A meeting of the Aneurin Bevan University Health Board Audit Committee will be held on Thursday 5th December 2019, commencing at 1:30pm in Seminar Room 4, Conference Centre, Health Board Headquarters, St Cadoc's Hospital, Caerleon

AGENDA

1	**Private Discussions – 1.15pm**			
	1.1	**Committee members to have facilitated discussion with Counter Fraud**	Verbal	**Committee Members and Head of Counter Fraud**
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 8th October 2019**	Attachment	**Chair**
	2.4	**Action Sheet**	Attachment	**Chair**
	2.5	**Audit Recommendation Tracker Report**	Attachment	**Board Secretary**
	2.6	**Committee Forward Work Programme 2020**	Attachment	**Chair**
3	**Risk – 2.00pm**			
	3.1	**Revised Risk Management Strategy – including revised risk appetite statement**	Attachment	**Board Secretary**
	3.2	**Risk Management Update and Corporate Risk Register – Top 10 Risks**	Attachment	**Board Secretary**
4	**External Audit – 2.30pm**			
	4.1	**WAO Progress Update**	Attachment	**Wales Audit Office**
5	**NWSSP Audit & Assurance - Internal Audit & Specialist Service Unit – 3.00pm**			
	5.1	**Internal Audit Progress Report**	Attachment	**Head of Internal Audit**
	5.2	**Pay Incentives – Update Against Recommendation 1**	To Follow	**Director of Operations**
	5.3	**Fire Safety – Limited Assurance**	To Follow	**Director of Therapies and Health Science**
	5.4	**Health and Safety – Limited Assurance**	To Follow	**Director of Therapies and Health Science**

6	**Governance and Assurance – 3.45pm**			
	6.1	**Update on Governance, Financial Control Procedures and Technical Accounting Issues** • **FCP on Payroll** • **Policy for engaging off payroll workers**	Attachment	**Assistant Director of Finance (Financial Systems & Services)**
	6.2	**Losses and Special Payments Report**	Attachment	**Assistant Director of Finance (Financial Systems & Services)**
	6.3	**Declaration of Interests Report**	Attachment	**Board Secretary**
7	**Date of Next Meetings**			
	Business Meeting: Tuesday 4th February 2020 at 9.30am in Conference Room 3, Headquarters, St Cadoc's			**Chair**

	Supplementary Papers • Welsh Lanaguage Standards (Reasonable) • Charitable Funds (Reasonable) • IT Service Management (Reasonable) • Unscheduled Care Divisonal Review (Reasonable)

Aneurin Bevan University Health Board

Minutes of the Audit Committee held on Tuesday 8th October 2019, in Executive Meeting Room, Headquarters, St Cadoc's

Present:

Shelley Bosson	-	Chair, Independent Member (Community)
Emrys Elias	-	Vice Chair, ABUHB

In Attendance:

Danielle O'Leary	-	Corporate Services Manager (Secretariat)
Bryony Codd	-	Head of Corporate Governance
Glyn Jones	-	Director of Finance and Performance
James Quance	-	Head of Internal Audit, NWSSP
Gabrielle Smith	-	Wales Audit Office
Chris Koehli	-	Special Adviser (Finance)
Mark Ross	-	Assistant Director of Finance

In Attendance for Specific Items:

Martyn Edwards	-	Head of Counter Fraud
Scott Lavender	-	PPV Manager
Sara Jeremiah	-	PPV Manager
Kate Hooton	-	Assistant Director Organisational Learning
Stephen Edwards	-	Deputy Medical Director

Apologies:

David Jones	-	Independent Member (IT)
Judith Paget	-	Chief Executive
Richard Harries	-	Wales Audit Office
Richard Bevan	-	Board Secretary
Richard Clark	-	Independent Member (Local Authority)

Audit 0810/01 Welcome and Introductions

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

Audit 0810/02 Apologies for Absence

Apologies for absence were noted.

Audit 0810/03 Declarations of Interest

There were no declarations of interest to note.

Audit 0810/04 Minutes of Previous Meeting 18th July 2019

The minutes were agreed as a true and accurate record.

Audit 0810/05 Action Log

The actions were noted and agreed.

Audit 0810/06 Audit Recommendation Tracker

The Committee received the regular report with the re-instated amber assessment category. The Committee was asked to approve the report, noting the request for recommendations to be removed from the tracker and the areas where progress had been made.

Of the 26 recommendations on the tracker database, 8 high level actions had been assessed by the Executive Team as completed and were proposed to be withdrawn from the tracking database.

The Committee welcomed the further assurances provided in the report noting the actions that were required for recommendations to become 'green'.

A general point was made with regard to the framing of some of the recommendations with regard to timescales. It was suggested that some of the timescales were not realistic and were too long, for example in relation to the medical equipment and devices recommendation. With regard to medical equipment and devices, work was underway to consider using a similar tagging system to the one being developed for fixed assets (see below). An update would be provided at the next meeting.
ACTION: Director of Finance and Performance

The Committee was updated on work to improve asset management and tagging systems in the Health Board, including the further use of technology similar to that which is used in the laundry services. It was agreed that an update

on this recommendation would be provided to the next Committee meeting.
ACTION: Director of Finance and Performance

Audit 0810/07 Terms of Reference

The Committee was advised that the draft Terms of Reference had been considered by the Chair of Audit Committee and the lead Executives. A meeting was scheduled to take place between all Committee Chairs and Lead Executives to discuss all the Terms of Reference for all the Committees of the Board. This meeting would take place prior to the November 2019 Board meeting, when all Terms of Reference would be presented for final ratification.

It was suggested that it would be helpful in terms of assurance to the Committee, to have one work plan that incorporated all Committees of the Board. It was confirmed that this was being developed and would be shared once it had been finalised.
ACTION: Board Secretary/Secretariat

The Committee approved the Terms of Reference and recommended that they be presented to the Board at the November 2019 meeting.
ACTION: Board Secretary/Secretariat

Audit 0810/08 Counter Fraud Progress Report

Audit Committee received the Counter Fraud Progress report and noted that the team was planning to recruit to the vacancy that was reported at the last update to the Committee. The vacancy had not affected the team's ability to meet the standards and the Health Board had attained a 'green' status in each area.

The Committee acknowledged the work that had been undertaken in relation to raising awareness of the Counter Fraud programme of work throughout the organisation. The high level of awareness of this area of work meant that there were increased levels of referrals and raised deterrent levels.

The Committee raised an issue in relation to the income of a managed GP practice. It was noted that this had been identified by the Corporate Finance Team and appropriate action had been taken to remediate the issue. It was agreed

that a review would be undertaken to ensure that other systems were compatible when being moved to Health Board systems.
ACTION: Assistant Director of Finance

The Committee recognised the work that had been undertaken and noted the progress report.

Audit 0810/09 Risk Management Update and Corporate Risk Register

The Committee was advised that the current Risk Management Strategy was due for review and renewal by January 2020. It was noted that the new Concerns Management and Risk system had been procured on a Wales basis and in the interim risk managers were utilising the risk management module on DATIX. It was also noted that a job description had been prepared for the role of Corporate Risk Manager and was currently going through the scrutiny process with the aim to have the post filled by the end of the calendar year.

The risk register that was presented to the Committee was the risk register that was presented to the Board in September.

It was noted that the future work programme for this Committee would need to drive improvement in management of risk and performance in an integrated way.

Chris Koehli commented that the new arrangement for risk management would need to be different in terms of determining if a risk was acceptable or not. In order to make this assessment, the Independent Members agreed they would need to understand the current performance, an analysis of costs vs. benefits and a recognition of when circumstances were beyond the Health Board's control. It was anticipated that a degree of this work would be done through the revision of the risk appetite statement which should be informed by the controls in place to manage the risk and safety of patients ie system wide measures. It was agreed that for future reporting purposes, performance and risk would be more closely linked and the Health Board should include its own performance measures not just the Welsh Government targets in delivery of its priorities.
ACTION: Director of Finance and Performance/Board Secretary

It was suggested that the top ten risks on the Corporate Risk Register could be amended to reflect whether or not they impact on the Health Board's ability to achieve its objectives in the IMTP. Also, the risk appetite for each of the corporate strategic risks would be clarified.
ACTION: Board Secretary/Head of Corporate Governance

The Committee noted the Strategic Risk Report.

Audit 0810/10 PPV Update – New Traffic Light System

Scott Lavender and Sara Jeremiah attended the Committee to present an update in respect of the new traffic light system in Post Payment Verification (PPV).

The Committee noted that the report captured 6 months of Post Payment Verification visits for the financial year 2019-2020 including Medical, Ophthalmic and Pharmaceutical services. In the new format of the report further emphasis on the history of a practice, their current visit status and two historical preceding visits were reviewed to demonstrate levels of performance over a longer time period. The report suggested that the training programmes alongside support and guidance delivered was aiding the practices to better inform their record keeping accuracy.

The Committee welcomed the new style of reporting and commented that it was helpful to review trends and measurement against an all Wales average. It was noted that if any Clinical issues arose as part of the visits these were referred to the advisor at the Health Board. The Committee thanked the PPV Team for the report and endorsed the new reporting format.

Audit 0810/11 WAO Progress Report

The Committee received the update report from Wales Audit Office. The report highlighted the financial areas of focus during the 2019 WAO Audit Plan and there were no areas of concern to note.

The following areas were noted as forming part of the performance related audits for 2019:

- Structured Assessment

- Thematic review - quality governance arrangements
- Thematic review - Well Being of Future Generations (Wales) Act 2015

In terms of NHS related national reports, a review of the Integrated Care Fund (ICF) was scheduled for publication. The Committee were informed that a report on Public Service Boards had been published that morning its key message being that the Boards were not filling their potential and needed to work more flexibly.

The Committee noted the progress report.

Audit 0810/12 Clinical Coding Assurance Report

Following the last Committee meeting in July 2019, it was agreed that a further assurance report on progress in relation to Clinical Coding would be presented to the Committee. The report highlighted issues in relation to completeness of coding, IMTP targets and the national targets.

It was found that the accuracy of coding in the Health Board surpassed other levels of accuracy of clinical coding however, the current system did not allow the Health Board to record ward attendances and therefore this created significantly higher rates of coding activity which added to the volume of coding activity. It was expected that an IT solution would be developed later on in the year to help address this.

The Health Board had recently appointed to two Trainee Clinical Coder positions. With regard to the artificial intelligence aspects that were outlined in the last report, the Health Board was awaiting the outcomes from an NHS Trust in Essex who had already implemented this software and some shared outcomes were expected. The aim was to reduce the manual coding activity by increasing digital activity.

In respect of the accommodation issues that were raised at the last Committee meeting, the sites had been visited and changes made to address the main concerns raised in the WAO report.

The Chair queried how the information was utilised after it had been coded. It was confirmed that the information was held centrally and could be used for a number of reasons such as reviews of case mix and commissioning purposes. It was also

available on line for clinicians to view to assist with service improvement.

The committee noted the outstanding concern remained the compliance with the clinical coding completeness target within 30 days along with the IMTP profile and noted from the report achievement of these targets was not possible in the short term. However the Committee were provided with assurance through the report and the discussion that the internal solutions were expected to achieve the IMTP target by the end of March 2020. The implementation of the automation would require a business case and alongside the other solutions being implemented should enable the Health Board to achieve the 95% completion target during 2021/22.

It was noted that the opening of the Grange University Hospital would also require adjustments to the current service.

Audit 0810/13 Clinical Audit Further Assurance Report

The Committee received the update in respect of Clinical Audit following the follow up audit and noted that an action plan was attached to the report to demonstrate the areas of progress against the recommendations.

It was acknowledged that the Quality Assurance Framework (QAF) had been developed and was in place to support the delivery of the Clinical Audit plan. The plan consisted of national and local level audits and adopted a risk based approach. In terms of assurance, the Committee was advised that the Quality and Patient Safety Operational Group (QSPOG) would be changing its format slightly and further focus would be on quality assurance.

The implementation of the Clinical Audit Plan would be overseen by the Clinical Effectiveness Group (CEG). A programme of audits for 2019/20 had already been agreed and the CEG would be responsible for overseeing all national audits. It was reported that the inaugural meeting of CEG had been well attended and it would be important to ensure that this level of attendance could be sustained going forward.

Some members queried how the Health Board would use the evaluation outcomes of the audits and demonstrate that actions were being taken to improve outcomes. It was noted that the CEG would be monitoring results which would then

report to the Quality and Patient Safety Committee. This would align with the work of the Value Based Health Care and ABCi work programmes.

It was anticipated that a re-audit in this area would commence in the New Year. It was agreed that a meeting would be scheduled to discuss the remit of the audit.
ACTION: Head of Internal Audit

Audit 0810/14 Internal Audit Progress Report

The Committee received the standard report and noted that there were no areas of concern to be highlighted. There were a number of reasonable and substantial assurance rated reports for the Committee to consider and note.

The WAST report that was included was for information however, it was felt that the recommendations should be shared with the Quality and Patient Safety Committee.
ACTION: Secretariat

Audit 0810/15 Medical Locum and Agency Limited Assurance Report Update

The Committee received the report and the update on progress against the recommendations. Hotspot opportunities had been identified and it was recognised that there were some areas where substantive appointments could be made with long term locum. It was noted that work on skill mix in key areas was ongoing.

In relation to the issues around Executive sign off of agency shifts, awareness raising had taken place with Divisions. It was agreed that the established process would be reinforced with Divisions and the Audit Committee urged the Health Board to test the process prior to the re-audit being undertaken in the next year.
ACTION: Deputy Medical Director

Audit 0810/16 Pay Incentives – Limited Assurance

The Committee noted that this limited assurance report covered doctors and nurses pay incentive schemes. The Committee was advised of the recommendations and noted that some work had been undertaken and was due to be presented to the Executive Team in October 2019. The

Committee were concerned that some individuals had continued to be paid on the incorrect rate therefore, an update on recommendation 1 and the outcome of discussion by Executive team in October on the revised process would be provided at the next Audit Committee meeting.
ACTION: Secretariat/Director of Operations

The Committee was advised that rates were variable in relation to payment of consultants. Job planning was highlighted as a concern in some areas. It was agreed that this would be raised with the Executive Team for their view on this and the following point would require consideration:

- Further consideration of some outsourcing.
- What was the short term plan.
- A value for money perspective should be included.
- What was the national approach to this area.

ACTION: Secretariat/Director of Operations

Audit 0810/17 Update on Governance, Financial Control Procedures and Technical Accounting Issues

The Committee noted the position regarding IFRS16 that the Welsh Government have not yet agreed how the new treatments will impact on capital and resource allocations. This may impact on future decisions about leases and managed service contracts, which will need to be fully understood and considered as part of ongoing plans. The report highlighted a number of assumptions and a further update would be provided at the December committee meeting.

The Committee was asked to consider and approve the 'write off' of some bad debt relating to overpayment of salary. The Committee was assured that all internal processes had been exhausted and due process had been adhered to. The Committee agreed to write off the bad debt.

The Committee noted and approved the report.

Audit 0810/18 Losses and Special Payments Report

The Committee noted the report.

The Audit Committee received the report and noted that there were no major issues identified.

Audit 0810/19 Revised Policy for Standards of Business Conduct

This policy was due for renewal and in line with due process was being presented to the Audit Committee for ratification prior to formal publication.

The Committee queried the relevance of the £100 specified in the policy and some of the wording around declaring an interest. It was agreed that the paragraph would receive further consideration.
ACTION: Board Secretary

Subject to the above amendments, the Audit Committee endorsed and approved the policy.

Audit 0810/20 Date of Next Meeting

The next meeting of the Audit Committee is on Thursday 5th December 2019 at 2:00pm in the Executive Meeting Room, Headquarters, St Cadoc's Hospital.

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Audit Committee
5th December 2019
Agenda Item: 2.4

Audit Committee
8th October 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 0810/06	**Audit Recommendation Tracker** An update to be provided on medical equipment and devices tagging system at the next meeting.	**Director of Finance and Performance**	December 2019	This update will be covered via the Audit Recommendation Tracker report.

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

Audit Committee
5th December 2019
Agenda Item: 2.4

Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
	A further update on the use of technologies similar to that used in Laundry Services to be included as part of the update on asset management and tagging systems at the next meeting.	**Director of Finance and Performance**	December 2019	This update will be covered via the Audit Recommendation Tracker report.
Audit 0810/07	**Terms of Reference** It was suggested that it would be helpful to have one work plan that incorporated all Committees of the Board. It was confirmed that this was being developed and would be shared once it had been finalised.	**Board Secretary/Secretariat**	TBC	Work is ongoing in this area and an update will be provided to the Committee as soon as the work has been completed.

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Audit Committee
5th December 2019
Agenda Item: 2.4

Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
	The Committee approved the Terms of Reference and recommended that they be presented to the Board at the November 2019 meeting.	**Board Secretary/Secretariat**	November 2019	The terms of reference were presented to the November 2019 Board meeting for endorsement and approved.
Audit 0810/08	**Counter Fraud Progress Report** It was agreed that a review would be undertaken to ensure that other systems were compatible when being moved to Health Board systems.	**Assistant Director of Finance**	Immediately	A member of the Financial Services team met with the relevant staff and all managed practices now use the Health Board income recording system. We are working with the manager to ensure all relevant procedures and SFI's are complied with
Audit 0810/09	**Risk Management Update and Corporate Risk Register** It was agreed that for future reporting purposes, performance and risk would be more closely linked and the Health Board should include its own performance measures not just the Welsh Government targets in delivery of its priorities.	**Director of Finance and Performance/ Board Secretary**	February 2020	Development work will commence with Independent Members of the Committee to shape the format aligned to the revision of the Health Board's Risk Management Strategy.

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

Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
	It was suggested that the top ten risks on the Corporate Risk Register could be amended to reflect whether or not they impact on the Health Board's ability to achieve its objectives in the IMTP. Also, the risk appetite for each of the corporate strategic risks would be clarified.	**Board Secretary/Head of Corporate Governance**	December 2019	Completed. Work was undertaken to further refine and clarify each risk with the respective Executive Leads. The risk appetite and target risk score has also now been included on the Corporate Risk Register and was presented to and endorsed by the Board in November 2019.
Audit 0810/13	**Clinical Audit Further Assurance Report** It was anticipated that a follow up audit in this area would commence in the New Year. It was agreed that a meeting would be scheduled to discuss the remit of the audit, as per usual practice.	**Head of Internal Audit**	November 2019	Completed. A meeting was convened as part of due process and the follow up audit is well underway.
Audit 0810/14	**Internal Audit Progress Report** Recommendations from the WAST report should be shared with the Quality and Patient Safety Committee.	**Secretariat**	Immediately	This action has been completed and a copy of the report has been distributed to members of the Quality and Patient Safety Committee.

Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
Audit 0810/15	**Medical Locum and Agency Limited Assurance Report Update** It was agreed that the established process would be reinforced with Divisions and the Audit Committee urged the Health Board to test the process prior to the re-audit being undertaken in the next year.	**Deputy Medical Director**	March 2020	Reinforcement of the process has been undertaken with the Divisions in advance of any follow up audit next year.
Audit 0810/16	**Pay Incentives – Limited Assurance** An update on recommendation 1 and the outcome of discussion by Executive team in October on the revised process would be provided at the next Audit Committee meeting.	**Director of Operations**	December 2019	Item scheduled on the December Committee meeting agenda.
	Job planning was highlighted as a concern in some areas. It was agreed that this would be raised with the Executive Team for their view.	**Director of Operations**	November 2019	Completed.

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Audit Committee
5th December 2019
Agenda Item: 2.4

Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
Audit 0810/19	**Revised Policy for Standards of Business Conduct** The Committee queried the relevance of the £100 specified in the policy and some of the wording around declaring an interest. It was agreed that the paragraph would receive further consideration.	**Board Secretary**	Immediately	Completed.

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Audit Committee 5th December 2019 Agenda Item: 2.5a

2.5

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 by the Executive Team. This was undertaken in readiness for the July 2018 Audit Committee Meeting and the Tracker has been reported to each committee meeting since that time. Further refinement of the tracker has been undertaken over recent months and good progress has been noted with the redevelopment and the reporting against recommendations.

This report provides the Audit Committee with an update on the progress with the tracker.

It was agreed that the Tracker would be submitted to each Audit Committee Meeting and 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 a collective discussion at an 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 are also recommendations 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: Lucy Bennett, Executive Assistant			
Report Received consideration and supported by :			
Executive Team		**Committee of the Board [Committee Name]**	
Date of the Report: 27th November 2019			
Supplementary Papers Attached: November 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 high level recommendations for Internal Audit and also Wales Audit Office 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.

At the July 2019 meeting, the Audit Committee agreed that the Amber assessment would be re-introduced to show those recommendations where progress had been made but had yet to reach full completion. The Committee also agreed that additional information would be added to each recommendation assessed as either red or amber to indicate what additional work was required to achieve green/completed status and a timeline within which that would be achieved. This approach has been incorporated into the tracker and is outlined in the final column of each recommendation on the attached report.

There are currently 16 recommendations within the database, as per the table below:

Red	0	Some progress, but outside the target deadline.
Amber	11	One Action has been agreed to remain Amber by the Audit Committee.
Green	3	The Action has been completed and it is proposed that the action is withdrawn from the tracker.
Purple	2	Action yet to reach its target date.

Three high level actions have been assessed by the Executive Team as completed and are proposed to be withdrawn from the tracking database with the agreement of the Audit Committee. One of the actions to be removed has been completed ahead of its deadline.

