST has a monthly 1-to-1 with the Assistant Director of QPS, during which they are able to report on progress for their NCAs and any issues that have been encountered.

NCA reports now form a standing agenda item at the QPSOG and one NCA report is also presented at each QPSC meeting. However, we identified that on three occasions within the past six months, no papers on the NCAOR or NCAs were presented to the QPSOG due to the absence of the Assistant Director of QPS (for genuine reasons).

The Assistant Director of QPS now presents an annual report on the NCAOR to the QPSOG and QPSC. The 2017/18 report, presented to the QPSC in February 2018, included a summary of the most recent information for individual NCAs, but it is not clear whether this covers all of the NCAs in the 2017/18 NCAOR plan and, therefore, which NCAs have yet to be completed. As such, it is not

possible to determine progress against the 2017/18 NCAOR plan from this report. Progress against the NCAOR plan has not been regularly reported to either the QPSOG or QPSC.

Our review of the highlights for the individual NCAs in the 2017 report (taken to the QPSC in February 2018) identified the following:

- 17 reports where the report template hasn't been fully completed, including: 11 where one data item was not completed (no explanation); five where no data items were provided at all (no explanation); and one where some of the actions did not have progress updates against them; and
- 18 reports that were RAG rated amber for progress against recommendations, but no explanation as to why and what was being done to get back on track with progress. Additionally, we identified a further one report where the RAG rating of progress against recommendations had not been completed.

There is no mechanism in place to provide assurance to the Health Board that recommendations and identified actions from the NCAs are being implemented within the divisions.

Conclusion	Priority Level
Progress has been made in improving the governance and accountability arrangements over the NCAOR programme. However, further work is required to ensure that progress is regularly reported, action plans are in place for the backlogs in data entry and NCAs not currently participated in and mechanisms exist to provide assurance that recommendations are implemented. The Health Board also needs to ensure that clinical audit receives sufficient, regular attention at Board level (via the QPSOG and QPSC or other function), including when the Assistant Director of QPS is unable to attend. These gaps in the process continue to leave the Health Board at risk of having an ineffective clinical audit programme that does not adequately address major clinical risks. Therefore, further work is required to address these issues and to ensure that the Health Board gains maximum value from the clinical audit programme. See Appendix B for the management action plan.	**High**

Previous Finding 3 Follow-up of Clinical Audit Results (Design)

Original Recommendation (Priority Rating: High)

An effective mechanism for the identification and follow-up of actions arising from clinical audit work, undertaken locally (should the Health Board agree to implement the approach outlined in recommendation 1) and nationally, should be implemented as soon as possible, in order to provide assurance that effective action is being undertaken to mitigate clinical risk.

Original Management Response

All NCAs on the NCAOR Plan have been allocated to a member of the MDST. A Workshop with Clinical Leads for NCAs in 2015 showed they supported the process of developing headline data slides to disseminate the findings of NCAs, so the main areas of focus for improvement could be agreed and appropriate actions put in place. The MDST will draft the headline data slides, but the clinical lead for each NCA is responsible for ensuring the key issues for the Health Board are being highlighted. The Welsh Government Assurance Form was introduced in Autumn 2016, but the information required, part of which is the key actions arising from the NCA findings, flows from the headline data slide process above. It will take 2 years to work through this process with all the NCAs, in partnership with the Divisions and Directorates, as some are repeated every 2 years. *Assistant Director – Quality and Patient Safety, Ongoing*

Implementation of actions to address findings of NCAs is the responsibility of Clinical Directors and Divisional Directors, but the MDST will undertake high level monitoring as part of the partnership working in order to report annually to QPSC.

Current Findings

The Clinical Audit Policy states that divisions should "ensure that re-audits are planned as part of their audit plans, allowing enough time for changes to be implemented". However, there is no requirement to centrally report actions arising, therefore there is no mechanism to hold the divisions to account in implementing these actions.

The Policy does not mention any mechanisms for the identification and follow-up of recommendations made under the NCAs and Health Board Wide clinical audits and no such monitoring is being undertaken.

Current Status of Implementation: Not Implemented

Conclusion	Priority Level
No progress has been made in implementing an effective mechanism for the identification and follow-up of actions arising from the clinical audit programme, whether it be from national, Health Board wide or divisional clinical audits. This leaves the Health Board open to the risk that quality and patient safety is not being improved because actions are not being implemented. Therefore, work is required to address these issues and to ensure that the Health Board gains maximum value from the clinical audit programme. See Appendix B for the management action plan.	**High**

4 Clinical Audit Activity (Design)

Original Recommendation (Priority Rating: Medium)

Should the Health Board agree to implement the approach outlined in recommendation 1, then an effective mechanism for collating and reporting on local directorate level clinical audit activity should be implemented as soon as possible.

Original Management Response

The MDST will collate and report on NCA activity and activity for the Health Board-wide audits undertaken as part of the Health Board Clinical Audit Plan.

The responsibility for collating and reporting on local directorate level clinical audit activity within Directorates e.g. junior doctor audits, since the decision by the QPSC, is within the Directorates. This will be clarified within the strategic documents for clinical audit.

Assistant Director – Quality and Patient Safety, Nov 17

Current Findings

National Clinical Audits

As noted in previous finding 2, an annual report on the NCAOR is presented to the QPSC. Additionally, reports from the NCAs are presented to the QPSOG and QPSC. Further work is required to ensure progress against the NCAOR plan is regularly reported and that there is a mechanism in place to track recommendations raised.

Current Status of Implementation: Partially Implemented

Health Board Wide Clinical Audits

The Clinical Audit Policy states that "the MDST will co-ordinate the completion of [Health Board wide] audits and reports on the results" and that "the reports and action plans will be taken to the QPSOG, principally through an annual report on the programme". Therefore, the MDST does have oversight of this tier of clinical audit within the Health Board. However, an annual report on the results is not sufficiently frequent to ensure significant issues are escalated on a timely basis or to monitor progress against the plan. At the time of our audit, the first Health Board Wide programme was underway, therefore the annual report had yet to be produced.

Divisional Clinical Audits

The Clinical Audit Policy states that the divisions are "responsible for having the structure and processes in place so that the audits are reported and presented locally, and that changes are agreed and implemented". However, there is no mechanism in place for holding the divisions to account for the local, directorate-level clinical audit activity. As noted in previous finding 1, we have not undertaken any detailed testing on the divisional clinical audits on the basis that the related oversight and governance arrangements are inadequate .

Reporting to the QPSOG

Our review of the QPSOG minutes for 2018 highlighted concerns that clinical audit is not covered during the meetings if the Assistant Director of QPS is unable to attend the meeting. This has been the case for the last three QPSOG meetings (all for genuine reasons).

Conclusion	Priority Level
Some progress has been made on this recommendation. However, further work is needed for the Health Board to implement a fully effective mechanism for reporting on Health Board wide and divisional clinical audit and ensuring that clinical audit receives adequate coverage at QPSOG/QPSC meetings when the Assistant Director of QPS is unable to attend. See Appendix B for the management action plan.	**Medium**

5 Training & Development (Design)

Original Recommendation (Priority Rating: Medium)

Management should:

- identify a potential programme of training courses / opportunities provided either internally or externally that staff can attend in order to develop knowledge and competency in order to improve clinical audit work and provide 'added value' to the Health Board; and
- develop a mechanism for monitoring training and development of staff within the Medical Directors Support Team going forward, to ensure that appropriate training has been received and identify where further training is required.

There are a number of E-learning courses relating to clinical audit available on the Healthcare Quality Improvement Partnership website. Alternatively, potential learning opportunities could be arranged through sharing information and observing the work of Internal Audit or through liaising with service areas within the clinical environment, when undertaking audit research.

Original Management Response (Priority Rating: Medium)

The MDST has been stable for the last 5 years and all staff had been trained in Clinical Audit. However, there has recently been new posts funded, and some turnover of staff in existing posts. Initial training in Clinical Audit for the newly recruited staff in the MDST has been completed and will be backed up with practical experience under supervision by experienced staff working on local health board wide clinical audits and completion of on-line training, such as HQIP's.

Training and development will be monitored through regular 1-1s with the Assistant Director – Quality and Patient Safety, and PADRs, with further development opportunities being arranged such as observing the work of the Internal Audit Department.

Assistant Director – Quality and Patient Safety, Ongoing

Current Findings

Clinical Audit training has been provided to the MSDT, who now also have monthly 1-1 meetings with the Assistant Director of Quality and Patient Safety.

The Health Board does not provide clinical audit training to the wider Health Board, other than that required as part of the Foundation and SAS teaching programme.

Current Status of Implementation: Partially Implemented

Conclusion	Priority Level
Progress has been made on clinical audit training delivered to the MDST. However, further work is required to ensure clinical audit training is available upon request to the wider Health Board. See Appendix B for the management action plan.	**Low**

Details of the previous recommendations and our current findings are included in Appendix A. This appendix details the current recommendations and management responses only.

Recommendation 1 Quality & Patient Safety Assurance Framework (Design)	Risk of not implementing	Priority level
1.1 The Health Board should develop a Quality & Patient Safety Improvement Strategy and Assurance Framework, based upon a review of its approach to clinical audit and other QPS assurance mechanisms. This should incorporate an assurance mapping exercise against the organisation's quality and patient safety risk registers, focusing on major clinical risks. Such a Strategy and Framework should bring together the quality and patient safety improvement work undertaken throughout the Health Board, including clinical audit, ABC*i*, Value Based Healthcare, etc, and explicitly cover: • the Health Board's approach to quality and patient safety improvement; • how this work addresses the Health Board's major QPS risks; • the governance and accountability structures within the organisation that support the delivery of the work; and • the reporting mechanisms to bring this work together to form an overview of QPS improvement work and the assurance it provides to the organisation; • how quality improvement activities comply with information governance legislation; and • how service users are involved and engaged in quality improvement activity. The Strategy and Framework should either make reference to, or incorporate, the existing strategies for individual elements of quality and patient safety improvement work ongoing throughout the Health Board. 1.2 The QPSC should formally approve the Quality & Patient Safety Improvement Strategy and Assurance Framework and all staff should be made aware of it. 1.3 Once this exercise has been completed, the Health Board will be able to assess the level of clinical audit required by the organisation (over and above participation in the NCAOR) and the level of resource needed to support this, including ensuring that clinical audit receives adequate coverage at QPSOG/QPSC meetings in the absence of the Assistant Director of QPS.	QPS Improvement work may not be efficient or effective in addressing major QPS risks. Quality and patient safety may be put at risk.	**High**

Management action plan

Management Response 1	Responsible Officer/ Deadline
A Quality Improvement Leaders Group will be set up, with the leaders of ABCi, Value based healthcare, clinical audit and R and D and innovation, to seek to develop a new way of using clinical information for improvement and from this, a Quality and Patient Safety Improvement Strategy and Assurance Framework. It will incoprporate a review of known clinical risks and those on the patient safety risk registers, focussing on major clinical risks. From this, the Executive Team will assess the level of clinical audit required by the organisation and the resource needed to support this, in order to undertake the Health Board wide audit above and beyond the NCAORP, ensuring that the clinical audit activity is effective in bringing about improvement. The Medical Education Team will be charged with randomly selecting 100 non-identifiable Consultant re-validation quality improvement domains, to identify the volume and subject of the audit activity in a year. This will be mapped against the broad areas where clinical risk has been identified, not withstanding large scale work undertaken via other QPS improvement mechanisms.	Medical Director Group set up – April 2019 Initial Output from the Group – September 2019 Strategy and Assurance Framework – Dec 19 Review of level of clinical audit – March 2020. Review of Consultant revalidation QI domains - Sept 2019 Mapping against risk – Nov 2019

Recommendation 2 Clinical Audit Framework (Design)	Risk of not implementing	Priority level
The Health Board is required to participate in a certain level of clinical audit, as noted in section 6. Therefore, it is necessary to have appropriate governance and reporting structures in place to support this. We have set out our recommendations to improve the current structures for national and Health Board wide clinical audit below. 2.1 The Clinical Audit Strategy and Policy should be updated to incorporate the recommendations of this review. The QPSC should formally approve the Clinical Audit Strategy and Policy. 2.2 The MDST should ensure that relevant staff are aware of, and adhere to, the requirements of the Strategy and Policy. 2.3 The MDST should bring together the top two tiers of the clinical audit plan (national and Health Board wide) into one document, 'the Clinical Audit Programme'. The Clinical Audit Programme should explicitly state which QPS risks it addresses and should be formally approved by the QPSC. 2.4 Governance mechanisms should be sufficient for the QPSC to regularly monitor delivery of the Clinical Audit Programme. This could be in the form of an overall summary within the QPS report that is currently written and presented by the Assistant Director of QPS. The summary could be in a narrative or dashboard style. See also recommendation 3.3. 2.5 There should be a clearly defined and documented mechanism for the dissemination of results and recommendations throughout the Health Board and the escalation of significant findings to the appropriate forums. Escalation of results could be done via the above suggested mechanism for monitoring delivery of the programme. At a minimum, the QPSC should be made aware of significant matters arising from clinical audit work. 2.6 The Health Board needs a mechanism to provide assurance that action to implement recommendations is being undertaken on a timely basis, for example through follow-up audits or by reporting progress to the QPSOG and/or QPSC. **National Clinical Audits** 2.7 The MDST should create, and report progress against, clear action plans for addressing: • the NCAs the Health Board is not currently participating in; and	The Health Board may not be maximising the potential impact of clinical audit. Clinical audit work may not be efficient or effective in addressing major QPS risks. Clinical audit work may not be of suitable quality. Quality and patient safety may be put at risk.	**High**

• the NCAs where there is a backlog of data entry. **Training** 2.8 Clinical audit training should be available upon request for relevant staff within the divisions. This could be achieved through e-learning, one-to-one support or via the directorate QPS meetings.	
Management Response 2	**Responsible Officer/ Deadline**
2.1-2.6. The Clinical Audit Strategy and Policy will be updated to include the outputs from the recommendations from this review once the process has been completed. This will be approved at Exec Board and QPSC and communicated across the organisation, through dissemination to the Clinical Directors. The MDST will bring together the NCA and health board wide audit into a clinical audit for improvement programme, through discussion at QPS Operational Group. It will be approved at QPSC. Set up a Clinical Effectiveness and Standards Group ('CESG'), chaired by the AMD for Clinical Effectiveness and with ADD representation from all Divisions, which will monitor the delivery of the Clinical Audit for Improvement Programme and monitor the implementation of recommendations. It will receive the results of the NCAs and Health Board Audits and determine which require escalation and reporting to QPSC. 2.7. The MDST wil develop over a number of meetings, a report on participation in NCAs within the Quality Performance Report for QPSC. 2.8.One to one support on clinical audit is always available to staff through the MDST. The training resources available will be clarified on the Clinical Audit Intranet page.	Assistant Director – QPS Update Clinical Audit Strategy and Policy, approve and communicate – June 2020 Clinical audit plan agreed at QPSC – Sept 2019 Medical Director CESG set up - June 2019 Assistant Director – QPS Initial Report QPSC – June 2019 Section on CA training on the intranet – June 2019

Recommendation 3 Divisional Clinical Audit (Design)	Risk of not implementing	Priority level
The Clinical Audit Policy states that the Divisional Directors "are responsible for maintaining the overview of local clinical audits within the Directorates, to ensure they comply with the Policy". However, there is no mechanism for holding the divisions to account in this process. We have set out our recommendations to ensure appropriate accountability in the divisional clinical audit process below. 3.1 The divisions should produce an annual workplan of assurance against their major clinical risks, including, but not limited to, clinical audit. 3.2 The divisions should provide a clinical assurance report to each QPSOG meeting, detailing the assurance work undertaken against the annual workplan. The reports should also highlight any significant issues arising from the assurance work and detail the action being taken to address these issues. 3.3 A high level summary of the clinical assurance reports should be included in the QPS report (see recommendation 2.4). 3.4 The Health Board's Clinical Audit Registration Form and Checklist should be updated to: • include consideration as to whether clinical audit is the most appropriate quality improvement methodology for a specific area/matter; and • clarify that clinical audit should not be used if another quality improvement methodology is more appropriate. Divisional management should ensure that the Clinical Audit Registration Form and Checklist are used for all divisional clinical audits.	The Health Board may not be maximising the potential impact of clinical audit. Clinical audit work may not be efficient or effective in addressing major QPS risks. Clinical audit work may not be of suitable quality. Quality and patient safety may be put at risk.	**High**
Management Response 3	**Responsible Officer/ Deadline**	
3.1-3.3.Whilst the Divisions will produce and present annual workplans of assurance against their major clinical risks, and significant issues arising from the work plan, alignment of these risks to clinical audit for improvement will be highlighted within the work plans. These will be presented	Medical Director Presentation to CESG from Nov 19 Summary to QPSC from Sept 2020	

to the CESG, and this will be summarised in an annual over view of Clinical audit to QPSC every September from 2020. 3.4 The clinical audit registration form and checklist will be updated and be available on the Clinical Audit intranet site.	Assistant Director – Quality and Patient Safety – June 2019

HQIP Best Practice in Clinical Audit: prerequisites to maximise the impact of clinical audit

In its 2016 Best Practice in Clinical Audit document, HQIP identifies the following prerequisites to maximise the impact of clinical audit:

	HQIP clinical audit best practice criteria	Link to management action plan (Appendix B)
1	Clinical audit is a quality improvement activity and therefore it functions best as part of a planned programme of quality improvement that has been approved by the Board and/or senior management of the organisation.	Recommendations 1, 2 and 3
2	The Board should have dedicated time set aside to review both the clinical audit programme and the outcomes of individual projects.	Recommendation 2
3	An effective clinical audit programme will cover the requirements and needs of a number of stakeholders including the Board, clinicians, service users and commissioning bodies. The programme should be developed in accordance with clear policy and agreed following consultation with clinicians, managers and patient representatives.	Recommendations 1, 2 and 3
	The programme should be closely monitored and progress reported regularly at Board and service delivery level.	Recommendation 2 and 3
	An annual report, linked where appropriate to the Trust quality account, should be presented to both the Board and patient groups for scrutiny before publication.	Recommendation 2
4	Service user and public involvement in clinical audit should be embedded in the organisation's public engagement strategy. The clinical audit programme should include patient-focused projects, and the roles played by service users and lay representatives should be acknowledged in clinical audit reporting at all levels.	Recommendation 1

	HQIP clinical audit best practice criteria	Link to management action plan (Appendix B)
5	In deciding which clinical audits should be undertaken, the following factors should be considered: • clinical priorities, including clinical risks, adverse incidents and patient safety; • organisational priorities, including service redesign and development; • patient and service user priorities; • commissioner priorities and specifications; • the outputs from the National Clinical Audit and Patient Outcomes Programme (NCAPOP) and other national clinical audits; and • professional revalidation, appraisal and training needs.	Recommendation 2 and 3
6	Clinical audit is only one of a range of quality improvement methodologies and should not be used if another is more appropriate.	Recommendations 1, 2 and 3
7	Organisations must have governance arrangements in place to ensure that clinical audits are planned, prioritised, undertaken and reported in a way that maximises the benefit of the audit to the organisation. The findings from clinical audits may be used as part of the Board Assurance Framework, but full assurance can only be obtained if the quality improvement aims of the project have been achieved. Governance plans should include arrangements for participation in local and regional cross-organisational audits.	Recommendation 2 and 3
8	Policies and procedures must be in place to ensure that clinical audits (and all other quality improvement activities) are undertaken in a way that complies fully with current information governance legislation and guidance, and in consultation with local information governance leads and Caldicott guardians.	Recommendation 1
9	All staff within an organisation should be made aware of, and comply with, the governance arrangements in place, including local policy and protocols on proposing, registering, undertaking and reporting on clinical audits.	Recommendations 1, 2 and 3

	HQIP clinical audit best practice criteria	Link to management action plan (Appendix B)
10	The organisation must enable the conduct of good quality clinical audit by providing appropriate resources to support the process. This includes dedicated time for audit and an appropriate level of funding. Organisations should have in place: • a senior clinician able to lead on clinical audit across the whole organisation; • clinical leads for quality improvement at service delivery level; • clinical audit practitioners who can manage the audit programme and support the process; and • a programme for supporting doctors in training to ensure that the clinical audit and quality improvement activities they undertake as part of their training deliver benefits to the organisation.	Recommendation 1
11	The organisation should seek to improve the knowledge and skills of all staff in quality improvement. Training in clinical audit should be available for all staff and where appropriate for lay representatives. All staff should be encouraged to participate in clinical and other networks that provide knowledge sharing and opportunities for staff development.	Recommendation 2

The full HQIP Best Practice in Clinical Audit document can be found at https://www.hqip.org.uk/wp-content/uploads/2016/10/HQIP-Guide-for-Best-Practice-in-Clinical-Audit.pdf.

Audit Assurance Ratings

 **Substantial assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

Follow up - All recommendations implemented and operating as expected.

 **Reasonable assurance** - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

Follow up - All high level recommendations implemented and progress on the medium and low level recommendations.

 **Limited assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

Follow up - No high level recommendations implemented but progress on a majority of the medium and low recommendations.

 **No Assurance** - The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved

Follow up - No action taken to implement recommendations.

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

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

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

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Audit

The audit was undertaken using a risk-based auditing methodology. An evaluation was undertaken in relation to priority areas established after discussion and agreement with the Health Board. Following interviews with relevant personnel and a review of key documents, files and computer data, an evaluation was made against applicable policies procedures and regulatory requirements and guidance as appropriate.

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems. These include the possibility of poor judgement in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Where a control objective has not been achieved, or where it is viewed that improvements to the current internal control systems can be attained, recommendations have been made that if implemented, should ensure that the control objectives are realised/ strengthened in future.

A basic aim is to provide proactive advice, identifying good practice and any systems weaknesses for management consideration.

Responsibilities

Responsibilities of management and internal auditors:

It is management's responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and detection of irregularities and fraud. Internal audit work should not be seen as a substitute for management's responsibilities for the design and operation of these systems.

We plan our work so that we have a reasonable expectation of detecting significant control weaknesses and, if detected, we may carry out additional work directed towards identification of fraud or other irregularities. However, internal audit procedures alone, even when carried out with due professional care, cannot ensure fraud will be detected. The organisation's Local Counter Fraud Officer should provide support for these processes.

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GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Audit Committee 3rd April 2019 Agenda Item: 6.1

Audit Committee

Update on Governance, Financial Control Procedures, Technical Accounting Issues and Single Tender Actions.

Executive Summary

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

- Governance Issues including standing orders, SFIs and financial control procedures
- Technical accounting issues
- Public Sector Payment Policy compliance
- Single Tender Actions
- Payments Exceeding £100K

The Audit Committee is requested to note this report.

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

Executive Sponsor: Glyn Jones, Director of Finance and Performance

Report Author: Mark Ross, Assistant Director of Finance

Report Received consideration and supported by :

Executive Team		**Committee of the Board [Committee Name]**	

Date of the Report: 22nd March 2019

Supplementary Papers Attached:

Appendix 1 – Single Tender Actions

Appendix 2 – Scheme of Delegation

Purpose of the Report

This report gives the Audit Committee an update in relation to a number of standing items which are reviewed in line with the committee's terms of reference and work plan.

Background and Context

This is a standard report.

Assessment and Conclusion

1. Review of Standing Orders, SFIs and Scheme of Delegation.

There are no proposed changes to update in relation to the Standing Orders and SFIs, however, some minor changes have been made to the Scheme of Delegation, largely to explicitly refer to the limit for Welsh Government approval in table 1 on the first page and reflect some organisational changes - in particular the new roles of Director of Operations and Director of Primary Care, Community and Mental Health.

Appendix 1 contains the revised document.

2. Financial Control Procedures (FCPs)

A number of policies are currently under review as follows:

- Stores and Stock
- Budgetary Control (FCP)
- Capital Assets and Charges
- Capital Procedures & Guidance Notes

Work is on-going with regard to these procedures and it is anticipated that all of the procedures
will be on the agenda for approval at the July committee.

The Recovery of Overpayments to Employees has been finalised and is included as item 7 on the agenda.

3. Technical Accounting Issues

In preparation for 2018/19 accounts this section reviews the main accounting policies of the Health Board in line with the Committee's work plan.

Accounting policies are determined from international financial reporting standards (IFRS) that cover all areas of accounting. WG issue a 'Local Health Board's Manual for Accounts' annually which has specific guidance that is formulated in turn from HM Treasury guidance and is compliant with IFRS. When specific issues of accounting arise reference to relevant accounting standards is made and interpretation formulated and discussed with external auditors.

3.1 New Accounting Policies

-IFRS 9 Financial Instruments
-IFRS16 Leases

An update was provided to the Audit Committee in January regarding the adoption and implementation of both of these IFRS'.

-IFRS15 Revenue from Contracts with Customers

This is a new financial reporting standard that is being implemented in 2018/19. It introduces a new five stage model for the recognition of revenue from contracts with customers to

- Remove inconsistencies and weakness
- Provide a more robust framework for addressing revenue issues
- Improve comparability of revenue recognition practices across entities
- Provide more useful information to users of financial statements re improved disclosure
- Simplify the preparation of financial statements.

The All Wales Technical Accounting Group adopted an all Wales approach with regard to the implementation of IFRS15. A review consistent with the portfolio approach was undertaken by the Technical Accounting Group members, which

- identified that the only material income that would potentially require adjustment under IFRS 15 was that for patient care provided under Long term Agreements (LTAs) for episodes of care which had started but not concluded as at the end of the financial period;
- demonstrated that the potential amendments to NHS Wales NHS Trust and Local Health Board Accounts as a result of the adoption of IFRS 15 are significantly below materiality levels

Under the Conceptual IFRS Framework due consideration must be given to the users of the accounts and the cost restraint of compliance and reporting and production of financial reporting. Given the income for LTA activity is recognised in accordance with established NHS Terms and Conditions affecting multiple parties across NHS Wales it was considered reasonable to continue recognising in accordance with those established terms on the basis that this provides information that is relevant to the user and to do so does not result in a material misstatement of the figures reported.

Having reviewed the standard, and based on materiality, all health bodies in Wales will continue to use the current methodology of income recognition.

3.2 Key Dates for Annual Accounts 2018/19 (incorporating the Annual Governance Statement) and Annual Public Disclosure Statements

The main deadlines, proposed Audit Committee review and Board approval dates are shown in the following table:

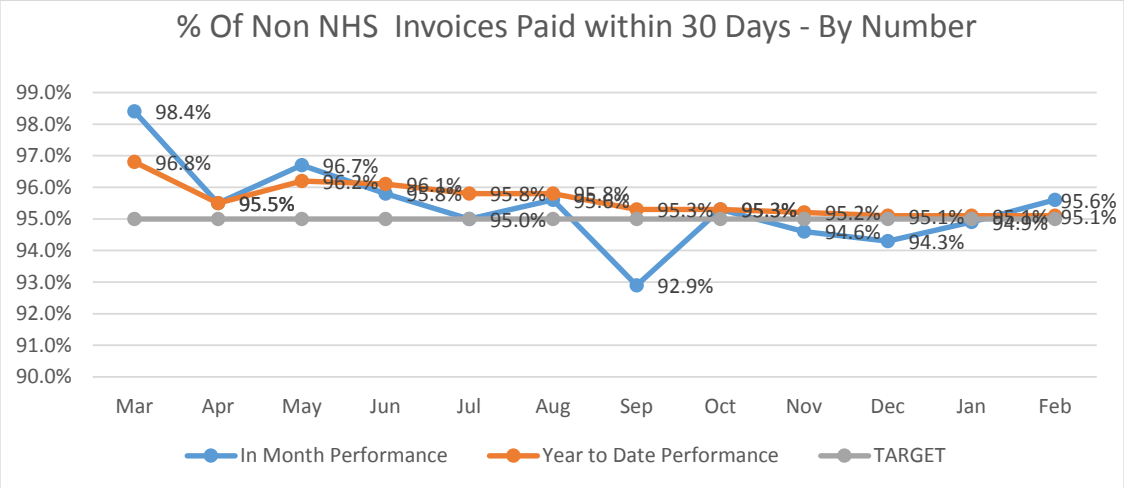
Annual Accounts 2018/19 - Key Dates	**2019**	
Draft Accounts Submission to WG	Fri	26-Apr
Draft Accounts & Report to Audit Committee Members	Fri	03-May
Audit Committee meeting to Consider Draft Accounts	Thu	09-May
Final Accounts & Report to Audit Committee Members	Fri	24-May
Audit Committee meeting to Consider Final Accounts	Tue	28-May
Board meeting to approve Final Accounts	Thu	30-May
Final Accounts Deadline for Submission	Fri	31-May

The Audit Committee is asked to note the dates for review of draft and final accounts.

4. Public Sector Payment Policy

The following table shows the Public Sector Payment Policy performance over the last 12 months on a monthly and year to date basis to February 2019. The target of 95% has been achieved on a year to date basis although the in-month performance has dropped below 95% for most of the second half of the year.

The main issue causing the dip in both November and December was related to processing of pharmacy invoices. Pharmacy ordering and payment authorisation is managed through the pharmacy department and there have been delays in processing these resulting in a drop in compliance. The department have recently appointed additional posts to help deliver improved compliance with the 30 day target. There has been a small improvement but this is still an area of concern going into the new year and will be kept under review.



5. Single Quotation and Tender Actions – January 2019 to March 2019

It is a requirement of Aneurin Bevan University Health Board Standing Financial Instructions that all requests for a Single Tender Action or a Single Quotation action are submitted to the Chief Executive for approval and also reported to the Audit Committee.

The Audit Committee should note the detail of the attached table (Appendix 2) and monitor the number and value of business that is 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 26 requests submitted which have been approved during the period with an annual value of £834K.

Of these 26 approved requests, 13 were classified as either licensing or maintenance/ service type arrangements, the scope of which could cover the on-going servicing / support of medical equipment, ICT Hardware/Software or general licensing. The other 13 were purchases of new/replacement equipment through the capital project.

6. Post Payment Verification

The annual report is on the agenda for this meeting and key areas/findings will be discussed as part of the report presentation which is item 4 on the agenda.

7. Payments In Excess of £100K

The Committee requested that, rather than a separate report, this item would be covered by exception.

The Health Board has made 100 payments in excess of £100,000 during the months of December 2018, January & November 2019, totalling £166.1m. 68 of the payments were regular and specifically identified within the scheme of delegation. 32 other payments were identified as requiring additional approvals prior to payment. Contracts were in place for all 33 payments made to private sector suppliers. Therefore there were no exceptional issues to report.

Recommendation

The Audit Committee is requested to note the contents of this report.

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

Aneurin Bevan University Health Board

Scheme of Delegation

The Scheme of Delegation, in line with the Health Board's Standing Orders and Standing Financial Instructions provides a framework of appropriate arrangements for certain functions to be carried out and financial approvals to be made on behalf of the Board by designated Committees or Officers within the organisation. The Scheme of Delegation is designed to enable the day to day business of the Health Board to be carried out effectively, and in a manner that secures the achievement of the organisation's aims and objectives. It also reflects the general consent required from Welsh Ministers for individual contracts and agreements over to the value of £1m in each case.

For further advice on the Scheme of Delegation, please contact Richard Bevan, Board Secretary on 01633 435938 or via e-mail at richard.bevan@wales.nhs.uk

General Delegated Financial Approval Limits:

Table 1

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

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

Specific Approval Limits:

The following provides specific provisions for delegation to identified roles within the Health Board structure, where regular payments exceed approval limits in Table 1 above:

Table 2

Company	Description	Approver
Abbott Laboratories Ltd	Pathology biochemistry managed service contract for analysers and consumables.	Pathology Directorate Manager
Baywater Healthcare Ltd formerly Air Products Ltd.	Home oxygen supplies	Director of Operations
Department for Energy & Climate Change (DECC)	Annual Purchase of Carbon Reduction allowances.	Divisional Director of Facilities
Fujifilm UK Ltd	PACS managed service contract	Radiology Directorate Manager
Honeywell Control Systems Ltd	Energy PFI Contract	Divisional Director of Facilities
Kintra	Chepstow PFI	Divisional Director of Facilities
Local Authorities	Section 28a agreements	Divisional Director of Primary Care and Community Services
Local Authorities	Payment to Local Authorities for their Share of Integrated Care Funding.	Chief Executive
NHS Dental Services	Reimbursement to NHS Dental Services of the payments they have made to Dental Contractors on behalf of ABUHB	Assistant Director of Finance (Financial Systems and Services)
Monmouth Facilities Ltd.	Monnow Vale PFI	Divisional Director of Primary Care and Community Services

Utilities	Invoices for gas, electricity, rates and water.	Divisional Director of Facilities
SLA's agreements with NHS bodies		Relevant Divisional Director
LTA Agreements with NHS Bodies		Chief Executive
Velindre NHS Trust (NWSSP)	Invoices for stock issued from NWSSP stores for ABUHB	Director of Operations
Velindre NHS Trust (NWSSP)	Annual Charge for Oracle Finance and iProcurement System	Assistant Director of Finance (Financial Systems and Services)
Velindre NHS Trust (NWSSP)	Annual Charge for the procurement and maintenance of GPICT systems for GP practices.	Chief Executive

Government Bodies & Private Contractors	**Description**	**Approver**
HM Revenue & Customs	PAYE and NI	Payroll Services (NWSSP)
Various charities and trades unions	Union & other deductions	Corporate Finance
HM Revenue & Customs	Superannuation	Payroll Services (NWSSP)
General Practitioners, Opticians and Pharmacists	Payments made over to private contractors under Primary Care	Contractor Services (NWSSP)

LOSSES & SPECIAL PAYMENTS

Table 3

Losses & Special Payments:

	Clinical Negligence/Personal Injury		Redress	
	Settlements	**Legal Fees**	**Settlements**	**Legal Fees**
>£1,000,000	Welsh Government	Welsh Government	N/A	N/A
>£100,000<£1,000,000	Board	Board	N/A	N/A
>£25,000<£100,000	CEO	CEO	CEO	N/A
>£10,000<£25,000	Senior Manager Legal Services	Senior Manager Legal Services	Senior Manager Legal Services	Senior Manager Legal Services
<£10,000	Senior Manager Legal Services	Claims Manager	Senior Manager Legal Services	Claims Manager

Ombudsman Claims	Per normal Scheme of Delegation approval limits.

Special Payments	Per normal Scheme of Delegation approval limits.

Capital Scheme of Delegation

(i) Capital Project Approval Limits

Table 4

Value of proposal	Documentation required	Scrutiny	Approval
Less than £75,000	Project Proposal Document	Head of Capital Planning /Head of Capital Finance	Director of Planning, Digital and IT
£75,000-£500,000	Project Proposal Document for low risk items such as replacement equipment/ICT or Business Justification Case depending on complexity of proposal	Capital Group, Pre-Investment Panel (if appropriate), Executive Team	Chief Executive and Chair (Deputy Chief Executive/ Vice Chair in their absence)
£500,000 - £1,000,000	Business Justification Case	Capital Group, Pre-Investment Panel (if appropriate), Executive Team	Board
Over £1,000,000	Scoping Document to be agreed with WG prior to development of Business Justification Case following Welsh Government requirements	Capital Group, Pre-Investment Panel (if appropriate), Executive Team	Board Welsh Government

(ii) Approving Expenditure against Approved Capital Contracts

The previous table shows the process for approving capital projects, whereas this section shows the approval process for payments, where projects have:

- been authorised to proceed;
- the contract has been approved;
- the contract has been let.

The authorisation of expenditure against those contracts will differ depending on whether or not the project is:

(a) An all-Wales Capital Programme Project
(b) The Grange University Hospital Project
(c) Other Capital Projects (Discretionary Programme)

(a) All-Wales Capital Programme Projects

Where schemes are part of the all-Wales procurement framework, in order for them to accommodate the processing of payments in a timely manner and to comply with the contractual obligations for these major construction contracts, the following process is to be applied where payments exceeding £100K are delegated to the Director of Planning, Digital and IT for approval:

- The External Cost Advisor (Quantity Surveyor representing the Health Board) shall advise the Health Board that a stage payment to the Supply Chain Partner (SCP) can be made and of the amount.