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 agree that the 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

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Audit Committee
5th December 2019
Agenda Item: 2.5b

Audit Recommendations – to the end of October 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	**September 2019 Update:** Overall completion 90% Completed actions: - Minor works quotes for gas extraction and fire stopping at Nevill Hall has been received. Outstanding Actions for September: - Minor works quote for gas extraction and fire stopping at St Cadocs - Minor works quote for gas extraction and fire stopping at Online House - Minor works quote for gas extraction and fire stopping at royal Gwent Hospital Outstanding actions for October 2019 - Completion for Minor works components Outstanding actions for November 2019 - Commissioning of fire suppression systems at all 4 sites **Executive Team Update – November 2019:** - Quotes received for minor works. - Currently seeking funding opportunities to progress the work prior to commissioning the fire suppression.	**Action required to achieve - green/completed status:** Therefore, the current status is amber and it is expected that the action will be green by the next report.

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Audit Committee
5th December 2019
Agenda Item: 2.5b

Audit Recommendations – to the end of October 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
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	**September 2019 Update:** A Clinical Effectiveness Group has been set up which is the vehicle for taking forward the recommendations in relation to the three levels of Clinical Audit. The Quality Improvement and Leaders Group is overseeing the development of the Quality Improvement Strategy and Assurance Framework, which will then allow the assessment of the level of clinical of clinical audit required to take forward the strategy. The identified date for completion is June 2020. **Executive Team Update – November 2019:** Implementation of the agreed Action Plan continues in line with agreed timelines. Update being provided to the Quality and Patient Safety Committee at its December Meeting.	**Action required to achieve - green/completed status:** Progress has been made with an action plan in place and groups actively working to complete this plan. Evidence of some elements being complete however, assessed as amber as the action plan will not be fully complete until June 2020.

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Audit Committee
5th December 2019
Agenda Item: 2.5b

Audit Recommendations – to the end of October 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
35 (IA)	Medical Equipment and Devices *February 2018*	Registers should be maintained for operational management of medical devices and equipment on each ward and department, which should record relevant equipment details. The register format should be consistent and overseen centrally, with periodic reviews/scrutiny completed.	No deadline stated in the report	Medical Director/ Director of Therapies and Health Science	**September 2019 Update:** A Medical Devices Group has been established and development of a medical devices/ equipment register is underway. A report is being submitted to the Executive in October 2019. This will provide the clear timeline for the pathway to green which has been identified as October 2020 for full completion. **Executive Team Update – November 2019:** Good progress with establishment of a Medical Devices Committee, including work to draft a policy on the management of medical devices in line with Medical Devices Regulations.	**Action required to achieve - green/completed status:** With implementation ongoing, the path to green has been identified to be achieved by October 2020. Current status updated to amber to reflect progress.

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Audit Committee
5th December 2019
Agenda Item: 2.5b

Audit Recommendations – to the end of October 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
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	**September 2019 Update:** A Clinical Effectiveness Group has been set up which is the vehicle for taking forward the recommendations in relation to the three levels of Clinical Audit. The Quality Improvement and Leaders Group is overseeing the development of the Quality Improvement Strategy and Assurance Framework, which will then allow the assessment of the level of clinical of clinical audit required to take forward the strategy. The identified date for completion is June 2020. **Executive Team Update – November 2019:** Implementation of the agreed Action Plan continues in line with agreed timelines. Update being provided to the Quality and Patient Safety Committee at its December Meeting.	**Action required to achieve - green/completed status:** Progress has been made with an action plan in place and groups actively working to complete this plan. Evidence of some elements being complete however, assessed as amber as the action plan will not be fully complete until June 2020.

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Audit Recommendations – to the end of October 2019

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	**September 2019 Update:** SOP is underway, with priority being given to key processes. Action completed: Change Management SOPs (policy, process and procedure) are ready for peer review and introduction via a workshop to be held in October 2019. **November 2019 update:** Change management workshop held and policy/process documents approved and implemented. New fortnightly Change Advisory Board (CAB) running with participation across informatics. All changes for CAB are assessed pre-CAB and reviewed post implementation. Now that the change management process is successful, the focus will move to address Incident Management activities. A Post Incident Review process has been formulated to ensure Root Cause Analysis for high priority incidents is carried out and that lessons learned and service improvements are implemented and actioned. **Outstanding Actions:** Draft SOPs & Hold Workshop for: Incident Management – to be complete by 31/12/2019 Request Fulfilment – to be complete by 31/01/2020 Problem Management – to be complete by 28/02/2020 Release & Deployment – to be complete by 31/03/2020 Remaining non priority processes complete by 31/10/2020	**Action required to achieve - green/completed status:** Good progress made. Timelines for finalisation of the remaining areas of work have been identified and agreed. Therefore, the current status is amber.

Audit Recommendations – to the end of October 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	**September 2019 Update:** Completed Actions: A stakeholder map has been identified including national service management board representatives. Key stakeholders have been subjected to structured interviews to gain their understanding of current Service Management Landscape. **Outstanding actions:** An internal service management board is to be established to consolidate opinions from individual SMB attendees, facilitating better appraisal of NWIS SLA at reviews. Completed by 31st October 2019. **November 2019 Update**: Communication within Informatics and across the wider Health Board has improved. ICT is now represented on the Clinical Information Council, Diagnostics Programme Board and other fora to ensure that the voice of service recipients is heard.	**Action required to achieve - green/completed status:** The one remaining action has been completed by 31st October 2019 and therefore this has taken the status to green. Recommendation that this can be removed from the tracker.

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Audit Recommendations – to the end of October 2019

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	**September 2019 Update:** National standards for classification, prioritisation and service level targets/metrics have been adopted and are reported at ICT monthly management board. **Executive Team Update – November 2019:** Requirements for SKMS have been identified and agreed, awaiting funding to develop revised share point. Content has started to be collated in terms of: • Policies and procedures • Knowledge articles • Post Incident Review reports • Operational Performance reports • Minutes from CAB meetings • Minutes from supplier review meetings With regards KCS process- a review of services and related predefined templates for service desk tickets has been commenced.	**Action required to achieve - green/completed status:** Progress made, but some SOPs outstanding and the timeline of completion is indicated up to the end of March 2020. Currently amber, but will move to green when work on SOPs has been completed.

Audit Recommendations – to the end of October 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	**September 2019 Update:** Finance have reviewed the original intention to utilise a system similar to that used in Swansea Bay and Velindre, this would have been a reasonably quick, pragmatic solution to implement and tag assets. However, having considered the business process and control benefits offered by this approach the benefits were very limited and whilst it would have met audit recommendations it did not practically add material benefits for ABUHB. The Finance Team have researched wider and reconsidered the proposal and are investigating the option of RFiD tagging which would offer greater business advantages, but will be at a higher cost. Aligned to this option the team are liaising closely with other departments to determine the wider opportunities and synergies which RFID tagging may present. The aim is to ensure that any early product which Finance choose can be up-scaled for future use by other departments. Provider demonstrations are being arranged and a case will be developed for executive consideration.	**Action required to achieve - green/completed status:** The Executive Team reviewed the status and it was agreed that there was a timeline to green and therefore assessed current status as amber. The timeline for completion has been agreed as follows: • Procurement - February 2020 • Implement - March/April 2020

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Audit Recommendations – to the end of October 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				**Executive Team Update – November 2019:** Provider Demonstrations have been received and attended by members of Finance, IT, Biomedical Engineering and Medical Records departments. In addition conversations have been held with the NWSSP Director of Procurement related to the potential implementation of 'Scan 4 Safety' in Wales, with the potential for ABUHB to link with that programme in order to benefit from central resources. Following discussion the potential national project scope and timescales are too extended and into the future to meet ABUHB requirements. We have engaged with 'Digital Health Ecosystems Wales' a WG funded organisation to discuss procurement and deployment options, with the aim of supporting the development of an output based specification. Site visits are being arranged with Cwm Taf during November, where they have implemented a tagging pilot.	

Audit Recommendations – to the end of October 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
96 (IA)	Clinical Futures Service Redesign	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.	End of October 2019 – Phase 2	Director of Planning, Digital and IT	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. 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/not endorsed 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.	**Action required to achieve - green/completed status:** Good progress has been noted, but further work being undertaken on this position with regular updates to the monthly Clinical Futures Delivery Board. It has been agreed that the action is assessed as amber at this stage.

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Audit Recommendations – to the end of October 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
96 (IA)	Clinical Futures Service Redesign		End of October 2019 – Phase 2	Director of Planning, Digital and IT	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. **Executive Team Update – November 2019:** Clinical Futures Investment Panel 1 recommendations were taken to Board in March and approved. This recommendation continues to be work in progress and delivered through an investment panel and part of IMTP prioritisation process, agreed at the CF Delivery Board. This is being communicated through several forums such as the Delivery Board and P&SCC. The IMTP deadline is used as a final marker to ensure all key areas are included within the plan. A Benefits review forum will be held in November to look at the financial savings element of the transformation.	

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Audit Recommendations – to the end of October 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
97 (WAO)	Structured Assessment 2018	**R1 - Governance** The Health Board should: • ensure board member induction and training meets the needs of Independent Members;	December 2019	Board Secretary	**September 2019 Update:** Programme continues. New all-Wales Programme to be launched with the first of the new approaches being held in early December. The Health Board's additional programme of monthly sessions has continued with an all-Board Development Session held in April 2019 and an Action Plan developed and agreed. **Executive Team Update – November 2019:** It has been agreed with the Chair that the follow-up all-Board session will take place in February 2020 to assess progress. It is anticipated that the action will be closed at that time.	**Action required to achieve - green/completed status:** Assessed as amber – will move to green at the end of February 2020 following completion of the additional externally facilitated Board Development Session.

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Audit Recommendations – to the end of October 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
97 (WAO)	Structured Assessment 2018	• Clarify perceptions around interoperability of the Board committees.	May 2019	Board Secretary	**September 2019 Update:** The Health Board at its meeting in May 2019 agreed changes to the Committee Structure which began to take effect from the 1st July 2019. The new structure is being implemented with new membership and arrangements for some Committees. New terms of reference have been developed to support enhanced interoperability. These will be considered by Committees during September and October and presented to the Board for approval in November 2019. **Executive Team Update – November 2019:** Revised Terms of Reference have been completed for all Committees, advice received from Internal Audit and WAO. Following approval at the Board Meeting in November 2019, it is considered that this has completed.	**Action required to achieve - green/completed status:** Assessed as green following approval by the Board of the revised terms of reference. It is proposed that this can now be removed from the tracker.

Audit Recommendations – to the end of October 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
98 (WAO)	Structured Assessment 2018	• in addition to reviewing all the high priority matches recommended for review, carry out a review of a sample of the remaining data-matches;	March 2019	Director of Finance and Performance	**September 2019 Update:** Investigation of the data matches on WLI is progressing well in all areas. In total ABUHB had 5,700 data matches, of which, 5,248 were for Procurement AP (Trade Creditors standing data). Just under 1,000 of those AP data matches were marked as high priority. When the data matches were released in Spring 2019, there was a 2-month delay on the part of the Cabinet Office before the Trade Creditor matches were released which delayed ABUHB actioning them. Once all high priority matches are completed, it will then be possible to implement reviewing a sample of remaining data matches. **Executive Team Update – November 2019:** All high priority data matches have been investigated and a significant number of medium and low risk categories likewise (circa 1,044) with no fraud identified to date. The consistent theme on Procurement AP matches is existing internal financial controls had identified the anomalies and had corrected them without NFI. This is assurance that Health Board internal financial controls are effective. NWSSP have Forensic Software (Fiscal Technology) in place, on which, a Risk Analysis Report is run and checked daily. It is checked for duplicate invoice numbers, amounts, descriptions also available is dates, invoice status and batch names. Remedial action is implemented on anomalies identified, hence the outcome described above.	**Action required to achieve - green/completed status:** Given the progress made and the level of completion and assurance, the Executive Team assessed this action as green. It is proposed that this is now removed from the tracker.

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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
					The LCFS now proposes to mark the remainder of outstanding low risk data matches under the heading, 'not selected for investigation' (which is a recent addition to the initiative outcomes) and close the initiative for this season.	

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Audit Recommendations – to the end of October 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
99 (WAO)	Structured Assessment 2018	**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%;	March 2020	Director of Planning, Digital and IT	**September 2019 Update:** IGU now undertake the updating of staff training on ESR. We experience challenges in placing ABUHB e learning on to the NHS Wales ESR – staff currently have to log in vis the ABUHB intranet. This affects compliance rates. The Health Board look to Director WOD to request ABUHB links on ESR. SIRO training arranged for September 2019. Believe that achievement of 95% compliance is ambitious when absence is taking in account. Initial target which is perceived as achievable is 90%. **Executive Team Update – November 2019:** SIRO training undertaken. Clarity has been sought about the national target and compliance rates. The NHS Wales IG Management Advisory Group (IGMAG) members consider that the Welsh Government target is 85%. This will be addressed through NHS Wales IGMAG.	**Action required to achieve - green/completed status:** At the time of review the deadline was not yet reached.

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Audit Recommendations – to the end of October 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
99 (WAO)	Structured Assessment 2018	• improving performance against information access targets for the Freedom of Information Act and Data Protection Act to reach the statutory targets	March 2020	Director of Planning, Digital and IT	The Health Board during 2018/19 has already improved its compliance with statutory targets and will continue with this focus for 2019/2020. **September 2019 Update:** The Information Governance Unit now undertake information awareness updated. **Executive Team Update – November 2019:** The responsibility for Freedom of Information sits with the Board Secretary and the FOI process has recently received 'substantial' assurance from Internal Audit. FOI compliance for the year to date is over 90%. SAR compliance is regularly reported to T2D and IGC. Compliance rates will vary by month dependant on SAR volume and the reported rate at October 2019 is 95%.	**Action required to achieve - green/completed status:** At the time of review the deadline was not yet reached.

Audit Recommendations – to the end of October 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
		• oversight of national system risks and their impact on the organisation	December 2019	Director of Planning, Digital and IT	ABUHB continues to engage with both Welsh Government and NHS Wales Informatics Service. Welsh Government have conducted a review of governance following the WAO report. The Health Board is actively engaged in this and other resultant actions including an architecture review. **September 2019 Update:** Continuing to engage Informatics reviewing risk process and registers. **Executive Team Update – November 2019:** Review of risk identification has started as these will now be assessed using the IMTP objectives (which meet strategy aims). Achievement of the December 2019 date is being re-assessed as part of IMTP completion during November 2019.	**Action required to achieve - green/completed status:** At the time of review the deadline was not yet reached.

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Audit Recommendations – to the end of October 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
100 (WAO)	Structured Assessment 2018	• updating its ICT disaster recovery plans and test these to ensure they work as intended.	March 2020	Director of Planning, Digital and IT	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. Infrastructure level failover and failback of 81 systems was undertaken in April/May 2019 respectively. Specific application testing and evaluation of this is an on-going task. **September 2019 Update:** Cyber Security Team operating model. The system availability testing continues and ICT DR plan is under development. **Executive Team Update – November 2019:** Further testing and development as outlined above continues.	**Action required to achieve - green/completed status:** At the time of review the deadline was not yet reached.

Audit Recommendations – to the end of October 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
101 (WAO)	Structured Assessment 2018	**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.	Reviewed every three months – Annual review March 2020	Director of Planning, Digital and IT	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 **November 2019 Update:** IGU holds an Information Asset Register and policies are in place for updating and reporting from Divisions to IGO. ICT hold an equipment asset register. Would consider closed and completed. Review and assurance will be through IGC.	**Action required to achieve - green/completed status:** The Executive Team agreed that this action had now been completed. It is proposed that the status of this action is green and can be removed from the tracker.

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Audit Recommendations – to the end of October 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
102 (IA)	Well-being of Future Generations (Wales) Act 2015	1) The Programme Board should include a review of the objectives and the progress against them as part of its agenda, to ensure objectives are fit for purpose and the activities required to meet them are identified and monitored. 2) Each Programme Board should be chaired by the Executive Lead in order to provide leadership, monitor effectiveness and highlight the importance of attendance. 3) Poor attendance at the Programme Board should be taken forward by the Executive Lead in order to ensure that it is rectified.	December 2019	Director of Public Health & Strategic Partnerships	1) The review of the Wellbeing Objectives will be undertaken in conjunction with a broader review of where these objectives sit in the context of other Organisational priorities and ambitions. A landscape review/mapping of these various aspects will need to be undertaken in conjunction with the ABUHB Planning Team to inform the review of Well-being Objectives as part of the IMTP process. The Programme board will include a review of progress against objectives as part of its agenda. 2) Programme Board meetings will be moved from a monthly to a quarterly basis and will be chaired by the Executive Director of Public Health and Strategic Partnerships. This will be supported by sub-Board meetings. 3) The Executive Director of Public Health and Strategic Partnerships will provide WbFGA update reports to the Executive Team, which would include attendance at Programme Board. **November 2019 Update:** The review of the Health Board's Well Being objectives is in progress as part of the IMTP refresh process. The Programme Board has new terms of reference and is meeting quarterly chaired by the Director of Public Health and Strategic Partnerships or Board Secretary. Attendance at the Programme Board has improved with all Divisions and Corporate Directorates engaging with the WBGF Programme.	**Action required to achieve - green/completed status:** Good progress has been made. The action is assessed as amber with the anticipation that this will be green by the next report.

Audit Recommendations – to the end of October 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
105 (IA)	Patients' Property & Monies	The Health Board should develop an information sheet which captures the key sections from the FCP and sets out the steps for staff to complete when receiving property or money (including high values of cash) from patients. A copy should be retained on each ward. A process should be established to monitor compliance with the FCP for patients' property and monies. This might, for example, contain a requirement to sample check a selection of wards per hospital over a specified time period.	End of October 2019 with distribution and first checks by end of December 2019.	Director of Finance and Performance	Agreed. A two-sided laminated information sheet will be produced in consultation with ward staff. Side 1 will document how to complete the PPB and side 2 will document what to do with any cash or property. The sheet should be placed inside the property book. PPB to FCP checking will be carried out by the Charitable Funds/Patients Monies Finance Team on an annual basis with the first visits being carried out with the distribution of the above information sheet. **November 2019 Update:** The information sheet has been written and has been sent to various ward staff for comment before finalising. We aim to finalise it by the end of the month and laminated and sent out shortly after.	**Action required to achieve - green/completed status:** Good progress has been made. The action is assessed as amber with the anticipation that this will be green by the next report.

Draft Audit Committee Work Plan 2020

	Frequency	4th February	2nd April	7th May	27th May	16th July	22nd October	3rd December
		Business	Business	Draft Annual Accounts	Final Accounts	Business	Business	Business
Audit Committee Members Private Meeting with Auditors and Counter Fraud								
Internal Audit		√					√	
External Audit			√					√
Counter Fraud						√		
Governance & Assurance								
Review of Standing Orders, SFI's, and Scheme of Delegation	Annually	√						
Development of Financial Procedures	Each Business Meeting	√	√			√	√	√
Finance and Governance Updates	Each Business Meeting	√	√			√	√	√
Divisional Assurance	Each Business Meeting	√	√			√	√	√
Corporate Assurance (Risk Report at every meeting)	Each Business Meeting	√	√			√	√	√
Update on PPV	Annually					√		
Additional Items								
Updated Risk Register following IM's Development	Additional Item	√						
Financial Management & Control Systems								
Single Tender & Single Quotations	Each Business Meeting	√	√			√	√	√
Losses & Special Payments	Each Business Meeting	√	√			√	√	√
Invoices > £100,000	Each Business Meeting	√	√			√	√	√
Interim Review of Governance Statement	Annually		√					
Tracking of Audit Recommendation Actions	Each Business Meeting	√	√			√	√	√
Additional Items								
Annual Accounts								
Lessons learnt form accounts process	Annually						√	
Annual Accounts Plan	Each Business Meeting	√	√			√	√	√
Accounting Policies Review	Annually			√				
Draft Accounts Review	Annually			√				
Approval of Annual Accounts	Annually				√			
Approval of Governance Statement	Annually			√				
Additional Items								
Clinical Audit								
6 monthly update on Clinical Audit	Every 6 months	√				√		
Additional Items								
External Audit								
Annual Audit Fee	Annually		√					
Approval of Annual Audit Plan	Annually		√					
Progress Reports	Each Business Meeting	√	√		√	√	√	√
ISA 260	Annually				√			
Final Accounts Memorandum	Annually				√			
Annual Audit Report	Annually							√
Additonal Items								
NWSSP Audit & Assurance - Internal Audit								
Approval of Annual Plan	Annually		√					
Progress Reports	Each Business Meeting	√	√			√	√	√
Receipt of Individual Reports	Each Business Meeting	√	√			√	√	√
Receipt of Annual Report	Annually			√				
Interim Head of Internal Audit Opinion	End of Quarter 3	√						
Head of Internal Audit Opinion	Annually			√				
Additional Items								
NWSSP Audit & Assurance - Specialised Unit								
Approval of Annual Plan	Annually		√					
Progress Reports	Each Business Meeting	√	√			√	√	√
Receipt of Individual Reports	Each Business Meeting	√	√			√	√	√
Receipt of Annual Report	Annually			√				
Additional Items								
Counter Fraud & Post Payment Verification								
Approval of Counter Fraud Annual Plan	Annually		√					
Counter Fraud Progress Report	Quarterly	√					√	
Counter Fraud Annual Report	Annually		√					
Annual PPV Report	Annually		√					
Additonal Items								
Planning & Review								
Agreement of Committee Annual Work plan	Annually	√						
Review of Committee Effectiveness	Annually		√					
Production Of Audit Committee Annual report	Annually		√					
Review Of Audit Committee Terms of Reference	Annually		√					
Additonal Items								

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Audit Committee Thursday 5th December 2019 Agenda Item:3.1

3.1

Aneurin Bevan University Health Board

Revised Risk Management Strategy

Executive Summary

This paper provides the Audit Committee with a copy of the draft Revised Risk Management Strategy (November 2019) for consideration and comment. It is currently planned that the revised Risk Management Strategy will be finalised in readiness for submission to the Board for approval in January 2020.