- The Project Director will have authority to approve payments of less than £50K.

- The Director of Planning, Digital and IT will have delegated authority to approve any payments exceeding £50K.

(b) The Grange University Hospital Project

Where the scheme is part the Grange University Hospital capital project it is proposed that the following delegations and process apply to ensure tight contractual payment terms are met:

1. The Director of Planning, Digital and IT will have delegated authority to approve annual expenditure commitments by approving a Purchase Order equal in value to the Welsh Government and Board approved capital budget for the financial year.

2. The External Cost Advisor (Quantity Surveyor representing the Health Board) shall advise the Health Board that a stage payment to the Supply Chain Partner (SCP) can be made and of the amount.

3. The Project Director, based on the advice of the External Cost Advisor, will have authority to approve payments not exceeding the value advised by the External Cost Advisor, provided it falls within the total approved budget for the financial year. The payment approval must be counted against the approved Purchase Order referred to in (1) above.

4. The Capital Group, chaired by the Director of Planning, Digital and IT, will formally review project payments against the approved budget and outturn forecast on a monthly basis in a report provided by the Head of Capital Finance. This report should also be periodically provided to the Board. Any variance to the forecast outturn and approved budget will require additional approvals in line with the normal scheme of delegation shown in Table 1.

(c) Discretionary Capital Schemes

Where projects with an expected value of less than £1M have been authorised to proceed and the contract has been approved and let, then the authorisation of expenditure against those contracts is as follows:

- Nominated project manager to certify stage payments where approvals are within delegated limits set out in Table 1 above. If approvals exceed limits the normal approval hierarchy must be followed.

Appendix 2 - Summary of Single Tender/Quotation Actions

Date of Request	Type of Request	Reference No	Description	Anticipated Annual Value (ex VAT)	Supplier	Type	Reason for request	Advice from Procurement	Approved / Rejected	CEO Approval Date
21/12/2018	Single Quotation	300	Integrated Autism Service	£16,000.00	Beca Jones	Services	Beca was previously working on a pilot project within PCMHSS for ABUHB to adapt the "road to wellbeing" theoretical approach underpinned by "acceptance commitment therapy approach" and is expert in the use of these materials. Beca has experience working with autistic adults and has previously undertaken a similar role within the health board. Beca has previously adapted the theoretical approach that is being used and also has previous experience of up-skilling ABUHB support staff. She is experienced in delivering group work and has specialised knowledge that links to the piece of work that is being undertaken so it would be impractical to use an external supplier. Beca is the only person who will be able to deliver this project within the timeframes required as she has already undertaken the necessary research, development of materials and our project will be underpinned by the evaluation of her pervious work. Otherwise the project will have been longer in duration, costing more.	Required for compatibility & cost reasons	Yes	08/01/2019
02/01/2019	Single Quotation	301	Mortuary Large Body Box	£5,790.00	Beechwood Refridgeration	Goods	The body store refrigerated unit affected by this breakdown is the only unit that can freeze deceased individuals down to -20 Deg C essential for any long storage if and when required. The unit is also the biggest bariatric unit the mortuary has, making it essential that it remains in service, particularly now that we are entering our period of winter pressures which, in recent years, has extended into March / April the following year. All the refrigerated body store fridges in the RGH Mortuary are maintained by Beechwood Refrigeration and Air Conditioning Ltd who are one of the Health Board's approved suppliers and local to our region.	Required for urgency of department & standarisation of equipment	Yes	07/01/2019
17/01/2019	Single Quotation	304	software upgrade to security system	£11,516.15	Trinity	Software	Guard Point Pro are the software developers and release upgrade versions. This version allows Windows 10 operation which is standard for the new Grange hospital.The whole Health Board is being upgraded to Windows 10 operating system.	Required to maintain the same computer software between existing Health Board units and the Grange hospital	Yes	30/01/2019
29/01/2019	Single Quotation	306	Consultancy Support for WBFGA	£19,305.00	JBPS Advisory Solutions Limited	Services	The self-assessment process which forms part of the Well-being of Future Generations Act (WbFGA) embedding programme is a bespoke process developed specifically by the existing Consultant for ABUHB. No other Consultant has the insight and understanding about how the self-assessment process works, and to our knowledge there is no other Consultant that has the expertise on how the WbFGA is applied to a Health Board context. The existing specialist Consultant has built up strong working relationships and credibility with the Divisional leads and the WbFGA Programme Board which underpin the progress made to date.	SQA is an appropriate course of action	Yes	31/01/2019
30/01/2019	Single Quotation	307	Constitution Institute	£6,500.00	Constitution Institue	Services	The consultation Institute is a not for profit organisation which has been setting the standards for best practice in public engagement for the past fifteen years. It is a well established organisation that has delivered accredited training to over 300 local authorities, the vast majority of the NHS, and a wide range of other public bodies. TCI has experience of the Welsh projects as part of the Health Boards existing membership with them. Bevan University Health Board is a member of the institute and can access its training at reduced cost.	SQA appropriate action for cost reasor	Yes	13/02/2019
07/02/2019	Single Quotation	310	MECC Consultancy and Training	£15,000.00	Worth Consulting	Services	1 To plan and deliver 13 x 3.5 hour Making Every Contact Count Level 2 training sessions to ABUHB staff with a maximum of 30 | staff attending each session. 2. To plan and deliver 2 x 1.5 days Making Every Contact Count Train the Trainer (TtT) sessions to ABUHB staff with a maximum of 10 staff attending each session. 3. To store and manage all training resources. Resources include up to: 1000x training brochures, 1000x folders, 1000x AS BMI charts, 1000x A5 AUDIT-C Cards, 1000x A5 Motivational Inten.'iew Skills Cards and 1000x A5 Scales Cards 4. To make all necessary preparations including resources for training sesslons (please do not quote for printing costs as resources will be provided). This includes compiling the required number of training packs for each session. prlnting attendance sheets and evaluation sheets. and when necessary TtT workbooks. 5. To ensure completion of the evaluation forms (pre & post evaluation forms) before and following the delivery of each MECC training session 6. To feedback suggestions and recommendations for improving the Making Every Contact Count (MECC) training based on trainer feedback forms 7. To draft a final report including recommendations for improvement by the end of commission. 8. To return documentation to the public health team in a timely fashion.	SQA is an appropriate course of action	Yes	15/02/2019

19/02/2019	Single Quotation	314	Excess Treatment Cost Application Form - for CamPROBE Study	£18,396.00	BK Ultrasound & NPL Medical	Goods	This transducer probe is to be purchase in order for us to take part in the CamPROBE prostate biopsy clinical trial developing a safer and simple device for local anaesthetic transperineal prostate biopies. This is equipment recommended by the study sponsor, Cambridge University Hospitals NHS Foundation Trust and University of Cambridge.	SQA is an appropriate course of action	Yes	06/03/2019
26/02/2019	Single Quotation	316	Affect repairs following failire of compnent on refrigeration system	£13,444.80	Total Cooling Services	Services	The unit serves main delivery unit inclusive of the two operating theatres and provides cooling for these unit. Both units cannot tolerate elevated temperatures which could result in risk to life.	SQA is an appropriate course of action	Yes	26/02/2019
20/02/2019	Single Quotation	317	Car Park Planning - County Hospital	£8,428.00	Asbri Planning Ltd	Services	Planning, application, preparation & submission for car park County Hospital	Requirement for futher works to be ca	Yes	04/03/2019
05/03/2019	Single Quotation	321	Micromed Remote Review	£6,000.00	Micromed	Services	Only this supplier which can provide. Currently we have to rely upon C&V consultants visiting which results in delays for treatment and diagnosis	Only one supplier in the marekt - avo	Yes	05/03/2019
06/03/2019	Single Quotation	322	Blinds & Curtains	£22,500.00	Gemini Blinds Gwent	Goods	Spend has increased significantly due to end of year capital spend. As a result this area has been highlighted as an area needing to be tendered in April/May and the procurement team is awaiting a specification from the minor works team.	Appropriate as a one off - full tender t	Yes	06/03/2019
06/03/2019	Single Quotation	323	Purchase of 4 DR/VR Kits for Virtual Reality Distraction Therapy	£12,000.00	Rescape Innovation Ltd.	Goods	We could separately purchase each individual component of equipment supplied in the case, but this would result in an equivalent unit cost of £4,900 + VAT without adding the cost of the VR programs and carry case. This calculates to a minimum saving of £2000 per kit purchasing through Rescape Innovation Ltd. This analysis identified that purchasing through Rescape Innovation Ltd. offered the most cost effective direct costs solution. Additionally, the purchase price giving us 12 months of equipment usage with full technical support offers three additional benefits:	STA Appropriate for cost reasons as ou	Yes	06/03/2019
19/01/2019	Single Tender	278	Fibroscan	£78,735.00	Echosen	Goods	Echosens are the only suppliers of the portable mini. To purchase from another supplier would mean purchasing a very large ultra sound scanner which is not a portable device.	STA appropriate due to most suitable device for needs and very limited market for the mini product	Yes	13/02/2019
21/01/2019	Single Tender	296	Robins Volunteer Service	£32,000.00	Age Cymru Gwent	Services	Age Cymru Gwent have 10 years of experience and very well established relationships within the Health Board. The Robins service is featured regularly within the local press and at community events and has a proven track record of effective volunteer recruitment. The Robins service successfully retains motivated volunteers; they have a significant core of long-standing volunteers who value their role and feel valued by the Health Board and Age Cymru Gwent. The Robins service is recognised as a volunteer service of excellence within the Health Board, at Board Level, within Welsh Health Boards end Trusts and at the Welsh Government. It is strongly recommended that the partnership with Age Cymru Gwent continues and expands.	STA appropriate due to previous experiences and lack of suitable alternative suppliers	Yes	04/02/2019
12/12/2019	Single Tender	300	Kowa Camera	£27,990.00	Sence Medical	Goods	This is a replacement of an existing system with a large installation base with the same manufacturer's brand. This is the only manufacturer that gives a simultaneous 3D stereo camera. Agreed competitive fixed price since 2013 when original contract awarded.	STA appropriate due to only manufacturer of required equipment & agreed better pricing	Yes	17/01/2019
14/12/2019	Single Tender	301	Getinge Laser Marker	£44,348.40	Getinge	Goods	Only marking solutions on the market that offers both instrument and tag marking. • Unique marking technology that bonds a compound to the surface rather than penetrating passive layer of instrument i.e. does not damage instrument Getinge Marking solution is not laser etching Getinge Marking solution is not dot peen It's the only marking solution on the market that is a CSI Compliant Certified Solution — we have partnered with GSI UK and are accredited by them to produce GSI datamatrix barcodes Vendor neutral — can be used with your existing traceability system Solution is "portable" Getinge are the only suppliers Of the tray tags used with the solution	STA appropriate due to only manufacturer of required equipment - SMTL have also tested this for quality	Yes	07/01/2019
08/01/2019	Single Tender	306	Lymph Node Probe	£23,000.00	DEVICOR MEDICAL UK LTD	Goods	The current probes are beyond repair and the supplier is no longer able to provide replacements	This is essential equipment for positive patient outcomes - STA process utilised due to urgent nature of patient requirements	Yes	30/01/2019
09/01/2019	Single Tender	307	Exercise testing equipment	£45,000.00	Medical Graphics UK	Goods	The Directorate is keen to purchase the CPET machine from Medical Graphics UK Limited as this equipment is used in neighbouring Health Boards and will provide familiarity for the CPET team and trainees on the Welsh rotation. Using the same kit will also provide consistency with regard to investigations undertaken and results and ensure robust quality control.	Appropriate for consistency across NHS Wales and also overall value	Yes	21/01/2019
24/12/2019	Single Tender	308	South East Wales Shared Lives Scheme	£138,329.20	Caerphilly County Council	Services	Only provider of the South East Wales Shared Lives Scheme	Only provider for service	Yes	25/02/2019
20/01/2019	Single Tender	309	Washer Reprocessor	£32,850.00	PFE Medical Ltd	Goods	Only supplier of UV decontamination system. The exising methods used are being changed due to the requirement for use of peracetic acid.	Only supplier that can provide the system - Process reduces risk to patients	Yes	30/01/2019

10/01/2019	Single Tender	310	Q-Pulse	£34,200.00	Ideagen Gael Limited	Software	The Health Board has seen the Q-Pulse set up working in Pathology and Radiology at ABUHB and also in R&D and Clinical Trials in Cardiff and Vale. We are confident the package will meet the regulatory needs for ABUHB as Clinical Trial activity expands.	Appropriate as already aware of suitablity - STA allows the rapid expansion of clinical trials	Yes	17/01/2019
05/02/2019	Single Tender	314	Multi-Header Microscope	£18,556.00	Nikon UK Ltd	Goods	The current Multi-header microscope is a Nikon product and therefore only Nikon can provide the additional heads required via extension of the current set-up.	STA appropriate for standardisation - Nikon are the original equipment manufacturer (OEM)	Yes	20/02/2019
08/02/2019	Single Tender	315	Sleep Study Equipment	£51,000.00	Philips	Goods	The Health Board has purchased Respironics equipment in the past and therefore to ensure value for money, the PSG replacement needs to be compatible with other existing equipment and software.	STA appropriate for standardisation	Yes	15/02/2019
18/02/2019	Single Tender	317	PR50 Power Wheelchair	£28,568.38	Precision Rehhab Ltd	Goods	Precision Rehab Ltd are the only UK approved supplier of this equipment which has been approved by the Access to Work Programme (AtW) as the only equipment which meets the staff member's requirements.	Specialised equipment assessed for member of staff to enable continuation of employment	Yes	20/02/2019
26/02/2019	Single Tender	322	Patient Non Emergency Transport Services	£80,000.00	Prudent Patient Group	Services	The transport prudent undertake is non emergency patient transport. This work is to transfer over to easc by end of June 2019	An interim arrangement until the transfer of work to easc - also cost reduction for ABUHB	Yes	06/03/2019
08/03/2019	Single Tender	324	Care Aims Training	£45,000.00	Kate Malcolmess Consultancy	Services	Funding allocated specifically for this training. Training developed only offered by this company and has demonstrated positively in service delivery	Specialised training only offered by this one company	Yes	13/03/2019

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

AUDIT COMMITTEE MEETING 3RD APRIL 2019

6.2

Title of Policy	Recovery of Overpayments to Employees Policy
Author	Finance Director /Director of Workforce & OD
Presented by	Glyn Jones – Director of Finance and Procurement
Purpose	To brief the Audit Committee on the changes to the Policy.
Key Changes	The policy has been in place for some years. After consultations with key stakeholders including trades union representatives, Payroll Services, Corporate Finance and Workforce and OD. The Executive Team approved the Draft Policy on the 11th February 2019 While there is nothing that has materially changed a number of points in the policy have been updates as follows: <u>Appeals Process</u> • Corporate Finance to be responsible for initiating the Appeals process and sending out packs of evidence to those attending the Appeal meeting at least 7 days in advance of the meeting. • Workforce & OD to participate in the Appeals meeting and Communicate the Decision of the Appeals Panel • Divisional General Managers or their nominated Deputy to Chair the Appeals Meeting.

	• Further explanation as to Payroll Services role in the Appeal process • A statement that if the appeal is not upheld then the recovery of the debt will follow the Normal Accounts Receivable Financial Control procedure. • General principles added to how an appeal meeting will operate. <u>Amendment to Communications to Employees when an Overpayment Arises</u> • Inclusion of a template letter for minor overpayments. • A rewording of the Significant Overpayment letter • General Principles in the appeals process. • A new section relating to what happens if an overpayment has been made to a deceased employee together with a covering template letter.
Action Required	The Audit Committee is requested to note and approve the changes.

Aneurin Bevan University Health Board

Recovery of Overpayments to Employees Policy

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

Status: Issue 3 Issue date: 11.02.19
Approved by: Audit Committee Review by date:11.02.22
Owner: Finance Director/Director of Workforce & OD Policy Number: ABHB/Corporate/0559

Contents

1. Introduction

This policy sets out how overpayments to staff arising from the payroll, expenses or other Health Board payment systems are recovered.

2. Policy Statement

The policy sets out a fair process so that all staff are treated equitably in a situation where an overpayment occurs.

3. Aims

To ensure all overpayments are recovered as quickly as possible without imposing undue financial hardship on staff and that staff are treated fairly and consistently.

4. Objectives

This policy sets out a process for overpayments to be recovered when they arise that is fair and takes due regard to personal financial circumstances of staff when this presents difficulties in prompt repayment. It clearly sets out the role of Payroll Services, Corporate Finance, line managers, staff and the Counter Fraud department who are all involved in the process.

5. Scope

This policy relates to all staff within the Aneurin Bevan University Health Board. The scope of the policy covers both manual and electronic systems. The vast majority of overpayments occur in the payroll system and so 'Payroll' is referenced through this document but must be interpreted to be any payment system such as the expenses or accounts payable systems.

6. Roles and Responsibilities

6.1. All Staff

It is the responsibility of all employees to ensure their pay is correct. Employees must check their payslips via Employee online (ESR) and alert their manager and Payroll Services immediately if they suspect an over or underpayment has been made.

6.2. Line Managers, Managers and Supervisors

Must ensure that all payroll documentation e.g.:

- Enrolment forms
- Change Forms
- Termination forms
- Manager Self Service

is completed and submitted immediately on notification by the employee of a change via the Manager Self-Serve in ESR or in certain circumstances manually. For example if a member of staff hands in a resignation the Termination notification must be actioned immediately (at point of resignation) even if there is a period of notice to be worked.

The same principle of timely submission of information holds for data transmitted via ESR Manager Self Service.

Untimely submission of payroll documentation/MSS update can cause significant inconvenience and anxiety for staff and unnecessary additional administration for the organisation. If managers repeatedly fail to comply with the requirement to submit information in a timely manner they may be subject to formal processes.

If an overpayment is identified Payroll will notify the employee and the line manager. The manager must also notify the employee immediately in order that any queries can be discussed and resolved.

6.3. Payroll Services

Payroll Services will:

- Identify when overpayments have occurred through a number of possible sources - Typically staff or manager referral, audit and review processes, budget and financial management review.

- Initiate the process of recovery and determine whether a payment is classified as 'minor' or 'significant'.

- Notify the employee and the employee's manager.

6.4. Corporate Finance

The Corporate Finance department will:

- Be responsible for issuing invoices to individuals to recover significant overpayments and process repayments.
- Negotiate payment terms within the parameters set out in this policy.
- Be responsible for initiating the appeals process and organising appeal meetings.
- Issue packs of evidence to all attending the appeal meeting at least 7 days in advance of the meeting. .

6.5. Workforce and OD

Workforce and OD department will be responsible for:

- Participating in the Appeals Meeting.
- Communicating the Decision of the Appeals Panel.

6.6. Divisional General Managers

Divisional general managers will be responsible for:

- Chairing Appeals Meetings (which may or may not relate to individuals within their own division) OR:
- Nominating a deputy to chair Appeals Meetings, who must be of sufficient seniority to make independent outcome decisions.

6.7. Counter Fraud Department

The Counter Fraud department will:

- Investigate all significant overpayments and may pursue criminal prosecution if it is deemed that overpayments were dishonestly retained.

7. Main Policy Content

An overpayment is a payment for which an individual member of staff is not entitled and which has been made as a result of an administrative error or delay in processing of appropriate documentation.

Payroll Services will determine the type of overpayment that has occurred. The type and category of overpayment is important because it determines the repayment process. The classification of overpayments is as follows:

7.1. Type of Overpayment

7.1.1. Minor Overpayment

Where the overpayment has occurred over a period of 3 months or less and is less than 25% of normal net monthly or weekly pay of the employee.

7.1.2. Significant Overpayment

Where the overpayment has occurred for a period of more than 3 months or is greater than 25% of normal monthly or weekly net pay of the employee.

7.2. Category of Overpayment

Overpayments typically fall into a number of categories as follows:

7.2.1. Late Documentation

These arise because documentation is received late or ESR (Manager Self Service) has not been updated in a timely manner leading to an overpayment. This will typically include late termination forms, late change forms notifying of a reduction in hours all of which can lead to staff being overpaid.

7.2.2. Calculation Errors

These are errors arising from a calculation of payments due for example the calculation of enhancements or overtime being incorrect. It may relate to incorrect information submitted to Payroll Services or an error by Payroll Services.

7.2.3. Interpretation Issues

These typically relate to a dispute about remuneration agreements, and may relate to additional sessions or cover arrangements where this is a difference in interpretation of policy between the individual, Payroll Services and/or manager.

7.3. Overpayment Recovery Process

Appendix 1 shows the process diagram and is also described in detail as follows:

Payroll Services identify that an overpayment has occurred.

Payroll Services then determine the category of overpayment as one that is either 'Minor' or 'Significant' as defined in 7.1 above.

7.3.1. Minor Overpayments

Where a *minor overpayment*, as defined in 7.1.1 above, has been made the employees pay will be adjusted in the next pay period to reclaim the amount of the overpayment. Payroll Services will also notify the individual of the adjustment within 5 working days of the issue being made known to the Team setting out the reasons and appropriate calculations. See Appendix 2.

Where an overpayment is defined as *minor* and has occurred over a consecutive period of up to 3 months the recovery will be actioned over the same time frame.

7.3.2. Significant Overpayments

Where a *significant overpayment*, as defined in 7.1.2 above, has been made the employee and manager will be notified in writing, by Payroll Services, within 10 working days of the issue being made known to the Payroll Services Team and confirmed.

Payroll Services will send to the Corporate Finance Department the completed overpayment letter set out in Appendix 3. The Corporate Finance Department will send the letter to the employee accompanied by an invoice for the amount due for repayment. Payroll Services will also send a letter to the manager notifying them of the employee overpayment as set in Appendix 4.

7.3.3. Staff Who Have Left the Organisation

Where an overpayment is discovered and the employee has terminated their employment then recovery cannot be made via Payroll Services and so all recoveries will be deemed as *significant overpayments* for the purpose of recovering any outstanding amounts.

7.3.4. Debt Recovery Process

Once an invoice has been sent to the individual the recovery process will be subject to the Accounts Receivable Financial Control Procedure which is available on the intranet. The debt recovery process is summarised from the policy as follows*:*

- *Invoice is issued for the net amount overpaid to employee after tax, NI and pension deductions with letter and supporting calculations.*
- *If the invoice remains unpaid a reminder letter is issued after 21 days.*
- *A second reminder is sent at 42 days.*
- *The Debt is referred to debt collection agents to attempt recovery after 56 days.*
- *The Debt is referred to court for recovery where recovery by the debt collection agency has not been successful.*

7.4. Repayment of Debt and Repayment Terms

Once an invoice has been issued to the employee the invoice must be paid as soon as possible to avoid escalation as shown in 7.3.4 above. However, if the employee has difficulty repaying the debt then extended terms of repayment can be agreed provided:

- The Corporate Finance Department- Accounts Receivable Section is contacted immediately.
- The employee can demonstrate financial hardship with immediate repayment.
- There has been no fraudulent retention of an overpayment by the employee.

A principle of '*matching*' repayments to the period that the overpayment occurred will be adopted if requested, *provided there has been no fraudulent retention of overpayments proven*.

Any request to extend the repayment period beyond the matching period can be agreed but will be subject to an administration fee of £1 per transaction from the end of the matching period.

7.5. Appeal Process

An Appeal Process is available where there is failure to agree that the overpayment is valid. The Appeal Process covers both *Minor* and *Significant* overpayments as defined in 7.3 above.

Where an overpayment is defined as a *calculation error or interpretation issue* the employee has the right to appeal against the overpayment if they consider the overpayment to be incorrect. If the overpayment is defined as *'Late Documentation'* then there is no right to appeal other than in exceptional or unusual circumstances.

In the first instance the employee must ensure that there is full communication with the line manager and Payroll Services to try to resolve the issue. Where an overpayment has occurred due to a Manager or ABUHB error the Payroll Services Team can only resolve any questions that may arise in respect of the calculation of the overpayment. Any resolution in respect of the principle of the overpayment will be a matter between the employee and manager. If this fails to reach agreement the employee must instigate the appeal via the Corporate Finance Department-Accounts Receivable Section Head. The Accounts Receivable section will inform the employees' line manager.

The Accounts Receivable Section will place the invoice 'on hold' pending the outcome of the appeal. The Appeal must be requested within 21 days of the letter informing the employee of an overpayment.

An Appeal Panel will meet (organised by Corporate Finance) on a monthly basis to consider appeals and will comprise the following staff with no conflict of interest in the case:

- Divisional General Managers (Chair)
- HR senior manager
- Corporate Finance manager
- Staff side representative (not associated with the employees Trade Union)

In attendance at the meeting will also be:

- Employee and Trade Union representative if required
- Payroll manager
- Employee line manager

The Appeal Panel is an opportunity to examine the evidence and allows the employee concerned the proper opportunity to comment on the evidence and make any representations or offer their views concerning the overpayment. The Appeal Panel must consider all the evidence and give the employee a fair opportunity to make their views known whilst at the same time ensuring that all evidence is examined thoroughly so that an appropriate decision can be reached. No new written evidence may be produced by either party after the exchange of case papers without the agreement of all parties.
The Panel will ensure that:

- Full and fair consideration will be given to all issues pertinent to the case.
- All evidence will be considered, and
- That the employee or their representative will have the opportunity to present their case.

Appropriate documentation and evidence supporting the appeal must be sent to Corporate Finance and made available to the attendees within 7 days of the appeal.

If the appeal is not upheld then the debt collection will follow the Normal Accounts Receivable Policy with no further right to appeal. The outcome of the appeal is final.

7.6. Recovery of Income Tax, NI and Pension Deductions

The net cash overpayment is recovered from an employee. Associated income tax, national insurance and pension contributions will be recovered from HMRC and the pension agency by Payroll Services relating to all incidences of employee overpayments.

7.7. Counter Fraud Referral

Employees should be aware that it is considered to be an offence to retain money to which they knowingly have no entitlement and is considered Theft contrary to Section 1, the Theft Act 1968. Failing to notify Aneurin Bevan University Health Board that a mistake has been made by paying an individual more than they are entitled is also an offence contrary to Section 1.3 of the Fraud Act 2006.

An employee therefore has a duty to immediately report any such incidences to Payroll Services.

All *significant* overpayments will be referred to Counter Fraud for further investigation. Where clear intent to withhold disclosure of an overpayment is established criminal proceedings may be invoked.

7.8. Death in Service

Where an overpayment is outstanding relating to an employee who is deceased the debt would normally be recovered through the deceased's Estate as set out in Appendix 5. In exceptional circumstances this can be waived by the Executive Team of the Health Board.

7.9. Overpayment waiver

Under no circumstances can a manger waiver the overpayment. If an employee disputes an overpayment which cannot be resolved, the employee in certain circumstances can request an appeal.

8. Equality

An Equality impact Assessment has been completed.

9. Audit

This policy will be subject to internal audit review from time to time.

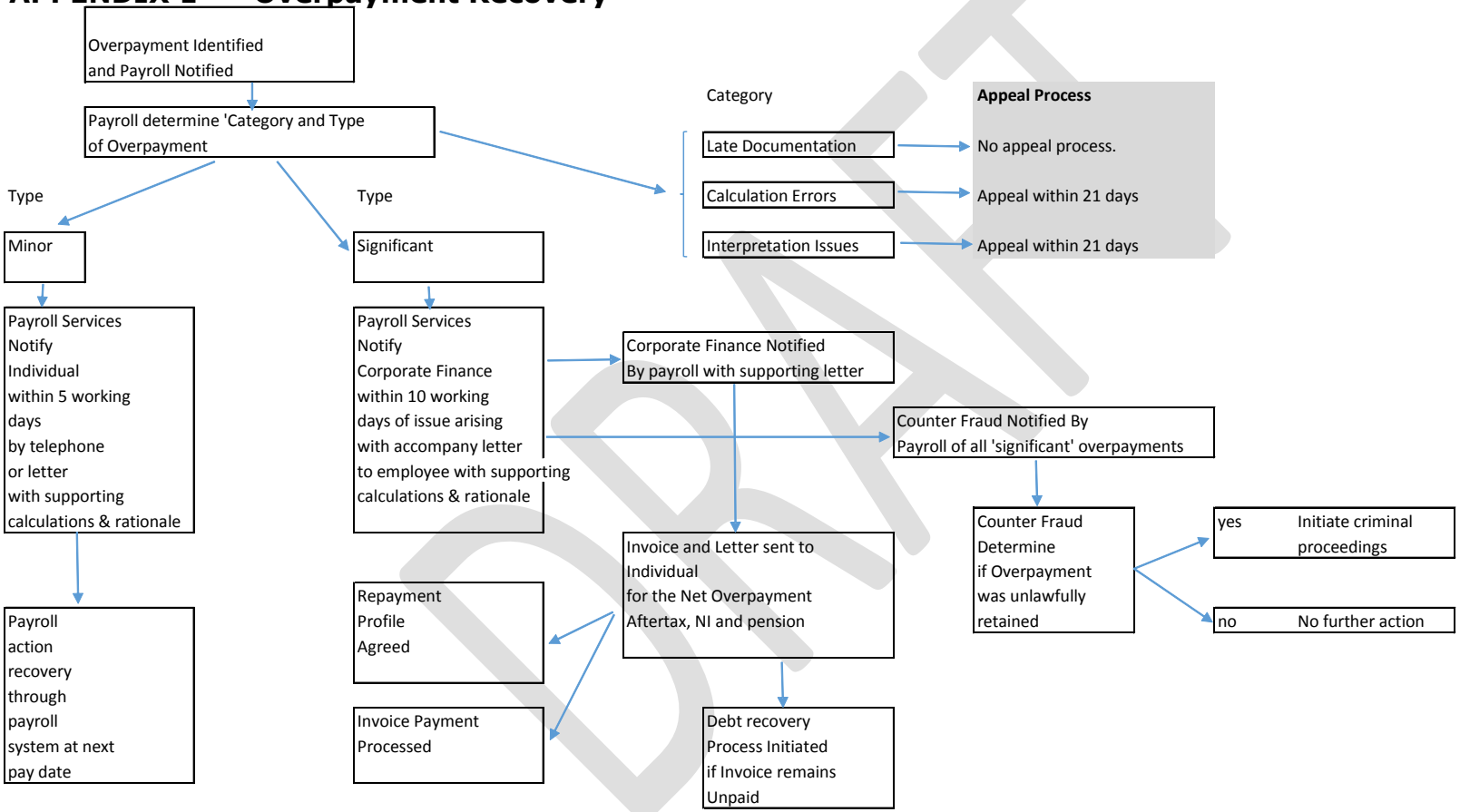
10. Review

This policy will be reviewed every 3 years.

11. Further Policies for Consideration

- Capability Policy
- Disciplinary Policy

APPENDIX 1 Overpayment Recovery



APPENDIX 2 **Minor Overpayment Letter**

Payroll

Direct Line (02920) 903908
E-mail Payroll.Services2@wales.nhs.uk

Our Ref

Insert date

PRIVATE & CONFIDENTIAL

Insert name and address of recipient

Dear

Re: OVERPAYMENT. OF (Insert overpayment type)

I regret to inform you that Payroll Services have been made aware of an overpayment of (salary,expenses etc.) It relates to the period ***<insert date from – to>.*** According to our records this overpayment arisen because ***<Insert reason i.e. details of relevant change or making an administrative error>.***

The overpayment is calculated as follows:-

>Insert gross pay plus deductions plus net pay value <

The organisation recognises that overpayments are regrettable and may cause staff anxiety. The organisation therefore ensures that any overpayment of salary or expenses are recovered from employees in a consistent manner. The organisation has therefore developed a policy to deal with overpayments which can be accessed via the following Internet Link www.********** .(*Comms to put on internet*)

In line with the policy this overpayment has been categorised as a *'Minor'* overpayment and will be recovered *by adjusting your pay in the next pay period.*

If you do not agree with the overpayment calculations provided, please contact the Payroll Team who can assist with your enquiry.

Please accept my sincere apologies for this administrative error and any inconvenience it may cause you.

Yours sincerely,.....
NHS Wales Shared Services Partnership (NWSSP)
On behalf of Aneurin Bevan University Health Board

APPENDIX 3 Significant Overpayment Letter

Payroll

Direct Line (02920) 903908
E-mail Payroll.Services2@wales.nhs.uk

Our Ref

Insert date

Insert name and address of recipient

PRIVATE & CONFIDENTIAL

Dear

OVERPAYMENT OF (*Insert overpayment type*)

I regret to inform you that Payroll Services have been made aware that an overpayment of (salary, expenses etc.**)** has occurred. It relates to the period ***<insert date from – to>.*** The overpayment has arisen because ***<Insert reason i.e. details of relevant change or making an administrative error>.***

The overpayment is calculated as follows:-

>Insert gross pay plus deductions plus net pay value<

The organisation recognises that overpayments are regrettable and may cause staff anxiety. The organisation therefore ensures that any overpayment of salary or expenses are recovered from employees in a consistent manner. The organisation has therefore developed a policy to deal with overpayments which can be accessed via the following Internet Link www.********** .(*Comms to put on internet*)

An invoice is attached for the amount that you have been overpaid after deducting taxation, national insurance and pension contributions.

The normal terms for repayment of an invoice is 21 days, however if repayment within this time period causes financial hardship the policy does allow for extended repayment terms which are set out in section 7.4 of the policy .

If you do not agree with the overpayment calculations provided, please contact the Payroll Team who can assist with your enquiry.

If your enquiry relates to the principle of the overpayment i.e. manager/organisation error please contact:-

(*Insert manager name*)

(*Insert manager e-mail address*)

(*Insert manager telephone number*)

If you consider the overpayment to be incorrect, the policy does allow a right of appeal. The appeal process is available on the Health Boards internet site under the following link XXXXXXX If you are unable to view this policy please contact your line manager. You must log an appeal in writing with the Accounts Receivable Section of the Health Board within 21 days of the date of this letter. The Accounts Receivable Department can be contacted by E Mail on AREnquiries.ABB@wales.nhs.uk or by telephoning 01495 765469.

If an appeal is not logged within the 21 days the Health Board will apply our normal debt chasing procedures to this invoice.

Yours sincerely

……

NHS Wales Shared Services Partnership (NWSSP)
On behalf of Aneurin Bevan University Health Board

APPENDIX 4 Managers Letter

Dear

It has been identified that as a consequence of late completion and or submission or incorrect completion of payroll documentation or late action in Manager Self Service, the employee named has been overpaid.

Name …….…… Assignment ……

Date ……

Reason for overpayment ……....

…….

…….

What To Do Now:

The employee has been issued with an invoice to repay the overpayment.

As the manager, you must meet with the employee to discuss the overpayment and ensure the employee understands the need to make repayment immediately. The employee will need to be made aware that where there is a failure to repay monies, Aneurin Bevan University Health Board will take legal action to recover the debt.

If there is any dispute in respect of the calculation of the overpayment the employee must contact Payroll Services in the first instance and discuss their rationale for querying it.

If the dispute is in relation to an 'Interpretation Issue' as set out in the Overpayment Policy it will be the responsibility of the Manager to resolve the dispute in the first instance. If the dispute cannot be resolved the employee has the right to an appeal, the process of which is set out in the Overpayments Policy. If the overpayment occurred because documentation was submitted late to the Payroll Services Department then it is the manager's responsibility to explain the reasons to the employee.

Yours sincerely

……

NHS Wales Shared Services Partnership (NWSSP)
On behalf of Aneurin Bevan University Health Board

Cc Accounts Receivable Section –Corporate Finance

APPENDIX 5 Death in Service Letter

Our Ref: Direct Line: Date:

Assignment Number/Reference

Date

Dear

Re: (input full name and assignment number).