Members of the Audit Committee are asked to consider the draft updated Risk Management Strategy and provide comments with regard to content and proposals for finalisation.

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

Executive Sponsor: 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: 27th November 2019

Supplementary Papers Attached:
Appendix 1 – Draft Revised Risk Management Strategy

Purpose of the Report

The purpose of this paper is to provide the Audit Committee with a copy of the draft revised Risk Management Strategy (November 2019) and seek the Committee's views and comments as a key stage in the finalisation of the Risk Management Strategy. It is currently planned that the revised Risk Management Strategy will be finalised in readiness for submission to the Board for approval in January 2020.

Background and Context

1. Background

The Health Board at its January 2017 Meeting agreed a new Risk Management Strategy following engagement with the Board, Audit Committee and engagement with the Risk Managers' Network within the organisation. The Risk Management Strategy agreed by the Board had a lifespan of three years up to January 2020. Therefore, over recent months preparations have been made to revise and update the Strategy in line with this timeline.

A revised version of the Risk Management Strategy and process is attached. This revised document has been updated following the comprehensive Risk Management Landscape Review that the Health Board undertook earlier in the year and as part of this

review extensive engagement was undertaken with colleagues from right across the organisation through a series of workshops to obtain their views, but also to take the opportunity to further train and awareness raise with regard to Risk Management. Also, as part of the Risk Management Landscape Review an Action Plan was developed and as part of that Plan a requirement was identified to review the current Risk Management Strategy.

However, Jeff Brown, who independently led the Risk Management Landscape Review in his final report made the assessment that the Health Board's current Strategy reflected accepted best practice, Risk Management Standards such as ISO 31000 and guidance from the Institute of Risk Management (IRM).

Therefore, using this as the backdrop, there has been further work undertaken to update the document based on the outputs of the Review. This has included seeking to highlight areas where the risk landscape has changed such as partnership working (Social Services and Well Being Act and the Well Being of Future Generations Act), the updating of the Health Board's Risk Appetite Statement and also reflecting changes that the Board has made during the year, such as the adoption of the 'Risk on a Page' reporting arrangements. Where changes and revisions have been made, these have been marked in yellow to assist the Audit Committee in its review.

In preparation to take this to the Board in January, the Executive Team discussed the draft on the 25th November 2019, it is being submitted to the Audit Committee for comment, it will also be circulated to the Risk Managers' Network for further comment during early December and particularly the risk appetite statement will be an element of the Board Briefing Session on the 18th December in order to obtain the Health Board's view of its appetite and tolerances for risk. Therefore, any comments and advice from the Committee would be welcomed. The document will be finalised by early January in readiness for Board consideration on the 22nd January 2020.

Recommendation

The Committee is asked to consider the revised Risk Management Strategy and provide advice and comments prior to its finalisation and submission to the Board.

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 and it is important that the Health Board has a document, such as the Risk Management Strategy to guide that work.
Financial Assessment, including Value for Money	There may be financial consequences of individual risks however there is no direct financial impact associated with this report and the Strategy.
Quality, Safety and Patient Experience Assessment	Impact and approach with regard to quality, safety and patient experience are highlighted within the proposed Strategy.
Equality and Diversity Impact Assessment (including child impact assessment)	There are no specific equality issues associated with this report at this stage.
Health and Care Standards	This report would contribute to the good governance elements of the Health and Care Standards for Wales.
Link to Integrated Medium Term Plan/Corporate Objectives	The risks against delivery of key priorities in the IMTP is a key organising principle of the Strategy.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	Not applicable to this specific report, however WBFGA considerations are included within the consideration of individual risks and the overall Strategy.
Glossary of New Terms	None
Public Interest	Report to be published.

Aneurin Bevan University Health Board

Draft Risk Management Strategy and Processes

(Revised – November 2019)

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

Contents

1. Introduction

Risk management is a normal continuing process and one based upon good governance practice. It is an integral part of Aneurin Bevan University Health Board's (Health Board) approach to ensure we achieve our organisational objectives (as expressed in our Integrated Medium Terms Plan) and our responsibilities as an organisation by identifying any problems or potential threats to their successful achievement.

- We aim to protect patients, service users, our staff, the public and other stakeholders and the interests of the organisation against all categories and kinds of risks to their safety and also the quality and standard of the services we deliver.

- The application of a continuous risk management approach will be effectively applied to anticipate, mitigate and manage the risks to the Health Board in achieving its objectives and goals. It will also be used to enable the organisation to continually improve its services and the support we give to staff and citizens.

Organisations, such as the Health Board, encounter risk every day as objectives are pursued and services are delivered. Therefore, both the Board and operational management of the organisation must assess and be aware of the potential risks that might impact on the successful and safe achievement of the organisation's strategic objectives. The organisation must also be clear about how much risk is acceptable (its risk appetite) in pursuit of those objectives?

The Health Board also needs to be clear about the assurances that it requires and the basis of these assurances (both internal and external to the organisation) to be satisfied that risks identified are being managed appropriately and also that the organisation is on track to achieve its stated objectives.

The potential benefits of good risk management are:

- The achievement of our objectives will be more likely;
- The costly duplication of effort will be reduced and more proactive management will be evident;
- Performance will be improved;
- Positive outcomes for stakeholders will result;
- Adverse and damaging events are less likely to occur;
- Our financial resources and other resources will be utilised more efficiently and effectively;

- Decision making will be better informed and will be more agile;
- The organisation's reputation will be protected and enhanced.

There is a direct relationship between objectives, which are what we are seeking to achieve, and forward planning and risk management components, which represent what we need to do to achieve them. The Health Board should identify any threats and obstacles which might affect the successful achievement of its objectives.

This Risk Management Strategy, therefore, is central to the development and implementation of a well-managed risk environment for the Health Board. This Strategy is underpinned and will be realised through risk management processes which provide detailed information and arrangements on leadership, the systems and processes for enacting effective risk management corporately and across the Health Board.

Employees of the Health Board are asked to note that this Risk Management Strategy does not refer in detail to the day to day management of clinical risks. Clinical risks will be subject to their own governance arrangements in line with each Health Care Profession and the Health and Care Standards for Wales.

In 2018, the Health Board undertook an independent comprehensive risk management review. The review concluded that the Health Board has a Risk Management Strategy that reflects current best practice and Risk Management Standards such as ISO 31000 and guidance from the Institute of Risk Management (IRM). However, it also concluded that further work was required with regard to implementation, consistency of approach to avoid variability and also to facilitate a truly connected risk management system across the organisation.

This revised Strategy builds on this review. It will continue to utilise the framework provided by the existing Risk Management Strategy. This approach will incorporate the developments proposed by the review in order to drive forward improvement in the risk management system and achieve increased risk management embeddedness and maturity to support the achievement of our organisational objectives.

2. Policy Statement

Aneurin Bevan University Health Board is committed to delivering services and environments of the highest quality and safety for our patients, staff and visitors. The complexity of healthcare and wider services delivered in partnership provides ever-growing demands to meet the needs of the population we serve and this means that there will always be an element of risk in providing these services and facilities.

The good management of risk therefore is a key factor in achieving the provision of the highest quality care for our patients and service users. We also have a legal duty to control any potential risk to staff and the general public as well as safeguarding the people we care for and the assets of the organisation.

The Health Board is committed to having in place arrangements alongside a comprehensive and integrated approach to risk management across the Health Board and in our partnerships, which embrace the active management of financial, clinical and non-clinical risks in all parts of the organisation.

The Health Board supports the effective identification, assessment and management of risk in all that we do. We are also clear about the responsibility placed on individuals, teams and partner organisations to aim for excellence in all that we do and through the good management of risk this can be achieved.

Therefore the commitment of the Health Board through this Strategy is to:

a) minimise risk and harm to patients, staff or visitors to a level as low as reasonably practicable, recognising that some risk is present in all that we do;

b) protect everything of value to the Health Board (such as high standards of patient care, promoting healthy lives and the well-being of our citizens and staff, our reputation, good community relations, our assets and resources);

c) maximise opportunities for development and improvement by understanding the risk environment and adapting and remaining resilient to changing circumstances or events;

d) lead and assist with managing and prioritising the business/activities of the Health Board through using risk information to underpin strategy, business planning, decision-making and the allocation of resources and assessing whether objectives are being met.

e) ensure that through our management of risk that there is no unlawful or undesirable discrimination, whether direct, indirect or by way of victimisation, against our patients and service users, carers, visitors, volunteers, existing employees, contractors and partners or those wishing to seek employment, or other association with the organisation.

This Strategy is therefore a high level statement of intent, outlining the Health Board's approach to risk, our appetite for risk, expectations of risk management systems and also sets out the arrangements for:

- assessing and identifying risks,
- managing risk,
- treating risks and
- reporting risks to appropriate levels within the organisation to ensure that effective responses can be made, supported and monitored.

3. Scope and Aims

This Strategy applies to all employees of the Health Board, those that we contract with, those seconded to work in the organisation and any volunteers that work in partnership with the organisation. Therefore accountability and responsibility for active risk management sits at all levels within the organisation and across our partnerships to ensure that risk management is a fundamental part of the total approach to health, partnership governance and service delivery.

The Board is committed to ensure that risk management forms an integral part of our philosophy, practice and planning rather than being viewed or practised as a separate programme of work. The Health Board recognises that the success of this strategy will depend upon the awareness, training requirements and commitment of staff and contractors at all levels, and the continued development of a culture of openness and transparency.

The Health Board's risk system therefore needs to include detailed elements derived from six high level characteristics which are expected to be found in our Risk Management approach. These are:

- Clear leadership and strategy
- Clarity of the context for Risk Management
- Risk Identification and Evaluation processes
- Criteria for the evaluation of risk/risk appetite and tolerances
- Risk control mechanisms
- Review, reporting and assurance mechanisms

The Health Board therefore, aims to minimise risks, where required, take more risk where this is justified and maximise the quality of services through good risk management processes.

The organisation through these approaches aims to be aware of all significant risks and be assured that they are being effectively managed. The Health Board will allocate resources and take action to ensure the risks are prioritised and managed to ensure that our strategic objectives are achieved.

4. Objectives

Risk is inherent in everything that we do, from determining service priorities, delivering services and care, taking decisions about future strategies, or in some cases, deciding not to take action at all.

Therefore, the Health Board will ensure that this Risk Management Strategy becomes aligned with other related quality and performance assurance areas and reporting, through ensuring there is clarity with regard to the Health Board's overall Board and risk assurance system and arrangements.

Therefore, the key objectives of this Strategy are to:

- Develop a culture where active risk management is integrated into all Health Board and partnership business;

- Clearly describe the risk appetite of the organisation and actively use our view of risk to inform our approaches and decision making;

- Ensure appropriate structures are in place to manage risks with clear escalation levels and processes;

- Create a system which is user friendly and allows the prompt assessment and mitigation of risk;

- Ensure the risk management system is supported by robust and clear monitoring and reporting processes at all levels in the organisation;

- Enable the Health Board to identify and manage risks emanating from the well-being goals and ways of working included in the Well Being of Future Generations Act 2015. Also, overtime to seek alignment with the risk management approaches used in our key partnership mechanisms e.g. Public Service Boards and the Regional Partnership Board (Social Services and Well Being Act).

5. Risk Management Process

The risk management process is a key approach to improving the quality and safety of care for patients, clients and others affected by the activities of the Health Board, offering a practical means of enhancing the safety of services, reducing the potential for systems failing and minimising the effects of the risk when things go wrong.

Our risk management system will consider the full range of the organisation's activities and responsibilities and constantly check that various good management disciplines are in place. The Health Board will therefore regularly seek assurance that arrangements are in place and that risk within these systems and processes are being appropriately identified, assessed, managed and reported. This will be scrutinised and advised via the Corporate Committee Framework as and when appropriate or required.

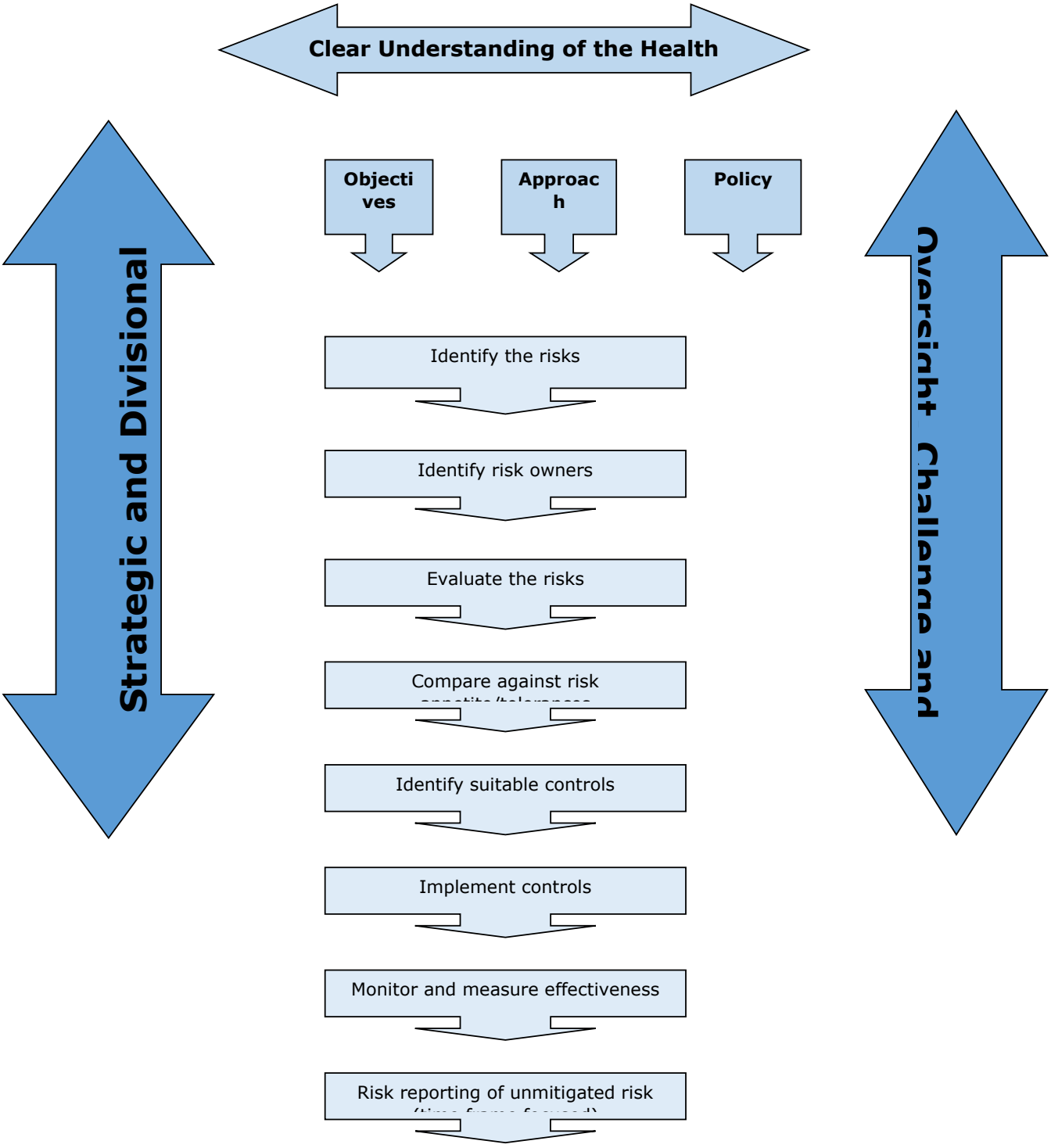
The Health Board's risk management system will ensure that:

- Objectives are clear and understood across the organisation;
- Risks to the achievement of objectives are identified;
- Effective controls and tolerances are understood by those expected to apply them and that these are in place to mitigate risks;
- The operation of controls is monitored by management with any gaps being rectified;
- Management are held to account for the effective operation of controls;
- Assurances are reviewed and acted on.

The Health Board will achieve the above by:

- Effective objective setting within its Integrated Medium Term Plan (IMTP);
- Effective learning and responsive management action, with dissemination of lessons learnt;
- Well developed employee engagement and provision of training and advice to managers and staff;
- A well designed and clear liaison with enforcing authorities, auditors, regulators and assessors;
- Effective Committee structures with appropriate reporting arrangements;
- Formulation of appropriate policies and procedures;
- Investigation of incidents and implementation of remedial actions and associated reporting;

Risk registers will be developed to assist in the management and reporting of risk at local levels (i.e. wards/teams/services). However, if risks cannot be appropriately responded to at local level they will be reported to the Department/Directorate level for support and advice. It is important to note however, that all Divisions and Teams within the organisation are encouraged to be accountable and are delegated to manage their own risk, as far as possible. It is important that ideally risks should be managed at the most appropriate level or where they occur within the organisation and are only escalated where they have wider risk implications. It is crucial, however, that there is a clear reporting culture, especially with regard to unmitigated risks or where further support is required. An example of an organisational view of this risk management approach can be seen in the below diagram:



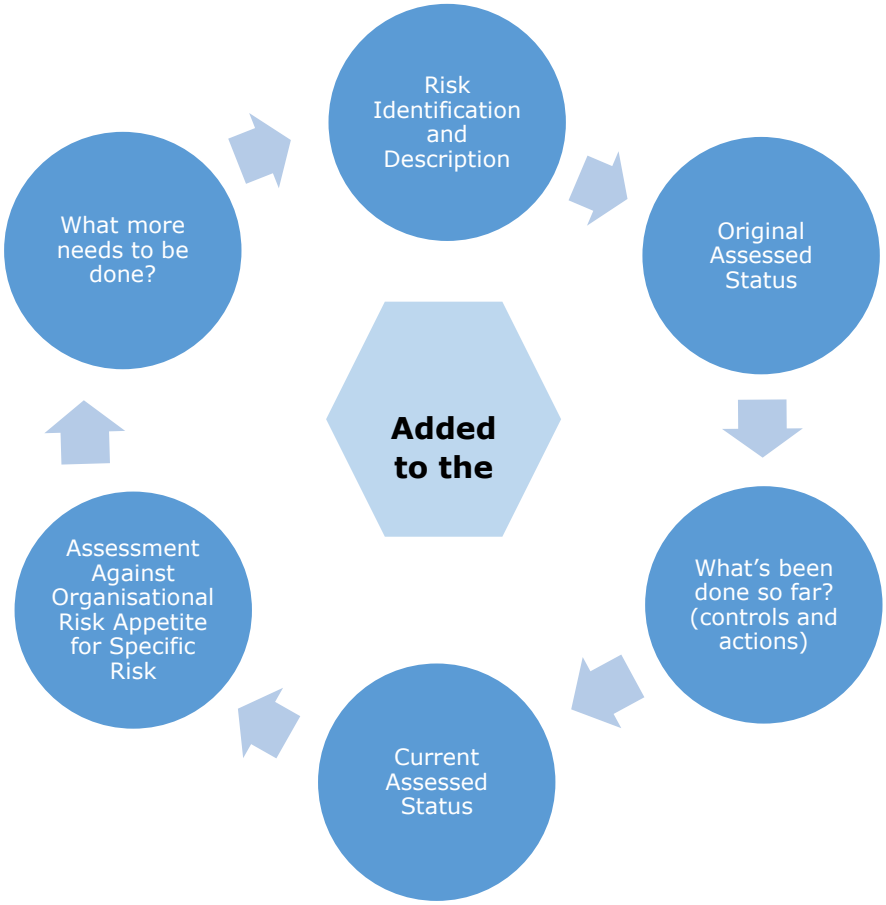
This diagram demonstrates the overall risk management process for the organisation and seeks to ensure that the Health Board is aware of any risks or issues that may affect the non-delivery of the key strategic objectives as identified in our Integrated Medium Term Plan (IMTP).

The Health Board will develop a corporate risk register focused on the strategic risks of the Health Board. At all levels of the organisation; each Directorate, Department and Division will have its own risk register. The Health Board's corporate risk register (which will be actively monitored by the Health Board's Committees, Executive Team and Board) will also be aligned to the Health Board's objectives in order to provide a clear and concise picture of risk within the Health Board at any given time to the non-achievement of the objectives. Therefore, all risk registers will be formatted similarly to enable the Health Board to respond appropriately to the potential non-delivery of its strategic objectives and have a clear understanding of the profile of risks.

The purpose and objectives of developing a system of good risk registers is defined as:

- Recording of all identified risks relating to a set of objectives,
- Ensuring discussions actively take place on risks and potential risks
- A day to day tool to help managers achieve their objectives
- A mechanism that drives and evidences Risk Management activities
- A means of or source for risk reporting
- A simple and practical overview of the profile of risks
- Information must be worthwhile i.e. overview of clear controls, clarity on mitigating actions and indicators of progress and status.

The risk management system used to identify, manage, mitigate and report risks is demonstrated in the diagram below. This system should be effective for directorate level to Board levels when considering and assessing risk:



Some risks will be common to more than one Division or Directorate. Therefore, Divisional and Corporate Department Risks will be reported routinely Executive Leads and monitored by the Executive Team to ensure that these are considered as part of the Health Board's Corporate Risk Register and that any new or common risks or risk themes can be identified. This risk process will be formulated and co-ordinated by the Board Secretary and Corporate Services Manager, Risk Management and Assurance, which will be based in the Board Secretary's Department.