ABUHB are sorry to hear of the death of (insertname) on the (insert date) and condolences are extended to the family for your loss at this time.

Whilst this is a sensitive issue to raise at this difficult time the Payroll Department has recalculated salary payment for (insert month and year) and unfortunately it has been calculated that an amount of £ (input value) is owing to Aneurin Bevan University Health Board in respect of the salary payments. When circumstances such as this arise the organisation has to seek repayment from the estate of the deceased employee. I would be grateful if you can ensure this information is passed to the Executors of the Estate for repayment to be made.

If you require any further information or assistance in respect of this matter please do not hesitate to contact the Payroll Services Team or the ABUHB Department Manager (insert name).

Yours sincerely

……

NHS Wales Shared Services Partnership (NWSSP)
On behalf of Aneurin Bevan University Health Board

GIG CYMRU NHS WALES — Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Audit Committee 3rd April 2019 Agenda Item: 6.3

Audit Committee
Losses and Special Payments Report

Executive Summary

- **Purpose**
  To provide Audit Committee with information in relation to financial losses and special payments made by the Health Board between January and February 2019.

- **Background and context**
  Losses and Special payments are reported in the financial position each month relating to cash payments for clinical negligence, personal injury claims, ex gratia payments as well as bad debt write offs. Losses are to be reported to the Audit Committee in line with the Committee's terms of reference.

- **Assessment and Conclusion**
  Audit Committee is asked to note that the net charge to the accounts at the end of February 2019 was £1,390k (inclusive of defence fees) which consisted of:

Clinical Negligence	£1,059k
Personal Injury	£290k
Minor Losses	£41k

- **Recommendation**
  The Audit Committee is asked to note the content of this report.

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

Executive Sponsor: Glyn Jones, Director of Finance			
Report Author: Mark Ross, Assistant Director of Finance			
Report Received consideration and supported by :			
Executive Team	**n/a**	**Committee of the Board [Committee Name]**	**n/a**
Date of the Report: 21st March 2019			

Supplementary Papers Attached:
Appendix 1 – Assurance Framework

Purpose of the Report

The purpose of the paper is to provide the Audit Committee with information in relation to financial losses and special payments made by the Health Board for the period January to February 2019. The report covers clinical negligence, personal injury and other payments that constitute a loss to the organisation.

Background and Context

1 Background

Losses and special payments are reported in the financial position each month. The amount charged to the accounts each year consist of cash payments for clinical negligence, personal injury claims, other ex gratia payments and bad debt write offs. An assessment is also made about the level of outstanding financial liability at the period end date and any increase or decrease in this 'provision' is charged to the accounts together with cash payments.

2 Issues

2.1 Assurance Framework

The current organisational structure and membership for the review of losses and special payment cases is set out in Appendix 1 which also identifies any significant issues highlighted in recent meetings.

2.2 Financial Analysis of Losses

Table 1 below shows analysis of the estimated liability for losses as at 28th February 2019 compared to the position reported earlier in the year.

Table 1 - Clinical Negligence & Personal Injury Provision

	31-Mar-18 £000	31-Aug-18 £000	31-Dec-18 £000	28-Feb-19 £000
Clinical Negligence	89,822	100,502	111,987	121,454
Personal Injury	3,674	3,530	3,656	3,622
	93,497	**104,032**	**115,643**	**125,076**
Income From Welsh Risk Pool	-88,034	-98,890	-110,361	-119,836
Net Liability	**5,463**	**5,142**	**5,282**	**5,240**

Table 1 reflects the estimated liability in relation to cases advised by NWSSP Legal Services for both clinical negligence and personal injury with the provision updated to reflect new or changed cases.

The key points are:-

- The net provision required for Clinical Negligence and Personal Injury cases as at 28th February 2019 compared to the 31st December 2018 has decreased by £42k.
- There was an increase of £9,467k in the Clinical Negligence provision since December 2018 as a result of the revised assessment of the likely outcome of these cases by NWSSP Legal Services with an associated increase in the anticipated income from the Welsh Risk Pool.

The number of cases provided for are shown in Table 2.

Table 2 -

	31-Mar-18	31-Aug-18	31-Dec-18	28-Feb-19
	No. of cases	No. of cases	No. of cases	No. of cases
Clinical Negligence	288	250	234	235
Personal Injury	68	83	79	76
	356	**333**	**313**	**311**
Income from Welsh Risk Pool	96	92	94	99

The amount charged to the revenue budget of the Health Board comprises of the cash paid out in the period as interim or final settlement of cases together with the overall movement in the provision. Table 3 summarises the total amount charged:

Table 3 – Charge to Expenditure

	31-Mar-18	31-Aug-18	31-Dec-18	28-Feb-19
	£000	£000	£000	£000
Clinical Negligence	7,857	2,514	5,245	6,209
Personal Injury	326	109	293	401
Irrecoverable Debts	0	0	0	0
Other	141	16	37	41
	8,324	**2,639**	**5,575**	**6,651**
Income From Welsh Risk Pool	-7,069	-2,201	-4,456	-5,262
Net Expenditure	**1,255**	**438**	**1,119**	**1,390**

The net charge to the accounts as at the end of February 2019 was £1,390k. This compares to a net charge to the accounts of £1,255k for the 2017-18. There is currently an underlying increase in the net expenditure compared to last year due to higher revaluations of provisions.

The following table 4 gives a further breakdown of the £1,390k shown above. The figures are inclusive of defence costs:

Table 4 - Breakdown of charge to Expenditure

	Payment Made	Accrued Income from WRP	**Net**	Change in Provision	**Net Charge to Accounts**
	£000	**£000**	**£000**	**£000**	**£000**
Clinical Negligence					
Previously Reported Apr 18 To Dec 18	5,288	-4,419	870	-43	826
Current Year to Date Apr 18 To Feb 19	6,255	-5,150	1,104	-46	1,058
Personal Injury					
Previously Reported Apr 18 To Dec 18	168	-38	130	126	256
Current Year to Date Apr 18 To Feb 19	316	-111	204	86	290
Other					
Previously Reported Apr 18 To Dec 18	37	0	37	0	37
Current Year to Date Apr 18 To Feb 19	41	0	41	0	41
Total					
Previously Reported Apr 18 To Dec 18	5,493	-4,456	1,037	82	1,119
Current Year to Date Apr 18 To Feb 19	6,612	-5,262	1,350	40	1,390

Commentary on Table 4

During the period January to February 2019 the following payments have been made:

Payments have been made totalling £967k for Clinical Negligence cases. Some of these payments were above the Welsh Risk Pool threshold of £25k enabling the Health Board to accrue £731k of income.

The £967k paid is analysed as follows:

- £545k (10 payments) – Settlements

- £250k – Failure to diagnose pulmonary embolism
- £150k – Misdiagnosis of a brain aneurysm
- £145k related to 8 payments ranging in value up to £50k

- £267k (19 payments) – Claimants Solicitors Fees
  - £267k related to 19 payments ranging in value up to £30k.
- £104k (61 payments) - Providing medical expertise
- £51k (34 payments) – Counsel fees incurred
- £2k (2 payments) – Professional fees incurred
- £6k (2 payments) – Compensation Recovery Unit
- <£1k (3 payments) – Other payments
- (£8k) – Costs won

Payments have been made totalling £148k for Personal Injury cases. Some of these payments were above the Welsh Risk Pool threshold of £25k enabling the Health Board to accrue £73k of income.

The £148k paid is analysed as follows:

- £50k (4 payments) - Settlements
- £68k (8 payments) - Claimants solicitors fees
- £27k (13 payments) – NWSSP Legal & Risk costs
- £3k (3 payments) – Counsel Fees

Other Losses

Minor losses incurred during the period January to February 2019 totalled £4k. These relate to settlements with regards to 2 Ombudsman cases and 8 other minor losses including patients' property. Lessons learnt reviews have been undertaken for each case and the Divisions and Departments of the organisation are actively responding to these reviews.

2.3 Redress

During the period January to February 2019, 18 payments were made in relation to redress cases totalling £70k. Funding will be requested from NWSSP to cover the costs incurred by the Health Board in relation to these redress cases with the exception of £5k in relation to claimant's solicitor's costs which are not reimbursable by NWSSP.

Recommendation

The Audit Committee is asked to note the contents of the report.

APPENDIX 1

Losses and Special Payments Assurance Framework

Name of Committee	Reporting to	Membership	Role in Relation to Review of Losses and Special Payments	Meeting Frequency	Date of Last Meeting	Issues Highlighted
Audit Committee	*Board*	***Independent members only:*** *Chair – Catherine Brown* *Vice Chair – Shelley Bosson* *IM - Katija Dew*	*Advise* and *assure* the Board and the Accountable Officer on whether effective arrangements are in place - through the design and operation of the LHB's assurance framework - to support them in their decision taking and in discharging their accountabilities for securing the achievement of the LHB's objectives, in accordance with the standards of good governance.	**Quarterly**	**17th Jan 2019**	
Quality & Patient Safety Committee	*Board*	*Chair – Professor Dianne Watkins* *Vice Chair – Frances Taylor* *IM – Emrys Elias,* *Richard Clark*	**Receive at each meeting:** • Bi Monthly complaints reports Contains details of total numbers, numbers by Division , trends, performance and details of second stage complaints • SI reports Contains new serious incidents by area and date, current under investigation including details of remedial actions and closed incidents with details of actions taken and lessons learnt. **Receive Twice Yearly** • Six Monthly Claims Report	**Bi Monthly**	**7th Feb 2019**	The PTR annual report was presented and received well at the Committee on 7th February.

Name of Committee	Reporting to	Membership	Role in Relation to Review of Losses and Special Payments	Meeting Frequency	Date of Last Meeting	Issues Highlighted
			Total numbers, numbers by area, trends and themes and lessons learnt following claim. **Receive Annually** Annual Summary from Learning Committee re key lessons learnt and actions taken to reduce risks resulting from patient safety concerns across the Health Board. **Periodically** WAO Reports WRP Reports PTR/Redress Reports			
Litigation Committee	Board	*Chair – Ann Lloyd* *Vice Chair – Emrys Elias* *IM – Professor Dianne Watkins* *IM – Catherine Brown* *CEO - Judith Paget* *Medical Director - Dr Paul Buss*	• To review and approve in conjunction with Welsh Health Legal Services major claims (exceeding £100K). • Consider inquests • Approve polices in relation to claims • Consider cases referred to trial	**3 meetings a year**	**3rd Dec 2018**	Review of claims. Consideration of appeals for minor losses
Quality & Patient Safety	*Quality & Patient*	Operational group no non	Highlight reports from each Division.	**Bi Monthly**	**19th Mar 2019**	The bi-monthly performance report for complaints and

Name of Committee	Reporting to	Membership	Role in Relation to Review of Losses and Special Payments	Meeting Frequency	Date of Last Meeting	Issues Highlighted
Operational Group	*Safety Committee*	officer members	Progress reports from Learning Committee, WRP and complaint /SI reports which need to be highlighted to the group for consideration re escalation			SI's was presented on the 19th March. The top three risks for each division were discussed and documented.
Learning Committee	*Divisional QPS Meetings*		• Discuss themes and trends and take learning across all Divisions of the Health Board to ensure health Board wide learning • Agree solutions and ensure escalation as needed. • WRP Claims Reviews • Claims trends/themes • SI and Serious complaint Action plans to cascade learning across Health Board • Second Stage Action Plans – (themes)	**Quarterly**	**9th Jan 2019**	A concerns workshop was held on the 9th January 2019 and a lead has been identified to take the Learning Committee forward. This is now part of the PTR Service Improvement Plan.
Divisional / Locality Quality & Patient Safety	*Learning Committee*		• Ensure divisions take their learning forward through review of Divisional Concerns and claims • Trends and themes and agree remedial actions		**9th Jan 2019**	A Concerns workshop was held on the 9th January with attendance from all Divisions and a Service Improvement Plan was developed with an ongoing programme of work.

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Audit Committee 3rd April 2019 Agenda Item: 6.4

Audit Committee

Risk Management Review and Link to Assurance Framework Development

6.4

Executive Summary			
The following paper is intended to provide an update on progress made to date and to present the Risk Management Landscape Review Report and its associated Action Plan. This paper also outlines that plans have been developed to use the outputs of the review to support the Health Board's finalisation of its Board Assurance Framework and a redevelopment of its Risk Appetite Statement. Initial consideration was given at the March 2019 Board Development session and further work is currently being undertaken aligned to the recently approved IMTP to implement the new arrangements at the May 2019 Board.			
The Audit Committee is asked to: (please tick as appropriate)			
Approve the Report			
Discuss and Provide Views			
Receive the Report for Assurance/Compliance			
Note the Report for Information Only	✓		
Executive Sponsor: Richard Bevan, Board Secretary			
Report Author: Richard Bevan, Board Secretary and Jeff Brown, Review Lead			
Report Received consideration and supported by :			
Executive Team		**Committee of the Board [Committee Name]**	
Date of the Report: 27th March 2019			
Attachments: Risk Management Landscape Review Report and Risk Management Action Plan 2019/2020			

Purpose of the Report
This report provides for the Audit Committee an update on progress made to date and to present the Risk Management Landscape Review Report and its associated Action Plan.

Background and Context
The Risk Management Landscape Review has been undertaken over the period between September 2018 and March 2019. The approach has included redeveloping and refining the Health Board's approach as it has progressed. The final report was presented to the Board Secretary on the 22nd March 2019. Following the receipt of the report an action plan has been developed which will be implemented during 2019/2020. This review and

its action plan are direct responses to the Internal Audit Report on Risk Management in 2018. Thanks are given to Jeff Brown of JBPS for his work and advice to the organisation as part of this review.

Further work will be undertaken with the Board, using the feedback from the review and the action plan to discuss and finalise the Board Assurance Framework. This will also include revising the current risk Appetite Statement and introducing the new Risk on a page approach, which will be presented to the May 2019 Board meeting.

Recommendation

The Audit Committee is requested to receive the review report, to note the progress made thus far and to approve the Action Plan, which will be monitored by the Executive Team and update reports will be provided to the Audit Committee.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The coordination and reporting of organisational risks are a key element of the Health Board's overall assurance framework.
Financial Assessment, including Value for Money	There may be financial consequences of individual risks however there is not direct financial impact associated with this report at this stage.
Quality, Safety and Patient Experience Assessment	Impact on quality, safety and patient experience are highlighted within the individual risks and assurance requirements contained within this report.
Equality and Diversity Impact Assessment (including child impact assessment)	There are no equality issues associated with this report at this stage, but equality impact assessment will be a feature of the work being undertaken as part of the risks and assurance framework.
Health and Care Standards	This report would contribute to the good governance elements of the Health and Care Standards.
Link to Integrated Medium Term Plan/Corporate Objectives	The risks and assurance arrangements will be fundamental elements against delivery of key priorities in the IMTP.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	WBFGA considerations are included within the consideration of individual risk and the assurance arrangements, as outlined.
Glossary of New Terms	None
Public Interest	Report to be published in public domain

Aneurin Bevan University Health Board (ABUHB)

Risk Management Landscape Review

Final Briefing Paper – 28th March 2019

Review conducted by: Jeff Brown – Director, JBPS Advisory Solutions Limited

6.4

Contents

Review objectives, approach and scope

Objectives

JBPS Advisory Solutions Limited were commissioned in Sept 2018 to undertake a high level Risk Management Landscape Review of the Health Board. The Review's primary objectives were to:

- Gather intelligence from across the Health Board to better understand current Risk Management approaches and practice and to use this to identify any opportunities or barriers that would enhance or frustrate the improvement of the Health Board's approach to Risk Management.
- To use the approach to the Landscape Review to build understanding, capability and knowledge around good/notable Risk Management practice with Risk Champions.

Approach

Our approach included

- Designing and running an anonymous Risk Management Survey (see Appendix 2 for Detailed Survey Report)
- Reviewing primary risk documentation – such as the Risk Management Strategy (Dec 2016)
- Undertaking 1:2:1 interviews with 30 Risk Champions/Leads
- Designing and facilitating two Risk Management Development Workshops for Risk Champions (see Appendix 3 for workshop content)
- Designing and Facilitating a Risk Management Board Development Workshop (see Appendix 3 for workshop content)
- Draft a briefing paper identifying key themes/findings and potential actions

Scope

Note that this review has sought to gather perspectives on the frameworks/structures and approaches that feed into the current committees of the Board, such as the Audit Committee, rather than the governance forums/committees themselves. However the findings from this review will be used to complement the work being undertaken by the Corporate Team in its current review of the Health Board Assurance Frameworks. Also this review has not been conducted using internal/external audit standards i.e. (testing of risk registers or controls etc.) However, the findings from this review will be used to inform the annual review of Risk Management currently being undertaken by the NHS Wales Shared Services Partnership Audit and Assurance Services as part of the internal audit programme for 18-19.

Executive summary

A robust and effective approach to Risk Management should be an integral part of an organisations approach to delivering its objectives by identifying any problems or potential threats to their successful achievement. It is recognised that risk is present in any organisation and therefore needs to be continuously managed in a systematic and consistent manner in all areas, such as with patients, staff, health and safety, environment, organisation, financial, information and commercial.

The Health Board has a longstanding approach to Risk Management which has evolved over time and is reflective of a complex organisation with multiple stakeholders. Similar to other NHS bodies in Wales embedding a systematic and consistent approach to Risk Management remains an ongoing challenge. Notwithstanding this the genesis for this review is in itself a healthy self-reflection by the Health Board that the current Risk Management approaches/practice need further development. This proactive approach to seeking to understand the specific Risk Management challenges and opportunities for improvement is to be commended.

In undertaking this work there were a number of positive findings which should be used by the Health Board on its journey to improving its approach to Risk Management. These included:

- The existence of a relatively new pan Health Board - Risk Management Strategy (Dec 2016) which reflects current best practice and Risk Management Standards such as ISO 31000 and guidance from the Institute of Risk Management (IRM).
- The identification of Pan Health Board Risk Management Champions
- Key areas which have a longstanding/professional and well-practiced approaches to Risk Management such as, the Clinical Future's Programme, Health and Safety/Facilities team and the Families and Therapies Division
- The initial piloting of Risk Management technology solutions (DATIX Risk Management Module) to explore a consistent and agile approach to recording and managing risks and issues.
- A willingness by those with a risk lead to work to ensure approaches Risk Management work and are effective

However, the review also highlighted that the current approaches and maturity in Risk Management practice varies significantly between Divisions and Departments. This variability is primarily driven by three key variables, these being:

- The Risk Management experience/capabilities of the individual charged with Divisional/Dept. Risk Management lead responsibilities
- The grade of this individual and their ability to influence senior (Divisional) management
- The value placed on the discipline of Risk Management by the senior team within the Division/Dept.

Notwithstanding these three variables the review findings highlighted four key themes where improvement will be required if the Health Board is to achieve its ambitions around a fully embedded and consistent Pan Health Board approach to Risk Management. These themes are:

- **Theme 1** - Risk Management responsibilities/accountabilities are not always clear and often undervalued
- **Theme 2** – Variability and confidence in and understanding of the current Risk Management framework
- **Theme 3** – Tensions between balancing everyday delivery with effectively identifying and managing risk
- **Theme 4** – Variability in the line of sight between objectives (either at the Strategic or Divisional level) and risks

The “Detailed Findings” section of this Briefing Paper provides further examples under each of the four themes and includes an “Implementation Plan" with suggested short, medium and long term priorities to address the key issues identified during the review.

Immediate progress

This review has been conducted using dynamic real-time feedback. This approach has been taken to ensure that where appropriate any immediate emerging findings have been shared with the Health Board to facilitate these being addressed immediately. Therefore during the course of this review the Health Board has already started to make progress on addressing some immediate areas for development including:

- Establishing a sub group to consider the wider role out of the DATIX Risk Management Module to the rest of the Health Board.
- The development of a new “risk on a page” visualisation format for the Corporate Risk Register
- Running a Risk Management Health Board Development session – with a focus on “Risk Appetite”
- Requiring Risk Management to be an agenda item at all Divisional Assurance meetings.

Detailed Findings

The review identified a number of positive Risk Management practice within the Health Board that should be used on its journey to improving its approach to Risk Management.

- The existence of a relatively new pan Health Board - Risk Management Strategy which reflects current best practice and Risk Management Standards such as ISO 31000 and guidance from IRM.
- The identification of Risk Management Champions across the Health Board – notwithstanding the areas for improvement highlighted below
- A self-reflective executive team and Board that have identified that there are areas within the current approach that need to be improved.
- Key areas within the Health Board where there is a longstanding/professional and well-practiced approaches to Risk Management such as within the Clinical Future's Programme, Health and Safety/Facilities team and the Families and Therapies Division – where there is an opportunity for shared learning.
- The initial piloting of Risk Management technology solutions (DATIX Risk Management Module) to explore a consistent and agile approach to recording and managing risk and issues.
- A recognition that more needs to be done fully embed Risk Management practice and discipline and a willingness by those with a risk lead to work to ensure approaches Risk Management work and are effective

However the review also highlighted that the current approaches and maturity in Risk Management practice varies significantly between Divisions and Departments. This variability is primarily driven by three key variables, these being:

- The Risk Management experience/capabilities of the individual charged with Divisional/Dept. Risk Management lead responsibilities
- The grade of this individual and their ability to influence senior management
- The value placed on the discipline of Risk Management by the senior team within the Division/Dept.

Notwithstanding these three variables the review findings highlighted four key themes where improvement will be required in the Health Board is to achieve its ambitions around a fully embedded and consistent Pan Health Board approach to Risk Management. These themes are:

Theme 1 - Risk Management responsibilities/accountabilities are not always clear and often undervalued

The following points provide further examples of the key emergent issues under this theme:

- Variability in the way in which risk is integrated into Divisional/departmental planning – some seeing this as "Any Other Business" rather than integral to Divisional planning. Despite the Risk survey suggesting that above there was above average confidence in Risk Management informing planning and decision making

- Those with responsibility for risk having this a bolt onto their other responsibilities and that those in this role suggest it is not as valued as it should be
- No clearly defined and owned role for Risk Champions
- Significant variation between individual Risk Champions Risk Management skills/experience and capabilities

Theme 2 – Variability and confidence in and understanding of the current Risk Management framework

The following points provide further examples of the key emergent issues under this theme:

- Despite the Risk Survey results suggesting that 82% of the Risk Campions considered themselves to have average to high levels of maturity around the ten Risk Management areas, further work has highlighted that there is inconsistent understanding and use existing Risk Management Guidance, structures/process/tools – for example:
    - Inconsistent mapping of risks to HCS, SSWBSA, WBFGA, despite this being a requirement of the Risk Management Strategy
    - Conflation of risks and issues
    - Significant variability in the robustness of risk descriptions
    - Inconsistent understanding of the relationship between Risk Management and controls, with controls and activities not clearly differentiated
    - Limited use of risk appetite to frame risks and implement controls/actions despite this being a requirement of the Risk Management Strategy. However a recognition by the Board that the current Risk Appetite Statement if used with Target Risk scores could provide the Board with a better indication of the effectiveness of current actions, controls and progress against planned trajectories for Corporate Risks
    - Limited use of suggested analysis tools such as the “Bow tie” Cause and effect approach
    - Perception that only high scores are important, leading to the potential for risk scores to be used perversely as a way to attract attention to an issue or to receive investment
    - A lack of clarity in understanding how the respective assurance structures/lines of governance relate to each other and what should get reported and discussed at each. (This will become clearer as the current review of the Assurance Framework is finalised)
- Limited visibility and confidence in feedback loops
    - Limited exposure to understanding how risks impact decision making at the Corporate level
    - Confusion over escalation and de-escalation of risks between the various governance levels
- Confusion/conflation over how you capture and record risks –
    - The Survey highlighted the variation in the way in which risks are recorded – approx. 36% on DATIX and 50% on s/sheet and other and 14% didn’t capture

risks. The figure of 36% on DATIX also highlights that peoples understanding of risks are different, as there are only a few pilot teams using DATIX Risk Module with the remainder of the organisation using DATIX to capture/report incidents and not Risks.

- Misunderstanding of risk language – words such as hazard, incident, risk and issue being used incorrectly and thereby leading to confusion

Theme 3 – Tensions between balancing everyday delivery with effectively identifying and managing risk

The following points provide further examples of the key emergent issues under this theme:

- Variability in confidence around a supportive/permissive culture which encourages and supports personal responsibility in managing risks – often leading to risks being unnecessarily escalated rather than locally managed
- Variable confidence in taking personal responsibility to manage risk at the earliest possible opportunity
- A recognition that understanding tolerance is context specific, however it is not always know who to check with to ensure these tolerances are understood and unchanged
- Limited exposure or understanding or consideration of risk interdependencies such as impacts on other Divisions
- Risks only being considered at the organisation level with limited consideration of system wide risks with other public bodies
- No central point of Risk Management excellence/support/training/challenge for Champions and others to use to ensure consistency or to support decision making

Theme 4 – Variability in the line of sight between objectives (either at the strategic or Divisional level) and risks

The following points provide further examples of the key emergent issues under this theme:

- No clear relationship between Risk Management and improvement although a recognition that this should exist
- A perceived disconnect between Divisions and the Corporate Risk Process and uncertainty about how risk score are impacted by local verses Corporate context
- Variability in understand of risk ownership – in particular where there are shared risks with enabling Divisions
- No specific consideration of risks shared with other Public Bodies to deliver shared objectives/outcomes
- Limited risk training for senior teams who ultimately take decisions which impact how risks are mitigated/managed

Implementation Plan - Short, medium and long-term actions

Short term – 3-6 months

1. Draft and agree a role definition for Risk Management Champions/leads
2. Design and deliver a tailored "role specific" Risk Management Training (based on the HB's approach) for:
    - All staff – Level 1
    - Risk Champions/Leads – Level 2
    - Senior Divisional staff – level 3
    - Executive team/Board – level 4
3. Undertake Risk Management review and challenge sessions with each Division – specifically looking at the robustness of their current risk register – This should be undertaken after the end to end training.
4. Design and manage a forum for Risk Champions/leads to meet on a quarterly basis and to receive training/discuss issues and share practice.

Medium term – 6-12 months

1. Appoint a dedicated central Risk Management resource with a clearly defined role and responsibilities and accountabilities – if appointed early enough this resource could support/deliver the short term priorities. (*Please note that this appointment process should start immediately with the expectation that the person will be in post within six months from the date the position is advertised*).
2. Undertake a session with the Executive team/Board to:
    a. Stress test the current Corporate Risk Register – against the current strategy and best practice
    b. Undertake horizon scanning to ensure that risks in delivering the long term objectives (Well-being Objectives) are identified and managed
3. Develop a Risk Management "handbook" to sit alongside the current Risk Management Strategy with worked case studies/examples and links to training material

Long-term – 12months – 2 years

1. Professionalise the Risk Management Champion/Lead role with the opportunity to gain a Risk Management Qualification.
2. Run a number of Divisional wide pilots to evaluate the potential for wider roll out of the DATIX RM module – with clearly defined brief and evaluation metrics.
3. Review of the current risk register in the context of developing an integrated risk register which aligns with the PSB and RPB objectives.

Appendix 1 –Barriers and opportunities

Opportunities for improvement	Perceived and actual barriers
• Extending the DATIX RM module to other Divisions. However with a stronger pilot/business case/benefits articulated • Cross Divisional risk work on Brexit might provide a method for other cross Divisional working around risk • Good practice approaches in Finance, F&T and clinical Futures, to considering, capture, reporting and monitor risk – could be shared • Potential to link improvement around H&C standards and risks (improvement plans and links to RM module in DATIX) • A genuine wish by those on the ground to get this right. • Opportunity to map the assurance and bring together current disparate risk governance structures with a focus on escalation and de-escalation • Opportunity to use "Quicksense" (data visualisation tool – currently being piloted by the Performance team) to make better use of risk data. • Opportunity to better integrate the current improvement agenda around HCS and Risk Management as part of the current Q&PS assurance review • Opportunity to have a more collaborative approach to risk identification and management with partners through the PSB and RPB.	• Confusion with some that have specific RM responsibilities over how the whole Health Board's RM universe works • Having many layers of risk classification – (H&CS, SCPs, Corp priorities, strategic risk areas can make the current framework seem overwhelming. • Misunderstanding of risk v issues and in consistently describing risks to facilitate grouping and comparison • Some parts of the org still only see risk from a clinical Q&PS perspective rather than wider risks • Culture in some parts of the organisation which often see RM only as a tool to manage potential litigation rather than genuinely manage the business • No clear articulation of the links between risks and delivering Corporate priorities • A concern around risk capture/management being overly bureaucratic and not adding value • Limited visibility or connection between Clinical Futures risks and Divisional risks (perceived or actual) • Taking personal accountability for and managing risk still presents a challenge – especially where there is blame culture • Variety of tools used to capture Risks leading to inconsistency • Limited clarity around the strategic assurance framework – e.g. Elements of the strategic assurance framework between Q&PS/H&S and Exec/Main Board are dependent upon individuals rather than a clear framework • Limited exposure or discussion around shared risks with partners (RPB/PSB)

Note that the where relevant the above opportunities and barriers have been integrated into the Detailed Findings and the Implementation Plan.

Appendix 2 – Risk Management Landscape Review - Survey – detailed results

Summary Survey results

The survey was based on a Maturity framework around ten key Risk Management areas.

- Very good response rate - 21 out of a possible 30 = 70% - with a significant amount of helpful narrative comments
- Variable way in which risks are recorded – approx. 36% on DATIX and 50% on s/sheet and other and 14% didn't capture risks
- Above average confidence in Risk Management informing planning and decision making
- Across all 10 risk areas:
  - 18% had a low level of maturity
  - 55% had average levels of maturity and
  - 27% had high levels of maturity.

The areas where maturity was highest were:

- Q7 - Responding to and managing risk
- Q8 – Reviewing and monitoring risks
- Q9 - Risk registers

The areas where maturity was lowest were:

- Q5- Risk appetite and risk tolerance
- Q8 - Reviewing and monitoring risks (this area also included those with the highest levels of maturity – very dispersed results

A significant number of the developmental comments were provided even where respondents had selected average or above average maturity scores.

For the detailed results please see Attachment 1 - Risk Management Survey Report.

Note that the results and comments from this survey have been used to inform the Detailed Findings and Implementation Plan.

Appendix 3 – Risk Champions and Board Development Workshops

Risk Development Workshops were undertaken with Risk Champions on the 22nd February 2019 and the 4th March 2019. A further Board Development session focused on Risk Management was undertaken on the 6th March. For the detailed content of these workshops please see Attachments 2 and 3. The agenda for the sessions included.

Note that the outputs from these workshops have been used to inform the Detailed Findings and Implementation Plan.

ABUHB - Risk Management Landscape Review

Survey Results Report – Nov 2018

Jeff Brown – Director - JBPS Advisory Solutions Limited

Introduction/background

This survey has been designed and executed by JBPS Advisory Solutions Limited as part of a wider Risk Management Landscape review of the Health Board. The survey was designed to achieve two primary objectives, these being:

- Objective 1 – to gather an anonymous perspectives on risk management practice from those individuals within the Health Board who have specific risk management responsibilities (Risk Champions)
- Objective 2 – To use the maturity narratives within each of the Survey's ten risk management areas, to build capability and knowledge around good/notable risk management practice.

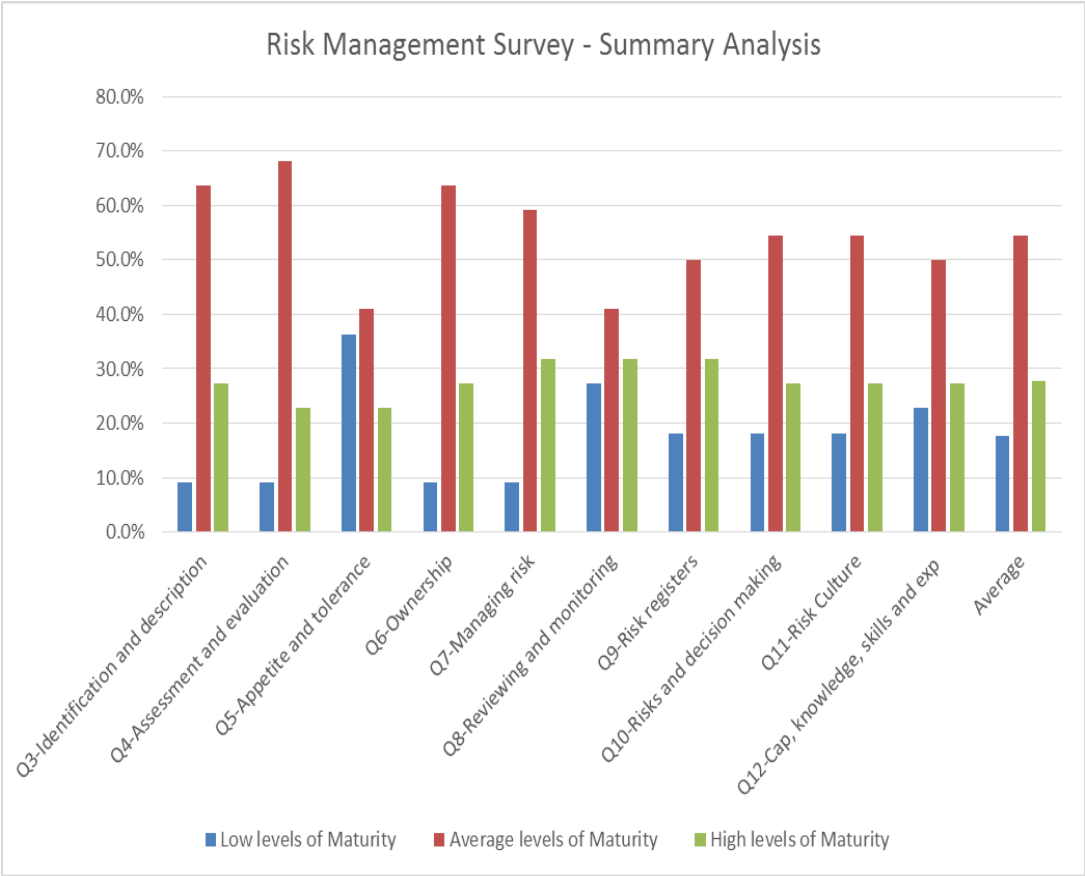
Note that the following survey results are based on respondents assessing their division/function against a set of three maturity statements (See Appendix 1) for ten key areas of Risk Management practice. The results are not necessarily a statement of evidenced fact, but rather a reflection of the respondents personal perceptions on risk management practice.

These survey results will be used in conjunction with the 121 interviews with Risk Champions and review of existing risk management strategies/processes, to inform the following two steps:

- Step 1 – the design and content for two Risk Management capacity building workshops
- Step 2 – a Briefing Paper which will highlight opportunities, barriers and some potential next steps for improving the Health Board's Risk Management strategy and approach.

Summary Analysis

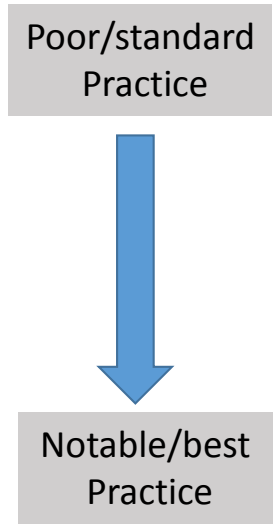
- Very good response rate - 21 out of a possible 30 = 70% - with high levels of helpful narrative comments
- Variable way in which risks are recorded
- Above average confidence in Risk Management informing planning and decision making
- Across all 10 areas, 55% have average levels of maturity. However, almost 18% have a low level of maturity and nearly 27% a high level of maturity.
- The areas where maturity was highest were:
  - Q7 - Responding to and managing risk
  - Q8 – Reviewing and monitoring risks
  - Q9 - Risk registers
- The areas where maturity was lowest were:
  - Q5- Risk appetite and risk tolerance
  - Q8 - Reviewing and monitoring risks (this area also included those with the highest levels of maturity – very dispersed results
- A significant number of the developmental comments were provided even where respondents had selected average or above average maturity scores



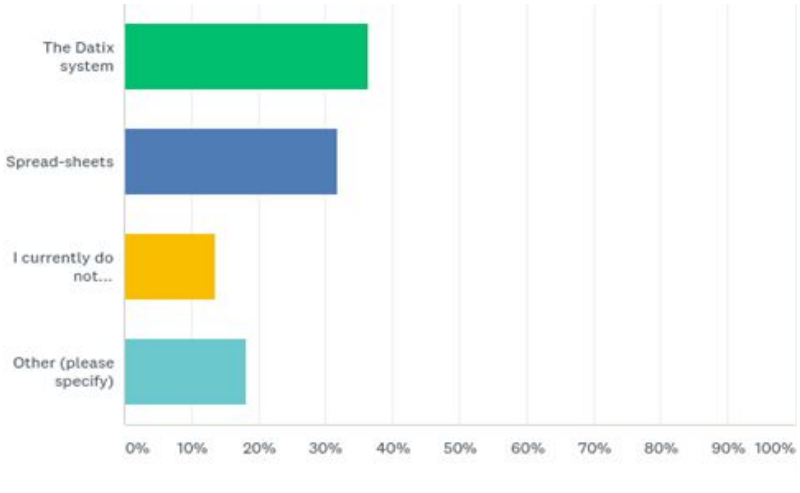
Detailed results

Key – Questions 3-12

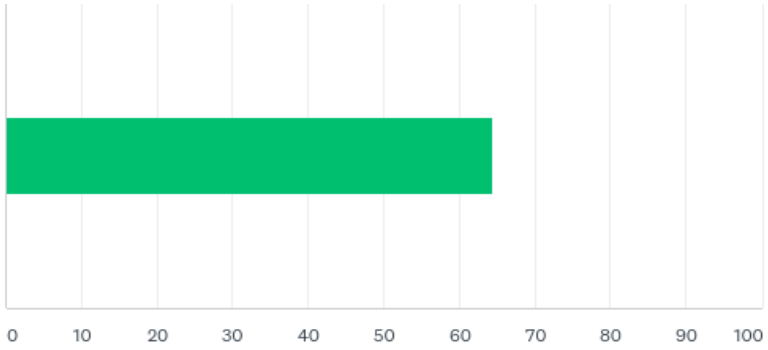
My experience is best described by Scenario 1	
My experience is best described by Scenario 1 but it has some of the elements described in Scenario 2	
My experience is best described by Scenario 2 but it has some of the elements described in Scenario 1	
My experience is best described by Scenario 2	
My experience is best described by Scenario 2 but it has some of the elements described in Scenario 3	
My experience is best described by Scenario 3 but it has some of the elements described in Scenario 2	
My experience is best described by Scenario 3	



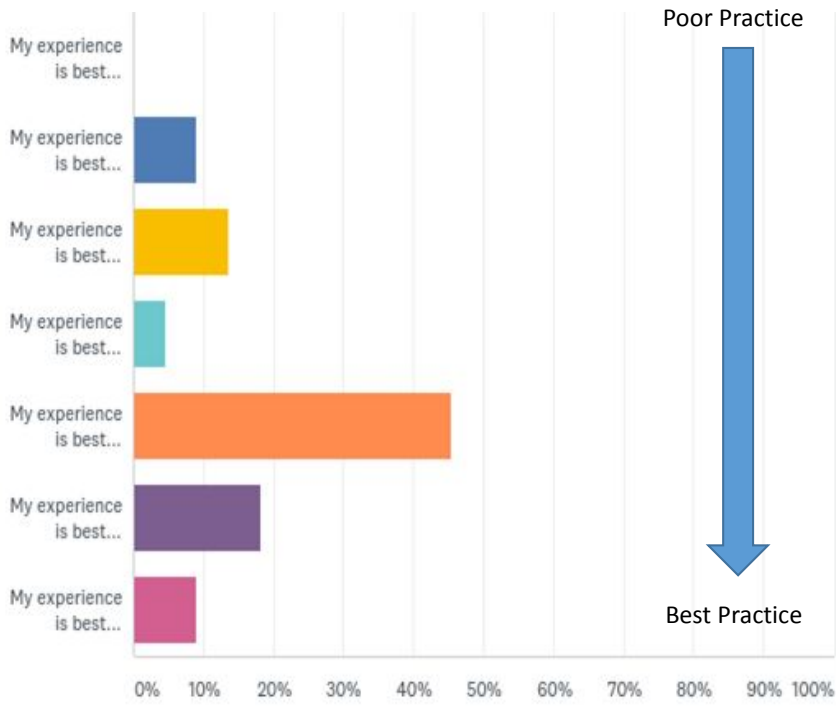
Q1: How do you currently record/capture risks for your Division/Function/Team?



Q2: How confident are you that the risks you identify and manage inform planning and operational decision making?



Q3: Area 1 - Risk identification and description



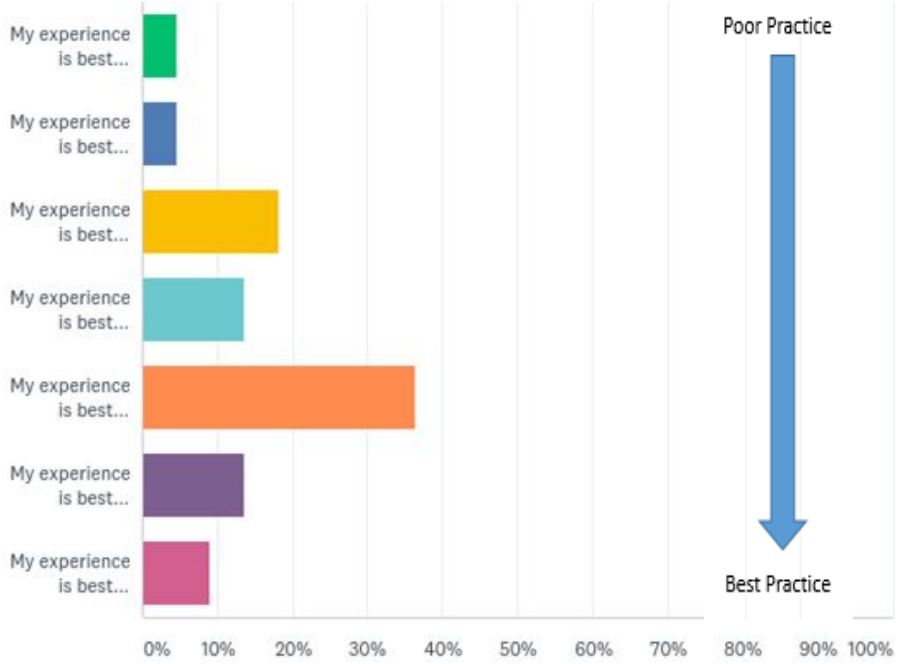
Key Analysis

Low levels of maturity	**9.09%**
Average levels of maturity	**63.64%**
High levels of maturity	**27.27%**

Key additional comments

- **Positive comments**
  - Well coordinated process for managing risks
  - Risks identified in consolation with staff
  - Wider impacts on HB considered
- **Areas for development**
  - Risks are often too vague
  - Little consideration given to impact on other Divisions or the HB as a whole
  - Need to distinguish between risks and issues
  - Adopting a consistent approach

Q4: Area 2 - Risk assessment and evaluation



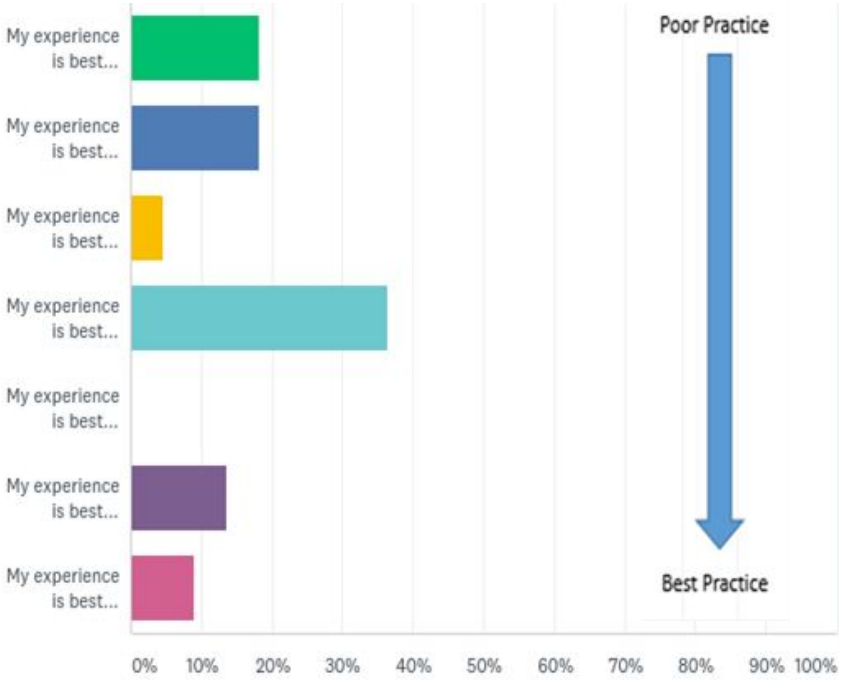
Key Analysis

Low levels of maturity	**9.1%**
Average levels of maturity	**68.2%**
High levels of maturity	**22.7%**

Key additional comments

- **Positive comments**
  - Risks organised around HCS and population health impacts considered
  - Links starting to be linked to IMTP and objectives
- **Areas for development**
  - Risks levels are not always discussed or understood
  - Risks are scored at the maximum consequence and likelihood for expediency rather than realistically
  - Risks tend to focus on the short term rather than the horizon

Q5: Area 3 - Risk appetite and risk tolerance



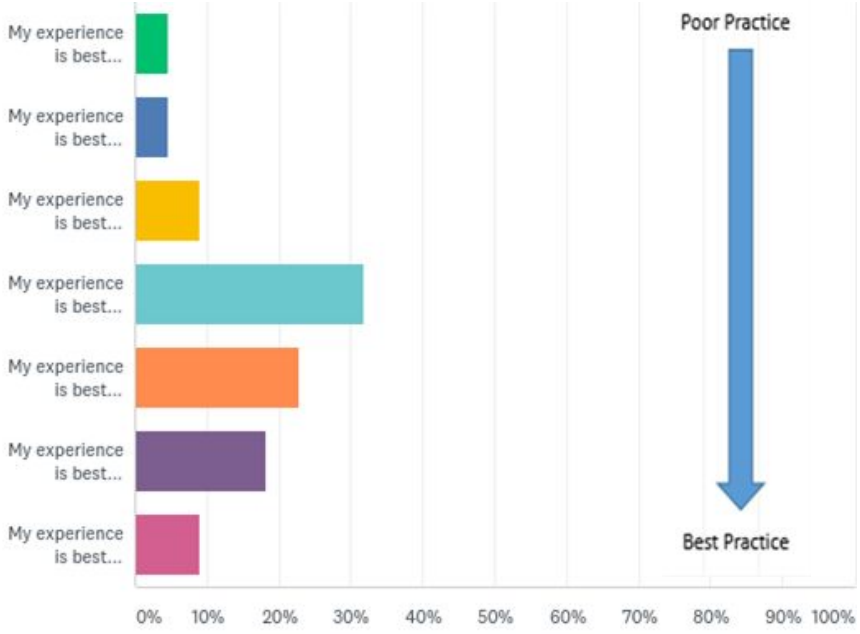
Key Analysis

Low levels of maturity	**36.4%**
Average levels of maturity	**40.9%**
High levels of maturity	**22.7%**

Key additional comments

- **Positive comments**
  - In some enabling divisions Risk appetite is regularly discussed
- **Areas for development**
  - Risk appetite is low and inhibits delivery and potential benefits. Appetite to risk taking is influenced by finance decisions which inhibit opportunity and value.
  - risk tolerance is mostly implicit rather than explicit
  - There is limited understanding and applications of Risk appetite and tolerance

Q6: Area 4 - Risk ownership



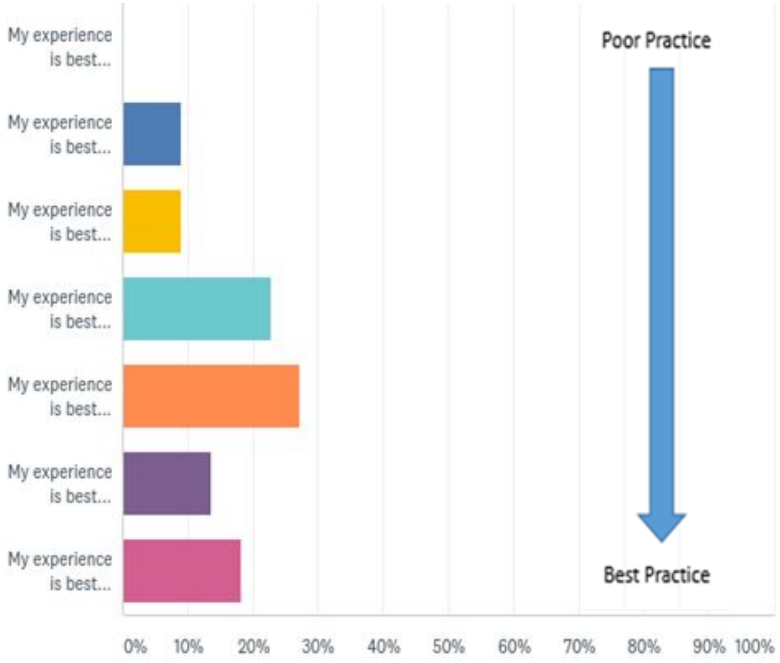
Key Analysis

Low levels of maturity	**9.1%**
Average levels of maturity	**63.6%**
High levels of maturity	**27.3%**

Key additional comments

- **Positive comments**
  - Well defined ownership for risk at an individual level (risk leads)
  - Risk ownership facilitates discussion around impact and opportunity
- **Areas for development**
  - Corporate risks - hard to pin down
  - We have risk owners and information on what that means but in reality it doesn't seem to change behaviours
  - There is no owner assigned to risks and therefore risks don’t get managed proactively.

Q7: Area 5 - Responding to and managing risk



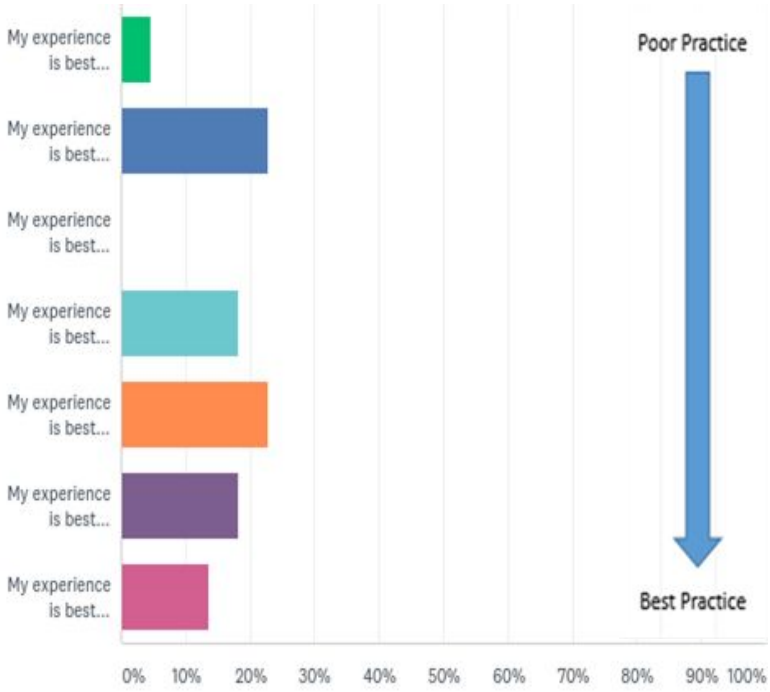
Key Analysis

Low levels of maturity	**9.1%**
Average levels of maturity	**59.1%**
High levels of maturity	**31.8%**

Key additional comments

- **Positive comments**
  - Generally well articulated action plans and review dates.
- **Areas for development**
  - Action planning is often seen as 'someone else's' role rather than a collective responsibility
  - Actions are not necessarily selected on a cost benefit basis, are not always resourced
  - A lack of owners impacts how risks are managed / progressed.

Q8: Area 6 - Reviewing and monitoring risks



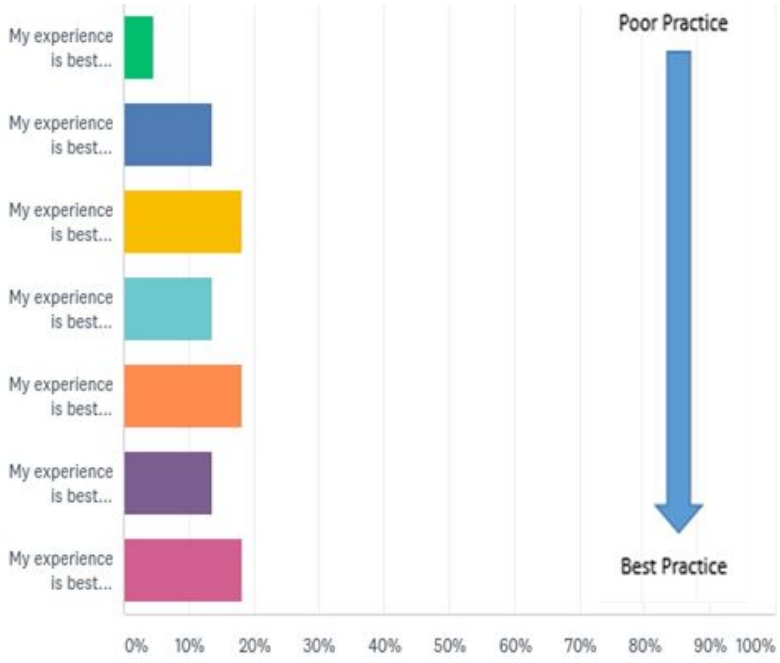
Key Analysis

Low levels of maturity	**27.3%**
Average levels of maturity	**40.9%**
High levels of maturity	**31.8%**

Key additional comments

- **Positive comments**
  - The review of risks at divisional reviews with the Executive Team has been a helpful development.
  - Major programmes all have risk register which are regularly reviewed
- **Areas for development**
  - Risk review should be carried out 'up front' to inform action plans, agendas and operational priorities but is often passed over.
  - We review risk at dept. level but then these are not circulated or engaged with other Divisions

Q9: Area 7 - Risk registers



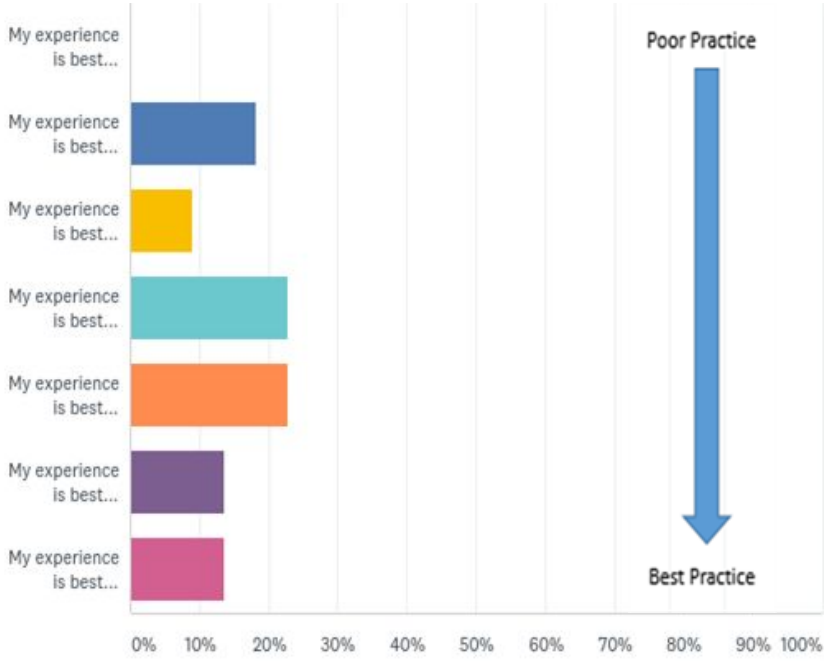
Key Analysis

Low levels of maturity	**18.2%**
Average levels of maturity	**50.0%**
High levels of maturity	**31.8%**

Key additional comments

- **Positive comments**
  - Regular review of risks. All risks recorded in one format and on one centrally held register. Risks integrated with Divisional IMTP
  - Dashboards for different areas to use
- **Areas for development**
  - Limited linkage at present between risks at an operational, planning.
  - Poor understanding of what a risk register is and how to use it effectively.

Q10: Area 8 - The relationship between risk and effective decision making



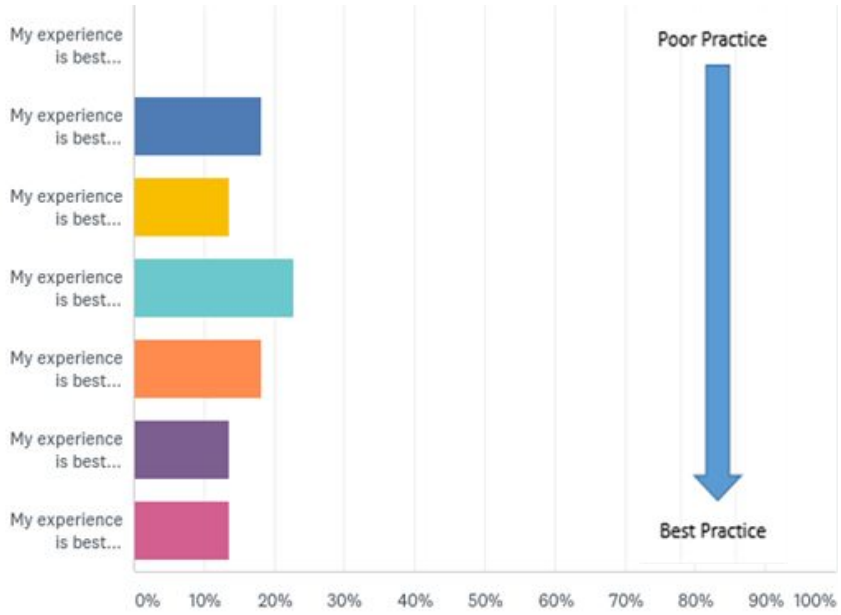
Key Analysis

Low levels of maturity	**18.2%**
Average levels of maturity	**54.6%**
High levels of maturity	**27.3%**

Key additional comments

- **Positive comments**
  - We have a KPI set which includes risk
  - Decisions generally well informed by risk and taken at appropriate level. Focus on priorities
- **Areas for development**
  - little consideration to wider corporate and operational risks - I.E Reputational Risk. .
  - Risk registers sit apart from decision making usually..

Q11: Area 9 - Risk Culture



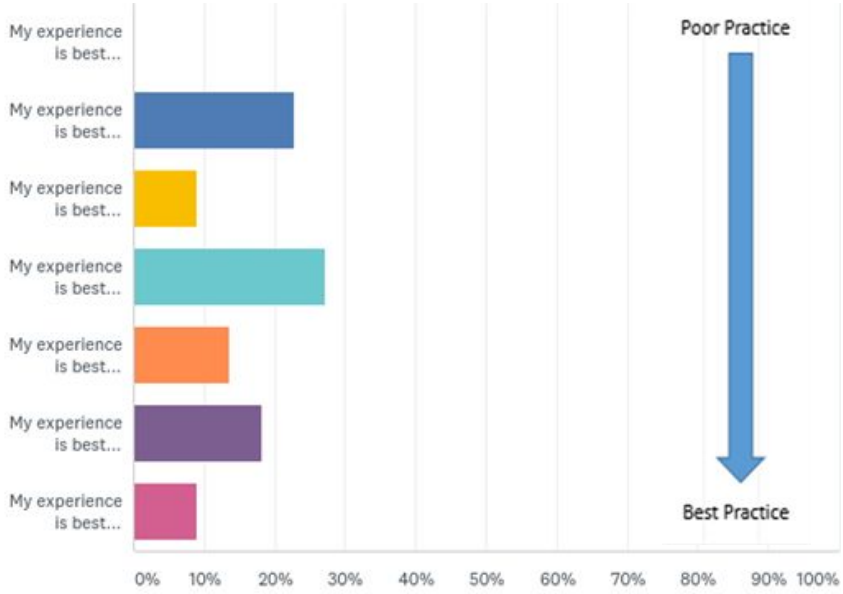
Key Analysis

Low levels of maturity	**18.2%**
Average levels of maturity	**54.6%**
High levels of maturity	**27.3%**

Key additional comments

- **Positive comments**
  - a culture of risk management is embedded at HB level.
- **Areas for development**
  - Risk management at ABUHB needs an executive focus and leadership to gain traction within the organisation
  - There is no dedicated owner of the risks and this gets overtaken by activity.
  - Individuals assess clinical risks on a day to day basis for individual patients. But we do not understand how to do this with organisational risks.
  - Exec Team to identify the clear objectives against which we can undertake Risk analysis.

Q12: Area 10 - Capability, knowledge, skills and experience



Key Analysis

Low levels of maturity	**22.7%**
Average levels of maturity	**50.0%**
High levels of maturity	**27.3%**

Key additional comments

- **Positive comments**
  - All operational staff are trained in basic risk assessment.
  - In 2018 sessions were held for senior managers on the role of investigating officer.
- **Areas for development**
  - Roles are often inherited by people who do not always have the RM experience
  - The HB needs a critical mass of risk specialist centrally that can provide advice, training and development
  - The bow tie model is good but needs expanding/explaining to show how it really works

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Risk Management Development Workshop

Jeff Brown – Director, JBPS Advisory Solutions Limited

22nd Feb and 4th March 2019

Today's Agenda

- Introductions
- Update on the Risk Management Landscape Review
- Responding to the Landscape Review - Group Exercise - Co-designing the next steps
- Break
- Active Learning session– Risk Appetite and Tolerance
- Evolving Risk Management approaches within the Health Board - Case study on the DATIX RM Module – H&S and Pathology
- Next Steps and content for future RM development sessions

Today's primary objective is to build Risk Management capability across the Health Board

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Introductions

The Risk Management Landscape review - update

JBPS Advisory Solutions Limited were commissioned in Sept 18 to undertake a high level Risk Management Landscape review across the Health Board. The review's primary objectives were to:

Gather intelligence from across the Health Board to better understand current risk management approaches and practice and to use this to identify any opportunities or barriers that would enhance or frustrate the improvement of the Health Boards approach to risk management. Our approach included:

- Designing and running a risk survey
- Reviewing key risk documentation
- Undertaking 121 interviews with Risk Champions (30)
- Delivering two risk development workshops

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Risk Management Landscape Review – Survey Results

The survey had two primary objectives:

Objective 1 – to gather an anonymous perspectives on risk management practice from those who have specific risk management responsibilities (Risk Champions).

Objective 2 – To use the maturity narratives within each of the Survey's ten risk management areas, to build capability and knowledge around good/notable risk management practice.

- 70 % response rate
- Variable way in which risks are recorded – approx. 36 % on DATIX, 50% using other methods, including s/sheet and 14% didn't capture risks. – Variability in the detail and format of risk registers
- Above average confidence in Risk Management informing planning and decision making

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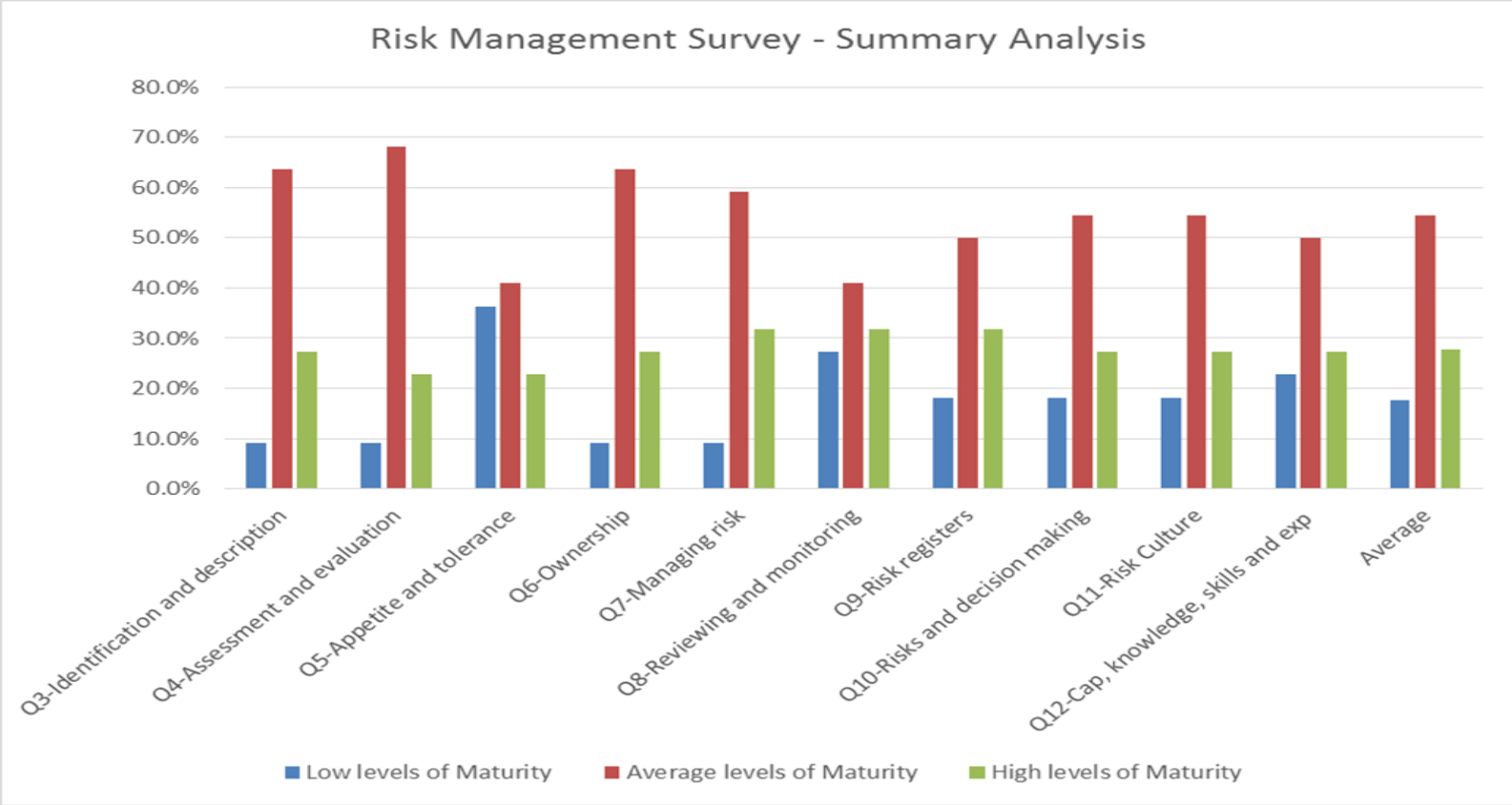
Risk Management - survey results



Across all 10 areas, 55% have average levels of maturity. However, almost 18% have a low level of maturity and nearly 27% a high level of maturity.

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Risk Management survey results

The areas where maturity was highest

- Responding to and managing risk
- Reviewing and monitoring risks
- Risk registers

The areas where maturity was lowest

- Risk appetite and risk tolerance
- Reviewing and monitoring risks – polarised results

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Key findings from the landscape review

- **A recognition by staff that Risk Management is an important part of the business and a willingness to work to get it right. However:**
  - Variability in the way in which risk is integrated into divisional/departmental planning
  - Those with responsibility for risk having this as a bolt onto other responsibilities
  - No clearly defined and owned role for risk champions
- **Variable confidence in and understanding of the current Risk Management framework**
  - Inconsistent understanding of Risk Management Structures/process/tools (including risks v issues)
  - Limited visibility and confidence in feedback loops
  - Confusion/conflation over how you capture and record different risk types (clinical v non clinical risks).

Key findings from the landscape review

- **Balancing everyday delivery with effectively identifying and managing risk**
  - Variability in a supportive/permissive culture which encourages personal responsibility
  - Limited exposure or understanding of risk impacts on other divisions
  - No central point of risk management excellence/support
- **Line of sight between objectives (either at the strategic or divisional level) and risks**
  - No clear relationship between risk management and improvement
  - A perceived disconnect between Divisions and the corporate risk process
  - Variability in understand of risk ownership – Enabling Divisions and Shared risks
  - Limited risk training for senior teams who ultimately take decisions which impact how risks are mitigated/Managed

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Responding to the Landscape Review Co-designing the next steps - Group exercise

Using the key themes from the Landscape review, consider the following key questions;

- What are the barriers to addressing these areas?
- What can be done collectively or individually to address these?
- What practice can I share from my Division/Dept. that might help?

20 mins to discuss, 15 minutes to feedback: Total 35 mins

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Break – 10 mins

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Active learning session

Risk Appetite and Tolerance

We use Risk appetite and tolerance to make decisions every day!

- Would you ever bungee jump? What about base jumping?
- Would you speed in your car? To get to an important meeting maybe – travel at 80, 75 or 70 on a motorway?
- If you were down to your last £1,000, would you bet £10 on a horse after a hot tip? £100? Your whole £1,000?
- At age 65, would you invest 25%, or 100% of your pension fund in the share market? Or none at all? What would you invest in – secure bonds, oil and gas, new Tec, defence.
- Would you walk across a busy road rather than use the crossing to save a minute?

Our individual appetite or preference for risk is different, impacted by our objectives and the context– therefore trying to define what this appetite is for the Health Board is important.

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What is Risk appetite and tolerance ?

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What's the rationale?

- Provides consistency in the decision-making process given that risk appetite and tolerance can be personally subjective
- Enables people to take well calculated risks when opportunities arise that will improve delivery and outcomes, and
- Conversely, to also identify when a more cautious approach should be taken to mitigate a threat and avoid erratic or inopportune risk taking
- Provides a real world context in which risks are identified and managed

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Risk appetite and tolerance

- Lots of guidance – IRM, COSO, IFGGPS, ISO31000, UK Corp Gov Code FRC….. (some differences) – terms used interchangeably – plus others such as: risk propensity, risk thresholds, risk attitude, risk limits…..