This will also be facilitated through a Risk Management Operational/Oversight Group (the Executive Team of the Health Board) on a monthly basis. The Executive Team will identify the Top risks and report these to the Board, Audit Committee and other Committees as appropriate. The Executive Team in its capacity as the Oversight Group will also engage with individual Divisions and Corporate Departments periodically to discuss in detail their risk profiles and key risk issues. This might be through Divisional Reviews, specific risk sessions at Executive Team or Deep Dives to offer support or enable further discussion with regard to the organisational response to external risks.

In relation to reporting to the Board, although it is important that the Board is aware of the current top risks on the Corporate Risk Register, it is also important that the Board is made aware of new risks, risks that might have changed in the preceding period and risks that have been mitigated and reduced in assessed level or removed from the Corporate Risk Register. Therefore, the Health Board in receiving the top risks will have this reported via a Risk Dashboard, which is a 'Risk on a Page' (see appendix 5) which tracks risks and increasingly outlines issues of impact, risk appetite and sources of assurance. This will be facilitated by the use of an electronic reporting system. The current system to be used will be DATIX.

It will also be important that the Board has the opportunity to discuss risks in detail and explore key influences and factors. As such, individual areas of risk or specific risks will be discussed. It is important to use the information the Health Board has on risk to inform the planning and performance targets for the organisation and also to use it for the setting of Committee and Board agendas to ensure a focus on the strategic objectives areas.

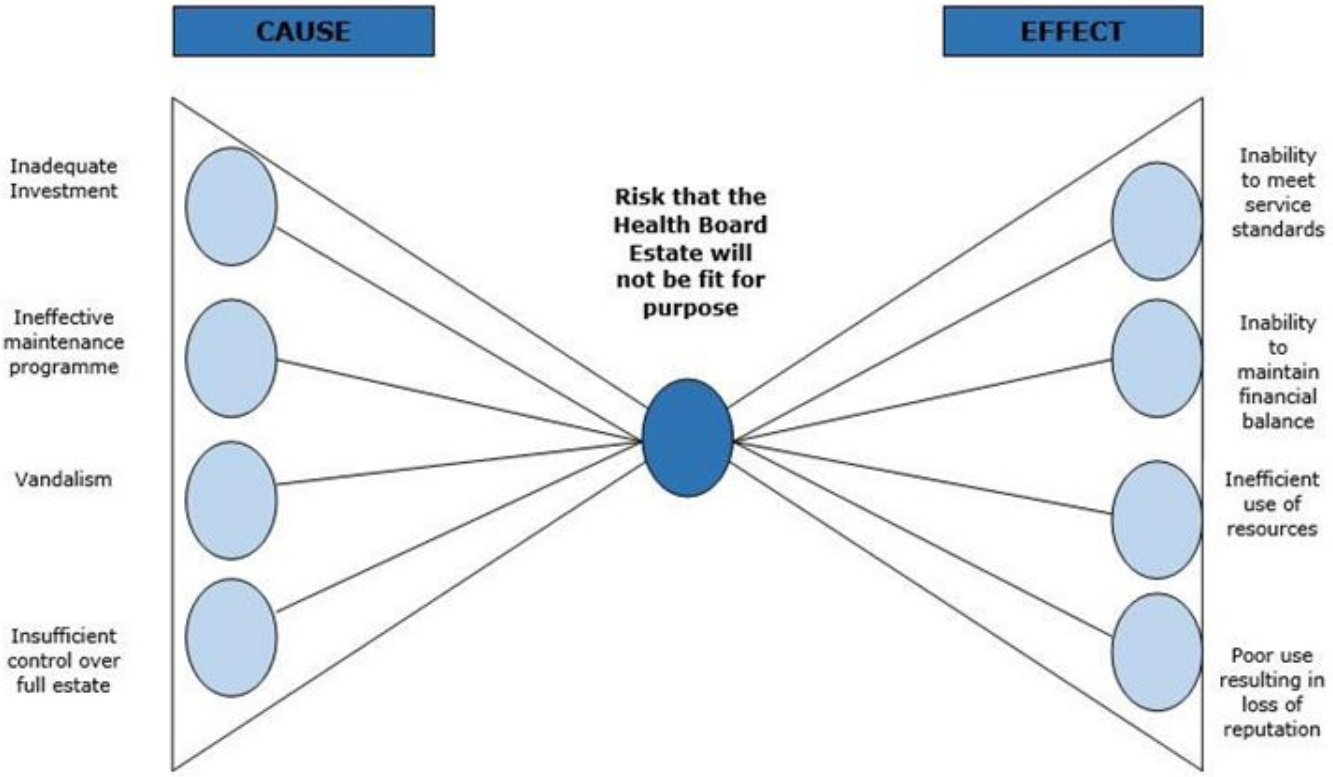
Also twice a year all Divisional and Directorate Risk Registers will be submitted to the Board Secretary and Corporate Services Manager (Risk and Assurance) to enable a full organisational review to be undertaken. The review early in the year will also assist with the completion of the Health Board's Annual Governance Statement.

The Corporate Risk Register will also map extreme and high level risks to the key objectives of the organisation as stated in the Integrated Medium Term Plan (IMTP) to ensure a clear and ongoing response to the risks which would adversely affect the organisation's ability to deliver its corporate priorities and achieve its objectives. This information will also shape the agenda for Board and Committee meetings to ensure the Health Board is actively responding to and considering its key risks and the current risk profile of the organisation. This will also allow the Board and Committees to take a view on areas of further risk development in line with the agreed risk appetite (***see section 7 Risk Appetite***).

6. Identification of Risk

There are various methods available to use when identifying and framing a risk either internal or external to an organisation. This strategy endorses the use of the 'cause and effect' analysis. This method works by reviewing the strategic objective or service objective, identifying what could threaten the achievement of the objective and analysing what the impact would be upon the services or organisation,

if the objective is not achieved. This method could be implemented through a 'bow-tie' analysis as outlined in the example below:



The benefit of this type analysis allows the individual or group that is managing the risk to list all potential causes of the risk alongside the effects, which in turn suggests and helps to frame the remedial action required.

7. Risk Appetite

The Health Board acknowledges that a certain degree of risk is unavoidable and therefore it needs to take action in a way that it can justify to manage risk to a tolerable level.

Risk appetite is the degree of risk exposure, or potential adverse impact from an event, that the Health Board is willing to accept or take in pursuit of its objectives.

Risk Appetite is defined as:

"The amount of risk that an organisation is prepared to accept, tolerate, or be exposed to at any point in time in pursuance of its objectives."

Developing and agreeing a risk appetite is about risk being actively managed with the organisation and not about developing a statement to be filed in a report or included in a strategy. A risk appetite is only useful if it is clear and can be understood and implemented across the organisation. The determination of risk appetite is about making clear the underlying reasons for accepting a specific level of risk. To determine risk appetite, management with the Board, will take three steps:

- Develop a risk appetite – there is no standard or universal risk appetite statement that applies to all organisations, neither is there a "right" risk appetite. Management and the Board must make choices in setting risk appetite. Risk appetite is not a single, fixed concept. There will be a range of appetites for different risks which need to align and may vary over time. Defining risk appetite is not about writing a one–off, standalone statement and will need to be reviewed at least annually by the Board in line with the planning cycle;

- Communicate the risk appetite and ensure there is awareness and understanding of the risk appetite across the organisation. The first step therefore, is to create an overall statement that is both broad and descriptive enough for the organisation to manage risks consistently. The second is to communicate the risk appetite for each strategic objective with the third being to communicate the appetite for different categories of risk that apply in different key areas of the organisation;

- Monitor and regularly update the risk appetite – once communicated, the risk appetite needs to be revisited and reinforced – it cannot be set once and then left alone.

The Health Board recognises the importance of a robust and consistent approach to determining risk appetite in order to ensure:

- The Health Board's collective appetite for risk and the reasons for it are widely known to avoid erratic or inopportune risk taking, or an overly cautious approach which may stifle growth and development;
- Managers throughout the organisation know the levels of risks that are legitimate for them to take, as well as appropriate

opportunities when they arise, in order to ensure service improvements and patient outcomes are not adversely affected.

7.1 Risk Appetite General Statement

The Health Board is clear that:

- The organisation must take risks in order to achieve its aims and deliver beneficial outcomes to owners/stakeholders.
- Any risks will be taken in a considered and controlled manner.
- Exposure to risks will be kept to a level deemed acceptable by the Board.
- The acceptable level may vary from time to time.
- Some particular risks above the agreed acceptable level may be accepted because of the reward/benefit that might arise, the cost of controlling them or the period of exposure.
- No risks will be acceptable (and therefore must always be controlled) if they have the potential to cause significant harm, compromise severely the organisation's reputation, have financial consequences that could endanger the organisation's viability, jeopardise substantially the organisation's ability to deliver its core purpose or threaten the organisation's compliance with law and regulation.

7.2 Initial Risk Appetite Definitions and Principles:

Assessment	Description of potential effect
Very High (hungry for risk) Risk Appetite Level 5	The Health Board **accepts and in some circumstances actively seeks risks because of the potential short and long term benefits that might arise.** However, it recognises that this might result in reputation damage, financial impact or exposure, major breakdown in services, information systems or integrity problems, significant incidents of regulatory and/or legislative compliance issues, potential impact on staff/service users.
High (open to risk) Risk Appetite Level 4	The Health Board **is willing to accept risks that may result** in reputation damage, financial impact or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and/or legislative compliance, potential risk of injury to staff/service users.
Moderate (cautious risk taking) Risk Appetite Level 3	The Health Board **is willing to accept some risks in certain circumstances that may** result in reputation damage, financial loss or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and/or legislative compliance, potential risk of injury to staff/service users.
Low (averse to risk) Risk Appetite Level 2	The Health Board **aspires to avoid (except in very exceptional circumstances) risks that may** result in reputation damage, financial impact or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and/or legislative compliance, potential risk of injury to staff/service users.
Zero (avoid taking risks) Risk Appetite Level 1	The Health Board **aspires to avoid risks under any circumstances that may** result in reputation damage, financial impact or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and/or legislative compliance, potential risk of injury to staff/service users or public.

The table below using the above descriptions seeks to provide further information regarding the Health Board's appetite and tolerance for risk in areas of activity of our core business.

Key Business Drivers (categories of risk)		Risk Appetite	Description	Reporting
1.	Patient Safety and Patient Experience	Zero/Low Levels 1	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. 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.	Risks relating to patient safety and patient experience scoring 5^{+} will be reported to the Quality & Patient Safety Committee and the Board. This is because the Health Board has a zero or low level of appetite for risk in this area. For patient safety and patient experience risks the Health Board will seek to eliminate or minimise risks in these areas.
2.	Quality and Patient Outcomes	Low/Moderate Levels 1 and 2	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. This key value driver directly supports our core objective to improve the outcomes for people using our services. The Health Board's preference will always be for safe and high quality delivery options that have a low degree of inherent risk.	Risks relating to Quality and Patient Outcomes scoring 10^{+} will be reported to the Quality & Patient Safety Committee and the Board. This is because the Health Board has a low to moderate level of appetite for risk in this area. Some moderate level of risk will be supported to enable innovation and a focus for improvement. For patient safety and patient experience risks the Health Board will seek to eliminate or minimise risks in these areas.

Key Business Drivers (categories of risk)		Risk Appetite	Description	Reporting
3.	Workforce and OD/Staffing and Competencies	Low Level 2	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. 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.	Risks relating to workforce scoring 10^{+} will be reported to the People and Culture Committee and the Board. This is because the Health Board has a low level of appetite for risk in this area. For workforce risks for the Health Board will seek to minimise risks in these areas.

Key Business Drivers (categories of risk)		Risk Appetite	Description	Reporting
4.	Finance	Low Level 2	We will always seek to deliver our services within the available funding as agreed in our financial plan and will not accept risks that if realised might cause us to exceed the financial plan. This key value driver directly supports our commitment to maximise our use of resources and deliver cost effectiveness. However, the Health Board might seek some risks with regard to invest to save initiatives, but the business case and return on investment would need to be clear.	Risks relating to workforce scoring 10^{+} will be reported to the Finance and Performance Committee and the Board. This is because the Health Board has a low level of appetite for risk in this area. For finance risks for the Health Board will seek to minimise risks in these areas.
5.	Public confidence/ reputation	Low Level 2	We will continue to maintain high standards of conduct and care delivery to maintain the positive reputation of the organisation. We will only accept risks in certain circumstances, such as service change or alteration of service delivery, if it is assessed that if the change is realised that the loss of short term public confidence/reputation would be outweighed by the longer term benefits that the change would bring for local people.	Risks relating to public confidence/reputation scoring 10^{+} will be reported to the Executive Team and People and Culture Committee and the Board. This is because the Health Board has a low level of appetite for risk in this area. For public confidence and reputation risks for the Health Board will seek to minimise risks in these areas.

Key Business Drivers (categories of risk)		Risk Appetite	Description	Reporting
6.	Compliance with legislation and legal requirements (e.g. including Information Governance and Safeguarding Requirements)	Zero/Low Level 1 and 2	We will continue to comply with all legislation relevant to the organisation. Avoidance of risk and uncertainty is a key objective, with a preference for safe delivery options to mitigate risks. We will seek to avoid risks that if realised could result in non-compliance with legislation.	Risks relating to compliance with legislation and legal requirements scoring 5^{+} will be reported to the appropriate Committee depending on the legislation and the Board. This is because the Health Board has a zero or low level of appetite for risk in this area. For compliance with legislation and legal requirements risks the Health Board will seek to eliminate or minimise risks in these areas.
7.	Environment and Estates	Low and Moderate Levels 2 and 3	We are willing to accept some risks in the pursuit of estates development and rationalisation but with preference for safe delivery options for both staff and patients, which do not breach health and safety requirements. We will continue to encourage a culture of sustainability to fulfil our environmental duties taking account of the impact of future environmental changes on our organisational ways of working. These changes to sustainable solutions might require some increased levels of risk as we innovative and change/alter systems.	Risks relating to Environment and Estates scoring 15^{+} will be reported to the Finance and Performance Committee and the Board. This is because the Health Board has a low to moderate level of appetite for risk in this area. Some moderate level of risk will be supported to enable innovation and a focus for improvement. For Environment and Estates risks the Health Board will seek to eliminate or minimise risks in these areas.

Key Business Drivers (categories of risk)		Risk Appetite	Description	Reporting
8.	Service and Business Disruption	Low Level 1	We will avoid, except in very exceptional circumstances, any risks that may cause disruption or compromise operational areas.	Risks relating to service and business disruption scoring 5^{+} will be reported to Executive Team, the appropriate Committee and the Board. This is because the Health Board has a zero or low level of appetite for risk in this area.For service and business disruption risks the Health Board will seek to eliminate or minimise risks in these areas.
9.	Partnership Working (including public health opportunities)	Medium to High Levels 3 and 4	We will continue to work with other organisations to ensure we are delivering the best possible service to our patients/service users and are willing to accept risks associated with this collaborative approach. Partnership working is a fertile ground for innovation in service delivery, new ways of delivering services and new service models. However, not where this compromises safety and quality of care for patients and service users. This key value driver directly supports our core objectives to strengthen and sustain our partnerships to ensure patients, carers and stakeholders receive seamless care from all agencies, especially with regard to legislation such as Social Care and Well Being Act and the Well Being of Future Generations Act.	The Health Board is willing to accept some risks in certain circumstances due to the need to innovate and develop new service models in this area. Therefore risks 16^{+} will be reported to the Public Partnerships and Wellbeing Committee and the Board. This is because the Health Board has a moderate level of appetite for risk in this area. For Partnership working risks the Health Board will seek to take some planned risks in these areas, but for areas where patients and service users are involved, risk will be minimised.

Key Business Drivers (categories of risk)		Risk Appetite	Description	Reporting
10	Maximising innovation and the use of new technology and ways of working	High Levels 4 and 5	We will continue to encourage a culture of innovation within the organisation and are willing to accept risks associated with this approach. This will include risks associated with the capacity to deal with the pace/scale of technological change, or the ability to use technology to address changing demands. This will also include new ways of working, trials and pilot programmes in the delivery of healthcare. This key value driver directly supports our value to foster research and innovation along with high quality service delivery and development to meet changing needs.	The Health Board is willing to accept and take some risks in this area to facilitate innovation and support new models of service delivery. Therefore risks 16^{+} will be reported to the Executive Team, Information Governance Committee and the Board. This is because the Health Board has a higher level of appetite for risk in this area. For maximising innovation and particularly in the use of new technology the Health Board will seek to take some planned risks in these areas, but for areas where patients and service users are involved, risk will be minimised.

8. Risk Tolerance:

Whilst risk appetite is about identifying the level of risk the Health Board is willing or plans to take, tolerance is about what the organisation is content to deal with or the parameters within which risk may be taken, as determined by the Board.

Risk tolerance differs from risk appetite in that it is:

- Derived from risk appetite;
- Looks at risk at a granular level (e.g. on specific risk, at a transactional level);
- Measured in the form of limits (financial risks) and thresholds (non-financial risks);
- Assists in day to day/operational decision making.

Risk tolerance therefore, relates to risk appetite, but differs in one fundamental way in that it represents the application of risk appetite to specific objectives.

Whilst risk appetite is broad, risk tolerance is tactical and operational and must be expressed in such a way that it can be:

- Mapped into the same metrics as the organisation uses to measure success/performance/outcomes;
- Applied to all four categories of objectives – strategic, operations, reporting and compliance;
- Implemented by staff throughout the organisation.

As risk tolerance is defined within the context of objectives and risk appetite, it should be communicated using the metrics in place to measure performance. Risk tolerances guide service/operational areas as they implement risk appetite within their sphere of activity and will need to be specifically identified and agreed for each identified area of risk.

Therefore, risk tolerances communicate a degree of flexibility whilst risk appetite sets a limit beyond which additional risk should not be taken.

9. Risk Culture

Risk culture is a term describing the values, beliefs, knowledge and understanding about risk shared throughout the Health Board and is shaped by the underlying values, beliefs and attitudes of individuals, which are partly inherent but are also influenced by the prevailing culture in the organisation. The culture of the organisation will

influence the way risk is understood and managed. Setting the right culture is not achievable without visible support from the highest level within the organisation, which is why overall accountability and responsibility for risk management lies with the Chief Executive, Executive Team and the Board.

The Health Board aims to develop a culture where risk management is viewed positively and seen as an opportunity for learning and development.

Problems with risk culture are often blamed for organisational difficulties and an effective risk culture is one that enables and rewards individuals and services.

The prevailing risk culture of an organisation can make it significantly better or worse at managing risks and can affect the capability to take strategic decisions and deliver on performance. A good risk management system will only achieve success if it has been adapted to the Health Board's values, culture, aims and resources and is understood throughout the organisation at all levels.

The Board has a responsibility to set, communicate, encourage and enforce a risk culture that consistently influences, enables, directs and aligns with the strategy and objectives of the organisation, thereby supporting the embedding of its risk management system and processes. Corporate governance requirements are increasingly demanding that boards of organisations should understand and address their risk cultures. Therefore, a good risk management system should be integrated into the culture of the organisation with an effective strategy and a programme led by Directors, senior management and dedicated support.

A good risk management system will translate strategy into tactical and operational objectives, assigning responsibility throughout the organisation with each manager and employee responsible for the management of each particular risk, as part of their job descriptions including budget delegation and accountability.

In order to ensure that the Health Board has the appropriate risk culture the Board will regularly consider the following:

- What is the current risk culture within the Health Board and how do we improve risk management within that culture?
- How do we want to change or develop that culture?
- How do we move from where we are to where we want to be by using a better understanding of risk?

Individual values, beliefs and attitudes towards risk contribute to and are affected by the wider overall culture of the Health Board. Any sustained change in risk culture needs to start at the top and may require a reappraisal of approaches consistent with bringing greater diversity of thinking into the board room. The Board recognises that although processes and organisational structures can be changed quickly, it takes substantially longer to change people's behaviour and the culture of the organisation.

10. Implementation

The Health Board will work to minimise risk to as low a level as reasonable in line with its risk appetite or seek to take managed risks where we are seeking to innovate and develop. However, there will always be a balance between risks and benefits for our decision making and in the delivery of our services. It will be necessary to make judgements as to whether the benefits gained by a course of action outweigh the identified risks.

Risks can be split between those which are acceptable (or tolerable) and those which are not acceptable. Details of the actions required to mitigate (reduce) risks will be included in corporate, divisional, service/team/ward and service Risk Registers.

Therefore, the Health Board will use the risk matrix below to score each risk based on the following calculation:

Potential Consequence x Likelihood of Adverse Outcome = Risk Score

(Where consequence and likelihood are allocated a score of between 1 and 5)

Consequence Score	Likelihood Score				
	1 Rare	**2 Unlikely**	**3 Possible**	**4 Likely**	**5 Almost certain**
5 - Catastrophic	5	10	15	20	25
4 - Major	4	8	12	16	20
3 - Moderate	3	6	9	12	15
2 - Minor	2	4	6	8	10
1 - Negligible	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows

1 - 3 = Low Risk	**Quick, easy measures implemented immediately and further action planned for when resources permit**
4 - 10 = Moderate Risk	**Actions implemented as soon as possible but no later than a year**
12 - 16 = High Risk	**Actions implemented as soon as possible but no later than six months**
20 - 25 = Extreme Risk	**Requires urgent action. The Health Board is made aware and it implements immediate corrective action**

Guidance on the scoring of consequence and likelihood can be found in Appendices 1 and 2 or by contacting the Corporate Services Department on 016533 431760.