IRM states that RA&T only works effectively if :

- Its **measurable** and not based on empty vacuous statements
- It's **not treated as a single, fixed concept**. Recognising a range of appetites for different risks which need to align and may well vary over time.
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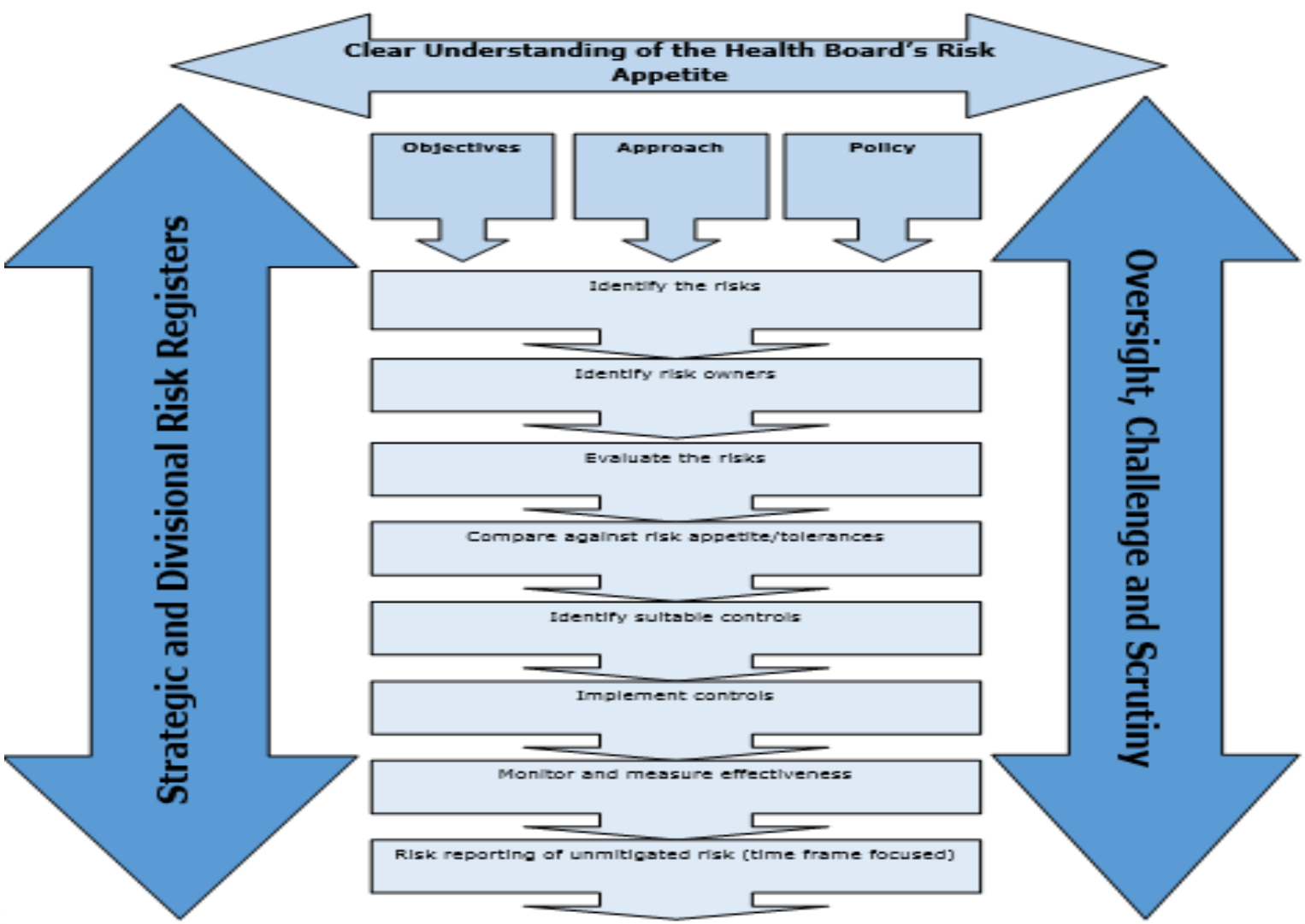
Risk appetite in the risk process?



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Risk appetite definitions

Risk Appetite Level (Assessment)	Level Score	Brief Descriptor	Description of potential effect	Brief Outline of impact
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ABUHB – Risk appetite set for areas of core business - extract

Categories of risk		Risk Appetite	Description
1	Patient Safety	Zero / Low	We will continue to hold the safety of people who use services in the highest regard and will at all times act to avoid risk and uncertainty. Only in exceptional circumstances would the Board have to make any decision that might jeopardise this.
		Levels 1 and 2	This key value driver directly supports our core objective to improve the safety of our services to patients. The preference is for ultra-safe delivery options with a low degree of inherent risk.
2	Quality	Low / Moderate	We will continue to provide high quality services ensuring value for money in a challenging arena and, depending on the circumstances will accept some risks that could limit our ability to fulfil this objective.
		Levels 2 / 3	This key value driver directly supports our core objective to improve the experience of people using our services, and that of their carers and relatives, by providing personalised and responsive services. The preference is for safe and high quality delivery options that have a low degree of inherent risk.
3	Workforce and OD / Staffing and Competencies	Low	We will continue to employ and retain staff that meet the high quality standards of the organisation and provide on-going training to ensure all staff reach their full potential, always mindful of the professional and managerial capacity and capability of the organisation. We will also actively promote staff well-being.
		Level 2	In certain circumstances we will accept risks associated with the delivery of this aim. However, the preference is for safe delivery options with low degree of inherent risk. However, there might be occasion as part of our future strategy to meet changing needs that we seek to develop new staffing models and new roles, which in their development might require a greater level of risk in development.

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Risk appetite's impact on treatment of risk implementation of controls. (IRM)

- Making risk appetite work depends on identifying the right level of control to match the risk aspirations.

- Simple level - controls will have to match the risk appetite, so "risk hungry" might require "empowering controls", whereas "risk averse" might require "harsh controls".
  - Empowering controls might be about high levels of delegation, minimal supervisory review and reporting by exception.
  - Harsh controls might include regular detailed sign-off, re-performance, pre- and post-authorisation and detailed regular reporting.

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For example

Risk description	Inherent risk score	Current controls & mitigations	Risk Appetite Considered	Additional actions and controls	Residual Risk level
Inability to recruit and retain nursing staff leading to inadequate ward staffing levels. Exposure to increased levels of variable pay and potential compromise to patient safety	5*5 = 25	Ensure a seamless robust scrutiny and recruitment process in place Journey of excellence for newly qualified nurses commenced Ensure divisional input into the commissioning arrangements of shared services Monitoring staffing levels, skill mix and nursing principles Ensure flexible use of staffing across services and sites ……	Business Driver - Workforce and OD/Staffing and Competencies – Set appetite – **Low.** …..preference is for safe delivery options with low degree of inherent risk. ……to meet changing needs that we seek to develop new staffing models and new roles, which in their development might require a greater level of risk in development.	Establish retention plan to improve opportunities for existing staff, ensure PADR in place and compliance with all training requirements Ensure correct staffing template & funding Robust sickness management Monitoring mat leave Ensuring efficient roster management Use of additional hours Where unavoidable use of agency staff……..	3*4 = 12

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Applying the Learning – Group Exercise

- Investment risk - Telecare Scenario – Good Governance Institute (NHS England)

- Using the HB's risk appetite descriptions you need to discuss and agree the risk appetite for a local programme of telehealth with three options:
  - What is our risk appetite for investment?
  - Which of the three options will you choose and why?
  - What controls and assurance will we need to give us confidence that reflect our risk appetite?

15 mins to discuss 15 mins feedback – Total 30 mins

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Evolving Risk Management approaches within the Health Board

Case study on the DATIX RM Module – H&S and Pathology

Next steps

- Risk Management – Board Development session 6th March
- Final Briefing Paper produced by the end of March 2019

What aspects of Risk Management would you find helpful to focus on in any future Risk Management Development sessions?

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Risk Management - Board Development Workshop

Jeff Brown – Director, JBPS Advisory Solutions Limited

6th March 2019

Today's Agenda

- Progress update - Risk Management Landscape Review
- Consideration of the framing of risks and how we use Risk Appetite and Tolerance
- Next Steps

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The Risk Management Landscape review - update

JBPS Advisory Solutions Limited were commissioned in Sept 18 to undertake a high level Risk Management Landscape review across the Health Board. The review's primary objectives were to:

Gather intelligence from across the Health Board to better understand current risk management approaches and practice and to use this to identify any opportunities or barriers that would enhance or frustrate the improvement of the Health Boards approach to risk management. Our approach included:

- Designing and running a risk survey
- Reviewing key risk documentation
- Undertaking 121 interviews with Risk Leads (30)
- Delivering two risk development workshops

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Risk Management Landscape Review – Survey Results

The survey had two primary objectives:

Objective 1 – to gather an anonymous perspectives on risk management practice from those who have specific risk management responsibilities (Identified Risk Leads for Departments and Divisions).

Objective 2 – To use the maturity narratives within each of the Survey's ten risk management areas, to build capability and knowledge around good/notable risk management practice.

- 70% response rate
- Variable way in which risks are recorded –
  - 36 % on DATIX,
  - 50% other methods - Variability in the detail contained in risk registers
  - 14% didn't capture risks.
- Above average confidence in Risk Management informing planning and decision making

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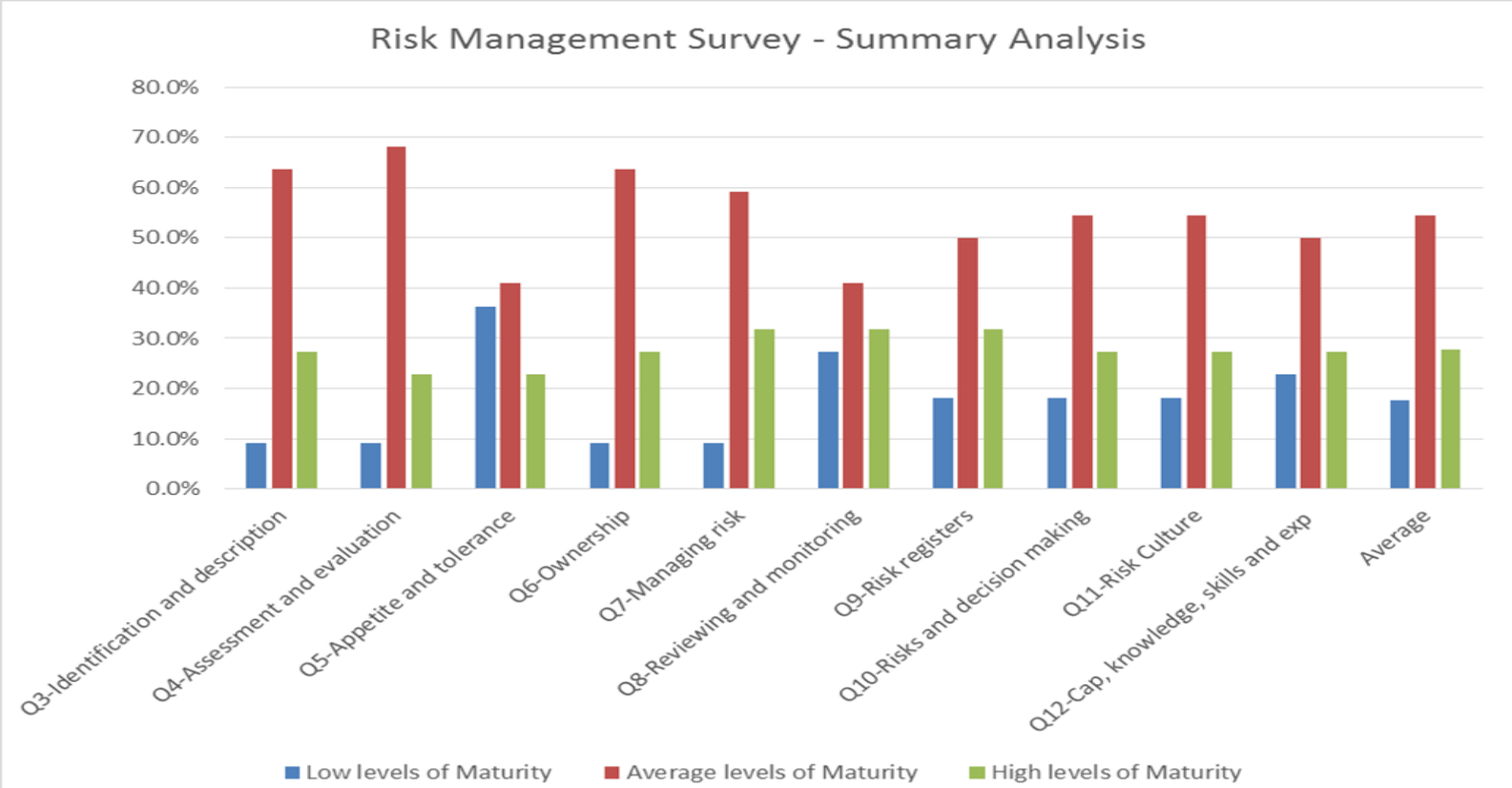
Risk Management - survey results



18% - Low level of maturity
55% - Average levels of maturity
27% - High levels of maturity.

Important narrative commentary to accompany the maturity scores

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Risk Management survey results

The areas where maturity was highest

- Responding to and managing risk
- Reviewing and monitoring risks
- Risk registers

The areas where maturity was lowest

- Risk appetite and risk tolerance
- Reviewing and monitoring risks – polarised results

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Emerging findings from the landscape review

Some examples of positive risk management identified include:

- Establishing a pan Health Board - Risk Management Strategy which reflects current best practice and risk management standards such as ISO 31000 and guidance from IRM.
- The identification of risk management leads across the Health Board
- Being self-reflective and recognising that aspects of the current RM approach needed to be improved – Awareness raised
- Examples of professional and well-practiced approach to risk management such as within the Clinical Future's programme, Health & Safety/Facilities and Families and Therapies Division
- Piloting risk management technology solutions (Datix Risk module)

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Emerging findings from the landscape review

- **A recognition by staff that Risk Management is an important part of the business and a willingness to work to get it right. However:**
  - Variability in the way in which risk is integrated into divisional/departmental planning
  - Those with responsibility for risk considered this as a bolt onto other responsibilities
  - No clearly defined and owned role for risk leads
- **Variable confidence in and understanding of the current Risk Management framework**
  - Inconsistent understanding of Risk Management Structures/process/tools (including risks v issues) in some areas
  - Visibility and confidence in feedback loops
  - Clarification required on capturing and recording different risk types (clinical v non clinical risks).

Emerging findings from the landscape review

- **Balancing everyday delivery with effectively identifying and managing risk**
  - Further work required on a supportive/permissive culture which encourages personal responsibility
  - Limited exposure or understanding of risk impacts on other divisions
  - No central point of risk management excellence/support
- **Line of sight between objectives (either at the strategic or divisional level) and risks**
  - Clearer relationship required between RM and improvement
  - Further work required to connect Divisions and the Corporate risk process – Risk now a feature at ET/Divisional Assurance meetings
  - Clearer risk ownership required – Enabling Divisions and Shared risks
  - Risk training required for senior teams who ultimately take decisions which impact how risks are mitigated/Managed

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Reflections

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Consideration of the framing of risks and how we use Risk Appetite and Tolerance

We use Risk appetite and tolerance to make decisions every day!

- Would you ever bungee jump? What about base jumping?
- Would you speed in your car? To get to an important meeting maybe – travel at 80, 75 or 70 on a motorway?
- If you were down to your last £1,000, would you bet £10 on a horse after a hot tip? £100? Your whole £1,000?
- At age 65, would you invest 25%, or 100% of your pension fund in the share market? Or none at all? What would you invest in – secure bonds, oil and gas, new Tec, defence.
- Would you walk across a busy road rather than use the crossing to save a minute?

Our individual appetite or preference for risk is different, impacted by our objectives and the context– therefore trying to define what this appetite is for the Health Board is important.

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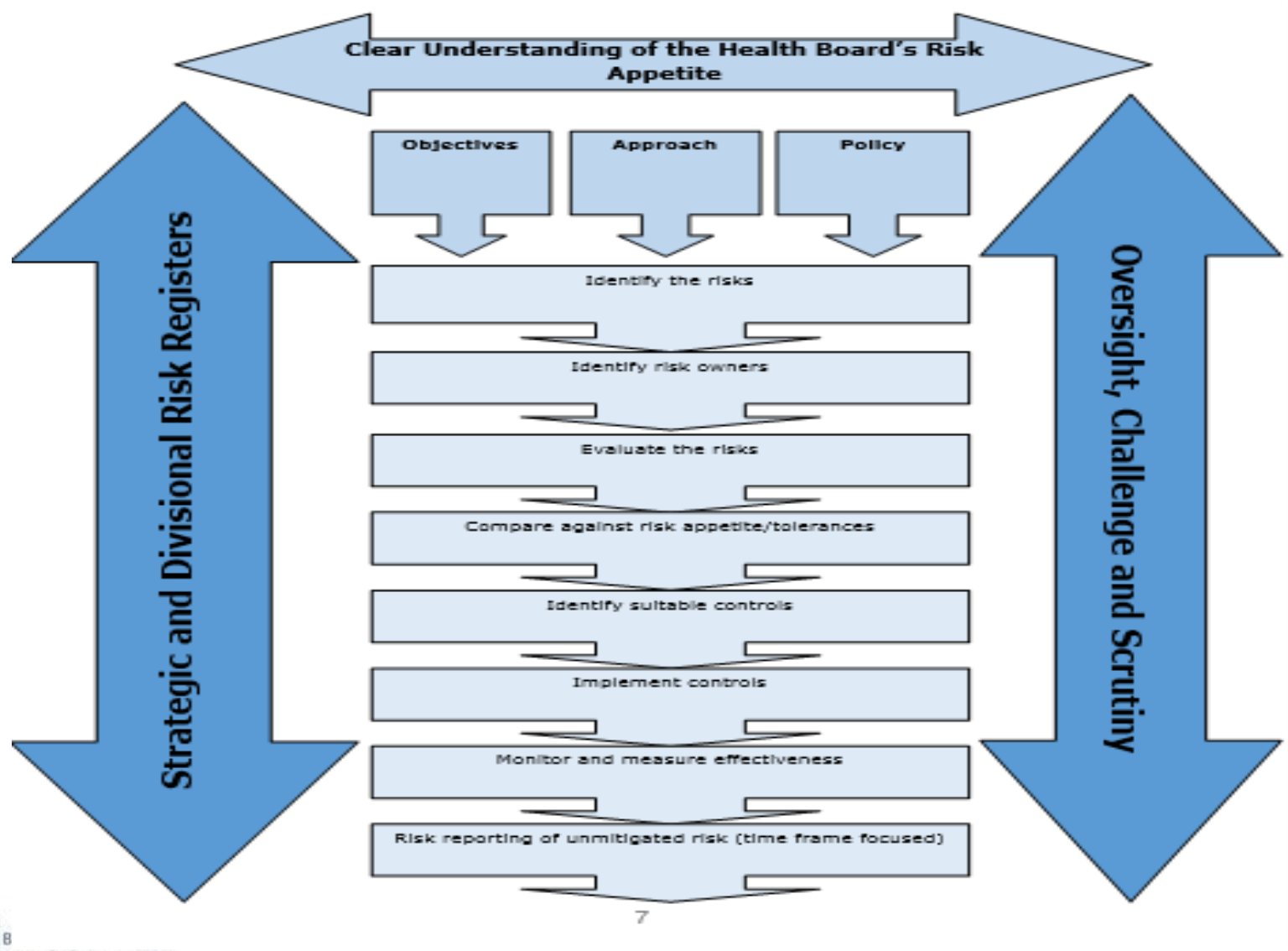

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Group Exercise – Applying Risk appetite

Using a sample of the Health Board's corporate risks and the current risk appetite statement, discuss if these risks accurately reflect the current stated appetite in the way they are being managed.

Risk expressed in new risk on a page format, which will also form part of new arrangements. Comments on this format will also be welcomed in feedback.

15 mins to discuss 15 mins feedback – Total 30 mins

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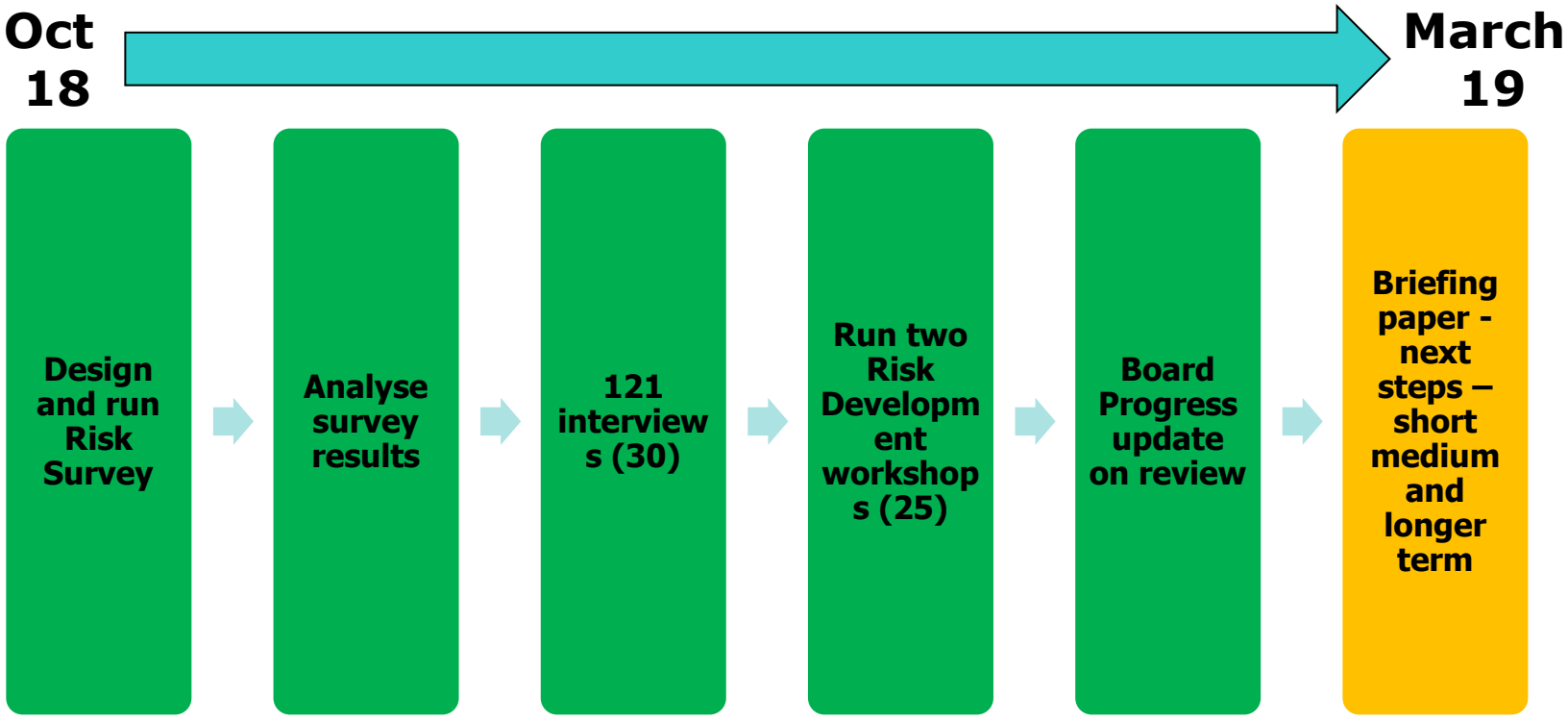
Next steps



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Aneurin Bevan University Health Board

High Level Audit Recommendations Tracker

Executive Summary

At the Audit Committee Meeting in April 2018, it was agreed that the current Audit recommendations Tracker would be fully reviewed with the Executive Team. This was undertaken in readiness for the July 2018 Audit Committee Meeting and was again reported to the October 2018 and January 2019 meeting.

6.5

This report provides the Audit Committee with an update on the progress with the tracker. Twenty-one recommendations are currently covered by the tracker with eleven having been taken off with the agreement of the Audit Committee at the January meeting.

At the Audit Committee Meeting in July, it was agreed that the Tracker would be submitted to each Audit Committee Meeting, that the categorisations used would be changed to better indicate progress. It was also agreed that the source of the reports i.e. Internal Audit or Wales Audit Office would be shown for each action.

This report provides information on the current status of the recommendations following extensive review by the Executive leads and also at the Executive Team meeting. The tracker indicates those recommendations in the opinion of the Executive Team that have been completed and are proposed to be taken off the tracker, those that have made significant progress but are still not fully complete and those where some progress has been made but a number of factors still remain which prevents the action being fully completed. There is also two that are yet to reach their deadline date.

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

Executive Sponsor: Richard Bevan, Board Secretary

Report Author: Richard Bevan, Board Secretary

Report Received consideration and supported by :

Executive Team		**Committee of the Board [Committee Name]**	

Date of the Report: 25th March 2019

Supplementary Papers Attached: February/Early March 2019 Audit Tracker Update

Purpose of the Report

To present to the Audit Committee for compliance and assurance purposes the tracking database of the current agreed actions for Internal Audit and Wales Audit Office high level recommendations.

Background and Context

The Audit Committee agreed in 2014 that in order to closely monitor progress with the programme of internal audits reports undertaken at the Health Board and the subsequent organisational responses to recommendations, that a tracking arrangement would be established, which would be monitored by the Executive Team. A detailed tracking database was set-up initially to record the progress of all the recommendations contained in each of the Internal Audit reports completed since the establishment of the Health Board.

The Committee subsequently agreed that the Wales Audit Office (WAO) report recommendations should also be included within the tracker in order to provide assurance that those recommendations were also being progressed, monitored and completed.

There are currently 22 recommendations within the database, as per the table below:

Red	12	Some progress, but outside the target deadline.
Green	7	The Action has been completed and it is proposed that the action is withdrawn from the tracker.
Amber	1	One Action has been agreed to remain Amber by the Audit Committee.
Purple	2	Action yet to reach its target date.

7 high level actions have been assessed by the Executive Team as completed, or are complete and are proposed to be withdrawn from the tracking database with the agreement of the Audit Committee.

Further work is underway to ensure that the remaining actions on the database are completed as agreed.

Recommendation

The Audit Committee is asked to note this report and green recommendations can be withdrawn from the database.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The coordination and reporting of organisational actions for audit activity are key elements of the Health Board's overall assurance arrangements.
Financial Assessment, including Value for Money	There may be financial consequences of individual actions however there is no direct financial impact associated with this report at this stage.
Quality, Safety and Patient Experience Assessment	Impact on quality, safety and patient experience are highlighted within the individual actions and assurance requirements contained within this report.
Equality and Diversity Impact Assessment (including child impact assessment)	There are no equality issues associated with this report at this stage, but equality impact assessment will be a feature of the work being undertaken as part of the actions.
Health and Care Standards	This report would contribute to the good governance elements of the Health and Care Standards.
Link to Integrated Medium Term Plan/Corporate Objectives	The actions will be aspects of the delivery of key priorities in the IMTP.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	WBFGA considerations are included within the consideration of individual actions.
Glossary of New Terms	None
Public Interest	Report to be published in public domain

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Audit Committee
3rd April 2019
Agenda Item: 6.5

Audit Recommendations – February/Early March 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
1. (IA)	Medicines Homecare Services Management Arrangements Audit *October 2015*	The clinical check requires a Pharmacist to review the current list of drugs prescribed to a patient to confirm that the newly prescribed drug will not affect the patient adversely when taken in combination with the patient's existing prescription. While the clinical check forms an integral part of the homecare process for Tecifera, no clinical check is undertaken for the other 7 drugs delivered through the homecare service. We understand that, due to the large number of patients receiving homecare drugs, there is not sufficient Pharmacist resource available to undertake all of the required checking.	March 2016	Clinical Director for Pharmacy Executive Lead: Chief Operating Officer	**December 2018 Update:** Adalimumab is one of the main historical homecare medicines that does not currently have a clinical check. Following approval of a business case by the Executive Team in December 2018, further pharmacy resource has been secured to support the implementation of biosimilar adalimumab. This will facilitate the clinical checking to be undertaken, as this is a requirement of the new service level agreement. Full implementation is dependent on recruitment and transition to the biosimilar and therefore it is expected that improved compliance will be achieved by April 2019 and will be monitored as part of KPIs presented to the homecare committee. **March 2019 Update**: The KPIs are awaited and are to be reported in April 2019.	The Audit Committee agreed to keep this item on the tracker as Amber until the report is received as planned in April 2019.

Audit Recommendations – February/Early March 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
7. (IA)	IT Access and Environmental Controls *February 2017*	All server rooms should have appropriate equipment installed to enable the effective combat of fire. Equipment should also be regularly maintained and inspected in line with the manufacturer's guidance.	May 2017	Director of Planning, Digital and IT	**March 2019 Update:** All work is complete with the exception of Royal Gwent Hospital, integrity testing revealed that the designated room was not fully suitable and work is being taken forward to correct, otherwise this would have been completed in July 2017, as previously reported. ICT are obtaining a quote from minor works for the work to be undertaken to make the room air tight and for the installation of appropriate venting for the gas to be extracted – confirmation of the timeline for minor works is awaited.	Good progress made. However, the one remaining element means the action cannot be fully completed at this stage. The Executive Team will monitor progress with finalisation of the required minor works to complete this recommendation.

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No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
13. (IA)	Theatres *May 2017*	Management should undertake a complete review of the current arrangements in place with regards to loan equipment and ensure that there are effective controls in place to mitigate the risks associated with this area, such as: • establishing a documented procedure/process for loaning equipment from suppliers or loaning kit out to other Hospitals/Health Boards; • implementing a tracking mechanism to monitor the location and status of loan equipment; • consider a recharge mechanism for loan equipment in order to recoup costs and balance potentially excessive expenditure; and • ensure that there is effective budgetary control concerning loan equipment to ensure that value for money is achieved and costs to the HB are minimised where possible.	September 2017	Director of Operations	**March 2019 Update:** The Business case has been amended to reflect the recruitment of two B3 coordinators who will provide cross cover across both the RGH and NHH sites. The Business case is currently with finance to realise cost benefits/savings. An Omnicell Project Board has been set-up which includes representation from the company. The Project Board is reviewing the current issues in relation to the reliability and success of Omnicell.	The Executive Team noted that work had progressed, but had not yet been completed to the required level. This a key priority to complete the actions and an update will be required by Executive Team in April 2019. Whilst progress has been made with this recommendation it is still unresolved, and remains red, as reflected above.

Audit Recommendations – February/Early March 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
16. (IA)	Private Patients and Overseas Visitors *May 2017*	**R2** - All the individuals should be trained to ensure the appropriate information is recorded. They should be provided with the procedures to be followed based on the latest legislation. These procedures should be uploaded to the intranet. The Health Board should review the resources allocated to overseas patients' administration to ensure that all the required information is captured and that they are billed appropriately.	June 2017	Director of Operations	**March 2019 Update:** The Overseas Visitor Policy is available on the intranet. The training package has been completed based on the policy. This has been sent to Shared Services to develop the online functionality. Shared Services are yet to confirm the timeline for completion. Roll-out of the training will be arranged once notification has been received from Shared Services.	Policy now approved – progress made with the on-line training package. Further work required to roll-out training. Given the progress this could be seen as amber, but the recommendation has passed its deadline date and should be marked red. The Executive Team will review this in April 2019.
20. (IA)	Clinical Audit – May 2017	**R3** - An effective mechanism for the identification and follow-up of actions arising from a clinical audit undertaken locally and nationally, should be implemented as soon as possible, in order to provide assurance that effective action is being undertaken to mitigate clinical risk.	November 2017	Medical Director	**March 2019 Update:** The Internal Audit Service has undertaken a follow-up review of this original Clinical Audit Internal Audit. It has remained 'limited' assurance. An assessment and update report was submitted to Executive Team in January 2019 to indicate progress made and determination of next steps. The follow-up report is to be submitted to the Audit Committee in April.	This recommendation remains red until assurance can be given that the original 2016/2017 recommendations have been completed. An update report was submitted to the Audit Committee on the 17th January 2019. Executive Team identified this area as a high priority. The Internal Audit Follow-up Report will be submitted to the Audit Committee in April. An assessment will then be made with regard the status of the recommendations. This remains red at this time.

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No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
76 (WAO)	Structured Assessment 2017	**R3 - Risk Management** The HB should review risk management arrangements to ensure that corporate risks are appropriately escalated and managed by: a. developing upon its current risk reports to ensure that the context of the risk and progress in managing it are clearly set out; and b. revising the risk rating based on the mitigating actions.	Ongoing End of May 2018	Board Secretary Board Secretary	**March 2019 Update:** The Health Board has fully reviewed its Corporate Risk Register in September 2018 and has updated its Risk Reporting arrangements. Technically, aligned to the recommendation, the required responses have been completed. The Health Board wide risk landscape diagnostic has been completed. Presentation of the initial findings have been presented to the Board. An action plan has been developed and is to be presented to the Audit Committee at its meeting of 3rd April 2019.	The review has been completed. An action plan has been developed and is being presented to the Audit Committee on 3rd April 2019. It is proposed that this action can be withdrawn from the tracker. However, the implementation of the action plan will monitored by the Executive Team.
77 (WAO)	Structured Assessment 2017	**R4 - Internal control** The Health Board should ensure that clinical audits provide assurance within an assurance framework, linked to the organisation's strategic objectives	End of May 2018	Medical Director	**March 2019 Update:** The Medical Director has presented updated work on the Management and Reporting of Clinical Audit. This report has been made to the Audit Committee and the Quality and Patient Safety Committee. The Deputy Director of Therapies and Health Science is leading work with Executive Team colleagues to create a Quality and Safety Assurance Framework in which clinical audit will play a key role, aiming to bring a proposal for consideration by the QPSC.	The Executive Team discussed the further work being undertaken on the Quality and Patient Safety Assurance Framework. However, this remains red as original timescale has passed. Further consideration will be given at the next review – as Executive Team considers this a priority area for completion.

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No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
83 (IA)	Risk Management April 2018	We recommend that the risk management strategy includes an 'Action Plan and Priorities for the year' where the Executive Team and Board agree the developments required over risk management and resources and timescales are set and monitored to ensure their achievement.	June 2018 Original timescale revised to March 2019, in line with agreed Risk Management Review.	Board Secretary	**March 2019 Update:** A Health Board wide risk landscape diagnostic has been completed. Presentation of the initial findings have been presented to the Board. An action plan has been developed and is to be presented to the Audit Committee at its meeting of 3rd April 2019.	The review has been completed. An action plan has been developed and is being presented to the Audit Committee on 3rd April 2019. It is proposed that this action can be withdrawn from the tracker. However, the implementation of the action plan will monitored by the Executive Team.
85 (IA)	Estates Assurance (Fire Safety)	**R6** The review/updating of local fire policies/procedures, fire manuals and risk assessments will be **appropriately** monitored and managed. (O)	July 2018	Director of Therapies and Health Science	**March 2019 Update:** A plan has been developed to review all the remaining overdue fire risk assessments for low risk areas. This is being regularly monitored and anticipated completion will be end of June 2019. Three Fire Safety Advisers have been appointed to support the delivery of the fire safety priority improvement plan, all of which will be in post by beginning of April 2019. The fire management dashboard which monitors compliance with fire risk assessments, local policies and fire manuals is regularly monitored by the Fire Safety Team and the ABUHB Fire Safety Committee.	The Executive Team noted the good progress that had been made as part of a full review undertaken at the 11th March 2019 Executive Team Meeting. However, as the original timescale had now passed, this remained red. It was recognised that this is a wide ranging and complex area. The Executive Team keep this area under close review. However, significant progress had been made over last 6-9 months.

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No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
86 (IA)	IT Service Management	**R1** Formal SOPs should be developed for operating the service desks that cover the following key items: - objectives; - definition of types of calls and routing of these; - roles and responsibilities; - process for recording and monitoring calls received; - service level targets and metrics; - process for handling calls received; and - classification and prioritisation scheme. Formal SOPs should be developed for change control. Formal SOPs should be developed for release and deployment management.	October 2018	Director of Planning, Digital and IT	**March 2019 Update:** All staff in ICT and CAIST are now trained in ITIL foundation. Team leaders have attended Lifecycle qualification courses. Call routing and types are defined for 2 of the 7 services. Further work needs to be done to define roles and responsibilities. Funding for an ITIL band 6 product specialist was prioritised from to support critical resource to support the outcomes of the service management audit. Despite successful recruitment, the candidate withdrew for a more attractive offer. The directorate is now considering alternative approaches. The ICT Service Manager appointed in September was an interim position and the incumbent has decided to return to their previous role. Recruitment of a substantive appointee has been successful. The ICT Service Manager will review the capacity and capability of the team and revisit the original ICT business case.	The Executive Team noted the good progress that has been made. However, as the original timescale had now passed, this remained red. It was recognised that this is a wide ranging and complex recommendation and a range of key elements have been achieved, but given the importance of this area of risk – the Executive Team noted that the timescale will be longer than originally assessed, especially with regard to the recruitment difficulties and therefore, it is anticipated that this action will be completed by September 2019. The Executive Team will keep the position monitored.