11. Risk Registers

A network of Risk Registers will be prepared at the following levels within the organisation:

- Team/ward/service (e.g. the overall orthopaedic service, the orthopaedic wards, the specialist children's orthopaedic team. You may not need a risk register for every part of the service, but you want every part of the service to contribute to the risk register.)
- Department/Directorate along with Corporate Teams
- Division or Overall Corporate Department
- Corporate/Organisational Level (corporate risk register and specific Committee Registers)

The purpose of the registers will be to record all risks and what is being done about them. They will be actively used as mechanism through which risks are monitored and responded to. It is a requirement that all risk registers should now be mapped to the Health and Care Standards (2015), the Social Services and Well Being Act and the Well Being of Future Generations (WBoFG) Act (Wales) and other

professional's standards, which will also assist in identifying key risks within Divisions and departments.

Risks must be actively addressed as promptly as possible and at the most appropriate level. They should not be put onto a risk register if something can be done about them simply and immediately. They should be actively managed at the level at which they are identified, if possible. They should not sit on the risk register in the longer term or be un-necessarily escalated in the organisation for decision if the action is required at the local level. Additional support should be sought to take the appropriate action at the appropriate level. It is recommended that risk registers are reviewed, at least, on a monthly basis or at each Divisional Senior Management Team meeting.

12. Roles and Responsibilities

12.1 The Chief Executive

The Chief Executive, as Accountable Officer, is responsible for systems of internal control and implementing the policies set by the Board. The Chief Executive also has overall accountability for risk management within the Health Board and is therefore responsible for ensuring there are adequate arrangements in place to identify and manage risk. This network of risk management arrangements will particularly focus on the risk of the Health Board not meeting its objectives as stated in its Integrated Medium Term Plan and not meeting its statutory responsibilities.

12.2 Director of Therapies and Health Science and Board Secretary

The Director of Therapies and Health Science will have responsibility for ensuring that arrangements are in place in liaison with the Medical Director and Director of Nursing to effectively assess and manage clinical risks across the Health Board. This will be managed via the Quality and Patient Safety Operational Group and a Quality and Safety Assurance Framework.

The Board Secretary will have responsibility for ensuring that corporate systems and processes are in place to effectively and consistently manage and co-ordinate risk systems throughout the organisation and ensure that reporting arrangements are appropriate and robust.

The Director of Therapies and Health Science and Board Secretary will work together to align systems and processes for risk management. The Board Secretary will have responsibility for maintaining and co-ordinating the corporate risk register and the Director of Therapies and

Health Science will ensure that clinical risk processes are effectively co-ordinated through the Quality and Patient Safety Operational Group.

The Board Secretary is responsible for ensuring that high and extreme risks are considered by the Executive Team and the Board, the Audit Committee and that all other appropriate committees have a bespoke Committee Risks Register.

12.3 The Board and Committees

The Board is responsible for the Health Board's overall system of internal control, including risk management, and must therefore seek and be provided with assurance on the effectiveness of the systems and processes in place for meeting the Health Board's strategic objectives, in line with the IMTP. Therefore, Board agenda will increasingly be framed according to the key risks of the Health Board not meeting its objectives, especially in relation to the IMTP and not meeting its statutory requirements.

The Board is responsible for debating and discussing its strategic risks and for reaching agreement on those risks set against the high level objectives and priorities for the Health Board and agreeing its appetite for risk. Therefore, at each Board meeting the Board will receive a dashboard report of the 'top' risks of the organisation from the Corporate Risk Register, using the 'Risk on a Page' format. This report will also show how risks have progressed over time by using the reporting/tracking template, the risk appetite for each risk, mitigating actions and sources of assurance as outlined at Appendix 5. The risk scores and colours will correspond to the risk assessment matrix outlined earlier.

The Board's assessment of its strategic risks will inform operational planning. The Board has a key role in deciding which high level and extreme risks are acceptable or not acceptable in line with its agreed risk appetite.

The Board will be advised of those risks assessed as extreme and high level to the organisation through a dashboard report. The dashboard report will also be submitted to the Audit Committee to advise the Board on the adequacy of the overall risk management arrangements of the Health Board.

12.4 The Audit Committee is responsible for reviewing the system of internal control, including risk management, for the organisation and, in particular, advises the Board on the adequacy on the risk management arrangements, which also informs the Annual Governance Statement as approved by the Board.

The Committee will also keep under review the risk approach of the organisation and utilise information gathered from Committee work and other activity in the organisation in order to do this work.

The Audit Committee will receive a report at each of its meetings summarising:-

- The total number of risks on the Corporate Risk Register at the beginning and end of the period;
- Those that have been added;
- Those that have been removed from the register;
- Those that have been reduced; and
- Those that have increased.

The Committee will use the information identified through the risk management and risk assessment arrangements to inform the overall Assurance Framework. It will report its discussion and decisions to the Board as part of its role in providing assurance to the Board.

12.5 Other Committees: The other committees in particular the Quality and Patient Safety Committee of the Board will keep under review the risks relevant to their areas of responsibility and escalate these through the organisational processes and structures, as necessary. This will include the identification and consideration of any newly assessed risk areas or issues as they arise. Therefore, each Committee will hold a specific committee risk register.

12.6 Network of Risk Management Champions/Competent Person: Risk identification and management is part of every staff member's role. To support this, the Health Board will develop a network of risk management 'champions' or 'competent person' throughout the organisation. These will be identified in each Directorate and Division to ensure that the Health Board's approach to risk management is communicated, awareness is raised at local levels, local approaches are well co-ordinated and reporting is undertaken as expected. The role of 'champions' will be to ensure that training and awareness raising is undertaken to promote good risk management through making sure that staff in their areas have the appropriate knowledge and skills.

The Health Board currently has a number of key contacts in each Division and Corporate Department for risk management. This will be formalised to ensure that each Division/Department has a representative and this will be established as a virtual network to share ideas and good practice.

12.7 Executive Directors

Executive Directors are responsible for ensuring that:

- Risk leads or 'champions' are identified within their areas of responsibility and ensure that comprehensive assessments have been undertaken of all risks that fall within their areas of responsibility.

- The assessment of risk is embedded within the day to day work of their areas of responsibility, and that arrangements are in place to ensure risks are addressed, at an acceptable level or escalated through the appropriate management reporting lines.

- Service and operational planning takes account of risks that have been identified and seeks to ensure that they are eliminated or managed to an acceptable level.

- Their Divisions and Departments/Directorates undertake suitable and sufficient risk assessments, record their findings, identify effective controls, develop appropriate action plans and ensure the risks are recorded in the Directorate Risk Register.

- The assessment of risk is embedded within the day to day management of their Division and Department/Service and that there are clear performance management arrangements in place to ensure that effective controls are in place and appropriate action is taken to manage risks at an acceptable level or escalate them through the appropriate management reporting lines within their Directorate;

- Risks are considered as part of all Division and Departmental meetings. When potential risks are identified the minutes of the meeting will record who is responsible for investigating and owning the risk, ensuring that it is assessed and recorded on a Division or Departmental Risk Register and develop appropriate action plans.

- Their staff are aware of the risk management process and arrangements for assessing, managing, reporting and monitoring risks within their Division or Department.

- The training needs of staff are assessed in accordance with the Knowledge and Skills Framework (KSF) and that where further development is required this is reflected within Personal Appraisal and Development Reviews (PADRs).

- Where the Health Board is engaged in partnership working, ensure that the appropriate risk assessments have been undertaken and where risks are identified ensure they are documented and appropriate arrangements put in place for their

effective control and management. The owner of each partnership risk must be clearly identified taking into account statutory and contractual arrangements to ensure that the Health Board is aware of those risks for which it could be liable.

This will include risk assessment of specific projects (within the Health Board or in partnership), at the inception of the project and ensuring there are clear performance management arrangements in place which include accountability for risk.

12.8 All Employees and Volunteers

All employees, as well as any volunteers, should be actively engaged in the risk assessment process within their area of work as part of their everyday roles in delivering care and services for patients and local people.

If an employee identifies a risk they must report it to the appropriate person in their Division or Department. They should also be actively engaged in the development of effective solutions including taking action as appropriate.

12.9 Divisional Directors and Assistant Directors

Divisional Directors and Assistant Directors of Corporate Directorates are responsible for the management of risk within their Divisions/Directorates/Departments. They must ensure, in association with their Senior Management Teams, that they have effective arrangements in place to identify and manage risk or the provision of additional support.

When risks are identified which are outside their control, or when they require that the Directors or the Board are made aware of emerging risks which need to be managed/tolerated and they must ensure that this is communicated effectively via their respective Executive Director.

Divisional Directors and Assistant Directors of Corporate Directorates should ensure that everyone in their areas of responsibility understand their risk management responsibilities and must make clear the extent to which staff are empowered to take risks and be concise with regard to what risks they are willing to accept and not accept.

Each Division should have a clearly defined structure to ensure the appropriate management of risk and this should be communicated to all staff within the Division, Directorate and Department.

12.10 Divisional and Senior Management Teams

Divisional Management Teams are responsible for the day to day management of risk within their Division. They will ensure that:

- Risk management is a key component of operational planning and management within the Division.

- Risks are identified, assessed and appropriate actions taken, where possible;

- Risk registers are populated and utilised to inform the management of risk at Divisional and Clinical Directorate level.

- Divisional Directors are informed of all areas of strategic and operational risk.

- Ensure that there is clinical input in the development and implementation of strategies and systems for the continual improvement services including clinical governance, risk management and health and safety.

- Ensure that robust systems of governance and risk management are in place.

- Ensure that clinical risk is assessed within the Division in accordance with the Risk Assessment and Risk Register Processes.

- Advice is provided on the development of Directorate and Divisional risk registers.

12.11 Corporate Functions

Corporate Functions such as the Clinical Governance, Health and Safety Advisors, Finance Directorate, Workforce and Organisational Development Directorate etc. will assist clinicians and managers by providing advice and support in relation to their specific area of responsibility. The Board Secretary or Head of Corporate Governance or Corporate Services Manager – Risk Management and Assurance will provide advice where it is of a more general nature in relation to the governance and risk management structures, systems and processes.

12.12 Internal Audit Service (IAS)

The Internal Audit Service provides assurance informed by the Corporate Risk Register and Assurance Framework. For the corporate and strategic risks identified by the Board, IAS will evaluate the effectiveness of the existing controls and risk management responses.

The IAS assurance will include an assessment of the reliability and effectiveness of the organisation's overall risk management systems. They will also review the effectiveness of risk management arrangements as part of their programme of audits and reviews and will report its findings to the Audit Committee, or other Committees, as appropriate.

12.13 Local Counter Fraud Service

The Health Board's Nominated Local Counter Fraud Specialist (LCFS) provides assurance to the organisation regarding risks relating to fraud and/or corruption. The Health Board's Annual Counter Fraud Work Plan, once agreed by the Director of Finance and Performance, also identifies the arrangements for managing and mitigating risks as a result of fraud and/or corruption. Where such issues are identified they are investigated by the LCFS and then reported to the Audit Committee as appropriate. Any risks associated with fraud will therefore, be registered on the Audit Committee Risk Register and the overall Corporate Risk Register.

12.14 The Health and Safety Department

The Health and Safety Department will be responsible for providing advice where a risk is related to health and safety. The Executive Lead for health and safety is the Director of Therapies and Health Science.

Health and safety issues are closely linked with risk management and the specialist Health and Safety Advisors (for example Manual Handling Advisors and Violence and Aggression Advisors) may be able to assist departments through the preparation of specific assessments for frequently recurring risks across the Health Board.

There is specific and additional guidance with regard to managing health and safety risks available from the Health and Safety Department and is also available on the Health Board's Intranet site for staff.

12.15 Occupational Health Department

The Occupational Health Department should be consulted on risk assessment issues where there may be an impact on the health and wellbeing of staff.

13. Risk Training and Awareness Raising

The Health Board recognises that this Strategy can only be successful through good training and awareness raising and therefore the need

for risk training and awareness raising for Health Board Members and staff is a key priority. Staff at all levels will be provided with training in the principles of risk management and the appropriate skills to effectively undertake risk management activities within their work areas. This training and awareness raising will cover both clinical and non-clinical areas.

Risk training, including health and safety, incident reporting, fire, security, data protection, infection control and waste management will be provided to all new staff on induction.

Training and awareness raising will also be undertaken with Board Members to enable them to properly discharge their responsibilities.

The Health Board will ensure that the risk management strategy forms part of the Health Board's induction processes. Also, a quarterly risk management briefing will be established and cascaded via the Health Board's Divisional Cascade systems and also placed on the Risk Management Intranet Pages. The Health Board will also explore electronic based training which will better generate engagement of staff.

14. Monitoring, Reviewing and Auditing

Internal Audit will conduct a programme of work each year to ensure that appropriate control frameworks are in place and operating effectively to mitigate risks. This programme of work will be summarised in an Annual Internal Audit report to support the Annual Governance Statement.

This Strategy will be subject to regular review and updated as required by legislation or changes in best practice and, as a minimum, reviewed in full every three years.

Appendix 1: Consequence scores

	Consequence score (severity levels) and examples of descriptors				
Domains	**1 Negligible**	**2 Minor**	**3 Moderate**	**4 Major**	**5 Catastrophic**
Impact on the safety of patients, staff or public (physical/ psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/ disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients

Quality/ complaints /audit	Peripheral element of treatment or service suboptimal	Overall treatment or service suboptimal	Treatment or service has significantly reduced effectiveness	Non-compliance with national standards with significant risk to patients if unresolved	Totally unacceptable level or quality of treatment/ service
	Informal complaint/inquiry	Formal complaint/ Local resolution	Formal complaint / Local resolution (with potential to go to independent review)	Multiple complaints/ independent review	Inquest/ombudsman inquiry Gross failure of patient safety if findings not acted on
		Single failure to meet internal standards	Repeated failure to meet internal standards	Critical report	Gross failure to meet national standards
		Minor implications for patient safety if unresolved	Major patient safety implications if findings are not acted on		
		Reduced performance rating if unresolved			
Human resources/ organisati	Short-term low staffing level that	Low staffing level that reduces the	Late delivery of key	Uncertain delivery of key	Non-delivery of key objective/ser

onal development/staffing / competence	temporarily reduces service quality (< 1 day)	service quality	objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/ key professional training	objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale Significant numbers of staff not attending mandatory/ key professional training	vice due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key professional training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Challenging external recommendations	Single breech in statutory duty Improvement notice	Multiple breeches in statutory duty Critical report Prohibition notices	Multiple breeches in statutory duty with high likelihood of enforcement action Complete systems change required Severely critical report Prosecution

Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP/AM concerned (questions in the House/Assembly)
		Elements of public expectation not being met			Total loss of public confidence
Business objectives / projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget	Loss of 0.25–0.5 per cent of budget	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget	Non-delivery of key objective/ Loss of >1 per cent of budget
		Claim less than £10,000	Claim(s) between £10,000	Claim(s) between £100,000	Claim(s) in excess of £1 million

			and £100,000	and £1 million Purchasers failing to pay on time	Loss of contract
Service/ business interruption	Loss/interruption of >1 hour	Loss/interruption of >8 hours	Loss/interruption of >1 day	Loss/interruption of >1 week	Permanent loss of service or facility
Environmental impact	Minimal or no impact on the environment	Minor impact on environment	Moderate impact on environment	Major impact on environment	Catastrophic impact on environment

Appendix 2: Likelihood score (L)

• What is the likelihood of the consequence occurring?
• The frequency based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify the frequency at which a risk is likely to occur. • The probability score is more appropriate for risks relating to time limited or one-off projects or business objectives

Likelihood Score

Descriptor	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
Frequency How often does it might it happen	This will probably never happen/ recur	Do not expect it to happen / recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently
Probability Will it happen or not? % chance of **not** meeting objective	<0.1 per cent	0.1-1 per cent	1 -10 per cent	10-50 per cent	>50 per cent

Appendix 3: Example of Risk Register Format

Risk Identifier					Risk Description			Risk Scoring										Risk Action Plan						
								Inherent Risk				Current Risk Level								Target Expected Risk Level				
Strategic Objective	IMTP Theme	Date	Executive Lead	Assuring Group/Lead Committee	Risk Description	Cause	Effect	Likelihood	Impact	Risk level	Key Current Controls and Assurances	Likelihood	Impact	Risk level	Trend	Risk Appetite level and Risk Decision	Action Plan	Due date	Likelihood	Impact	Risk level	Progress	RAG Status (on/off track)
The relevant corporate objectives will be indicated here	The link to the IMTP and specific SCPs will be indicated here	Date when risk is first registered	Executive lead will be identified	Committee or group to provide scrutiny or oversight of the risk	An overview of the risk	Factors which could prompt the risk	Implications and consequences of the risk occurring	Risk level when no action has been taken		##	Current controls and sources of assurance that the potential risk is being prevented, treated or mitigated.	Risk levels with existing controls and additional treatments		##	This will show whether the risk has increased, decreased or stayed the same.	The agreed risk appetite for this area will be identified	This will be the additional actions that we have agreed will need to be taken to respond to the risk.	Due date for actions to be completed	Residual risk level after treatment		##	Progress made against the actions identified and whether actions are on or off agreed profile and timescales.	

Notes:

1. The risk score is calculated using the Risk Matrix of consequence x likelihood

2. Information should be kept brief but sufficiently detailed to enable a good understanding of the risk, issues and controls.

3. All risks must be assigned to an appropriate senior manager.

4. All review dates should be no later than one year after the risk has been identified. However, it is suggested that the review of risks should be undertaken based on the following:

   - Extreme Risks – Weekly Review
   - High Risks - Monthly Review
   - Moderate Risks - Quarterly Review
   - Low Risks - Six monthly Review

5. All high and extreme risks must be reported to the Board/Audit Committee via the Board Secretary.

Appendix 4 – Control Measures

Good risk management should also include sound control mechanisms of risk. Each risk should have identified appropriate mechanisms of control as outlined in the table below:

TYPES OF RISK CONTROL	
Terminate	Eliminates the risk completely
Transfer	Passes the risk to a third party, who bears or shares the impact
Treat	***Containment***: Reduces the likelihood and/or the impact
	Contingent: Establishes a contingency to be enacted should the risk happen
Tolerate	Accepts the risk, subject to monitoring

Appendix 5 – Example of Risk Dashboard – 'Risk on a Page'

CRR*** To be completed by Corporate Team	**Director Lead:** <Executive Director>	**Date Opened:**
	Assuring Committee: <Committee details>	**Date Last Reviewed:**
	Risk: <Description of Risk>	**Target Risk Review Date:**
	Impact: <Description of Impact>	

<Graph to be inserted here – to be completed by Corporate Team>		**Consequence**	**Likelihood**	**Score**
	Initial Risk Rating	<1-5>	<1-5>	<C x L>
	Current Risk Rating	<1-5>	<1-5>	<C x L>
	Target Risk Score (Risk Appetite Level Low Business Driver – Level	This section will be completed in future reports following the Health Board's review and approval of a new risk appetite statement.		
	Movement since last presented to Board in May 2019	New Risk		

Controls in place	**Further action to achieve target risk score**
• <please add your controls in place here> •	• <please add your sources of assurances here> •

Sources of Assurances	**Links to**
• <please add your sources of assurances here>	**Strategic Priorities in the IMTP** Links to Priority – <please list your priorities>

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Audit Committee Thursday 5th December 2019 Agenda Item:3.2

3.2

Aneurin Bevan University Health Board

Update Report on Top Ten Risks

Executive Summary

This paper also provides an overview of the top ten risks as currently assessed in the Health Board's Corporate Risk Register. They reflect the position reported to the Board in November 2019.

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

Executive Sponsor: 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: 28th November 2019

Supplementary Papers Attached:
Appendix 1 – Top Ten Risks (using the Risk on a Page format)

Purpose of the Report

This report is provided for assurance purposes to highlight for the Committee the current top ten risks as expressed in the Corporate Risk Register.

Background and Context

1. Top Ten Risks

Attachment One provides an overview of the top ten risks as currently assessed in the Health Board's Corporate Risk Register, which currently contains 31 assessed risks. These risks reflect the position reported to the Board in November 2019.

The reporting of these to the Committee reflects the Audit Committee's role in assessing the adequacy of the design, delivery and reporting of the Health Board's Risk Management arrangements, its advice to the Board with regard to these matters and its assessment of their adequacy.

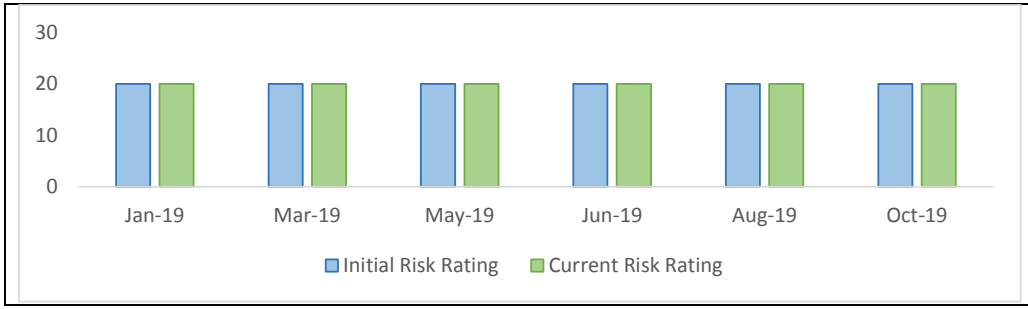
For future reporting the Audit Committee will receive twice yearly full updates on the Corporate Risk Register and a comprehensive overview of risk work within the organisation. The remaining two quarterly meetings will receive the top ten risks and an overview of progress. The first comprehensive risk management report will be submitted to the February 2020 meeting in line with work on revising the Risk

Management Strategy and process and the completion of the Risk Management Action Plan. This will assist the Committee to make determinations of the adequacy of the risk management systems as part of its active role in the end of year reporting arrangements and the agreement of the Annual Governance Statement.
Assessment and Conclusion
This paper provides an update on progress with risk management and an overview of the top ten risks as reported to the Board in November 2019.
Recommendation
The Committee is asked to note this report and note the identified top ten risks for the Health Board as reported to the Board in November 2019.

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 no direct financial impact associated with this report.
Quality, Safety and Patient Experience Assessment	Impact on quality, safety and patient experience are highlighted within the individual risks contained within this report.
Equality and Diversity Impact Assessment (including child impact assessment)	There are no specific 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 outlined in the register.
Health and Care Standards	This report would contribute to the good governance elements of the Health and Care Standards for Wales.
Link to Integrated Medium Term Plan/Corporate Objectives	The risks against delivery of key priorities in the IMTP, will be outlined as specific risks on the risk register.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	Not applicable to this specific report, however WBFGA considerations are included within the consideration of individual risks.
Glossary of New Terms	None
Public Interest	Report to be published.

Corporate Risk to a Page Report - as at end of October 2019

CRR012	**Director Lead:** Director of Operations	**Date Opened:** December 2018
	Assuring Committee: Finance and Performance Committee	**Date Last Reviewed:** October 2019
	Risk: Failure to meet the needs of the local people in relation to emergency care provision including WAST provision.	**Target Risk Review Date:** Weekly review undertaken
	Impact: Not meeting Welsh Government targets and patients will not receive services they require in a timely way.	



	Consequence	Likelihood	Score
Initial Risk Rating	5	4	20
Current Risk Rating	5	4	20
Target Risk Score (Risk Appetite - Level Low Business Driver - Level Low)	**Ultimate Target**		**Incremental Target**
	5		15 - March 2020
Movement since last presented to Board in September 2019	Risk remained unchanged		

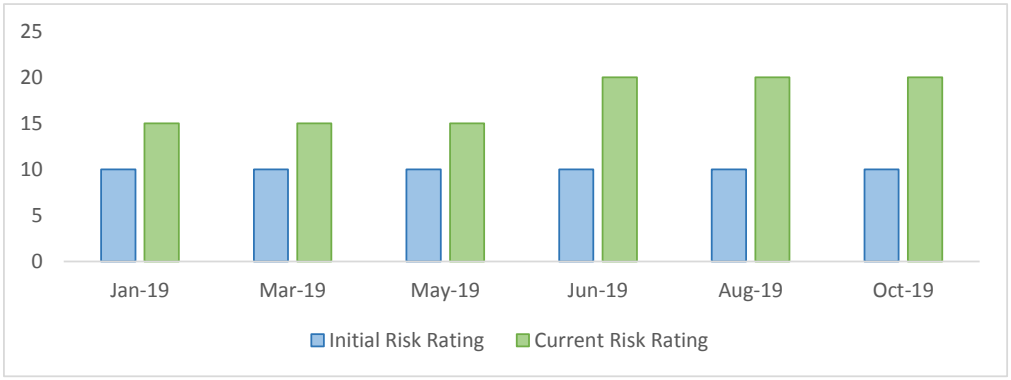
Controls in place	Action taken to mitigate the risk
• Ongoing monitoring is provided on a weekly basis at meetings with the Divisions and through the Urgent Care Board. • Executive Led Improvement Programme in place monitoring improvements on a weekly basis, and tracking any progress/risks. Risks and incidents associated with Urgent Care pressures received and managed through Divisional governance processes and overseen at weekly Executive Huddle.	• New models of care have been introduced including Ambulatory Care at the RGH. Stage 2 (ED Ambulatory Care) GP Streaming pilot to commence in November. • Welsh Government Delivery Unit supporting targeted piece of work on flow in month. • Core Care team project in progress to improve safer ward establishment, and this will improve effectiveness and efficiency of the ward (flow) • Successful recruitment of Physicians Assistant to support ward flow (from November). • Integrated Discharge Team work to streamline flow and early discharge/Discharge to Assess. • GPs to be based in RGH Emergency Department as a pilot from 26th October 2019. • Additional capacity opened to temporarily support pressures 8th October 2019. • Winter Plan to Board in November Winter Plan, includes additional senior decision makers in ED and Assessment Units, admission avoidance schemes, step-up and down capacity, additional hospital capacity, respiratory plan to manage admissions, discharge to assess schemes and GP streaming • EFU ambulatory care will open on 11th November 2019. • Lightfoot – full analysis of data and opportunities to improve areas of potential improvement, concentrate on plan to improve the <72 hour stays and pathway management and the use of forecasting based on statistical modelling.

Assurances	Links to
• HIW Reports • Working with the Delivery Unit and Reporting • Community Health Council Reports • Internal Audit and Wales Audit Office Report • Divisional Reports including assessments of Health and Care Standards • Executive Team weekly review of USC pressures and Clinical Huddle reports.	**Strategic Priorities in the IMTP** Links to Priority number 6.

CRR009	**Director Lead:** Director of Planning, Digital and IT	**Date Opened:** May 2019
	Assuring Committee: Information Governance Committee	**Date Last Reviewed:** October 2019
	Risk: Failure to implement Welsh Community Care Information System (WCCIS)	**Target Risk Review Date:**

Corporate Risk to a Page Report - as at end of October 2019

	Impact: Reduced ability to support integration between Health and Social Care.	Monthly review undertaken



	Consequence	Likelihood	Score
Initial Risk Rating	5	2	10
Current Risk Rating	5	4	20

Target Risk Score (Risk Appetite - Level Low Business Driver - Level Low)	Ultimate Target	Incremental Target
	5	15 – March 2020

Movement since last presented to Board in September 2019

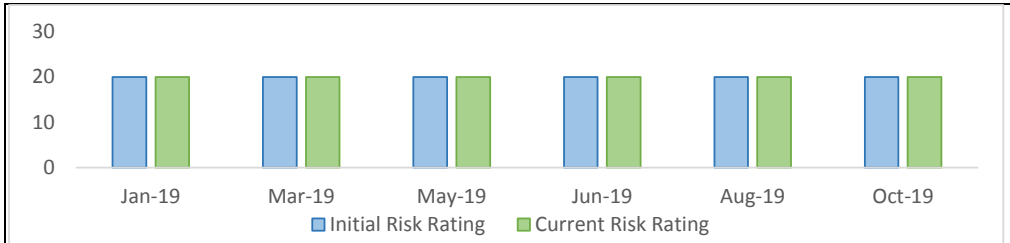
Risk remained unchanged

Controls in place	**Action taken to mitigate the risk**
• Continued engagement with national WCCIS team and Leadership Board and Careworks. • The Gwent Regional WCCIS Board and ABUHB Programme Board continue to meet and review risks regularly. • ABUHB required timescales and critical path imperatives identified. • A series of escalation meetings led by SRO have taken place, with the national programme SRO, Programme Director and NWIS.	• The Health Board continues to work with the supplier and commercial instruments are being utilised as per the contract. The Gwent Regional WCCIS Board and ABUHB Programme Board continue to meet and review risks regularly. ABUHB required timescales and critical path imperatives identified. • A series of escalation meetings led by SRO have taken place, with the national programme SRO, Programme Director and NWIS. • Continued engagement at a national level and local plans to manage any risks to the resilience of existing systems. • Due to the delay notification from the supplier a specific business continuity work stream has been established to consider options to safeguard MH services core system.

Assurances	**Links to**
• Internal Audit and Wales Audit Office Report • National and Local Informatics and Programme Reports • Internal gap analysis and assessment reports.	**Strategic Priorities in the IMTP** This is an enabling risk in support of the delivery of all priorities of the IMTP.

Corporate Risk to a Page Report - as at end of October 2019

CRR029	**Director Lead:** Director of Workforce & OD, Director of Nursing, Medical Director, Director of Therapies and Health Science	**Date Opened:** March 2017
	Assuring Committee: People and Culture Committee	**Date Last Reviewed:** October 2019
	Risk: Failure to recruit and retain appropriately skilled staff and senior leadership to deliver high quality care.	**Target Risk Review Date:** Weekly review undertaken
	Impact: Negative impact on patient care and service delivery due to lack of skilled workforce, low staff morale, increased sickness and turnover.	



	Consequence	Likelihood	Score
Initial Risk Rating	5	4	20
Current Risk Rating	5	4	20
Target Risk Score (Risk Appetite - Level Low Business Driver - Level Low)	**Ultimate Target**		**Incremental Target**
	5		15 – June 2020
Movement since last presented to Board in September 2019	Risk remained unchanged		

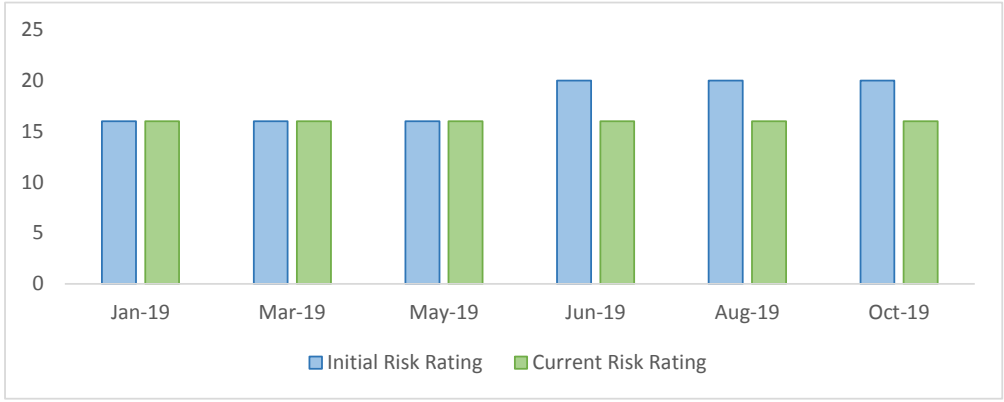
Controls in place	**Action taken to mitigate the risk**
• Regular workforce reporting including medical and nursing vacancies to the Finance & Performance Committee. • Regular reporting of Clinical Futures recruitment activity to the Workforce & OD Clinical Futures Workforce Recruitment Sub Group/Delivery Board. • Internal performance monitoring of recruitment plans and KPIs including workforce performance dashboard. • Review of nursing vacancy tracker, profiling vacancies to March 2020. • Monitoring of Job Planning compliance and the Escalation Policy. • Robust escalation and authorisation process for filling bank/agency shifts. • Regular review of plans in place to maximise recruitment and support retention in all identified areas including registered nurses and medical staff. • Review of nursing vacancies and staffing at Strategic Nurse Workforce Group & Nurse Staffing Act Implementation Group. • Annual winter workforce plan with reporting regular Executive Team Deep Dive meetings.	• Continued implementation of the Nurse Staffing Act across acute areas • Implementation and pilot "Core Care Team Model" which is a new workforce configuration for the wards, commencing beginning of November 2019. • Recruitment of Portfolio GP roles and continued focus on hard to fill areas: Nursing – NHH wards: Medical – Mental Health, Paediatrics, Obs & Gynae, Medicine and ED and develop actions to reduce current recruitment timelines. • Flexible use of Bank and Agency to ensure safe staffing levels. • Continue to implement and monitor recruitment plans for registered nurses and medical vacancies. This includes overseas recruitment campaigns and working with national initiatives e.g. "Train, Work, Live" and BAPIO recruitment in October 2019. • Continued focus and support of workforce and recruitment and Staff engagement plans for the Clinical Futures Programme and review in line with national recruitment market. • Continued promotion of the new recruitment materials and webpages, including the development of a multi-disciplinary recruitment video advert. • Individual Ward risk reviews undertaken of actions and plans by Executive Team. • Continue to consider skill mix including opportunities for multi-disciplinary teams in acute and primary care settings e.g. Primary Care Academy and Physicians Assistant roles. • Supporting the Divisions to understand the findings and put in place actions from the Employee Experience Survey. • Continue to review workforce data on turnover, stability index etc.

Assurances	**Links to**
• HIW Reports • Working the Delivery Unit and Reporting • Community Health Council Reports • Internal Audit and Wales Audit Office Report • Reports from the Learning Committee and Lessons Learnt Reports • Divisional Reports including assessments of Health and Care Standards • Bi-annual report to Board regarding Nurse Staffing levels Act (Wales) 2016 and compliance.	**Strategic Priorities in the IMTP** • This is an enabling risk in support of the delivery of all priorities of the IMTP.

CRR015	**Director Lead:** Director of Nursing and Medical Director	**Date Opened:** July 2018
	Assuring Committee: Quality and Patient Safety Committee	**Date Last Reviewed:** October 2019

Corporate Risk to a Page Report - as at end of October 2019

	Risk: Poor patient experience, deterioration of patient outcomes and quality of care in hospital and community settings due to staff shortages and patients not able to access services on a timely way in both primary and secondary care.	**Target Risk Review Date:** Monthly review undertaken
	Impact: Deteriorating patient experience/outcomes and quality of care.	



	Consequence	Likelihood	Score
Initial Risk Rating	4	4	16
Current Risk Rating	4	4	16
Target Risk Score (Risk Appetite - Level Low Business Driver - Level Low)	**Ultimate Target**		**Incremental Target**
	4		12 – April 2020
Movement since last presented to Board in September 2019	Risk remained unchanged ⇔		

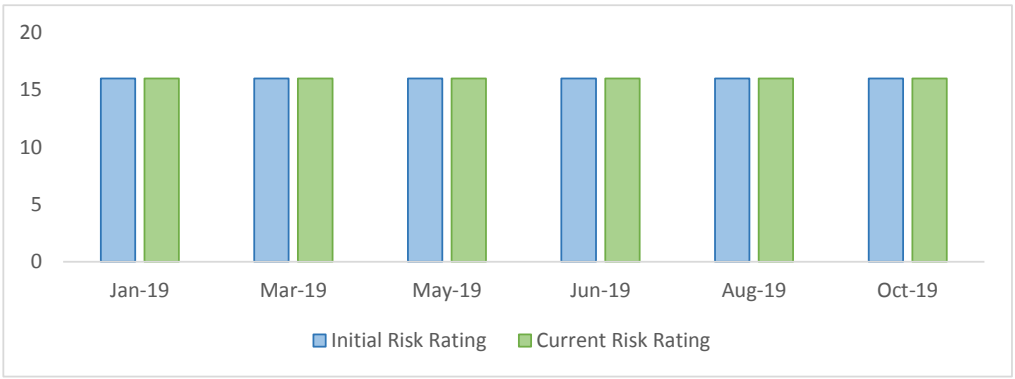
Controls in place	**Action taken to mitigate the risk**
• Monitoring of quality measures via Quality and Patient Safety Committee; • Patient experience is being captured and specific spot checks are being undertaken • Pressure Ulcer Collaborative and ED turnaround programme • Continued monitoring of HIW/CHC/Complaints/incidents to identify any areas of concern and lessons learnt reported to Executive Team • Workforce planning, planned use of temporary staffing and recruitment strategies in place with regular review • Weekly Clinical Executive Huddles take place and are reported to the Executive Team A Winter Review and learning has been undertaken and reported to the Board in May 2019 and Quality and Patient Safety Committee June 2019.	• Executive work to impact on flow and demand • Effort to exploration of new models of care • Daily reviews of staffing and escalation in the event of gaps • Weekly Executive Huddle to discuss Quality and Safety • Cliksense module to record Quality and Safety metrics which are reviewed and presented to Quality and Patient Safety Operational Group. • Improved reporting of patient experience.

Sources of Assurances	**Links to**
• HIW Reports • Working the Delivery Unit and Reporting • Community Health Council Reports • Internal Audit and Wales Audit Office Report • Reports from the of Lessons Learnt to Quality and Patient Safety Operational Committee • Divisional Reports including assessments of Health and Care Standards	**Strategic Priorities in the IMTP** Links to Priority – 3, 4, 5, 6, 7 and 8

CRR052	**Director Lead:** Chief Executive	**Date Opened:** September 2018
	Assuring Committee: Executive Team and Board	**Date Last Reviewed:** October 2019
	Risk: Risk of the impact of the UK to leaving the European Union (BREXIT) and a no-deal BREXIT on the delivery of health and care services.	**Target Risk Review Date:** Monthly review undertaken
	Impact: Potential impacts on the availability of workforce, employment issues and the legal framework for some professional qualifications. Potential impact for the management of public health and communicable disease.	

Corporate Risk to a Page Report - as at end of October 2019

	The potential impact of the availability and regulation of medicines. Also, research, development and availability of medical devices and technology.	



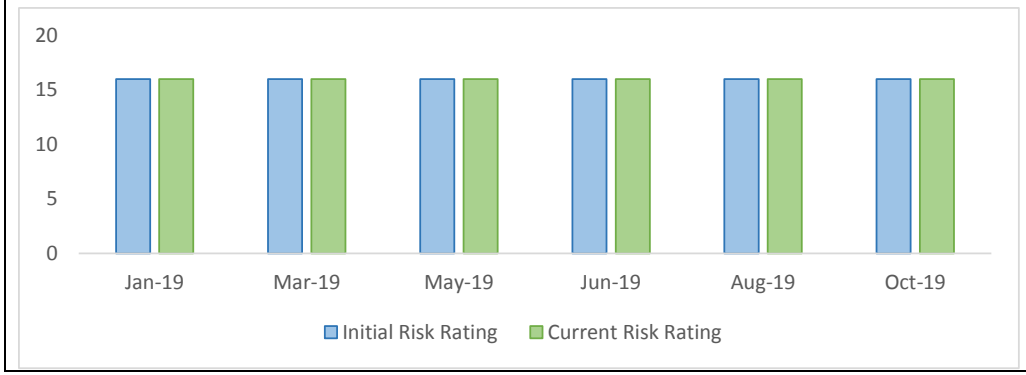
	Consequence	Likelihood	Score
Initial Risk Rating	4	4	16
Current Risk Rating	4	4	16
Target Risk Score (Risk Appetite - Level Low Business Driver - Level Low)	**Ultimate Target**		**Incremental Target**
	4		12 – January 2020
Movement since last presented to Board in September 2019	Risk remained unchanged ⇔		

Controls in place	**Action taken to mitigate the risk**
• The Health Board continues to liaise with Welsh Government, the NHS Confederation and other partners (business continuity preparedness and working with the Local Resilience Forum) in readiness for the outcome of negotiations. • Organisational EU Transition Steering Group has been established and risk and desktop planning exercises are underway. • A series of protocols, action cards and processed have been designed in preparation. • Regularised monitoring of progress at the Executive Team.	• Preparations continue at a national and local level on a range of areas following the extension agreed to the date for the UK to leave the European Union.

Source of Assurances	**Links to**
• National and Local Reports and reporting requirements • Local Action Plans and Processes • Partnership Resilience Plans and Health Board Business Continuity Plans • Reports to the Board and Executive Team.	**Strategic Priorities in the IMTP** This is an enabling risk in support of the delivery of all priorities of the IMTP.

Corporate Risk to a Page Report - as at end of October 2019

CRR036	**Director Lead:** Director of Public Health and Strategic Partnerships	**Date Opened:** July 2016
	Assuring Committee: Public Partnerships and Well Being Committee.	**Date Last Reviewed:** October 2019
	Risk: Failure to prevent and control communicable disease outbreaks and provide immunisations.	**Target Risk Review Date:** Monthly review undertaken
	Impact: There would be an impact on general public health and also increased demand for services and the ability of the NHS to respond.	



	Consequence	Likelihood	Score
Initial Risk Rating	4	4	16
Current Risk Rating	4	4	16
Target Risk Score (Risk Appetite - Level Low Business Driver - Level Low)	**Ultimate Target**		**Incremental Target**
	8		12 – April 2020
Movement since last presented to Board in September 2019	Risk remained unchanged ⇔		

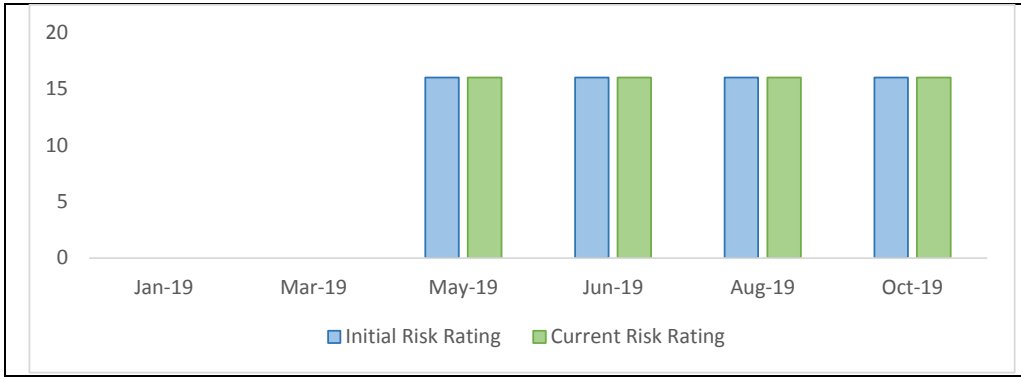
Controls in place	**Action taken to mitigate the risk**
• A Health Protection Team is in place and incident and outbreak plans established • Well established policies and processes to support any required action. • Look back exercises have been undertaken and learning from these adopted and shared. • Multidisciplinary 'Strategic Immunisation Group' meets biannually and is also represented on the Infectious Diseases sub group of the Gwent LRF.	• Continued prevention work and refining of well-established and tested outbreak plan.