Audit Recommendations – February/Early March 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
87 (IA)	IT Service Management	**R2** Informatics should seek to identify the Informatics service needs of the organisation. This should be done by identifying customers' desired outcomes and recognition of value and should include an assessment of customer need, impacts recovery objectives etc. Services should be designed/ restructured to appropriately match these needs and the services provided should be recorded in a service catalogue.	October 2018	Director of Planning, Digital and IT	**March 2019 Update:** ICT has held an initial event with attendees from across the Health Board to meet with informatics staff. A follow-up event is planned early in 2019/2020. A programme for full engagement and understanding of the needs of services will be mapped out, including the resource implications, once the ICT Service Manager starts in post. The digital transformation strategy is integrated with the Clinical Futures Programme. This will be aligned to the clinical models due to considered by the Board in March 2019. Once this has been completed then the current draft digital transformation strategy will be refined to align with the clinical models. This will then be go to Transformation to Digital (T2D) Delivery Board for sign off before presenting to Executive Board for final approval.	The Executive Team noted the good progress that has been made. However, as the original timescale had now passed, this remained red. It was recognised that this is a wide ranging and complex recommendation and a range of key elements that have to be achieved. The Executive Team noted that the timescale will be longer than originally assessed, especially with regard to the recruitment difficulties and alignment to the service models. Therefore, it is anticipated that this action will be completed by September 2019. The Executive Team will keep the position monitored.

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No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
88 (IA)	IT Service Management	**R3** Informatics should seek to develop a SKMS in order to share knowledge across departments. This process should include developing a Knowledge Centred Service (KCS) process within the service desks and ensuring models for calls and problems are catalogued and indexed and easily available.	October 2018	Director of Planning, Digital and IT	**March 2019 Update:** Work has been undertaken with a third party to investigate how SharePoint can be used as an SKMS. The Service Desk has commenced a gap analysis of standard operating procedures they require vs those that are available. The analysis is completed for service desk and procedures are now developed. A formal management process in operation. Deployment of this into further teams will be part of the defined work for the ICT Service Manager.	The Executive Team noted the good progress that has been made. However, as the original timescale had now passed, this remained red. A formal plan will be developed within 3 months of the ICT Service Manager starting in post. (Circa September 2019). The Executive Team noted that progress had been made, but agreed to keep this under review.
89 (IA)	IT Service Management	**R4** A Change Advisory Board should be established for Informatics.	October 2018	Director of Planning, Digital and IT	**March 2019 Update:** The Change Advisory Board is operational within ICT and meets on a monthly basis – with emergency change processes operating in between, as required.	The Executive Team noted the position and agreed that the action should be marked as green and proposed to be taken off the tracker.

Audit Recommendations – February/Early March 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
93 (IA)	Management of Balance Sheet Assets	We recommend that the Health Board introduces tagging/identity marking of all relevant assets in order to facilitate the identification and physical verification of assets against the asset register.	March 2019	Director of Finance	For clarification, whilst capital assets are not tagged with the individual Fixed Asset Register number, a significant proportion of assets are tagged by other departments such as Medical Electronics and IT. Current processes involve the asset register being updated with serial numbers and the appropriate Medical Electronics reference, however, this information is not available for all historic assets. To improve the security of assets, and identification as part of the annual verification process, the Capital Team will, in consultation: • Develop a policy for asset tagging which defines where tagging is appropriate; • Investigate options for the purchase of an asset tagging system, considering existing systems in use in ABUHB and potential for linking to the Medical Electronics database and research the systems employed at other health boards and trusts; • Develop a business case and plan for the implementation of a preferred option in 2019/20 including outline specification, cost/benefits analysis, procurement options, funding requirements and resource implications.	At the time of review the deadline was not yet reached. An update will be made as part of the next report.

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No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
94 (IA)	Patient Discharge Process	**R1** Staff should be reminded of the requirement to set an estimated date of discharge for the patient as soon as possible following admission.	January 2019	Director of Operations	**March 2019 Update:** All Ward Managers, Junior Doctors and Consultants reminded of the need to set EDD's within 24 hours of the patient's admission. The Board Round, Ward Round and MDT will be the means by which this is set and reviewed. Scheduled Care/Unscheduled Care have relaunched the SAFER Patient Flow Bundle and will audit compliance using NHS Improvement template in January 2019. This work is ongoing as part of the Divisions daily flow work.	The Executive Team considered that this action had been completed in terms of reminding staff, but will keep the position under review to monitor impact.
		Consideration should be given to updating the Discharge Policy with a timescale for setting an EDD. For example, another Health Board advise this should be set within 24-48 hours.	January 2019	Director of Operations Director of Nursing Medical Director	**March 2019 Update:** A Task and Finish Group was established to review the policy across all divisions and relaunch of the policy. The policy has been completed and has been sent out for further consultation. Significant feedback was received, so an amended version has been sent out for further consultation.	Significant work has been undertaken against this recommendation. However, the further consultation required has meant that the deadline has passed. However, it is anticipated that this will be completed by the end of April 2019 and could then be turned green.
		EDD's are often written on ward boards, however this information is not kept. EDD's assigned on board rounds must be captured on CWS for recording keeping and audit purposes – this should sit as a role for ward clerk.	November 2018	Director of Operations	**March 2019 Update:** Scheduled Care/Unscheduled Care continue to use PSAG to capture EDD but when discharge is confirmed this transfers to CWS for wider communication. KPIs for discharge performance management being agreed by group led by Assistant Director of Operations. Monthly cross Divisional discharge Improvement Board to start from April with fortnightly performance management of KPIs (EDD, time of day discharge etc).	The necessary changes have been made for capturing the ward board information and saving this to CWS. The cross divisional process will commence in April and it is anticipated that this recommendation will turn green at its next review.

Audit Recommendations – February/Early March 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
		Monthly audit of EDD's to be undertaken centrally and reported to the Divisional Nurse for monitoring and action as required.	November 2018	Director of Operations	**March 2019 Update:** CWS reports are being run for Scheduled Care/Unscheduled Care to determine compliance with EDD reporting and are being checked by Divisional Nurses. Also two workshops were held with Informatics and Divisions (including clinicians) to further enhance the transfer of critical discharge information to CWS real time at the Board Round. This will include EDD and constraints.	The Executive Team considered that this action had been completed in terms of reminding staff, but will keep the position under review to monitor impact.
		EDD will be added to paediatric discharge pro forma and discussed at ward manager level for dissemination to nursing staff	December 2018	Director of Operations	**March 2019 Update:** Discussions continue with the Divisional Nurse for Family and Therapies about adding EDD to the paediatric discharge pro forma.	An assessment will be made following the conclusion of these discussions with regard to the benefit of adding this information to the pro forma as initial feedback has been that there will be minimal benefit. The Executive Team will make a judgement when these discussions have been concluded. This remains red until this time.
		Mental Health and Learning Disabilities to review expectations for EDD across wards, due to the variation in average length of stay.	March 2019	Director of Operations	**March 2019 Update:** This work is on track and will be reviewed by Executive Team in April 2019. It is anticipated that this will be concluded by that time.	At the time of review the deadline was not yet reached. An update will be made as part of the next report.

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No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
		R2 Staff should be reminded of the need to fully complete the Hospital Admissions Document, including the discharge checklist and all staff who make an entry in the document must include their details in the Signature Register. A monitoring process should be put in place by management in order to ensure that required records are completed in order to ensure that the approved practice is followed.	December 2018	Director of Operations	**March 2019 Update:** 1. Nursing staff have been issued with directive that all documentation must be signed for (name printed) to comply with policies and professional requirements for record keeping. 2. The discharge policy has been reviewed and requirements reflected in the documentation. 3. Completion of the discharge checklist for all patients discharged is being actively monitored. 4. Senior Nurses to audit x5 sets of notes per week to monitor compliance. Immediate feedback to staff to enable correction of documentation. 5. Documentation audited at Divisional level for Scheduled Care and Unscheduled Care though Health and Care Standards Assurance. 7. Paediatric directorate is reviewing the current discharge documentation for its area. 8. Mental Health and Learning Disabilities Division is reviewing the range of discharge documentation used across all directorates.	Given the actions taken and the progress made. It is proposed that this recommendation is completed and can be taken off the tracker.

Audit Recommendations – February/Early March 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
95 (IA)	Budgetary Control	We recommend that directorate budget monitoring meetings take place monthly, that minutes and actions of these are recorded in all cases and that in the Scheduled Care Division, the Finance Business Partner team introduce a process of critical review of the financial summary reports that the directorates submit.	Completed (This was identified as completed at the time of the IA Report)	Director of Finance and Performance	**March Update 2019** Agreed recommendation has been actioned with the Scheduled Care Division.	Executive Team proposes that this recommendation can be withdrawn as it is satisfied that the action has been completed.

Clinical Futures - Service Redesign

Final Internal Audit Report
2018/19

Aneurin Bevan University Health Board

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Review reference:	ABU-1819-07
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Fieldwork commencement:	23 November 2018
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Auditors:	James Quance, Head of Internal Audit Stephen Chaney, Deputy Head of Internal Audit
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Committee Audit Committee

ACKNOWLEDGEMENT

NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

8.1

1. Introduction and Background

The review of Clinical Futures – Service Redesign was completed in line with the 2018/19 Internal Audit Plan.

Clinical Futures is the key strategic direction within Aneurin Bevan University Health Board (the 'Health Board'). It is the Health Board's plan for a sustainable health care system across the Gwent area.

In summary, it seeks to:

- deliver most care close to home;
- create a network of local hospitals to provide routine diagnostic and treatment services; and
- centralise specialist and critical care services, within the Grange University Hospital.

Within the transformation programme and by the end of December 2018, a complete refresh of the 54 clinical models (e.g. neurology, critical care and ENT) within the Health Board was planned. This was subsequently reduced to 47 clinical models, following the amalgamation of numerous models throughout the Health Board. A particular example is within the Mental Health and Learning Disabilities division, where six were condensed into one.

Each model was formally reviewed and scrutinsed as part of a structured challenge and support process. The main objective of the Challenge and Support Group is to provide recommendations and support in model content and alignment for performance improvement benchmarks, Workforce and Finance, prior to consideration and ratification by the Service Redesign Board, which then makes recommendations for approval to the Clinical Futures Delivery Board (Executive Team).

Each of the clinical pathways is assigned a priority rating, based on the following criteria:

- **Priority One:** located at multiple sites, but required for the Grange University Hospital;
- **Priority Two:** acute service, with a strong Grange University Hospital presence; and
- **Priority Three:** other clinical pathways.

The clinical model refresh is intended to embed the following principles:

1. **Patient centred**, concentrating on safety, quality and experience.
2. **Home to home**: integrated services in the community to prevent illness and improve wellbeing, and providing care closer to home where appropriate.
3. **Data** and **evidence driven,** patient **outcome** focussed.
4. **Innovative** and transformative, considering new ways of organising and delivering care around the patient and their carers.
5. **Standardised, best practice** processes and care pathways.
6. **Sustainable** with efficient use of resources.
7. **Prudent** by design, following NHS Wales prudent healthcare principles.

The current workstreams within the Clinical Futures process are:

Programme HQ	To lead, monitor and control the entire programme
Service Redesign	Designing new models of care
Strategic Capital & Estates	Support the delivery of the capital and estate
Supporting Infrastructure	Manage the strategy and delivery of supporting infrastructure
Informatics	Identify and deliver enabling informatics
Workforce & OD	Workforce plans to underpin the service redesign models, training and re-deployment of staff
Comms and Engagement	Promote the awareness of Clinical Futures

The workstreams are operating in tandem to help deliver the Clinical Futures transformation. One of the first key stages is the completion of the service redesign workstream, where a complete review and refresh of all clinical models is being undertaken, taking the original full business case, which was approved by the Welsh Government, as its baseline.

Each model was required to be scrutinised by the Challenge and Support Group, comprising of senior managers throughout the Health Board, this process may be iterative to attain the best model. Once it had passed through the Challenge and Support process, the subsequent model was due to be presented to the Service Redesign Board for review and approval,

where core members (Executive Directors, Clinical Futures Team and Senior Managers) attended the monthly meeting. The Service Redesign Board then makes recommendations for approval to the Clinical Futures Delivery Board (Executive Team and additional members). In addition, financial expenditure within the clinical models may be governed via other avenues, in accordance with the Health Board's Scheme of Delegation. For example, financial investment within a team that is required. This may be approved by the full Board, depending upon the value.

2. Scope and Objectives

The internal audit assessed the adequacy and effectiveness of internal control for the redesign of the clinical pathways within the Service Redesign workstream of the Clinical Futures transformation project, as indicated above.

Weaknesses were brought to the attention of management and advice issued on how particular problems may be resolved and control improved to minimise future occurrence.

The specific objectives reviewed were:

Divisions and Directorates

- to ensure that divisions / directorates have robust measures in place for developing sustainable clinical pathways, including:
  - the financial implications of delivering the plans are appraised;
  - strong challenge and oversight of the pathways takes place within the service areas, prior to submission to the Challenge and Support Group;
  - key personnel are involved within the decision making and development of the clinical pathways;
  - assumptions developed to achieve the implementation of the clinical pathways are appropriate;
  - the clinical design principles are embedded into the clinical pathways;
  - sufficient time and resource has been allocated to achieve the key milestones within the delivery of the clinical pathways and in particular, Priority One and Priority Two pathways; and
  - contingency arrangements where milestones are not met or slippage is expected.

Corporate

- to ensure that there is suitable oversight (and where appropriate, involvement) by the Executives / Board; and
- the effectiveness of scrutiny within the Challenge and Support sessions over the clinical pathway process.

Limitation of Scope

The audit assessed the key controls in place for the process of developing, reviewing and approving each clinical model sampled. It did not assess the quality or success likelihood of each model, other than to test against each of the audit objectives.

3. Associated Risks

The potential risks considered in the review were as follows:

- divisions do not dedicate sufficient time and / or resource to the development of the clinical pathways, resulting in an unsustainable service;
- assumptions used within the redesign process are materially inconsistent with service redesign principles;
- ineffective challenge or scrutiny of the proposed pathways;
- key milestones are not met, resulting in delayed implementation of Clinical Futures;
- insufficient engagement from key personnel within the Health Board, including clinicians; and
- a lack of cross-divisional support and integration of pathways.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with Clinical Futures – Service Redesign is **Reasonable** Assurance.

RATING	INDICATOR	DEFINITION
Reasonable		The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

There is clear evidence that models will not be fully endorsed by the Challenge and Support Group or ratified by the Service Redesign Board until the models are fit for purpose. Whilst the timeliness of the clinical models may result in pressures arising later during the Clinical Futures project, at this stage the controls are generally operating in line with expectations.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Financial Implications		✓		
2	Challenge and Oversight			✓	
3	Key Personnel			✓	
4	Assumptions			✓	
5	Clinical Design Principles				✓
6	Time and Resource		✓		

Assurance Summary					
7	Contingency Arrangements			✓	
8	Suitable Oversight			✓	
9	Effectiveness of Scrutiny			✓	

** The above ratings are not necessarily given equal weighting when generating the audit opinion*

Design of Systems/Controls

The findings from the review have highlighted two issues that are classified as weaknesses in the system control/design for Clinical Futures – Service Redesign. These are highlighted in Appendix A as *(D)*.

Operation of System/Controls

The findings from the review have highlighted two issues that are classified as weaknesses in the operation of the designed system/control for Clinical Futures – Service Redesign. These are highlighted in Appendix A as *(O)*.

6. Summary of Audit Findings

The complete review and refresh of 54 clinical models by the end of December 2018 was always going to be a significant challenge for the Health Board. This challenge was recognised in prioritising certain critical pathways above others in order to focus upon those having the greatest impact upon the Grange University Hospital.

The majority of the resultant 27 (59%) clinical pathways were submitted to the Challenge and Support Group in November and December.

We reviewed the process for ten clinical models. Each passed through the Challenge and Support Group, following considerable challenge, and were approved for submission to the Service Redesign Board with many significant issues yet to be resolved.

The majority of these issues are in respect of finance and workforce which are symptomatic of other aspects of the models needing to be concluded upon before workforce and financial implications can be fully assessed.

In terms of financial implications, currently cost pressures of £5.3m have been identified as a result of investment being requested for a number of clinical models and certain models were submitted to the Challenge and

Support Group with insufficient consideration of factors which influence an assessment of their financial impact.

However, we observed two Challenge and Support sessions and we did not observe the level of challenge to have been compromised by the pressure caused by many models coming through late in the process. However, the November meeting of the Service Redesign Board was not as fully attended as it should have been and there is a lack of clarity as to what constitutes core membership for decision making purposes.

Major decisions remain to be made to conclude the service redesign work so that the Health Board can have a complete picture of the performance, financial, workforce and operational requirements and it is vital that these decisions are made as part of a robust governance process and not compromised now that Challenge and Support has ceased. This will prove extremely challenging under the pressure that exists to move on to the implementation stage.

Detailed Findings

For each audit objective, further analysis has been provided below.

Financial Implications

We examined the process for identifying the financial costs associated with each clinical model sampled, to identify the availability of funding to fulfil the approved pathways.

For each model the general financial requirement set out is to at least operate within the existing cost envelope, with a level of savings required throughout the service redesign process for funding the operation of the Grange University Hospital. Within Section 11, 'Financial Assessment' of the clinical model redesign template, the guidance states:

'To be undertaken by finance business partner. Must show how proposal meets financial envelope. If variance is requested that should be shown but we cannot assume it would be agreed at this point as would require much more discussion.'

Whilst there may be some requirement to increase funding or variance from the original business case for some models, the overall objective across the Health Board is to operate within the existing funding available, with savings generated to at least fund an additional hospital.

However, at this stage the financial appraisal process is still ongoing, with seven of ten models examined requesting additional funding, following the model refresh. These are as follows:

Clinical Model	Possible Cost Increase (circa)
Critical Care (additional funding may be available)	£1.6m to £2.6m
Pharmacy	£328k
Oral and Maxillofacial	£461k
Gastroenterology	£133k to £181k
ENT	£358k
Cardiology	£286k
Acute Medical Take	£588k

Whilst considerable work is still ongoing across all areas to finalise the clinical models, including determining the overall financial implications and associated business cases to be approved, workforce numbers / availability, performance improvements and the bed utilisation numbers, we do not yet know if the delivery will generate the expected savings to operate within the existing cost envelope, as intended.

The following clinical models detail some specific examples of additional work still required, to allow the Health Board to finalise the overall position:

- Theatres were planning a saving of £579k within the original business case, but a more detailed reconciliation around unsociable hours is required following the Challenge and Support Group;
- Liaison Services - Mental Health and Learning Disabilities, according to Challenge and Support Group the model was developed within resource constraints, but more analysis is required regarding the sites, workforce plan, capacity and demand and pathways, prior to the Financial Assessment being completed; and
- Palliative Care require further engagement with Finance.

Indeed, the December 2018 Progress Tracker shows that every clinical model still has a degree of action required prior to finalisation, with 32 of 54 at 'amber' status and two showing 'red' status. The current expected increase in costs, if all business cases are approved is up to £5.3m.

We have raised a recommendation within Appendix A on the above financial implications.

We were informed by the Clinical Futures Team that there had been concern regarding the engagement of Business Partner Accountants early in the process and a general feeling that Finance had not been sufficiently engaged in service redesign.

Our discussions with service leads and observation of the Challenge and Support Process and review of documentation did not provide notable evidence of this.

Engagement will be considered further in our next Clinical Futures review in respect of action taken by the Health Board in response to the recommendations of the Welsh Government Gateway Review undertaken in July 2018.

Challenge and Oversight

The process for challenge and oversight is similar within each directorate. The original business case from 2015 has served as the starting point / baseline for each clinical model. However, some directorates started afresh and developed their models in line with best practice. We have been informed that within the last 12 months, that a complete refresh has taken place of all clinical models (following a reduction of 54 to 47), with involvement throughout of Clinical Leads, Management Leads, Divisional Director, General Manager, Service Managers, Finance, Workforce and Organisational Development, Clinical Futures Senior Programme Managers and other planning staff.

Typically, the process commences with a workshop involving key personnel to outline the approach, timeframes and to develop ideas. The progress of the clinical model is monitored via directorate / divisional management meetings.

Each clinical model plan contains a log of personnel involved with changes taking place.

At the Challenge and Support Group, senior representation from the directorate attended to present the model(s).

Within the Unscheduled Care Division, an extensive exercise was undertaken on 1,400 patients to understand their condition that was presented at accident and emergency, their home address to understand which localities patients are travelling from, average length of stay, diagnosis and discharge outcome.

Furthermore, this was analysed in more depth to understand which speciality the patient was seen by versus the team that was best placed to look after the patient e.g. Cardiology, the intervention completed, distance of travel and admission method. This data helped to inform the development of each of the clinical models within Unscheduled Care to target key areas of demand.

The process for challenge and oversight, including the Challenge and Support Group sessions observed, generally worked well.

Key Personnel

Within the divisions and directorates, key personnel are involved from a clinical perspective, in addition to general managers. To support each directorate, the Clinical Futures Team assist with preparing the clinical models.

Each divisional management team receives the clinical models and senior managers present to the Challenge and Support Group.

Upon review by the Challenge and Support Group, plans are escalated to the Service Redesign Board, whereby they are reviewed and ultimately considered for recommendation to the Clinical Futures Delivery Board.

However, upon reviewing the attendees at the Service Redesign Board, in November 2018 the breadth of representation was considerably lower than other meetings.

For example, during the meeting, 7 of 18 members were present (6 of 10 were core members), with no representation from Primary Care and Nursing, who are core members. However, it is not clear if all core members are required to be present for the meeting to be quorate.

The models from Therapies and Anaesthetics were presented in addition to three models for discussion (ENT, Rheumatology and Maxillo-facial). There is a risk of insufficient expertise available for discussion (and ultimately approval) of clinical models if core members are not present. This is in addition to the risk of the Service Redesign Board making decisions and recommendations when the meeting may not be quorate.

The terms of reference, paragraph 6 explains that for decision making purposes, a quorum includes core members and their deputies, but it does not define the number of members required or the classification of a deputy or indeed if it is within a particular speciality for such purposes. This should be explicitly detailed within the terms of reference. In addition, when a meeting does not meet the quoracy requirements, this should be noted in the minutes.

Representation from the clinical side of the Health Board (Deputy Medical Director) was present, together with appropriate clinical representation for the models approved and discussed at length (notably Therapies Service Model and Anaesthetics Model, respectively) In addition, the Executive Director of Planning and Performance chaired the meeting, as the Clinical Futures lead. The remaining models were discussed, with further action still required. In addition, there was considerable challenge by the Assistant Finance Director throughout the meeting regarding the clinical models presented.

The remaining meetings that we examined included either the core members or their deputies present. However, within the August meeting it is not immediately apparent if a deputy was present or required for the absence of one core member, although the individuals attending were in line with expectations.

Assumptions

Each of the clinical models contains a range of assumptions, ranging from examples including the current use of a hospital site remaining the same to an interdependency being ready or available for the service.

However, as the models are prepared at a fixed point in time, there is a continuing need to review and refresh each model and map and understanding the linkages between each of them. For example, in order for the Stroke Clinical Model to be successful, there is a requirement to access a seven day Doppler service and 24 hour access to radiology services. If this is not available, then the ability to deliver on this model is compromised.

Throughout each clinical model there are a range of interdependencies, whereby the clinical model depends upon the services or other requirements from another directorate or other external bodies e.g. Welsh Ambulance Service NHS Trust. Such interdependencies are important, for example, to improve the throughflow of patients, the stepping down of patients between sites, the transfer of patients and access to diagnostic services etc. A weakness in one interdependency can have significant impacts upon a model.

Therefore, we recommend within Appendix A that an ongoing review and refresh of each model takes place, to allow contingency arrangements to be developed in time for the opening of the Grange University Hospital.

Clinical Design Principles

Each clinical model is required to adhere to the seven principles required for the design of the clinical model. All models reviewed adopted this template and reported into the Challenge and Support Group with this approach.

Sufficient Time and Resource

A high amount of effort has been input into each clinical model reviewed. However, the completion of the updated clinical models from the 2015 Business Case has been undertaken very close to the self-imposed deadline.

Whilst the Priority One and Priority Two models were completed prior to the end of December 2018 or combined into an existing model, 16 (59%) were

scheduled for the Challenge and Support Group during November and December 2018.

An earlier version of the Progress Tracker detailed a delivery profile of 36% of models for November / December to the Challenge and Support Group. This had also appeared to have changed from a previous delivery profile too, with delivery of the clinical models expected some months earlier, with an initial target delivery date set ranging from the end of January to the end of September 2018.

To accommodate the high portion of models towards the end of the process, extra Challenge and Support Group meetings were scheduled. However, the level of discussion, challenge and further action required was not tapered towards the end. Indeed, there was a wider overview across all preceding clinical models, which help to inform discussion around the later clinical models to come through.

Furthermore, the discussion and approval at the Service Redesign Board of the models also led to increased agenda volumes. There is a risk that the high volume of information to be assimilated and challenged diluted the process and left insufficient time to cover all major risks, interdependencies and assumptions within each clinical model. In addition to the low attendance at the November Service Redesign Board, there is an increased risk throughout of key attributes of each model being overlooked or a key issue not being identified as a result of the compression of timescales.

A recommendation has been raised accordingly, within Appendix A.

Contingency Arrangements

Each clinical model details numerous interdependencies, assumptions and risk factors. However, once a clinical model has been approved, it should be continuously reviewed and refreshed accordingly, particularly where further action is required. The process of reviewing each clinical model at Challenge and Support should be the start of an ongoing process until all uncertainties have been addressed / mitigated as much as possible.

Suitable Oversight

Once a clinical model has been approved by the Challenge and Support Group then it is presented to the Service Redesign Board for approval.

The Service Redesign Board consists of Executives and senior managers from all divisions. With the exception of the issue noted above we found the Board to be operating in line with expectations.

However, we noted that the update report to the Health Board meeting in January stated that '*all 54 service models had passed through the Challenge and Support process*.' However, we understand that this figure should have

been 47 and 'passed through the Challenge and Support process' may infer a degree of finality that is not yet in place. In contrast it was reported that the models need to be brought together to give an overall view for the Delivery Board and this would happen during January. However, we understand this is yet to be concluded.

Challenge and Support Group

We attended two Challenge and Support Groups and reviewed the sign-off notes / minutes for the clinical models reviewed. The Group covered a range of key discussion points (affordability, interdependencies, workforce plans and demand and capacity). The clinical model was scrutinised to ensure that each of the sections address the requirements and fulfil the design principles. Where there was insufficient evidence or further work required, this was identified for action by the Group. This approach was prevalent throughout each session observed.

The Group consisted of a range of senior managers, both clinical and non-clinical, to help challenge and raise queries / concerns over the proposed clinical models, with representation from the Clinical Futures Team, Finance, Workforce and the Divisions.

Of the five clinical models sampled, each of them were approved with further action required. For example, refining workforce plans, determining capacity and demand and discussing financial implications as a result of savings made from bed number reductions or performance improvements.

Challenges

We reviewed the controls in place for the mitigation of risk regarding the Service Redesign Workstream and identified challenges that we are unable to provide assurance over at this early stage, but these will be incorporated into future reviews.

We have encapsulated the challenges identified below within an advisory recommendation in Appendix A to address risks which are relevant for going forward within the Clinical Futures project. Typically, an advisory recommendation would be defined as a low priority rating. However, due to its importance, in this case it has been raised as a medium priority recommendation and further detail of each of the main challenges is listed below:

Interdependencies / Risk Management

At this stage it is not possible to determine if all of the key requirements for each clinical model will be available. The consequence of a critical interdependency not being implemented can severely limit the full delivery of another clinical model.

For example, if patients are not progressing through other service areas (e.g. radiology or transport between hospital sites) quickly enough, there is an impact throughout each clinical model. This is no different to the current operating model, but may be exacerbated with the introduction of an additional hospital site.

For three models (Stroke, Liaison Services and Theatres), Stroke had listed four specific risks, but no assessment of impact and likelihood had taken place. For Liaison Services and Theatres, three were rated at 16+. If one of these risks or indeed other significant unidentified risks arise and they are not mitigated this could also severely impact upon the delivery of a clinical model.

Engagement

The level of engagement that remains to be undertaken between service areas is high. The five clinical models sampled contained a total of 114 plans to engage (internal and external to the Health Board). However, 76 plans to engage have not yet taken place. Whilst a large portion relates to external interdependencies, there are still outstanding requirements to meet with internal stakeholders too (other divisions). There will inevitably be pressure on this engagement to proceed at pace prior to the opening of the Grange University Hospital.

With this outstanding engagement still to take place, there may be further interdependencies arising or significant challenges presenting themselves that are not yet known.

Workforce

Within the clinical models, assumptions have been made over the number of staff required to staff a 7 day service or indeed other variations. In some cases, a business case is being presented to increase the number of staff required within the service area.

Even though progress has been made in determining workforce requirements for each clinical model, ongoing assessment of the establishment levels is still taking place, to determine the overall resource requirement.

At present, the Health Board is operating with 320 WTE (as at November 2018) nursing vacancies, under a model of care which has been in situ for many years. The Health Board continues to face challenges in staffing wards with substantive nurses and medical staff and continues to rely on bank and agency staff to fill large numbers of shifts.

It is expected that the Grange University Hospital will serve as an attracting feature to the Health Board, but there is still a finite number of nurses on the market to recruit from. Therefore, there is no certainty that sufficient staff will be available for recruiting into the additional positions.

Bed Utilisation

The original business case stipulated a reduction in acute beds of 86 to contribute towards the revenue funding of the Grange University Hospital and the increased cost of facilities. Alongside the financial requirements, work is still underway towards reducing the number of beds required. This process will take place during 2019.

As each iteration of the clinical models is completed, this number will continue to be revised. At this stage, we are unable to confirm what the final bed number will be or if a sufficient reduction will be achieved.

Communication

We were informed by the Clinical Futures Team that engagement with some directorates was slow in the first instance, with considerable improvement taking place as the months progressed. Indeed, we observed an increased uptake in engagement within divisions during the latter half of 2018.

The communication plan for 2019 was released during December 2018, and the intention is to reach a wide audience, including staff, patients and other users of the service.

Good Practice

The following examples of **good practice** were demonstrated by the Health Board during our review:

- Cardiology, as part of their clinical model, has undertaken an extensive review of each clinical model that is used, from Acute Heart Failure through to Ventricular Tachycardia. In addition, the directorate has mapped out each patient journey that can take place for the existing hospitals and the Grange University Hospital. Together with the workforce planning, they have been able to determine a comprehensive range of factors within the model.
- The service model developed by Theatres is based upon service and care provision promoted by a wide range of professional bodies.
- The Theatres workforce model was compiled through engagement with staff, asking them questions around their preferred working site and preferred retirement age. This was undertaken via a survey and

received positive engagement, with 77% of staff at the Royal Gwent Hospital (RGH) and 79% at Nevill Hall Hospital (NHH) responding.

- The review of the service model for Liaison Services (including older adult RAID, adult and learning disabilities) involved a review of patient intake into accident and emergencies throughout the Health Board, utilising Qliksense. This has allowed a more detailed analysis of patient demand.
- Within the Stroke clinical model, an analysis of future patient numbers using Simul8 has taken place, to help predict bed capacity and nursing whole time equivalents required post 2021.
- Unscheduled Care undertook detailed analysis of 1,400 patients, to understand key data surrounding reasons for patient admission, the points of presentation (e.g. accident and emergency), distance travelled and other key data to help inform the development of all clinical models within the division.
- Additionally, we experienced prompt responses to our queries and information requests from the Clinical Futures Team, with active engagement and a strong oversight throughout.

7. Summary of Recommendations

The detailed audit findings, recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**2**	**2**	**-**	**4**

Finding 1: Financial Implications *(D)*	Risk
The financial implications, alongside the bed capacity and workforce requirements have not yet been finalised, with further work required to establish the positions for each key attribute of Clinical Futures. This is expected to be completed during early 2019. We reviewed ten clinical models and currently each service area is responsible for determining the financial implications and working within a cost neutral / sustainable financial envelope. In particular, we found that seven of ten models examined are requesting additional funding:	Insufficient financial, workforce and performance information to base decisions upon. Clinical models are not fit for purpose, due to incomplete information available. The delayed implementation of Clinical Futures. Insufficient funding available for each clinical model.

Clinical Model	Possible Cost Increase (circa)
Critical Care (additional funding may be available)	£1.6m to £2.6m
Pharmacy	£328k
Oral and Maxillofacial	£461k
Gastroenterology	£133k to £181k
ENT	£358k
Cardiology	£286k
Acute Medical Take	£588k

In some cases, the requirement is based upon changes from the original business case, with best practice. For example, Pharmacy and the requirement to fund vending machines for stock, which is also expected to generate additional efficiencies (financial and non-financial). Whilst considerable work is still ongoing across all areas to finalise the clinical models, including determining the overall financial implications and associated business cases to be approved, workforce numbers / availability and the bed utilisation numbers, we do not yet know if the delivery will operate within the existing cost envelope, as intended. However, only three of the ten clinical models sampled have demonstrated an intention to operate within the existing resource constraints and even with these, further work is still required to finalise the other key aspects of the process (beds, workforce etc.).	
Recommendation 1	**Priority level**
1. A plan should be developed to ensure that all clinical model assumptions (as part of recommendations 2 & 4), variables, requirements and business cases are appraised, with a clear timeline set out for a final position over: • which models will be fully / partially funded; • total bed numbers; • workforce requirements; • risks and interdependencies; and • any other key attributes.	**High**

Management Response 1	Responsible Officer/ Deadline
The Service Redesign Team is working closely with a multidisciplinary team (including clinical, workforce, finance and wider programme management) to address the points raised in recommendation 1. Specifically the Delivery Board agreed to a holistic approach to enable approvals to take place in January 2019: *2.4 - Proceed with the suggested timeline through a bespoke 'PIP' style process in February to then deliver an endorsed recommendation to the Delivery Board on 4th March. This will then, if required, be escalated to the UHB Board on 27th March for a final approval.* As set out in the actions of January 2019 Delivery Board, the programme has conducted the following process to reach firm recommendations in the time given: • Broad agreement of process / principles / methodology / investment themes to utilise. • Construction of a common service model proforma to present to the panel to ensure an objective analysis and prioritisation of models. • Clinical Futures team conducted close working with services, finance, workforce to finalise key areas of models in a uniform format ready for the panel. • Papers finalised in advance of the panel and pre-briefings given. • Panel formed and took place over a two day period to analyse and prioritise the cases for investment.	Leanne Watkins, Associate Director for Service Redesign End of March 2019 – Phase 1 End of September 2019 – Phase 2

• Follow up / clarification sought were appropriate and panel agreement on priority order and recommendations. The outcome of this 2 day panel concluded with a prioritised list of models highlighting which models (or elements of models) would be endorsed and which would not at this time. A comprehensive paper has been produced to show clearly to the Delivery Board what this means for costs, benefit opportunities, risks and beds. This will be presented to the 4th March Delivery Board and then the 27th March UHB Main Board on the current plan. It is expected that any further investment will also be dealt with via this method later in the year as required with modification of the models, as and when they arise.	

Finding 2: Time and Resource *(O)*	**Risk**
Whilst the Priority One and Priority Two models were completed prior to the end of December 2018 or combined into an existing model, 16 (59%) were scheduled for the Challenge and Support Group during November and December 2018. An earlier version of the Progress Tracker detailed a delivery profile of 36% of models for November / December to the Challenge and Support Group. This had also appeared to have changed from a previous delivery profile too, with delivery of the clinical models expected some months earlier, with an initial target delivery date set ranging from the end of January to the end of September 2018. To accommodate the high portion of models, extra Challenge and Support Group meetings were scheduled, often operating on consecutive days. Furthermore, the discussion and approval at the Service Redesign Board of the models also led to increased agenda volumes. There is a risk that the high volume of information to be assimilated and challenged dilutes the process and leaves insufficient time to cover all major risks, interdependencies and assumptions within each clinical model.	Clinical models may be approved inappropriately. The clinical models may not be fit for purpose. There may be increased financial costs as a result of insufficient scrutiny.
Recommendation 2	**Priority level**
1. There should be a documented trail of what is required for each action identified from the Challenge and Support process, including risks and interdependencies – i.e. everything required to achieve a final version of the clinical model. 2. The documented output should inform the details of the plan referenced within recommendation 1 above.	**High**

Management Response 2	Responsible Officer/ Deadline
Agreed - The Clinical Futures Team are in the intermediate stages of producing a document that will act as a 'contract' with the services. This will be issued to be a baseline and a 'one version of the truth' for all stakeholders to refer to going forward in 2019. An early draft version of this ongoing work is already in development to bring together a number of variables in one place. It should be noted however that as with all clinical service delivery, clinical services change over time. Whilst a final version will be produced at this stage for planning purposes, and for tracking financial and non-financial benefits the clinical model should always remain under constant review. *Audit and Assurance Comment* *We agree with the above paragraph that clinical models should always remain under constant review.*	Associate Director for Service Redesign End of April 2019

Finding 3: Attendance at Service Redesign Board *(O)*	Risk
The November Service Redesign Board had 7 of 18 members present (6 of 10 were core members), with no representation from Primary Care and Nursing, who are core members. However, the Executive Director of Planning and Performance chaired the meeting, as the Clinical Futures lead. However, it is not clear if all core members should have been present for the meeting to be quorate. The low attendance was minuted for action to ensure that sufficient representation is present in subsequent meetings, with the importance of appropriate representation throughout the Health Board noted. The terms of reference, paragraph 6 explains that, for decision making purposes, a quorum includes core members and their deputies, but it does not define the number of members required, the classification of a deputy or if it is within a particular speciality for such purposes. Representation was present from the clinical side of the Health Board (Deputy Medical Director) and appropriate clinical representation for the models approved and discussed at length (notably Therapies Service Model and Anaesthetics Model, respectively). The remaining models were discussed, with further action still required. In addition, there was considerable challenge by the Assistant Finance Director throughout the meeting regarding the clinical models presented. The remaining meetings that we examined included either the core members or their deputies present. However, within the August meeting it is not immediately apparent if	Decisions are made without the appropriate members present. Approval of clinical models may be delayed.

a deputy was present or required for the absence of one core member, although the individuals attending were in line with expectations.	
Recommendation 3	**Priority level**
1. The terms of reference for the Service Redesign Board / future alternative forum should clearly stipulate the attendance requirements for the meeting to be quorate, particularly regarding the role of core members. 2. The Health Board should be clear as to when the Service Redesign Board / future alternative forum is quorate or not and minuted accordingly. 3. The importance of clarity, regarding key membership of future forums as the Clinical Futures programme develops, should be enforced by the Clinical Futures Team.	**Medium**
Management Response 3	**Responsible Officer/ Deadline**
Agreed - The Clinical Futures Delivery Board approved the change of Service Redesign to Service Transformation at the January 2019 board. A new and more robust terms of reference, incorporating all points from the internal audit recommendation, will be created and shared with its membership.	Leanne Watkins, Associate Director for Service Redesign April 2019

Finding 4: Contingency Arrangements *(D)*	Risk
Each clinical model details numerous interdependencies, assumptions and risk factors. However, once a clinical model has been approved, it should be continuously reviewed and refreshed accordingly, particularly where further action is required. The process of reviewing each clinical model at Challenge and Support should be the start of an ongoing process until all uncertainties have been addressed / mitigated as much as possible. At present, actions are tracked for resolution by the Clinical Futures Team. However, each service area will depend upon a range of key dependencies. If one of these is not develops weakness, then the clinical model may no longer be viable. Furthermore, a review of a sample of clinical models identified that a range of risk management approaches were identified. In the instance of Stroke (a list of four risks was provided), but in the case of Acute Medicine and Cardiology there were no separate risks identified. Within the plans, risks are identified as part of numerous sections, but not necessarily labelled as risks. For example, interdependencies and service / workforce requirements for the model will often identify risks, which are scrutinised at Challenge and Support. In addition, the top risks are tracked and monitored via a range of other methods, including the Service Redesign Board and the Service Redesign Tracker.	The clinical models can not be delivered. There may be increased financial costs. Patient throughflow can not be achieved. Assumptions are not delivered or do not meet the expected requirements. Insufficient staff resource is available.

Recommendation 4	Priority level
1. Each challenge, assumption and other variables related to the clinical model delivery should be identified and tracked. This should be completed alongside recommendation 2, to achieve an overall statement of what is required for each model and affects the challenge of delivery of each model. 2. Once complete, this should feed into the plan listed within recommendation 1 to achieve a timely final position on the service redesign.	**Medium**
Management Response 4	**Responsible Officer/ Deadline**
• There will be a refreshed and increased usage of the Service Redesign / Transformation dashboard to enable clear tracking of challenges (issues), assumptions and risks facing successful delivery of clinical models. • The draft 'contract' document outlined in recommendation 2 will be used as a baseline to enable this more detailed tracking to take place. • Roles and responsibilities within the Service Transformation Team will be evaluated to ensure the full scope of programme management work is covered effectively, ensuring there are never any gaps present.	Associate Director for Service Redesign May 2019

Audit Assurance Ratings

 **Substantial assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

 **Reasonable assurance** - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

 **Limited assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

 **No Assurance** - The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved

8.1

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

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

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

Confidentiality

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Audit

The audit was undertaken using a risk-based auditing methodology. An evaluation was undertaken in relation to priority areas established after discussion and agreement with the Health Board. Following interviews with relevant personnel and a review of key documents, files and computer data, an evaluation was made against applicable policies procedures and regulatory requirements and guidance as appropriate.

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems. These include the possibility of poor judgement in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Where a control objective has not been achieved, or where it is viewed that improvements to the current internal control systems can be attained, recommendations have been made that if implemented, should ensure that the control objectives are realised/ strengthened in future.

A basic aim is to provide proactive advice, identifying good practice and any systems weaknesses for management consideration.

Responsibilities

Responsibilities of management and internal auditors:

It is management's responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and detection of irregularities and fraud. Internal audit work should not be seen as a substitute for management's responsibilities for the design and operation of these systems.

We plan our work so that we have a reasonable expectation of detecting significant control weaknesses and, if detected, we may carry out additional work directed towards identification of fraud or other irregularities. However, internal audit procedures alone, even when carried out with due professional care, cannot ensure fraud will be detected. The organisation's Local Counter Fraud Officer should provide support for these processes.

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Equality, Diversity and Inclusion

Final Internal Audit Report
2018/19

Aneurin Bevan University Health Board

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Executive sign off	Geraint Evans, Director of Workforce and Organisational Development
Distribution	Sue Ball, Assistant Director of Workforce and OD Jill Evans, Head of Equality, Senior Organisational Development Manager
Committee	Audit Committee

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NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

1. Introduction and Background

The review of Equality, Diversity and Inclusion was completed in line with the 2018/19 Internal Audit Plan. The review sought to provide Aneurin Bevan University Health Board (the 'Health Board') with assurance that appropriate and up to date policies, procedures, objectives and a strategic plan are in place, aligned to legislative requirements.

Equality, diversity and inclusion are at the heart of the operation of the NHS and require any services, interventions or actions to take into account those needs arising from identified protected characteristics. The following are defined as protected characteristics:

- age;
- disability including physical limitations and mental health;
- sex;
- sexual orientation;
- race;
- religion or belief;
- gender reassignment;
- marriage or civil partnership; and
- pregnancy / maternity.

The Equality Act 2010 legally protects people from discrimination in the workplace and in wider society and in particular, Section 149 of the Act outlines the duty of a public authority:

A public authority must, in the exercise of its functions, have due regard to the need to-

a) eliminate discrimination, harassment, victimization and any other conduct that is prohibited by or under this Act;
b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; and
c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

2. Scope and Objectives

The audit sought to provide assurance that the Health Board has effective mechanisms in place to ensure that the requirements of Section 149 of the Equality Act 2010 are being complied with. Specifically, it has sought to provide assurance on the following areas:

- policies and procedures demonstrate due regard to the three elements of the Act (as detailed above);
- equality objectives have been set and progress is subject to regular reporting to an appropriate committee;
- training on all equality issues is available to managers and all relevant staff including completion of equality impact assessment;
- the Board is updated with all relevant findings and progress;
- an Equality Impact Assessment / Screening is completed where applicable; and
- controls are in place for the needs of individuals, whether they are patients, service user, carers or staff. For example through a patient assessment form.

Weaknesses have been brought to the attention of management and advice issued on how particular problems may be resolved and control improved to minimise future occurrence.

3. Associated Risks

The risks considered in the review are as follows:

- non-compliance with health care standards;
- non-compliance with legislation;
- needs of individuals may not be appropriately addressed resulting in discrimination; and
- existing and potential inequalities may not be correctly addressed when developing new policies.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

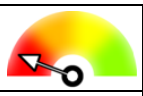
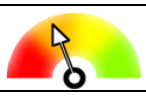
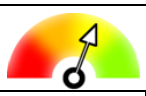
The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with Equality, Diversity and Inclusion is **Reasonable** Assurance.

RATING	INDICATOR	DEFINITION
Reasonable Assurance		**Reasonable assurance** - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Equality policy and procedures				✓
2	Equality objectives set and reported				✓
3	Training			✓	
4	Equality impact assessment / screening			✓	
5	Board updates			✓	
6	Controls are in place for the needs of individuals, whether they are patients, service user, carers or staff			✓	

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

The findings from the review have highlighted three issues that are classified as weaknesses within the system control / design for Equality, Diversity and Inclusion.

Operation of System/Controls

The findings from the review have highlighted one issue that is classified as a weakness in the operation of the designed system/control for the Equality, Diversity and Inclusion.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

We identified four **Medium priority** issues that we consider require management's attention and provides scope for improvement to be made. These concerned:

- An Equality Impact Assessment (EqIA) screening is the first step towards considering if proposed policy / service changes will impact upon service users / staff protected characteristics. If there is a high negative impact towards a protected characteristic then a full EqIA is required. Whilst major projects / policy changes complete an EqIA, via the level of scrutiny that they receive from the Board and sub-committees of the Board, smaller changes may not have documented a completed EqIA screening, as evidence of their decision / outcome.
- The Gender and Equalities Statistics Report is a mandatory part of the Annual Update on Equality Objectives, reporting the percentage of Health Board employees across the nine protected characteristics.

  The report is based on personal details stored on Employee Staff Records (ESR). However, ESR has a significant percentage of data not completed for some protected characteristics.

- The completion of the statutory and mandatory training module for Equality, Diversity and Human Rights is one method for embedding the requirements of the Equality Act 2010. However, the current completion rate for the module is 67%.
- The Health Board utilises a monitoring tool to ensure ongoing compliance with the Health and Care Standards. However, we have not been able to determine if all of the applicable requirements of the Equality Act 2010 and Standard 6.2 Peoples Rights have been included within the monthly testing that takes place as a result of the use of the monitoring tool.

Good Practice

In addition to the findings summarised above, we identified the following good practice:

- as a member of the All Wales Equality Group, the Health Board shares ideas and best practice, to help further promote equality, diversity and inclusion considerations throughout the Health Board;
- there is a strong corporate knowledge base and resource to assist staff with ensuring that the requirements of the Equality Act 2010 are embedded throughout;
- equality impact assessment procedures and templates used by the Health Board are those provided by the NHS Wales Centre for Equality and Human Rights; and
- the annual update to the Board on progress of the equality objectives provides a clear and detailed analysis of actions taken in the year and next steps.

7. Summary of Recommendations

The audit findings, recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**-**	**4**	**-**	**4**

Finding 1 Equality Impact Assessment (EqIA) (Design)	Risk
For significant new proposals across the Health Board, procedures and controls are in place to ensure consideration of the nine protected characteristics stated in Section 149 of the Equality Act 2010. Such proposals, (policies, procedures and operational activities) must be approved by the Board, who appraise whether sufficient and appropriate equality and diversity considerations have been made. If this is not the case, then the proposal is returned to the service area for further assessment. For smaller scale changes, an EqIA screening should take place, with a documented outcome in place, justifying the decision. However, the procedure is not clear on what documentation should be completed and retained to support the decision making process. For example, within 'Step 1 – Preparation' of the 'EqIA in 10 Steps: Screening' document, the following sentence is included, 'you may wish to use Form 1 to record your responses'. However, there is no copy of Form 1 included within the document.	There is an increased risk of consideration not being given to protected characteristics, on proposals for change.
Recommendation 1	**Priority level**
The Health Board should update the guidance for EqIA screenings, to clarify the documentation that should be completed (and retained) when a screening takes place.	**Medium**

As part of the Health and Care Standards KPI suite, a measure should be developed to determine the completeness and quality of EqIA screenings within the Health Board. This should form a key part of measuring performance against Standard 6.2 Peoples Rights and in turn compliance with applicable components of the legislation.	
Management Response 1	**Responsible Officer/ Deadline**
A) The Guidance for Equality Impact Assessment screening will be updated to make explicit which documentation should be completed and retained.	Director of Workforce and Organisational Development April 1st 2019
B) As part of the Health and Care Standards KPI suite a measure is in development to determine the quality and completeness of equality impact assessment screenings. This will form a key part of measuring against Standard 6.2 'People Rights'. Work will be undertaken with Divisions to identify an appropriate measure which will be presented at the Health and Care Standards meeting on 3rd June 2019.	Director of Workforce and Organisational Development and Divisional Leads for Healthcare Standards/Quality and Patient Safety June 3rd 2019

Finding 2 Gender and Equalities Statistics Report (Operation)	Risk
The Gender and Equalities Statistics Report is a mandatory part of the Annual Update on Equality Objectives, reporting the percentage of Health Board employees across the nine protected characteristics. The report is based on personal details stored on Employee Staff Records (ESR). ESR has a significant percentage of unspecified data in respect of the following protected characteristics during 2018: • disability - 56%; • ethnicity - 20%; • marital status - 15%; • religion/belief - 42%; and • sexual orientation - 42%. Whilst these gaps are reported to the Board and an awareness campaign was launched in October 2018, the lack of completeness of the data potentially reduces the ability of the Health Board to effectively establish action plans / next steps for its strategic equality objectives.	Inappropriate strategies / initiatives / objectives and actions plans are adopted. Insufficient data to make appropriate decisions.

Recommendation 2	Priority level
Clear instructions for completion of the appropriate fields within ESR should be issued to all staff to encourage the completion of the data fields. This should be issued on a periodic basis, for example every six months. The data should be used to inform decision making of future equality objectives.	**Medium**
Management Response 2	**Responsible Officer/ Deadline**
A user friendly guide to completing your equality data on the ESR will be developed by April 30th 2019 and a further programme of awareness raising will run on a six monthly basis commencing in May 2019. The use of the data to inform decision making on future equality objectives will be undertaken as part of the annual review of progress against the Health Boards Strategic Equality Objectives.	Director of Workforce and Organisational Development May 31st 2019 Director of Workforce and Organisational Development 1st April 2019

Finding 3 Equality Training across all Departments (Design)	Risk
The Equality and Diversity Policy states that all employees are responsible for awareness of equality, diversity and inclusion considerations. This also serves as a measure to assist with the embedding of the Equality Act 2010 requirements throughout the Health Board. Ultimately, everyone is responsible for helping to uphold the principles of the Act. There are a variety of methods to which awareness and training is cascaded throughout the Health Board, including bulletins, induction, refresher sessions, newsletters, the intranet, procedures (e.g. completion of patient assessment forms) and the policy framework. However, one method is for everyone to complete, on at least a three year basis, the Equality, Diversity and Human Rights module. This is one of the ten statutory and mandatory training modules. However, the current compliance rate for the completion of the training module is 67%.	A lack of awareness of the equality, diversity and inclusion requirements throughout the Health Board.
Recommendation 3	**Priority level**
A plan should be developed demonstrating how the Equality, Diversity and Human Rights statutory and mandatory training will be completed to achieve the KPI of 85%. The plan should prioritise service areas within the lower quartiles of training compliance.	**Medium**

The plan should be monitored by an appropriate forum (e.g. Quality and Patient Safety Operational Group) to ensure that the compliance improvements are on target and sustained.	
Management Response 3	**Responsible Officer/ Deadline**
A report will be undertaken to determine compliance according to Division and disseminated accordingly. A plan will be developed by each Division to identify and implement the actions required to improve compliance. An initial progress report will be taken to Quality and Patient Safety Operational Group and the process for on-going monitoring agreed.	Director of Workforce and Organisational Development March 31st 2019 Divisional General Managers July 2019

Finding 4 Health and Care Standards Monitoring Tool (Design)	Risk
The Health Board utilise a monitoring tool to ensure compliance with the Health and Care Standards, which has a strong overlap with the requirements of equality, diversity and inclusion, particularly from a patient perspective. On a monthly basis the Health Board has started rolling out, across divisions, the monitoring tool and through the testing of a sample of patient files, wards that require further training or support are identified. We examined a sample of five wards from Unscheduled and Scheduled Care to ensure that the monthly reviews were being completed. Each of them were being completed, but within Standard 6.2 Peoples Rights there were no specific questions / testing completed. This is because other standards incorporate the requirements of Standard 6.2. For example, Standard 4.1 Dignified Care includes multiple tests which are relevant to Standard 6.2. However, whilst we identified many components of Standard 6.2 throughout the monitoring tool, we do not know if all equality, diversity and inclusion requirements are being tested.	A lack of awareness of the equality, diversity and inclusion requirements throughout the Health Board.
Recommendation 4	**Priority level**
We recommend that the Health Board review the equality, diversity and inclusion requirements, as laid out within the Equality Act 2010 and Standard	**Medium**

6.2 Peoples Rights, and ensure that each are addressed through the testing of the monitoring tool. Where there are gaps, additional testing should be included.	
Management Response 4	**Responsible Officer/ Deadline**
A review will be undertaken of the monitoring tools in place to determine if the requirements of the Equality Act and Standard 6.2 'People's Rights' are being adequately tested, any additional testing required will be developed.	Director of Workforce and Organisational Development and Divisional Health and Care Standards Leads. June 2019 - Review October 2019 – additional testing in place if required

Audit Assurance Ratings

 **Substantial assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

 **Reasonable assurance** - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

 **Limited assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

 **No Assurance** - The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved

8.2

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

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

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

Confidentiality

This report is supplied on the understanding that it is for the sole use of the persons to whom it is addressed and for the purposes set out herein. No persons other than those to whom it is addressed may rely on it for any purposes whatsoever. Copies may be made available to the addressee's other advisers provided it is clearly understood by the recipients that we accept no responsibility to them in respect thereof. The report must not be made available or copied in whole or in part to any other person without our express written permission.

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The Health Board shall apply any relevant exemptions which may exist under the Act. If, following consultation with the Head of Internal Audit this report or any part thereof is disclosed, management shall ensure that any disclaimer which NHS Wales Audit & Assurance Services has included or may subsequently wish to include in the information is reproduced in full in any copies disclosed.

Audit

The audit was undertaken using a risk-based auditing methodology. An evaluation was undertaken in relation to priority areas established after discussion and agreement with the Health Board. Following interviews with relevant personnel and a review of key documents, files and computer data, an evaluation was made against applicable policies procedures and regulatory requirements and guidance as appropriate.

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems. These include the possibility of poor judgement in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Where a control objective has not been achieved, or where it is viewed that improvements to the current internal control systems can be attained, recommendations have been made that if implemented, should ensure that the control objectives are realised/ strengthened in future.

A basic aim is to provide proactive advice, identifying good practice and any systems weaknesses for management consideration.

Responsibilities

Responsibilities of management and internal auditors:

It is management's responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and detection of irregularities and fraud. Internal audit work should not be seen as a substitute for management's responsibilities for the design and operation of these systems.

We plan our work so that we have a reasonable expectation of detecting significant control weaknesses and, if detected, we may carry out additional work directed towards identification of fraud or other irregularities. However, internal audit procedures alone, even when carried out with due professional care, cannot ensure fraud will be detected. The organisation's Local Counter Fraud Officer should provide support for these processes.

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Falls Prevention

Final Internal Audit Report
2018/2019

Aneurin Bevan University Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Service

8.3

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Review reference:	ABUHB-1819-18
Report status:	Final
Fieldwork commencement:	21st November 2018
Fieldwork completion:	13th December 2018
Draft report issued:	19th December 2018
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Final report issued:	22nd January 2019
Auditor/s:	James Quance, Head of Internal Audit Stephen Chaney, Deputy Head of Internal Audit Johanna Butt, Principal Auditor
Executive sign off	Peter Carr, Executive Director of Therapies and Science
Distribution	Martine Price, Acting Executive Director of Nursing; Kate Hooton, Assistant Director – Quality and Patient Safety
Committee	Audit Committee Falls Steering Group

ACKNOWLEDGEMENT

NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

1. Introduction and Background

The review of Falls Prevention was completed in line with the 2018/19 Internal Audit Plan for Aneurin Bevan University Health Board (the 'Health Board'). The review sought to provide the Health Board with assurance that falls prevention is appropriately managed and monitored within the Health Board. The relevant Executive lead for the assignment is the Director of Therapies & Health Science.

The Health Board recognises that the prevention of falls, and effective management of patients following a fall, is an important patient safety challenge for the Health Board, in common with all Health Boards.

The inpatient falls dashboard as at October 2018, which details the number of inpatient falls over a rolling 13 months, detailed a total of 4,417 falls within the Health Board for that period, of these 81 resulted in a fracture.

The Health Board has identified and included the operational risk of the failure to prevent an inpatient fall on its Corporate Risk Register in July 2016, being, Corporate Risk Reference CRR023 "*The safety of patients will be put at risk if the Health Board fails to maximise inpatient falls prevention*". The most recent Corporate Risk Register indicates that controls have been put in place which has resulted in an improved risk score resulting from the assessed decrease in the likelihood of an inpatient fall.

The National Institute of Health and Care Excellence (NICE) identifies that falls and fall-related injuries are a common and serious problem for older people. People aged 65 and older have the highest risk of falling, with 30% of people older than 65 and 50% of people older than 80 falling at least once a year. The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and mortality which also affects the family members and carers of people who fall. It details that falls are estimated to cost the NHS more than £2.3 billion per year. As such, falling has an impact on quality of life, health and healthcare costs.

Consequently, NICE has developed Clinical Guidance, 'Falls in older people: assessing risk and prevention' (CG161) which offers best practice advice on the care of older people who are at risk of falling. This guidance provides recommendations for the assessment and prevention of falls in older people for use by healthcare and other professionals and staff who care for older people who are at risk of falling. All people aged 65 or older are covered by all guideline recommendations. The guidance recommends that all people 65 or older who are admitted to hospital should be considered for a multifactorial assessment for their risk of falling during their hospital stay. They should also be offered a multifactorial assessment of their community-

based falls risk, if appropriate. These assessments may be done together or separately. People aged 50 to 64 who are admitted to hospital and are judged by a clinician to be at higher risk of falling because of an underlying condition are also covered by the guideline recommendations about assessing and preventing falls in older people during a hospital stay.

The Welsh Government issued Welsh Health Circular (2016) 22, 'Principles, Framework and National Indicators: Adult In-Patient Falls' which mandated that all Welsh Health Boards and Trusts implement the national standards and evidence based guidelines. As a result, the Health Board drafted its initial Falls Prevention Action Plan to assist in meeting the requirements of the guidance.

2. Scope and Objectives

The objective of the review was to evaluate and determine the adequacy and effectiveness of the arrangements in place within the Health Board to reduce inpatient falls, including monitoring the effects of changes to the environment and working practices, and, whether policies and procedures are being complied with in order to provide assurance to the Health Board's Audit Committee that risks material to the system's objectives are appropriately managed.

Any weaknesses were brought to the attention of management and advice issued on how particular problems may be resolved and controls improved to minimise future occurrence.

The main areas that the review sought to provide assurance on were:

- there are adequate policies/procedures/guidance notes relating to falls prevention in place detailing the process to follow and these incorporate identified best practice such as NICE CG161;
- policies/procedures/guidance notes are consistently followed throughout the Health Board;
- there is standard documentation in place for undertaking risk assessments to ensure that there is a consistent approach within the Health Board (i.e. the correct version of assessment forms are used);
- risk assessments are carried out for all patients over 65 years old, and patients aged between 50 and 64 years old judged by a clinician to be at higher risk of falling because of an underlying condition;
- appropriate action is taken to reduce the risk of patient falls;
- ward staff have received appropriate training for assessing a patient's risk of falling and identifying hazards that could result in trips and falls;

- there is an appropriate forum/group in place to monitor patients falls;
- falls data is appropriately captured and a trend analysis is undertaken to identify any recurring issues and where appropriate, action plans put in place to rectify any issues and/or implement improvements;
- identified good practice within the Health Board is shared with other wards within the Health Board and / or incorporated into procedures; and
- there is benchmarking or sharing of good/best practice with other Health Boards for reducing patients falls.

The audit reviewed the processes in place for assessing, managing and monitoring falls prevention at a sample of sites / wards within the Health Board.

3. Associated Risks

The risks considered in the review were as follows:

- failure to properly risk assess patients leading to increased falls;
- lack of appropriate monitoring of falls leading to missed opportunities to identify weakness and implement improvements;
- reputational risk as a result of negative publicity arising from increased or serious falls;
- human cost of falling, including distress, pain, injury, loss of confidence, loss of independence and mortality; and
- financial loss to the Health Board.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The level of assurance given to the effectiveness of the system of internal control in place to manage the risks associated with Falls Prevention is **Reasonable** Assurance.

RATING	INDICATOR	DEFINITION
Reasonable Assurance		The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Adequate policies/ procedures/ guidance notes in place.				✓
2	Policies and procedures are consistently applied.			✓	
3	Standard documentation available and used for undertaking falls risk assessments.			✓	
4	Risk assessments undertaken on all patients over 65 year and patients aged between 50 and 64			✓	

Assurance Summary					
	years judged to be at higher risk of falling.				
5	Appropriate action taken to reduce risk of patient falls.			✓	
6	Ward staff have received appropriate training for assessing patient's risk of falling.				✓
7	Appropriate forum / group in place for monitoring falls.				✓
8	Falls data is appropriately captured and reported and a trend analysis undertaken and action plans put in place to rectify any issues/implement improvements.				✓
9	Identified good practice within the Health Board is shared with other wards and divisions.			✓	
10	Benchmarking or sharing of good/best practice with other Health Boards.				✓

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

The findings from the review have highlighted two issues that are classified as weaknesses within the system control / design for Falls Prevention.

Operation of System/Controls

The findings from the review have highlighted one issue that is classified as a weakness in the operation of the designed system/control for Falls Prevention.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

No High priority issues were identified as part of our review.

We identified **two Medium priority** issues which we consider require management's attention and provide scope for improvements to be made. These concerned:

1) Sample Testing – Review of Inpatient Files

We reviewed a sample of 55 inpatient files, from a sample of four hospital sites, being Royal Gwent Hospital, St Woolos Hospital, Nevill Hall Hospital and Ysbyty Ystrad Fawr and 11 wards across these Health Board sites. Our review of inpatient files confirmed that a Multifactorial Risk Assessment (MFRA) had been commenced for 50 of the sample of inpatients selected. However, our review of the MFRA forms confirmed that these are not always fully completed, signed and dated in a timely manner.

Additionally where the MFRA identifies a risk of falling the action taken for the corresponding identified risk is not always detailed on the 'Falls Prevention Action Plan'. Also, where the care plan is completed there are inconsistencies with the actions detailed – some forms detail 'Yes'/'No' answers and some forms do not detail an action, examples include "patient is confused", "patient wears glasses" which are statements rather than actions taken to reduce the risk of the patient falling. However, we acknowledge that the form does not provide much space to fully document the action taken.

We also note that the minimum weekly review of the 'MFRA Care/Action Plan Review Sheet' is not always undertaken. We acknowledge that the review may have be undertaken, but this is not evident from our examination of the review sheet.

The Health Board's Policy also requires that where an inpatient falls that a new MFRA is completed and that an 'Immediate Assessment Following Inpatient Fall' form should also be completed. One inpatient selected had fallen twice. The ward had appropriately commenced a new MFRA following each fall and raised a Datix incident for both falls. However, a copy of the

'Immediate Assessment Following Inpatient Fall' was not included on the inpatient file.

2) Sharing of Good Practice

From discussions with ward managers there were some instances of good practice being identified at a ward level that highlighted the ward's commitment to fully consider and reduce the risk of inpatient falls.

This included displaying an exemplar of a fully completed MFRA form on the training board within the ward as an aide-memoire to staff completing the form. This did not appear to be shared with another wards at the same site where the standard of completion were not as high a standard.

Additionally, one ward visited confirmed that they had reviewed their incidents of falls and found that falls were more prevalent at handover. As such they introduced new practices to ensure that there was greater staff visibility on the ward at times of handover to reduce the risk of falls. Only one ward visited confirmed that they had tried to identify a pattern to falls and implement any changes to help reduce the risk of inpatient falls.

We identified **one Low priority** issue which is generally an issue of good practice for management consideration. This concerned:

1) Policy Appendix References

The Health Board has a Policy for the Prevention of Falls, namely, 'Policy and Prevention and Management of Inpatient Falls' which is in date and has been appropriately approved by the 'Clinical Standards and Policy Group'. We reviewed the minutes to the 'Falls Steering Group' which confirms that the Policy is regularly reviewed and updated.

We reviewed the current Policy and found that it included the incorrect appendix references throughout the Policy for the 'Multifactorial Risk Assessment' (MFRA) tool and the 'Immediate Assessment Following Inpatient Fall' form. However, we acknowledge that a copy of the MFRA is included on the landing page of the 'Falls Prevention' intranet pages. We also note that the Policy provides a description of the document and the MFRA toolkit is printed off and included as part of the inpatient admission document on the ward.

Good Practice

In addition to the findings summarised above, we identified the following good practice:

- The Health Board has undertaken a considerable amount of work to establish an appropriate multi-disciplinary group and has engaged with wards to develop an appropriate MFRA toolkit and is continually trying to identify improvements to reduce the risk of inpatient falls.
- The Falls Steering Group has developed a Falls Prevention intranet page that provides a good source of information and includes links to relevant Falls Prevention resources.
- The Health Board has developed a MFRA tool which identifies 17 risk factors that could contribute to a fall. The MFRA tool also includes a Care Plan for completion to detail the actions taken where a risk of falling has been identified on the MFRA and a Review Sheet for use by ward staff to ensure that there is a consistent approach throughout the Health Board when assessing an inpatient's risk of falling. Full completion of this form ensures that the Health Board is in line with the requirements set out in NICE CG161. The form also includes guidance to facilitate the completion of the form.
- The Health Board has provided training to designated staff from wards within all divisions. The training provided guidance on the risks of falls, the actions required to reduce the risk of falling and how to complete Falls Prevention resources, including, the MFRA tool, the Falls Prevention Care Plan and Review Sheet. We also note that the MFRA form provides guidance to facilitate the completion of the form and as such staff that have not received the training should be able to complete the form.
- The Health Board has a multi-disciplinary and multi-agency Falls Steering Group that regularly meet, usually bi-monthly. There are standard agenda items, which includes reviewing and overseeing the development, implementation and monitoring of a Falls Strategy Action Plan. Review of a sample of papers to the meetings confirms that the action plan is appropriately reviewed and updated.
- The Falls Steering Group has an appropriate reporting line to the Quality and Patient Safety Committee.
- The Health Board has a Falls Scrutiny Panel that meets monthly to scrutinise inpatient falls that have resulted in a fracture to assess whether the fall was avoidable or unavoidable. Where falls have resulted in a fracture the ward manager completes an SBAR and must provide evidence that demonstrates that actions were taken to avoid a fall, which includes whether the MFRA was appropriately completed.

- The Falls Scrutiny Panel reviews and decides whether the fall was avoidable or unavoidable and whether redress is required. Review of a sample of two months of papers confirms that the relevant papers are provided by the wards and that falls resulting in a fracture are fully reviewed and scrutinised. The Falls Scrutiny Panel provides summary reports to the Falls Steering Group on falls that have resulted in a fracture, which was confirmed, from our review of the papers presented to the Falls Steering Group.

7. Summary of Recommendations

The audit findings, recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**-**	**2**	**1**	**3**

Finding 1 Sample Testing – Review of Inpatient Files (Operation)	Risk
We selected a sample of 55 inpatients across four sites and 11 wards throughout the Health Board. We reviewed the inpatient files for the sample selected to ensure that: 1. a Multifactorial Risk Assessment (MFRA) had been included and fully completed as part of the ward admission document; 2. the MFRA was completed or commenced on a timely basis; 3. the correct version of the MFRA was completed; 4. where the MFRA identified a risk of falling a corresponding action had been detailed on the Falls Prevention Care Plan; 5. the MFRA toolkit was subject to the minimum weekly review; and 6. where the inpatient had fallen that the 'Immediate Assessment Following Inpatient Fall' was completed. We reviewed the inpatient files for the sample and the following is noted: • 39 inpatients selected were over 65 years (24 of which were over 80 years) and as such a MFRA must completed. Of these there were two instances where the MFRA had not been completed. • 16 inpatients selected were 50 – 64 years where a MFRA should be completed if the inpatient is deemed by a clinician to be at risk of falling due to an underlying condition. Of these, there were three instances where the MFRA was not completed. However, it was not clear whether	Failure to properly risk assess inpatients leading to increased falls.

they should have been. One inpatient file made reference to a Zimmer frame and as such may have been at risk of falling and one stated "N/A", but did not indicate why. We note that there is no set criteria for assessing when it is necessary to complete the MFRA for this cohort. Of the 50 MFRA forms that were completed, the following is noted: • 2/50 had been completed on the older version of the form which does not include a 'Falls Prevention Action Plan' or 'Review Sheet'. Our visit to two wards confirmed that the older version of the MFRA form was still available on these wards which could result in the incorrect version being completed. • 19/50 where the date of the MFRA assessment was not completed, however, we acknowledge that for 14 of these the date was completed at the end of the document where the assessor is expected to sign and date the form and as such only five forms did not include any indication of completion date. • 18/50 where the ward was not detailed on the MFRA. • 7/50 where the MFRA from the previous ward, not the current ward was used. • 6/50 where the inpatient label/addressograph had not been affixed to the form. For one of these, the inpatient's details had been hand-written on the form. • 15/50 the name of the person completing the form was not recorded. • 15/50 the job title of the person completing the form was not completed.	

• 15/50 of the forms had not been signed by the person completing the assessment. • 14/50 of the forms had not been dated by the assessor. The MFRA template requires that *"This assessment checklist should be commenced within 6 hours"*. The following is noted: • 21/50 were commenced more than two days after the inpatient had been admitted to the ward. We understand that on admission the patient can be less mobile and that the likelihood of falling increases the more mobile the patient becomes. We also acknowledge that it is not always possible to commence the assessment within six hours, for example, if the patient is admitted to the ward during the night it will not be possible to commence the assessment until the following day when the patient is awake. Additionally, we were informed that it is not always possible to complete all sections of the MFRA on admission, for example, undertaking and recording the lying / standing blood pressure if the patient is unable to stand. This highlights the importance of signing and dating when each of the 17 risk factors included on the MFRA have been completed – which may not always be the same date. • 4/50 had been dated as being completed before the inpatient had been admitted to the ward which may be as a result of the form being incorrectly dated, or, the completed form being from a previous ward and not the current ward.	