Assurances	**Links to**
• Look back exercise reports • Internal Audit and Wales Audit Office Report • Divisional Reports including assessments of delivery • Reports from Divisional Assurance Meetings • Delivery Framework updates • Executive Team Meetings	**Strategic Priorities in the IMTP** This is an enabling risk in support of the delivery of all priorities of the IMTP.

CRR056	**Director Lead:** Director of Workforce and Organisational Development	**Date Opened:** April 2019
	Assuring Committee: People and Culture Committee	**Date Last Reviewed:** October 2019
	Risk: Inability to comply with the Welsh Language Standards, imposed as a result of the Welsh Language (Wales) Measure 2011	**Target Risk Review Date:** Monthly review undertaken

Corporate Risk to a Page Report - as at end of October 2019

	Impact: Failure to deliver on the Standards presents 3 main risks; namely, patients will not get the Welsh medium service they need and as such their experience and outcomes may be compromised; the reputation of the Health Board will be damaged which could reduce public and staff confidence and we may receive substantial financial penalties from the Welsh Language Commissioner if a failure to deliver on a Standard is proved (up to £5,000 for each infringement).	



	Consequence	Likelihood	Score
Initial Risk Rating	4	4	16
Current Risk Rating	4	4	16
Target Risk Score (Risk Appetite - Level Low Business Driver - Level Low)	**Ultimate Target**		**Incremental Target**
	4		12 – August 2020
Movement since last presented to Board in September 2019	Risk remained unchanged ⇔		

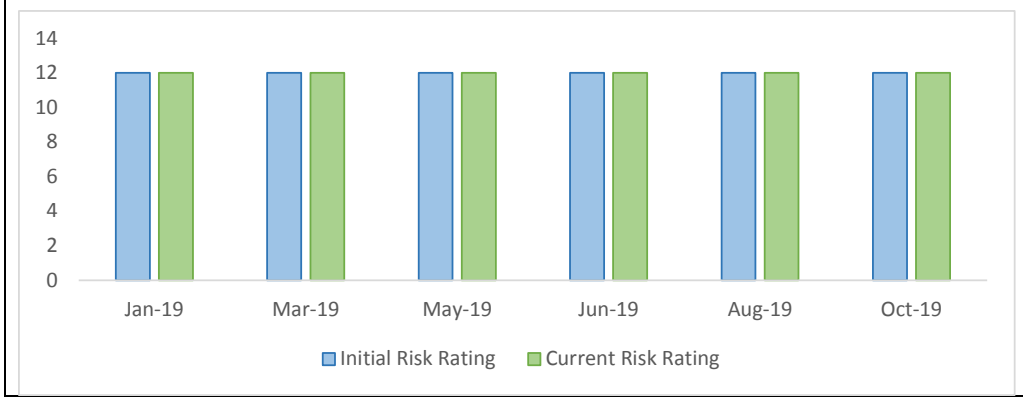
Controls in place	**Action taken to mitigate the risk**
• Detailed action plan for the implementation of the Standards to mitigate this risk. Monitored through the Welsh Language Strategic Group. • A series of Working Groups led by subject matter experts are informing the challenge against the time scales for implementation and the development of more detailed programmes of work for implementing the Standards. • Close liaison with the Office of the Welsh Language Commissioner and Welsh Language leads in Welsh Government. • Additional funding agreed by the Executive Team to support implementation. Welsh Language Standards awareness activities have been held across the Health Board, these including; roadshows, training sessions, attendance at team and departmental meetings, one to ones with all Executive Directors, attendance at Health Board events such as conferences, community events, joint community and staff language awareness training.	• A series of Protocols and Guidelines are in development to meet the requirements of the Standards. • Working collaboratively with other Health Boards and Public sector bodies to learn lessons and share best practice. • A series of Frequently Asked questions have been developed and are being published one at a time on the intranet as well as on the Welsh Language homepage • The Welsh Language homepage has been revised and updated with useful links and additional resources for staff • A Welsh language Tutor has been appointed to support individual staff and teams locally to improve both confidence and competence in using the Welsh language • The Welsh Language Unit is being restructured to ensure effective use of the limited resource available so that performance, efficiencies and economies of scale are realised

Assurances	**Links to**
• National and Local Reports and reporting requirements to Welsh Government and the Welsh Language Commissioner • Welsh Language Commissioner Assessments • Local Action Plans and Processes • WAO and Internal Audit Reports	**Strategic Priorities in the IMTP** This is an enabling risk in support of the delivery of all priorities of the IMTP.

CRR037	**Director Lead:** Director of Public Health and Strategic Partnerships	**Date Opened:** July 2016
	Assuring Committee: Public Partnerships & Well-being Committee	**Date Last Reviewed:** October 2019
	Risk: Poor uptake of flu vaccination among Health Board staff, primary school-age children, patients aged 65 and over and people under the age of 65, staff in care homes and delays in vaccine availability.	**Target Risk Review Date:** Monthly review undertaken
	Impact: Influenza outbreaks in hospitals, care homes and prison settings and excess morbidity and mortality among vulnerable groups at risk of flu complications.	

		Consequence	Likelihood	Score

Corporate Risk to a Page Report - as at end of October 2019



Initial Risk Rating	4	4	16
Current Risk Rating	4	4	16
Target Risk Score (Risk Appetite - Level Low Business Driver - Level Low)	**Ultimate Target**	**Incremental Target**	
	8	12 – March 2022	
Movement since last presented to Board in September 2019	Risk remained unchanged ⟺		

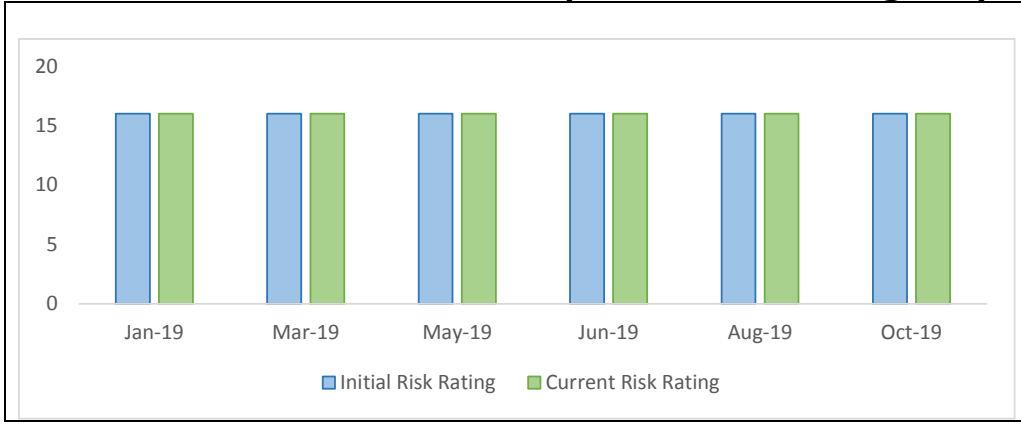
Controls in place	**Action taken to mitigate the risk**
• Seasonal flu action plans agreed by the Health Board's Strategic Immunisation Group for primary care (including care home staff), schools and staff. • Actions taken forward to mitigate the impact of staggered delivery of the adjuvanted trivalent influenza vaccine for people aged 65 years and over. • Additional communications campaign completed. End of year uptake (as at 24 April 2019) is above Wales average for those aged 65 and over and under 65 in clinically at risk groups, but below average for 2-3 year olds.	• Continued focus on the seasonal flu action plans • Continued communication and engagement activities generally and through Flu Champions Network.

Assurances	**Links to**
• Internal Audit and Wales Audit Office Report • Divisional Reports including assessments of delivery • Reports from Divisional Assurance Meetings • Delivery Framework updates • Executive Team Meetings	**Strategic Priorities in the IMTP** This is an enabling risk in support of the delivery of all priorities of the IMTP, but particularly priority 1.

CRR005	**Director Lead:** Director of Planning, Digital and IT	**Date Opened:** May 2018
	Assuring Committee: Finance and Performance Committee	**Date Last Reviewed:** October 2019
	Risk: Insufficient levels of capital funding for estate requirements	**Target Risk Review Date:** Monthly review undertaken
	Impact: Health Board will be unable to meet the levels of refurbishment required for Health Board to meet its plans	

	Consequence	**Likelihood**	**Score**
Initial Risk Rating	4	4	16

Corporate Risk to a Page Report - as at end of October 2019



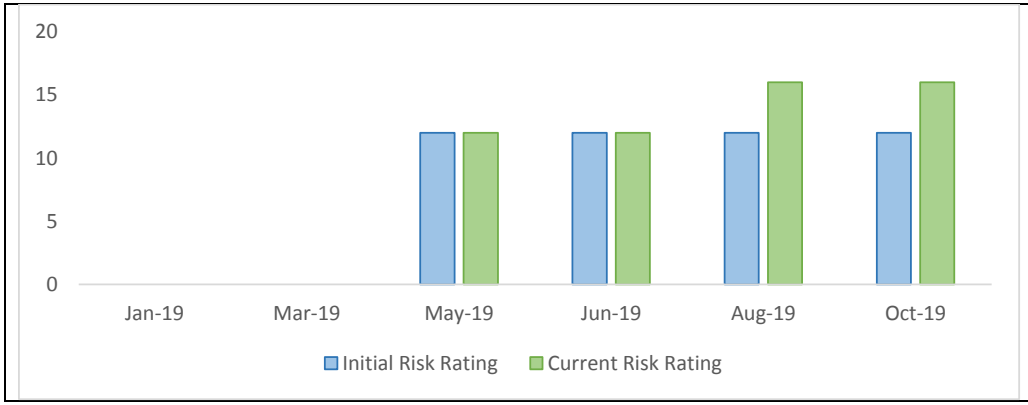
Current Risk Rating	4	4	16
Target Risk Score (Risk Appetite - Level Low Business Driver - Level Low)	**Ultimate Target**	**Incremental Target**	
	8	12 – December 2020	
Movement since last presented to Board in September 2019	Risk remained unchanged ⇔		

Controls in place	**Action taken to mitigate the risk**
• Detailed capital programme that is regularly re-prioritised by the Executive Team and agreed by the Board. • Opportunities maximised with regular dialogue with Welsh Government. • Issue escalated to Directors of Planning and Chief Executives. • Comprehensive Estates Strategy agreed and being implemented.	• Implementation of the agreed Estates Strategy in line with Clinical Futures. • Implementation of the agreed Capital Programme. • Further more detailed development of LGH plans post GUH opening • Engagement with WG re future capital requirements linked to the Estate Strategy • Development of proposals for agile working

Assurances	**Links to**
• Internal Audit and Wales Audit Office Report • Divisional Reports including assessments of delivery • Reports from Divisional Assurance Meetings • Delivery Framework updates • Executive Team Meetings • The Grange University Hospital Project Board and Clinical Futures Delivery Board	**Strategic Priorities in the IMTP** This is an enabling risk in support of the delivery of all priorities of the IMTP.

Corporate Risk to a Page Report - as at end of October 2019

CRR057		
	Director Lead: Chief Executive and Director of Finance and Performance	**Date Opened:** November 2018
	Assuring Committee: Finance and Performance Committee and Board	**Date Last Reviewed:** October 2019
	Risk: Failure to achieve financial balance at end of 2019/20	**Target Risk Review Date:**
	Impact: Funding confirmed by Welsh Government as part of IMTP approval	Monthly review undertaken



	Consequence	Likelihood	Score
Initial Risk Rating	4	3	12
Current Risk Rating	4	4	16
Target Risk Score (Risk Appetite - Level Low Business Driver - Level Low)	**Ultimate Target**		**Incremental Target**
	4		12 – January 2020
Movement since last presented to Board in September 2019	Risk has remain unchanged		

Controls in place	Action taken to mitigate the risk
(i) Delivery of savings plans essential to deliver financial balance. Approx. £5m savings requirement with savings delivery plans still to be identified. (ii) IMTP Delivery Framework and Divisional Assurance meetings in place which will incorporate implementation of savings plans and delivery of service and workforce plans within available resources. (iii) Executive Team identified list of savings areas (iv) Performance funding of £4m received in 2019/20 conditional on meeting RTT targets and £0.5m received conditional on meeting follow-up outpatient targets.	• Revised RTT Delivery Plan to be agreed by Executive Team. Welsh Government informed that 0>36weeks target will not be met with discussions ongoing regarding funding. • Follow-up outpatient plan in place. • Increased focus on efficiency opportunities, through Executive Team. • Further cost reduction measures to be identified by Executive Team.

Assurances	Links to
• Internal Audit and Wales Audit Office Report • Internal savings plans • IMTP Delivery Framework and Divisional Assurance Meetings • Savings delivery plans – specific Executive Team focus and priority • Performance and Finance Reports • Direct engagement through Business Partner model.	**Strategic Priorities in the IMTP** This is an enabling risk in support of the delivery of all priorities of the IMTP.

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

Archwilydd Cyffredinol Cymru
Auditor General for Wales

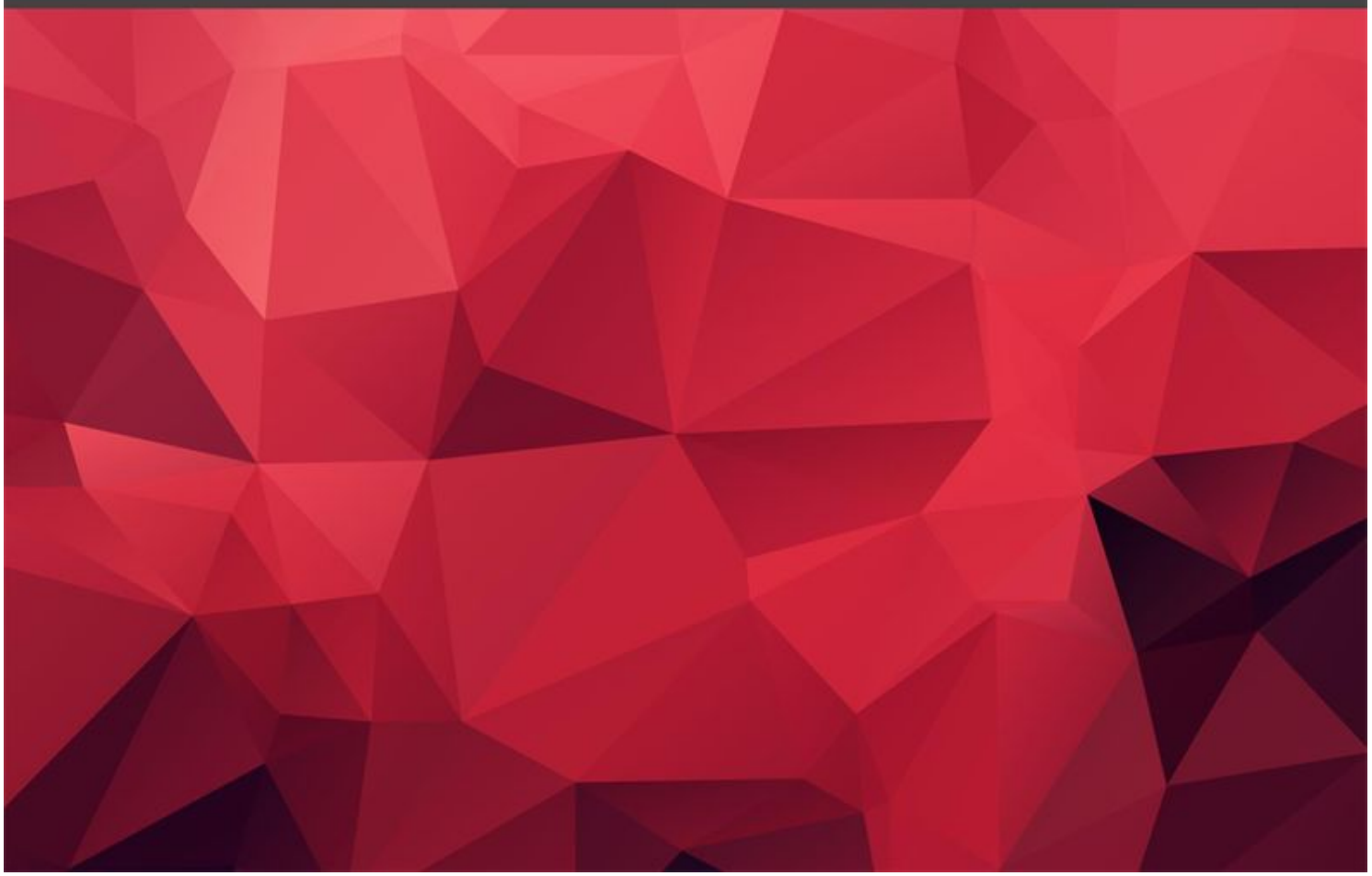
4.1

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

Audit Committee Meeting – December 5, 2019

Date issued: November 25, 2019

Reference: 648A2018-19



This document was prepared by Gabrielle Smith and Tracy Veale.

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 2018 audit plan

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

Exhibit 1: progress against previous audit plans

Topic	Details	Status	Executive lead
2018 financial and performance audits			
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.	Completed	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.	Onsite fieldwork scheduled to finish end November and reporting by January 2020	Claire Birchall
Follow-up work against previous recommendations	This work will track progress made by the Health Board to address our recommendations on:	Medicines management report with the Health Board for clearance of factual accuracy. Two other reports	Nick Wood

Topic	Details	Status	Executive lead
	• Medicines management in acute hospitals (2015) • District nursing services (2014/2015) • GP out-of-hours services (2017)	in draft for clearance at beginning December	

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	Glyn Jones
Financial accounts audit work	All our work to support the audit of the financial statements was completed by May 2019.	Complete	Glyn Jones
Audit of Financial Statements Report (ISA 260)	This report was presented to the Committee at its meeting on 28th May and the Board meeting on 30th May 2019.	Complete	Glyn Jones
Opinion on Financial Statements	The Auditor General gave his audit opinion on the financial statements on June 11, 2019.	Complete	Glyn Jones

Topic	Details	Status	Executive lead
Charitable Funds	Our work on the Charitable Funds was completed by the end of October 2019.	Complete. Our ISA260 Financial Statements Report will be presented to the November 2019 Board meeting	Glyn Jones
2019 Annual Audit Report	This report will summarise our financial and performance audit work during 2019.	Report to be drafted and issued for clearance on factual accuracy before end December	Judith Paget/ Glyn Jones
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.	Report in draft; clearance on factual accuracy to start end November / beginning December	Judith Paget
Thematic review - quality governance arrangements	This audit will consider the Health Board's quality governance arrangements and how these underpin the work of the Quality and Patient Safety Committee.	Not started – now scheduled to start by March 2020	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'.	Draft report issued for clearance on factual accuracy	Sarah Aitken

Topic	Details	Status	Executive lead
Locally focused audit project	The precise focus of this work is yet to be agreed.	Not started - to confirm by January 2020	To be confirmed when audit topic agreed

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. Upcoming events in early 2020 include Accountability and governance in partnership services and Adverse Childhood Experiences - alternative delivery models.

Exhibit 3: NHS-related national reports

Report topic	Publication date
Review of Public Services Boards This report looks at how Public Service Boards (PSBs) operate and concludes that PSBs are unlikely to realise their potential unless they are given freedom to work more flexibly and think and act differently.	October 2019
Primary Care Services in Wales This report looks at the national leadership and governance arrangements for improving primary care. The report concludes that despite considerable investment and many plans for primary care transformation over the years, change has not happened as quickly or as widely as intended. The report sets out ten national-level recommendations that require Welsh Government and the National Primary Care Board to work with health boards and independent contractors and to seek views from others, such as regional partnership boards.	October 2019
Greater Gwent Regional Partnership Board – Integrated Care Fund This supplementary report, which should be read in conjunction with our national report, sets out more detailed findings for the Greater	November 2019

Report topic	Publication date
Gwent RPB. It builds on feedback that we provided to the RPB in November 2018.	
A joint review of quality governance arrangements at Cwm Taf Morgannwg University Health Board Following well-publicised concerns about maternity services at the former Cwm Taf University Health Board, Healthcare Inspectorate Wales (HIW) and the Wales Audit Office jointly reviewed the organisation's overall approach to quality governance and found numbers of fundamental weaknesses in the Health Board's governance arrangements in respect of the quality of care and patient safety. The Minister for Health and Social Services has written to all NHS Chairs and Chief Executives asking them to consider their own quality governance arrangements and review these against the report's recommendations.	November 2019
Follow-up review for the management of local public resources	Spring 2020
Counter fraud arrangements in public bodies – phase 2[1]	Spring 2020

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[1] The Auditor General's work on counter fraud arrangements commenced in November 2019.

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INTERNAL AUDIT PROGRESS REPORT 2019/2020

5.1

5 December 2019 Audit Committee

NHS Wales Shared Services Partnership

Audit and Assurance Service

5.1

1. INTRODUCTION

1.1 The purpose of this report is to highlight progress against the 2019/20 Internal Audit Plan at 28 November 2019 to the Audit Committee.

2. PROGRESS AGAINST THE 2019/20 INTERNAL AUDIT PLAN

Number of audits in plan	41*
Number of audits reported as final	14
Number of audits reported in draft	3
Number of audits in progress	18

* Total excludes AGS and G&A Module and includes one audit carried forward from 2018/19.