The current MFRA form includes 17 risks of falling that the inpatient must be assessed against. The 'Falls Prevention Care Plan' requires that "*If you have Ticked "yes" to a risk in the assessment, please enter the action/referral in the boxes below and sign when the action/referral has been completed/made and file in patient notes*". Where the MFRA included a risk of falling – indicated by a 'Yes', we reviewed the 'Falls Prevention Care Plan' to confirm that the action taken to reduce the risk of falling was documented against the corresponding identified risk. 2/50 of the MFRA's were completed on the old version of the form, which does not include a 'Falls Prevention Care Plan'. Of the 48 MFRA forms that had been completed using the current version of the form, the following is noted: • 18/48 instances where the Care Plan had not been completed. • Of the 30/48 instances where the Care Plan had been completed 18 of these did not detail the actions taken to mitigate the identified risk of falling from the MFRA. We also note that the action taken does not always read as an action. For example, "Patient is Confused", "Yes/No" answers which does not detail the action taken. The MFRA toolkit is printed off and the hard copy completed and placed in the inpatient's file. We note from our review that the 'Falls Prevention Care Plan' section does not provide enough space to fully document the actions taken which could result in ward staff not fully completing this section. There is a 'MFRA Care/Action Plan Review Sheet' which requires that "*The patient should be reviewed after any inpatient fall, if their medical condition changes – deteriorates or improves - or every week as a minimum*". For the	

sample of inpatients selected we obtained the inpatient's date of admission and noted the date that MFRA had been completed to confirm that there was evidence of the review sheet being reviewed at least weekly. Of the 48 MFRA forms that had been completed using the current version of the form 19 of these were not due for review, either because the MFRA had been completed less than a week before the audit visit or the inpatient had not yet been in hospital for a week. Of the remaining 29 the following is noted 13/29 instances where a weekly review had not taken place. After an inpatient fall, the Policy requires that the 'Immediate Assessment Following Inpatient Fall' is completed. One inpatient included in the sample had fallen twice since admission. Whilst a new MFRA had been completed after each fall, the 'Immediate Assessment Following Inpatient Fall' form was not included on the inpatient file. However, we acknowledge that a Datix Incident had been raised for the two falls.	
Recommendation 1	**Priority level**
1. All divisional ward staff should be reminded of the requirement to fully complete the correct MFRA toolkit on a timely basis, including: • starting the MFRA within six hours of the inpatient being admitted on the ward; • adding the inpatient's addressograph label where required; • fully completing the form and signing and dating the form where required;	**Medium**

• detailing the action taken on the 'Falls Prevention Care Plan' which should mirror where a risk has been identified on the MFRA i.e. where a risk is identified the corresponding action taken should be detailed on the Care Plan against the relevant risk number; and • update, sign and date the 'MFRA Care/Action Plan Review Sheet' at the minimum weekly interval. 2. Wards should consider sharing an exemplar MFRA with staff responsible for completing the MFRA and including the exemplar on its training notice board or at team meetings / handovers as an aide memoire to ward staff to assist full completion of the form. The Health Board should consider including an exemplar MFRA on its 'Falls Prevention' intranet pages and Policy to facilitate completion of the form. 3. Older versions of the MFRA should be removed from wards to reduce the likelihood of the incorrect form being used to assess the inpatient's risk of falling to ensure that there is a consistent approach throughout the Health Board and that the risk of falling is regularly reviewed. 4. The 'MFRA Care/Action Plan Review Sheet' only includes a section to sign and date at the end of the review sheet. Given that the form should be reviewed and updated at a minimum weekly basis it may be more appropriate to include columns to sign an date each line detailing that the date and by whom the review has been undertaken.	

5. The 'Immediate Assessment Following Inpatient Fall' form must be completed and included on the inpatient file following an inpatient fall. 6. Ward Managers should consider undertaking ad-hoc spot checks on inpatient files to satisfy themselves that the MFRA is fully completed and that there is evidence of the form being reviewed at the minimum weekly basis. 7. The Health Board should consider whether criteria needs to be set to provide clarity on when the MFRA tool should be completed for inpatients between 50 and 64 years. This would ensure that there is a consistent approach throughout the Health Board, and that all inpatients assessed as being at risk of a fall due to an underlying medical condition are appropriately and consistently assessed. We acknowledge that the NICE guidelines do not encourage the use of risk scoring. However, the nursing staff should be provided with details of when the MFRA must be completed for the cohort.	
Management Response 1	**Responsible Officer/ Deadline**
1. Current, ongoing training of the ward staff will reinforce the need to properly complete the MFRA, using the examples identified in this audit to raise awareness of common mistakes and omissions. The training package (slide deck) will be updated to reflect these areas for focus.	1. Peter Carr, Kate Hooton, and Caroline Rowlands – by end of February 2019

2. The Falls Steering Group will agree a process and mechanism that better enables ward managers to share and adopt, at ward level, examples of good practice in falls prevention, including that which has been identified by this audit. The Falls Steering Group will also consider how the intranet Falls Prevention pages can be used to share examples of good practice. 3. (a) Divisional Nurses will ensure that ward managers take action to remove older versions of the MFRA still in circulation. (b) The Falls Steering Group will agree an ongoing process to audit wards for use of correct falls prevention documentation. 4. Aligned to the work to implement an all-Wales digitised nursing document (which will include an all-Wales MFRA and replace the ABUHB MFRA in 2019), the Falls Steering Group will share this recommendation about documenting a new date for each review. 5. Medical staff will be reminded to fully complete the 'Immediate Assessment Following Inpatient Fall' form after every inpatient falls and include this in the inpatient file. This requirement will also be reinforced in the ongoing training of the ward staff on falls prevention. 6. The Falls Steering Group will agree a process and mechanism that whereby ad-hoc spot checks can be undertaken on inpatient files to ensure that the MFRA is fully completed and that there is evidence of the form being reviewed at the minimum weekly basis (linked to action 3.b) 7. The Falls Steering Group has previously considered whether criteria needs to be set to provide clarity on when the MFRA tool should be completed for inpatients between 50 and 64 years. It was agreed that, because of the NICE guidelines not to use risk scoring, then this should not be included in the updated policy. However, the Falls Steering Group	2. Falls Steering Group – to be completed by end of March 2019 3. (a) Divisional Nurses and ward managers, overseen by Falls Steering Group – to be completed by end of February 2019. (b) Falls Steering Group – to be completed by end of March 2019 4. Caroline Rowlands, overseen by Falls Steering Group – to be completed by end of January 2019 5. Consultant leads overseen by the Falls Steering Group – by end of February 2019 6. Falls Steering Group – to be completed by end of March 2019 7. Peter Carr, Kate Hooton, and Caroline Rowlands –

	will use the ongoing training of the ward staff on falls prevention to clarify when an MFRA should be used for patients in this age group. The training package (slide deck) will be updated to reflect this areas for focus (linked to action 1)	to be completed by by end of February 2019

Finding 2 Sharing of Good Practice (Operation)	Risk
Instances of good practice were identified from our visit to a sample of wards and from discussions with ward managers, these included: • One ward visited had completed and displayed on the training board within the ward an exemplar MFRA toolkit, which provided ward staff with an example to facilitate completion of the MFRA toolkit. The exemplar used was the one utilised at the training provided, which had been fully signed and dated by the physiotherapist on the ward to indicate the sections to be completed. A ward at the same site was not aware of the exemplar and it was evident from the review of a sample of MFRA forms from this ward that the completion of the risk assessment was not as high a standard on this ward, in comparison with the ward using the exemplar. • One ward visited had reviewed falls on the ward and found that falls were more prevalent at handover. As a result, they ensured that staff were more visible at times of handover, which they believe assisted in preventing falls.	Missed opportunity to share good practice and potentially reduce the number of falls.
Recommendation 2	**Priority level**
The Health Board/Falls Steering Group/Divisions should review the exemplar MFRA and communicate the document to all divisional wards to ensure that all staff on the ward are aware of the required standard and to facilitate ward staff with completing the toolkit.	**Medium**

The Health Board/Falls Steering Group/Ward Managers should review the falls data to establish whether there are any trends relating to falls at a ward level. For example, whether there is a pattern with the time that the falls occur and use this information to identify and implement any change that could result in a reduction in the number of falls.	
Management Response 2	**Responsible Officer/ Deadline**
1. The Falls Steering Group will agree a process and mechanism that better enables ward managers to share and adopt, at ward level, examples of good practice in falls prevention, including that which has been identified by this audit. The Falls Steering Group will also consider how the intranet Falls Prevention pages can be used to share examples of good practice. (same as Action 1 in Management Response 1) 2. The Falls Steering Group already reviews inpatient falls data in the form of a detailed dashboard at every meeting, and circulates to all members monthly. Ad-hoc requests for more detailed and specific scrutiny of the data also takes place. This assists in identifying any trends relating to inpatient falls, including time of day and then any improvement action in response. This existing sharing and review of data by the Falls Steering Group will continue and action will be taken in response to any trends identified.	1. Falls Steering Group – to be completed by end of March 2019 2. Falls Steering Group – already completed

Finding 3 Policy Appendix References (Design)	Risk
We reviewed the Health Board's Policy on Falls Prevention, namely, the 'Policy and Prevention and Management of Inpatient Falls' which has been appropriately approved, is in date, and subject to regular review by the 'Falls Steering Group'. Appendix 1 of the Policy includes the 'Multifactorial Risk Assessment' toolkit and Appendix 2 of the Policy includes the 'Immediate Assessment Following Inpatient Fall' form. We note from our review of the Policy that it includes several incorrect references within the body of the Policy. It makes reference to Appendix 2 being the MFRA and Appendix 1 being the 'Immediate Assessment Following and Inpatient Fall'.	Failure to properly risk assess patients leading to increased falls.
Recommendation 3	**Priority level**
The Policy should be updated to accurately reference the correct Appendix to avoid confusion. However, we acknowledge that the body of the report also provides a description of the document and as such updating the Policy is considered 'good housekeeping'.	**Low**

Management Response 3	Responsible Officer/ Deadline
1. The Policy will be amended to accurately reference the correct Appendix.	1. Peter Carr and Kate Hooton – to be completed by end of January 2019

Audit Assurance Ratings

 **Substantial assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

 **Reasonable assurance** - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

 **Limited assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

 **No Assurance** - The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

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

Confidentiality

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Audit

The audit was undertaken using a risk-based auditing methodology. An evaluation was undertaken in relation to priority areas established after discussion and agreement with the Health Board. Following interviews with relevant personnel and a review of key documents, files and computer data, an evaluation was made against applicable policies procedures and regulatory requirements and guidance as appropriate.

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems. These include the possibility of poor judgement in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Where a control objective has not been achieved, or where it is viewed that improvements to the current internal control systems can be attained, recommendations have been made that if implemented, should ensure that the control objectives are realised/ strengthened in future.

A basic aim is to provide proactive advice, identifying good practice and any systems weaknesses for management consideration.

Responsibilities

Responsibilities of management and internal auditors:

It is management's responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and detection of irregularities and fraud. Internal audit work should not be seen as a substitute for management's responsibilities for the design and operation of these systems.

We plan our work so that we have a reasonable expectation of detecting significant control weaknesses and, if detected, we may carry out additional work directed towards identification of fraud or other irregularities. However, internal audit procedures alone, even when carried out with due professional care, cannot ensure fraud will be detected. The organisation's Local Counter Fraud Officer should provide support for these processes.

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Health and Care Standards

Internal Audit Report 2018/19

Aneurin Bevan University Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Committee	Quality and Patient Safety Committee Audit Committee

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ACKNOWLEDGEMENT

NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

1. Introduction and Background

The review of Health and Care Standards has been completed in line with the 2018/19 Internal Audit Plan for Aneurin Bevan University Health Board (the 'Health Board'). The review sought to provide the Health Board with assurance that operational procedures were compliant with key corporate policies within Aneurin Bevan University Health Board.

The Health and Care Standards set out the Welsh Government's common framework of standards to support the NHS and partner organisations in providing effective, timely and quality services across all healthcare settings. They set out what the people of Wales can expect when they access health services and what part they themselves can play in promoting their own health and wellbeing. They set out the expectations for services and organisations, whether they provide or commission services for their local citizens.

The Health and Care Standards came into force from 1 April 2015 and incorporate a revision of the 'Doing Well, Doing Better: Standards for Health Services in Wales (2010)' and the 'Fundamentals of Care Standards (2003)'.

The Standards provide a consistent framework that enables health services to look across the range of their services in an integrated way to ensure that all they do is of the highest quality and that they are doing the right thing, in the right way, in the right place, at the right time and with the right staff.

2. Scope and Objectives

Internal audit assessed the adequacy and effectiveness of internal controls in operation. Any weaknesses have been brought to the attention of management and advice issued on how particular problems may be resolved and control improved to minimise future occurrence.

The objectives of this audit were to ensure that:

- the Quality and Patient Safety Committee are provided with assurance, through regular reporting, over the management and progress of the Health and Care Standards;
- suitable oversight of the Health and Care Standards throughout the Health Board is in place, through the Health and Care Standards Group;
- staff receive appropriate information and induction in respect of the Health and Care Standards; and

- previous audit recommendations raised, have been fully implemented.

3. Associated Risks

The risks considered in the review were as follows:

- insufficient governance and oversight of Health and Care Standards throughout the Health Board;
- non-adherence to the relevant requirements of the Health and Care Standards; and
- a lack of awareness of the Health and Care Standards within the Health Board.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

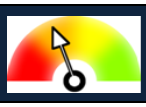
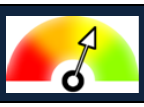
The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with Health and Care Standards is **Reasonable** Assurance.

RATING	INDICATOR	DEFINITION
Reasonable Assurance		The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact on residual risk** exposure until resolved.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	QPS Committee Assurance			✓	
2	Suitable Oversight through the Health and Care Standards Group			✓	
3	Training and Awareness				✓
4	Previous actions raised completed and additional actions identified			✓	

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

The previous review of 2017/18 identified three medium priority issues. Although the current audit identifies three similar medium priority issues, the audit found good progress in the actions from the previous recommendations.

Design of Systems/Controls

The findings from the review have highlighted three issues that are classified as weaknesses in the system control/design for Health and Care Standards.

Operation of System/Controls

The findings from the review have highlighted two issues that are classified as weaknesses in the operation of the designed system/control for Health and Care Standards.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

In 2018-19, the following progress was made in developing the Health Board's Health and Care Standards framework:

- The Terms of Reference for the Health and Care Standards Group was updated and published.
- The "Health and Care Standards Assurance, Self-Assessment and Improvement Planning Guidance" was reviewed and re-written and is currently in Draft format. This guidance will provide Health and Care standards assurance within the Quality Assurance Framework.
- The driver diagram guidance for Health and Care Standards was reviewed, updated and published.
- The intranet site for Health and Care Standards was reviewed and updated.
- The Health and Care Standards Implementation Plan was amended to distinguish between periodic and singular actions.

We identified three **Medium priority** issues. We consider that these issues require management attention and provide scope for improvement.

1) Quality and Patient Safety (QPSC) Committee Assurance

We reported last year that neither the QPSC nor the Health and Care Standards Group (HCSG) had defined the frequency or details of assurance reporting requirements to the QPSC in respect of Health and Care Standards compliance within the Health Board. It was therefore not possible to confirm if sufficient assurance had been provided to the QPSC. Whilst this has now been addressed through revisions to the Health and Care Standards guidance document and the terms of reference of the HCSG, the former has not been finalized and as such the defined requirements remain of draft status.

It is therefore recommended that the Health and Care Standards **-** Assurance, Self-Assessment and Improvement Planning Guidance is finalised and approved for publication. **(see Recommendation 1)**

2) Suitable Oversight - Health and Care Standards Group

We reviewed the minutes of the meetings held by both the Health and Care Standards Group and QPS Operational Group over the last 12 months. As noted in our 2017/18 audit review (where attendance issues and lack of

escalation were identified), there continues to be an overall lack of attendance with an average attendance of 52% and 50% respectively.

We appreciate that a number of those expected to attend are senior managers and it may not be appropriate for them to attend every meeting. However, we observed that the terms of reference for the Health and Care Standards Group was recently updated and now clarifies the leads responsible for each of the Health and Care Standards and includes minimum attendance requirements.

Whilst this may help improve future attendance, there is still a correlation between members not attending the Group meetings and a lack of progress in addressing the outstanding actions assigned to them.

We therefore again recommend that attendance is monitored and where actions are outstanding beyond an agreed deadline, these should be escalated to the QPSOG. **(see Recommendation 2)**

3) Previous Outstanding Actions

The Health Board utilises Health and Care Standard driver diagrams as a tool for staff to identify which policies or procedures apply to each standard/theme requirement.

In the 2017/18 audit of the Health and Care Standards, we raised a medium priority recommendation that the Health Board complete the outstanding driver diagrams.

Whilst several driver diagrams are yet to be completed, we assess that the Health Board has made good progress in this area. Out of 34 driver diagrams originally required, we noted that only for Standard 4.1 Dignified Care had these not been completed.

Additionally, we were informed that four standards were deemed unsuitable for a driver diagram and that these standards will be discussed at future QPSOG meetings to determine the best alternative means of illustrating the standard's requirements.

We examined a sample of 10 driver diagrams in detail and our findings are recorded in Appendix A. Whilst we are content that progress is being made with the driver diagrams, we note that several in this sample have not been completed.

(see Recommendation 3)

7. Summary of Recommendations

The audit findings and recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**0**	**3**	**0**	**3**

Finding 1 Quality & Patient Safety Assurance (Design)	Risk
To determine whether the Health Board received appropriate assurance over the management of the Health and Care Standards, we reviewed meeting minutes the Quality & Patient Safety Committee (QPSC), Health and Care Standards Group (HCSG) and the Quality & Patient Safety Operational Group (QPSOG) over the last 12 months. Terms of reference for the HCSG were also reviewed. As reported last year, neither group had defined the frequency or details of assurance requirements to the QPSC members for the Health and Care Standards within the Health Board. It was therefore not possible to confirm then if sufficient assurance had been provided to the QPSC. Whilst previously there was a lack of clarity in the level of assurance required by the QPSC in this area, this has now been clarified in the two documents "Health and Care Standards - Assurance, Self-Assessment and Improvement Planning Guidance" document (although draft and yet to be published) and the HCSG terms of reference. Regarding inclusion of Health and Care Standards matters in the business of the appointed oversight committee/ group, we noted that Driver diagrams were discussed at only one of the four meetings held by the QPSC throughout 2018/19 (this mirrors the finding in the prior year audit) although in addition, an overview report of progress with the Health Board's implementation of the Standards was also given at their meeting of February 2019.	Obsolete documentation provides incorrect guidance to staff.

Going forward, we anticipate more regular reporting in compliance with the requirements set out in the updated "Health and Care Standards **-** Assurance, Self-Assessment and Improvement Planning Guidance" and the HCSG terms of reference.	
Recommendation 1	**Priority level**
The Health Board should finalise and approve for use the recently reviewed and amended "Health and Care Standards **-** Assurance, Self-Assessment and Improvement Planning Guidance" document.	**Medium**
Management Response 1	**Responsible Officer/ Deadline**
The "Health and Care Standards **-** Assurance, Self-Assessment and Improvement Planning Guidance" document will be finalised and approved through QPS Operational Group.	Assistant Director – QPS June 2019

Finding 2 Representation at Groups (Design/ Operation)	Risk
We reviewed the minutes of the meetings held by both the HCSG and QPSOG over the last 12 months to assess levels of attendance. From this we noted there continues to be a low level of attendance (52% and 50% respectively) at the meetings of these groups and the table below indicates the number of people who attended the 3 HCSG meetings held during 2018/19.	There is a risk of divisional representatives / standard leads not fully embedding the Health and Care Standards and a lack of mitigation and escalation of risks.

Health and Care Standards Group	
Total Meetings Attended	Number of People
3	4
2	8
1	16
0	21

The "Health and Care Standards Group - Terms of Reference" (ToR) has recently been reviewed and amended and explicitly identifies both the Divisional/Locality and Corporate leads to whom a Health and Care Standard has been assigned and the minimum meeting attendance requirements of the leads, although we note a small number remain unassigned.

Whilst the minimum attendance requirements that have now been documented may improve future attendance, we note that in 2018/19 this has been low. We noted too a correlation between members not attending the Group meetings and a lack of progress in outstanding actions assigned to them.

Recommendation 2	Priority level
The Health Board should finalise the assignment of Health and Care Standards to the leads documented in the Health and Care Standards Group terms of Reference. The Health Board should specifically identify the most appropriate employee for membership of the groups and closely monitor attendance at both the HCSG and QPSOG meetings. Where actions assigned members are outstanding beyond an agreed deadline, these should be escalated to the QPSOG.	**Medium**
Management Response 2	
Terms of Reference and Assignment of Health and Care Standards lead finalised Monitoring of Attendance at HCSG and escalation of actions assigned to members that are beyond their deadline to QPS Operational Group.	Assistant Director – QPS June 2019 Ongoing from April 2019

Finding 3 Health and Care Standard driver diagrams (Design/ Operation)	Risk
The Health Board utilises Health and Care Standard driver diagrams as a tool for staff to identify which policies or procedures apply to each standard / theme requirement. During the 2017 / 18 audit of the Health and Care Standards, we raised a medium priority recommendation requesting that the Health Board complete the outstanding driver diagrams. Whilst there still remain a number of driver diagrams to be completed, we assess the Health Board has made good progress in this area. Out of 34 driver diagrams originally required, we noted that only Standard '4.1 Dignified Care' and its four driver diagrams are still outstanding and incomplete. Additionally, we were informed that 4 standards were deemed unsuitable for a driver diagram and that these standards will be discussed at future QPSOG meetings to determine the best alternative means of illustrating and communicating the standard's requirement. We examined 10 driver diagrams in detail and the results of this are shown in the table below:	There is an increased risk of the Health Board being unable to manage and monitor the true position against the Standards. There is an increased risk of non-adherence to the Health and Care Standards.

Driver Diagram	Observation
2.1 b – Civil Contingencies and Emergency Planning	The overall 'aim' of the standard stated in the guidance is not included in the driver diagram. The flow lines provide confusion as it is not clear to which box they relate. The Driver Diagram encapsulates this Health and Care Standard.
2.2 - Preventing Tissue Damage	The Driver Diagram encapsulates this Health and Care Standard.
2.4 Infection Prevention and Control and Decontamination	The Primary and Secondary drivers do not provide the level of detail defined within the guidance. The Driver Diagram does not encapsulate this Health and Care Standard.
2.5 - Nutrition and Hydration	The overall 'aim' of the standard is not included. The Primary and Secondary drivers do not provide the level of detail defined within the guidance although the Actions are explicit and provide appropriate detail. The Driver Diagram does not encapsulate this Health and Care Standard.
2.6 - Medicines Management	The Driver Diagram encapsulates this Health and Care Standard.
2.9 - Medical Devices, Equipment and Diagnostic System	The driver diagram omits one of the standards primary drivers: *Suitable and sustainable systems, policies and procedures are in place for medical device*

	decontamination by competent staff in an appropriate environment. The Driver Diagram does not fully encapsulate this Health and Care Standard.	
3.3a - Participating in Quality Improvement	Minor amendment required – the arrows showing linkage are pointing the wrong way so either remove arrow head or rotate so they are correct. The Driver Diagram fully encapsulates this Health and Care Standard.	
3.5 - Record Keeping	Minor amendments required include rearrangement of the information provided in the driver diagram and inclusion of 1 omitted Primary driver. These amendments are as follows: 1 x Primary Driver omitted was as follows: • Care, treatment and decision making is supported by structured, accurate and accessible patient records documenting the conversations between people and health professionals and the resulting decisions and actions taken and reflects best practice founded on the evidence base. The 1 x Primary Driver included as an Aim was as follows: • Record keeping supports the delivery of services, patient care and communications.	

	The 2 x Primary Drivers included as Secondary Drivers were as follows: • Evidence shows how decisions relating to patient care were made. • Identification of risks enables early detection of complications. The Driver Diagram does not fully encapsulate this Health and Care Standard.
6.1 - Planning Care to provide independence	The driver diagram produced is not as per guidance and requires updating. The Driver Diagram does not encapsulate this Health and Care Standard.
7.1b - Workforce Recruitment & Employment Practices	The Driver Diagram encapsulates this Health and Care Standard.

Whilst we are content that progress is being made in respect of the driver diagrams, there remain areas that have not been completed.

Recommendation 3	**Priority level**
The Health Board should ensure that the remaining driver diagrams are completed.	**Medium**

Where driver diagrams remain incomplete, this should be escalated to the QPSOG for assistance in prioritising the actions.	
Management Response 3	**Responsible Officer/ Deadline**
Driver Diagrams for all Standards where a DD is appropriate to be completed and published on the intranet. Driver Diagrams to be reviewed by Standard Holders Annually	Assistant Director QPS and Standard Holders Sept 2019 Initiate Review Sept 2019 to be completed by Jan 2020

Aneurin Bevan University Health Board

Health and Care Standards

Audit Assurance Ratings

 **Substantial assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

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In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

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Audit

The audit was undertaken using a risk-based auditing methodology. An evaluation was undertaken in relation to priority areas established after discussion and agreement with the Health Board. Following interviews with relevant personnel and a review of key documents, files and computer data, an evaluation was made against applicable policies procedures and regulatory requirements and guidance as appropriate.

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Where a control objective has not been achieved, or where it is viewed that improvements to the current internal control systems can be attained, recommendations have been made that if implemented, should ensure that the control objectives are realised/ strengthened in future.

A basic aim is to provide proactive advice, identifying good practice and any systems weaknesses for management consideration.

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Responsibilities of management and internal auditors:

It is management's responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and detection of irregularities and fraud. Internal audit work should not be seen as a substitute for management's responsibilities for the design and operation of these systems.

We plan our work so that we have a reasonable expectation of detecting significant control weaknesses and, if detected, we may carry out additional work directed towards identification of fraud or other irregularities. However, internal audit procedures alone, even when carried out with due professional care, cannot ensure fraud will be detected. The organisation's Local Counter Fraud Officer should provide support for these processes.

Aneurin Bevan University Health Board

Health and Care Standards

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Nurse Staffing Levels (Wales) Act 2016

Internal Audit Report

2018/19

Aneurin Bevan University Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Service

8.5

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8.5

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Committee	Audit Committee

ACKNOWLEDGEMENT

NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

1. Introduction and Background

The review of the implementation of the Nurse Staffing Levels (Wales) Act 2016 (the 'Act') was completed in line with the 2018/19 Internal Audit Plan for Aneurin Bevan University Health Board (the 'Health Board').

The Act first became law in March 2016, requiring organisations across NHS Wales to calculate and monitor the number of nurses required to care sensitively for patients. The Act applies to acute medical and surgical in-patient wards although in the future this may be extended.

Whilst the Act does not prescribe the staff levels required on each ward, it does set out the key principles and guidance to be followed to help achieve/assure a safe level of staffing.

The Act places five key responsibilities on the Health Board which are to:

- provide enough nurses to care sensitively for patients across services that are managed and those that are commissioned;
- use a triangulated methodology to determine nurse staffing numbers in prescribed areas, currently medicine and surgery wards;
- inform patients of the nurse staffing levels;
- take steps to maintain those numbers; and
- report to Welsh Government compliance with maintaining the roster, actions taken in response to shortage and the impact of not maintaining those numbers on patient outcomes.

2. Scope and Objectives

The focus of the review was to assess whether the Health Board was meeting its duty to comply with the Act, including the use of agency/ temporary staffing.

Any weaknesses were brought to the attention of management and advice issued on how particular problems may be resolved and control improved to minimise future occurrence.

The internal audit assessed the extent to which the Health Board is compliant with the Act and provides recommendations for improvement relevant to the following areas:

Policy Framework / Governance etc.

- Health Board policy in respect of safe nurse staffing levels;
- financial and workforce impact of compliance with the Act; and
- executive management oversight of Act requirements.

Compliance with the Act - Strategic

- appointment of a designated person;
- determining relevant wards where the Act applies;
- interpretation of the Act in calculating ward establishment levels;
- Board approval of establishment levels determined by the Act; and
- periodic reviews of ward establishment levels.

Compliance with the Act - Implementation

- communicating the Act requirements to staff and patients;
- developing and implementing compliant establishment levels for affected wards;
- monitoring and maintaining compliant staffing levels; and
- operating ongoing oversight, action planning and issue management.

3. Associated Risks

The risks considered in the review are as follows:

- patient harm through unsafe staff levels (measured through quality indicators – falls, pressure ulcers, medication errors, infection prevention and control);
- breach of legislation;
- non-compliance with corporate policies and procedures; and
- failure to identify and manage key risks.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with Nurse Staffing Levels (Wales) Act 2016 is **Reasonable** Assurance.

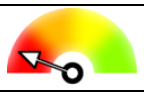
RATING	INDICATOR	DEFINITION
Reasonable Assurance		The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
Policy Framework / Governance etc.					
1	Health Board policy in respect of safe nurse staffing levels;			✓	
2	Financial and workforce impact of compliance with the Act; and				✓
3	Executive management oversight of Act requirements.				✓
Compliance with the Act - Strategic					
4	Appointment of a designated person;				✓
5	Determining relevant wards where the Act applies;				✓
6	Interpretation of the Act in calculating ward establishment levels;				✓

Assurance Summary					
7	Board approval of establishment levels determined by the Act; and				✓
8	Periodic reviews of ward establishment levels.				✓
Compliance with the Act - Implementation					
9	Communicating the Act requirements to staff and patients;			✓	
10	Developing and implementing compliant establishment levels for affected wards;			✓	
11	Monitoring and maintaining compliant staffing levels; and			✓	
12	Operating ongoing oversight, action planning and issue management.			✓	

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

The findings from the review have highlighted one issue that is classified as a weakness in the system control/design for Nurse Staffing Levels (Wales) Act 2016.

Operation of System/Controls

The findings from the review have highlighted one issue that is classified as a weakness in the operation of the designed system/control for Nurse Staffing Levels (Wales) Act 2016.

6. Summary of Audit Findings

Prior to the implementation of the Act, staffing levels were determined by the 'All Wales Nursing Principles' guidance. For this reason, staffing levels have not been significantly altered by the adoption of the Act and this is consistent with the findings of the audit.

The Act introduced new and enhanced monitoring and reporting of staffing levels. This is in addition to the existing safety and incident handling processes, which remain unaffected. Similarly, initiatives to address the high level of vacancies, which are behind the staff breaches or deficits reported on the wards both pre and post Act, has been a Health Board priority for some time and continues to be taken forward.

The key findings are reported in the Management Action Plan in Appendix A.

We identified two **Medium priority** issues that we consider require management's attention and provide scope for improvement to be made. These concerned the following:

(i) We noted in testing the rosters following calculations of staffing levels under the terms of the Act that in one case out of the 10 in our sample, the ward roster had changed but the change had not been reflected in the live e-roster template; and

(ii) Staffing levels on the shifts of the wards are continuously monitored and by comparing actual levels of staff present on shifts against the calculated planned levels, deficits are determined, assessed by an Executive group (the Safety Huddle) and reported to the Executive team in the weekly corporate dashboard. We noted however that staff level deficits are determined not against calculated planned levels (on some shifts 5 or 6 Registered Nurses) but against a generic ward 'core' staff level (typically 4 Registered Nurses). As a result, for wards where this is the case, deficits may be understated. We also noted some lesser issues with the accuracy of other elements of the deficit reports.

7. Summary of Recommendations

The audit findings and recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**-**	**2**	**-**	**2**

Action Plan

Finding 1 Implementing Act compliant ward staffing levels (Operation)	Risk
As a result of the implementation of the Act, the updated calculations for the staffing levels were completed in October 2018 and due for implementation immediately afterwards. We examined a sample of 10 ward staffing level calculations, from the 27 in the Health Board that were within the scope of the Act, to ensure that changes were reflected within the revised ward establishment levels and subsequently updated within the active ward rosters. All 10 calculations had been completed, but the active roster for one ward (3/3 Nevill Hall Hospital) had not been updated to reflect the change.	There is an increased risk that ward nurse staffing numbers are below those stipulated in the Act due to insufficient updating of the rosters.
Recommendation 1	**Priority level**
We recommend that all ward rosters are amended to reflect changes arising from staffing levels calculations required by the Act.	**Medium**
Management Response 1	**Responsible Officer/ Deadline**

• In order to secure bank and agency staff over the winter month's rosters were developed 3 months in advance – as a consequence rosters could not be amended immediately after the bi-annual review as rosters had already been populated. • Additional shifts could still be added in line with the new roster templates if required to meet acuity and to adhere to the triangulated approach requirement of the staffing act. • All ward rosters are now amended to reflect the bi-annual calculation • Future recalculations need to consider rosters will ***not*** be amended until the next available unpopulated roster - normally prepared 6 weeks in advance	E-rostering Team - **Completed** Senior Nurse/Ward Sister - **Completed** E-rostering Team - **Completed** Divisional Nurses/E-rostering Team

Finding 2 Recording and reporting ward staffing deficits (Design)	Risk
We noted that the staffing deficit monitoring and reporting activity on the wards is a manual process and does not appear to draw on or link to the e-roster records in its shift data comparison and analysis of deficits (although we understand an e-roster unfilled shifts report is available). Staff level breach data from daily ward meetings are captured initially in hand written hard copy documents and are later transcribed into Word based tabular/ narrative deficit reports. These are then incorporated into a tabular weekly corporate dashboard for Executives. With these records we noted the following issues / errors: **Daily ward deficit analysis** • the daily ward deficit analysis schedules compare counts of staff that worked on a shift to a generic ward establishment (typically four registered nurses for the wards sampled) and record a deficit only where the actual numbers on a shift are less than the generic ward establishment. This means that for wards where the establishment levels calculated under the Act are higher, for example five or six registered nurses, then the deficit level reported is under-stated; **Weekly deficit reports** • the deficit report variant tables within the corporate dashboard reports are not reconciled to the daily ward deficit analysis schedules from which they are derived. As there is no audit trail between the reports, it is not possible	Inaccuracy and error in the capture and reporting of ward nurse staffing level deficits.

to confirm how the deficit reports are compiled, i.e. the totals within the dashboard do not easily reconcile to the underlying data; • the Unscheduled Care, Royal Gwent Hospital ward variant tables within the deficit reports repeat the same data set for the weeks 15.12.18 and 22.12.18; • furthermore, the Unscheduled Care commentary provided within the explanatory comments fields, below the variant tables, is a repeated paste of text each week and therefore does not support the particular data reported; and • the data set date ranges within the document footnotes/ headers/ footers are not always accurate (e.g. Unscheduled Care variant tables commentary footer in deficit reports for the 2 periods 22.12.18-28.12.18 and 19.01.19-25.01.19).	
Recommendation 2	**Priority level**
We recommend that the Divisional Nurse Team: • compare the staff levels on each of the 27 applicable wards with the calculated establishment levels for each ward and report the deficit levels accurately; • ensure that there is a complete audit trail in the reconciliation from the deficit report variant tables within the corporate dashboard reports to the daily ward deficit analysis schedules;	**Medium**

• ensure that the information and data is not copied from one week to the next and that each report is updated for the applicable data of that week; and • seek in the longer term an automated process where ward deficit analysis/ reporting is derived from e-roster shift records.	
Management Response 2	**Responsible Officer/ Deadline**
• A new template has been developed and currently being piloted in both divisions to capture daily staffing and deficits to planned rosters more accurately, this will be captured electronically going forward. Please see attached:  Staffing Plan 07.03.19.docx • Further clarification is being sought through the All Wales Staffing Act Implementation Group with regards supernumerary/supervisory status – an agreed definition is currently being developed. • Discussions have been held with the USC Division with regards, repeating of data, repeated text each week and accuracy of dates. This has now been rectified and a new data set has been developed for both divisions to populate on a weekly basis which will be reported to executive board. Please see attached:	Senior Nurses - **Completed** Assistant Director of Nursing **April 2019** Divisional Nursing Team - **Completed**

Action Plan

Copy of Staffing Deficits Template (0(	

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