2.1 The following reports from the 2019/20 Internal Audit Plan have been issued since the previous meeting of the Audit Committee:

AUDIT ASSIGNMENT	ASSURANCE RATING
Welsh Language Standards	Reasonable
Health and Safety Management Follow-up	Limited
Charitable Funds	Reasonable
IT Service Management Follow-up	Reasonable
Divisional Review – Scheduled Care	Reasonable
Fire Safety Follow-up	Limited

2.2 Appendix A details progress in respect of each of the reviews in the 2019/20 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 October 2019:

Welsh Language Standards

3.2 The overall objective of this review was to evaluate and determine the adequacy of the systems and controls in place over the implementation of the Standards.

3.3 We reported reasonable assurance and made one high priority and one medium priority recommendation for improvement.

We concluded that the work recently undertaken by the Health Board should ensure that the Standards are implemented but our high priority recommendation focussed on the need for robust monitoring and escalation arrangements in order to ensure that the embedding programme maintains momentum.

Charitable Funds

3.4 The purpose of this review was to establish if the Health Board has appropriate processes in place to ensure that the Charitable Funds are appropriately managed and administered in accordance with relevant legislation.

3.5 We reported reasonable assurance and made one high priority and one medium priority recommendation.

3.6 Our high priority recommendation focussed upon the recording of donated income on wards and the need for increased awareness of the Health Board's Financial Control Procedure. Our sample testing identified a number of instances in which the required documentation was either not retained or not fully completed. We also highlighted that more could be done to maximise the level of gift aid that the Charity could claim.

IT Service Management Follow-up

3.7 This review sought to provide assurance that sufficient progress is being made in addressing the recommendations from our 2017/18 review of IT Service Management.

3.8 The original audit was against a number of areas of best practice and it was accepted by the Health Board that improvement in this area is a longer term project with resource implications. As such this follow-up review focussed on whether resources are in place with a robust plan to deliver the improvements, utilising a risk based approach.

3.9 A specialist ICT Service Manager has been recruited and a Service Management Landscape (SML) document has been produced with actions in progress. We reviewed the SML in detail and concluded that the actions therein are appropriate to deliver the improvements in our original report and provided reasonable assurance over progress.

Divisional Review – Scheduled Care

3.10 This review sought to provide assurance over compliance with policies and procedures and the management of risk within the Scheduled Care Division. This was a broad audit covering ten objectives.

3.11 We reported reasonable assurance overall, with limited assurance for policies and procedures and declarations of interest. We raised one high priority and three medium priority recommendations.

Our recommendations focussed on improving the management and control of policies and procedures in the Division, local declarations of interest, clarity in the terms of reference and membership of key management groups and driving consistent improvements in known issues of ward based patient documentation.

4. CONTINGENCY

There is a contingency element in the 2019/20 Internal Audit Plan. These days will be utilised in discussion with the Health Board in response to emerging risks.

5. ENGAGEMENT

ADDITIONAL MEETINGS HELD AND COMMITTEES ATTENDED DURING THE REPORTING PERIOD

5.1 Board/Sub Committee/other events:

- Board;
- Quality & Patient Safety Committee;
- Information Governance Committee; and
- Finance & Performance Committee.

5.2 Meetings:

- Regular update meetings regarding the Clinical Futures Programme;
- Audit scoping and debrief meetings;
- Chief Executive quarterly;
- Board Secretary monthly;
- Director of Finance and Performance quarterly;
- Assistant Director of Finance (Corporate Finance) monthly;
- Audit Committee Chair quarterly;
- Chair bi-annually;
- Well-being of Future Generations Act Programme Board; and
- Wales Audit Office, Health Inspectorate Wales and Ombudsman quarterly.

5.3 We also provide ongoing proactive advice and support to a number of Health Board developments including the recent restructure of the Health Board's committees and refresh of terms of reference.

6. RECOMMENDATION

6.1 The Audit Committee is invited to 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 - Planning	
Welsh Language Standards	Q2	Final Report	Reasonable
Health and Care Standards	Q4		
Health and Safety Management Follow-up	Q1	Final Report	Limited
Strategic Planning, Performance Management and Reporting			
Clinical Futures – Staff Engagement	Q2	Final Report	Substantial
Clinical Futures II – Operational Commissioning Planning	Q3	Work in Progress - Planning	
Clinical Futures III – Critical Path	Q4		
Service Change Plan 2	Q3	Work in Progress - Planning	
Dashboard Reporting	Q3	Work in Progress - Planning	
Financial Governance and Management			
Financial Planning and Budgetary Control	Q3	Work in Progress - Planning	
Losses and Special Payments	Q4		
Business Case Scrutiny Arrangements	Q2	Draft Report	Reasonable

Planned output	Outline timing	Status	Assurance
Procurement	Q1	Draft Report	Limited
Charitable Funds	Q2	Final Report	Reasonable
Patients Property and Monies	Q1	Final Report	Reasonable
Clinical Governance, Quality and Safety			
Annual Quality Statement	Q1	Final Report	N/a
Medical Equipment and Devices Follow-up	Q3	Work in Progress - Fieldwork	
Maternity Services	Q3	Work in Progress - Fieldwork	
Discharge Planning Follow-up	Q4	Work in Progress - Fieldwork	
Putting Things Right	Q3	Work in Progress - Fieldwork	
Clinical Audit Follow-up	Q3	Work in Progress - Fieldwork	
Patient Experience	2018/19	Work in Progress - Fieldwork	
Information Governance and Security			
111 Service	Q4		
Freedom of Information Requests	Q1	Final Report	Substantial
IT Service Management Follow-up	Q3	Final Report	Reasonable
IT Business Continuity/Disaster Recovery	Q3	Work in Progress - Fieldwork	

Planned output	Outline timing	Status	Assurance
Operational Service and Functional Management			
Job Planning	Q1	Draft Report	Limited
Outpatients	Q2	Work in Progress - Fieldwork	
Escalation Policy	Q4		
Divisional Review – Scheduled Care	Q2	Final Report	Reasonable
Theatres	Q4	Work in Progress - Fieldwork	
Workforce Management			
Staff Experience Framework	Q4		
Pay Incentives	Q1	Final Report	Limited
PADR Follow-up	Q2	Final Report	Reasonable
Healthcare Support Workers Delegation Framework	Q3	Work in Progress - Planning	
Capital & Estates			
Carbon Reduction Commitment	Q1	Final Report	N/a
Environmental Sustainability Report	Q1	Final Report	N/a
Fire Safety Follow-up	Q1	Final Report	Limited

Planned output	Outline timing	Status	Assurance
Major Capital Projects	Q3	Work in Progress - Fieldwork	
Anti-Fraud Capital Systems	Q3	Work in Progress - Fieldwork	
Estates Assurance	Q2	Work in Progress - Fieldwork	
Grange University Hospital	Separate Plan	Work in Progress - Fieldwork	

Indicator	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2019/20		April 2019	By 30 April	Not agreed	Draft plan	Final plan
Report turnaround: time from fieldwork completion to draft reporting [10 days]		13 of 13	*80%*	v>20%	10%<v< 20%	v<10%
Report turnaround: time taken for management response to draft report [15 days]		6 of 8	*80%*	v>20%	10%<v< 20%	v<10%
Report turnaround: time from management response to issue of final report [10 days]		8 of 8	*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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Fire Safety Follow-up

Final Internal Audit Report

2019/20

Aneurin Bevan University Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Service

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5.3

Review reference:	AB/1819/26
Report status:	Final
Fieldwork commencement:	1 May 2019
Fieldwork completion:	5 July 2019
Draft report issued:	15 July & 24 October 2019
Draft report clearance meeting:	5 July, 16 July & 17 September 2019
Management response received:	28 November 2019
Final report issued:	29 November 2019
Auditors:	James Quance, Head of Internal Audit Stephen Chaney, Deputy Head of Internal Audit Rhian Gard, Principal Auditor
Executive sign off	Peter Carr, Director of Therapies & Health Science
Distribution	Scott Taylor, Head of Health & Safety
Committee	Audit Committee Health & Safety Committee

Strategic Fire Safety Committee
Quality and Patient Safety Committee

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

ACKNOWLEDGEMENT

NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

1. Introduction and Background

The follow-up review of Fire Safety was completed in line with the 2019/20 Internal Audit Plan.

The review sought to provide assurance that Aneurin Bevan University Health Board (the 'Health Board') are operating in line with key fire safety policies and procedures.

2. Scope and Objectives

The purpose of the follow-up review was to assess and report whether the Health Board has implemented the Internal Audit recommendations made within the Fire Safety audit report issued during 2017/18, which received a 'Limited Assurance'opinion.

The scope of this follow-up review does not aim to provide assurance against the full review scope and objective of the original audits. The 'follow-up review opinion' provides an assurance level against the implementation of the agreed action plans only. The recommendations made in the 2017/2018 audit and the current audit findings are set out in Appendix A.

Where significant improvement has taken place, we have recognised the recommendation as being implemented. There may be some areas where some progress has taken place, but the outcome is still yet to be fully implemented, if this is the case the recommendation has been recorded as partially implemented. Overall, there has been progress made with each recommendation.

3. Associated Risks

The overall risk to consider in the follow up review was failure to implement agreed audit recommendations and therefore continued:

- non-compliance with policies, procedures and legislation, resulting in harm to staff and users of the service and possible legal action;
- financial and reputational implications associated with the failure to effectively manage fire safety risks; and
- non-compliance with the principles of NHS Wales Firecode.

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		**Follow up -** Progress on the majority of recommendations but insufficient progress on high priority recommendations to reduce risk to an acceptable level.

This follow-up audit has identified progress towards addressing the original audit findings, as illustrated within the Assurance Summary below. The Health and Safety team of 22 staff is close to full capacity, with two posts vacant and through the Health and Safety Priority Improvement Plan (the 'Plan'), audit recommendations (alongside other issues identified) are monitored and progress updates provided to the Health and Safety Committee.

The progress made has resulted in three recommendations being closed as implemented, with all but one of the remaining recommendations being partially implemented. The limited assurance opinion for the follow-up audit is derived from insufficient progress in ensuring that fire manuals are in place for all sites where required and the increasing backlog of overdue manuals and local fire policies. Whilst there has been a slight decline in overdue risk assessments, the level remains around 20% as was the case at the original audit.

5. Assurance Summary

The following table summarises the extent to which the original recommendations have been implemented and provides classification of current risks:

5.3

Area	Classification 2017/18 audit	Direction of travel	Classification 2019/20 audit
Finding 1: Strategic Fire Safety Committee	Medium	Recommendation implemented.	Closed
Finding 2&3: Fire Strategy / Fire Manuals	High	Some progress made, but insufficient to reduce the risk priority.	High
Finding 4: Policy	Low	Recommendation implemented.	Closed
Finding 5: Local Fire Policy & Procedures	Medium	Some progress made, but insufficient to reduce risk to a lower priority.	Medium
Finding 6: Fire Safety Audit Dashboard	High	No progress made.	High
Finding 7&8: Completion of Actions	Medium	Some progress made, but insufficient to reduce risk to a lower priority.	Medium
Finding 9&10: Fire Extinguishers	Medium	Recommendation implemented.	Closed
Finding 11: Fire Doors	Medium	Some progress made, but insufficient to reduce risk to a lower priority.	Medium
Finding 12, 13 & 14: Training Compliance	Medium	Some progress made, but insufficient to reduce risk to a lower priority.	Medium

6. Summary of Audit Findings

1) Strategic Fire Safety Committee (Medium)

The 2017/18 review highlighted that the Strategic Fire Safety Committee met on a quarterly basis and provided strategic development of fire safety within the Health Board. The terms of reference for the Committee were dated 2010 and required updating.

Current Finding:

During this follow-up review, we confirmed that the terms of reference have been reviewed and agreed by the Strategic Fire Safety Committee.

Current Status: Implemented

2 & 3) Fire Strategy / Fire Manuals (High)

In the 2017/18 review, we identified sites that did not have a detailed fire manual in place. Fire manuals give clear instructions and guidelines and act as the organisation's repository for all relevant fire safety information relating to a particular site. It sets out fire precautionary measures, details of fire management within the Health Board and the related staff responsibilities. The use of fire manuals is recommended for all existing buildings.

Current finding:

With the exception of one, there are now fire manuals together with an Operational Fire Safety Management / Area Evacuation Strategy (included at the back of the fire manual) for all hospital sites.

On each of the manuals - there is a compiled date and a review date. Alongside this, there is a live dashboard in place, which monitors the current status. In addition, there is a rolling programme of risk assessments and a plan for updating the fire manuals.

However, according to the April 2019 dashboard there still remains a backlog of fire manuals to be reviewed, with the majority at health centres and clinics in addition to one hospital. The summary is provided below:

Total overdue: 39

Percentage overdue: 71%

Location of over due Manuals	Figures
Overdue fire manuals - hospitals	1
Overdue fire manuals - Health Centres / clinics	36

Over due fire manuals - GP surgeries	1
Overdue fire manuals - LD Homes	1
Overdue fire manuals - offices	0

We retested the sites where fire manuals were not in place during the last audit and found that two of the sites still had no up-to-date fire manual in place (Grange House and Ringland Health Centre).

Current Status: Partially Implemented

Current Priority: High

4) Fire Safety Policy (Low)

The Fire Safety Policy in place for the Health Board was marginally out of date during the 2017/18 audit. Management had developed an updated policy for the Health and Safety Committee, which was subject to consultation at the time of the review.

Current Finding:

The Fire Safety Policy was updated and agreed at the January 2018 Health and Safety Committee. The Policy was also approved by the Workforce Operational Development Group and is now hosted on the Health Board's intranet.

Current Status: Implemented

5) Local Fire Policies and Procedures (Medium)

In the 2017/18 audit, we tested a sample of sites to see if there was a local building-specific fire policy in place that provided fire precautionary information. Three sites did not have a review date on their local policy and two of those sites required a review of the documents.

Current Finding:

During the follow-up review, we retested the three sites that did not have local fire policies and procedures during the 2017/18 audit. We identified a similar position, with two of the three sites possessing out of date procedures. This audit identified that the Assessment and Treatment Unit has updated the local fire policy and procedure, although we have not been able to verify this.

Furthermore, 89% of policies and procedures in relation to fire safety throughout the Health Board were also out of date or outstanding.

A dashboard has been produced, which monitors the local policies and procedures that require review and updating regarding fire safety. As at April 2019, the dashboard presented the following local policies and procedures as being out of date for review.

We were informed by the Health Board that there may be an opportunity to eliminate duplication of fire procedures at a local level, thus reducing the number of documents that require updating. However, this is still being explored.

Total overdue: 326

Percentage overdue: 89%

Location of overdue policies / procedures	Figures
Overdue fire policies - Hospitals	281
Overdue fire policies - Health Centres / clinics	29
Over due fire policies - GP Surgeries	3
Overdue fire policies - Learning & Dev Homes	6
Overdue fire policies - offices	7

Current Status: Medium

Current Priority: Partially Implemented

6) Fire Safety Dashboard (High)

The 2017/18 audit review of the fire safety dashboard regularly reported that there were overdue policy reviews, fire manuals and site risk assessments. However, in spite of reporting compliance performance to the Health and Safety Committee, the poor compliance rates continued.

Current Finding:

The follow-up review noted some progress had been made in completing patient care site risk assessments by December 2018. However, the compliance rates are still poor, with April 2019's dashboard detailing the following as outstanding:

Overdue item	Figure
Fire Policies / Procedures	326 (89%)
Fire Manuals	39 (71%)
Fire Risk Assessments	103 (21%)

The percentages of Fire Policies/Procedures and Fire Manuals overdue have increased since the 2017/18 audit. The percentage of Fire Risk Assessments overdue has reduced slightly from 24% to 21%.

Current Status: High

Current Priority: Not Implemented

7 & 8) Completion of Actions (Medium)

The 2017/18 audit indicated that risks were recorded on the Datix risk register and monitored by the Strategic Fire Safety Committee and lower levels were not captured. Action plans had columns to sign off the completion of tasks, but it was unclear if these were actively used and how the actions were monitored (other than being captured at the next risk assessment).

Current Finding:

The follow-up review found that fire risk assessments and action plans are emailed to the action owners, to help ensure actions are addressed.

The report in place monitors 'high' and 'extreme high' rated risks and is discussed in fire team meetings and the Strategic Fire Safety Committee. However, a report for monitoring other risks has not yet been developed.

The action plans reviewed have been updated with a target date with a completion column. However, in the majority of cases, no specific dates are inserted into the plans. Instead, non-specific targets are included, for example, 'manage as usual' or 'to be completed immediately'. These descriptions are applied to all level of risks.

As such, it is not possible to identify how the formal close out of these actions are being monitored.

Current Status: Medium

Current Priority: Partially Implemented

9 & 10) Fire Extinguishers (Medium)

The 2017/18 review confirmed that equipment was located in the correct location, as required by the Fire Safety Policy. However, there were exceptions within the Assessment and Treatment Unit at Llanfrechfa Grange Hospital, with one less water fire extinguisher present than required. Also, one water fire extinguisher required servicing and a replacement pin.

Current Finding:

Within the follow-up review, we found all listed fire extinguishers present when tested. In addition, all extinguishers are secure, serviced and with the correct pins in place. The local fire policy has also been updated.

Current Status: Implemented

11) Fire Doors (Medium)

As part of the 2017/18 review, the audit identified some fire doors at the Ringland Health Centre wedged open. As fire doors, they are required to be kept closed when not in use.

We therefore recommended that appropriate management action should be taken to ensure identified fire doors are kept closed at all times. The management response agreed and stated that respective fire warden(s) will be notified and to focus on such issues as part of their daily checks.

Current Finding:

Whilst communication from the Health and Safety Team has been provided to the teams sampled during the previous audit, reminding them of the importance of closing fire doors, we still observed a similar set of results as previously, with fire doors at Ringland Health Centre continuing to be wedged open. We are therefore unable to conclude that the management action has been effective in reducing risk to an acceptable level.

Current Status: Partially Implemented

Current Priority: Medium

12, 13 &14)Training Compliance (Medium)

The previous audit identified a low compliance rate with health and safety related statutory and mandatory training. This was consistent with the finding raised within the previous Health and Safety audit (finding 4).

Current Finding:

The follow-up review identified an increase in health and safety related training, compared to November 2017 target. The completion figures identified during the audit are summarised below:

2017		**March 2019**	
Health & Safety	74%	Health & Safety	78%
Fire Safety	67%	Fire Safety	77%
Manual Handling	49%	Manual Handling	60%
Violence & Aggression	70%	Violence & Aggression	84%

Fire Safety in particular shows a significant increase from 67% to 77%. Whilst this remains below the target of 85%, the trajectory of improvement is positive and should be continued. There is a health and safety and fire safety education programme in place and this is promoted on the Health Board's intranet.

This progess should be continued, together with development of the training needs analysis in order to ensure that both overall compliance continues to increase and that areas of greater risk receive appropriate training and support.

Current Status: Partially Implemented

Current Priority: Medium

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.

Actions Implemented in Full	Actions Implemented in Part	Actions Not Implemented
3	5	1

2017/18 Recommendations: Fire Strategy / Fire Manuals	
Original Recommendation (Priority Rating: High) Fire Manuals will be prepared for all sites. (D) Review dates for Fire Manuals will be appropriately monitored and updated on a timely basis. (O) **Management Response:** Agreed. An informal process has been in place to review manuals at the time of undertaking a risk assessment. A formalised Programme is being prepared to better capture this exercise. The outdated manuals are unlikely to require significant amendment, but will be reviewed nonetheless. **Responsible Officer:** Head of Health & Safety July 2018	
Current Findings 1	**Current Status of Implementation**
With the exception of one hospital, there are now fire manuals together with an Operational Fire Safety Management / Area Evacuation Strategy (included at the back of the fire manual) for all hospital sites.	Partially Implemented

On each of the manuals there is a compiled date and a review date. Alongside this, there is a live dashboard in place which monitors the current status. In addition, there is a rolling programme of risk assessments and a plan for updating the fire manuals.

According to the April 2019 dashboard there still remains a backlog of fire manuals to be reviewed, with the majority at health centres and clinics. The summary is provided below:

Total overdue: 39

Percentage overdue: 71%

Location of over due Manuals	**Figures**
Overdue fire manuals - hospitals	1
Overdue fire manuals - Health Centres / clinics	36
Over due fire manuals - GP surgeries	1
Overdue fire manuals - LD Homes	1
Overdue fire manuals - offices	0

One of the objectives of the Health and Safety Priority Improvement Plan (the 'Plan') is for all community premises to have an up to date fire safety manual by December 2019.

We retested the sites where fire manuals were not in place and identified a similar position to the previous audit, with fire manuals not in place in two locations (Grange House LGH and Ringland Health Centre).	
Current Recommendation 1	**Priority Level**
As in the previous audit, fire manuals urgently need to be prepared for all sites and review dates for the manuals appropriately monitored and updated on a timely basis. All fire manuals should be stored in a visible location.	**High**
Updated Agreed Management Action 1	**Responsible Officer/ Deadline**
A full review of the requirements for a fire safety manual in health centres, clinics, learning disabilities residential homes and GP managed practices has be undertaken and it has been agreed that these premises no longer require a fire safety manual. The requirement of a fire manual will be replaced with a building fire strategy and evacuation procedure document. The compliance of fire safety manuals will be recorded via the Fire Safety Dashboard and monitored at the Fire Safety Team Meeting and ABUHB Fire Safety Committee.	Head of Health and Safety January 2020 (Development of building fire strategy and evacuation procedure for all health centres and clinics) Head of Health and Safety December 2019 (Review of compliance of fire safety manuals)

2017/18 Recommendation: Local Fire Policy & Procedures	
Original Recommendation (Priority Rating: Medium) Local Fire Policies should be reviewed periodically and the date of review appropriately recorded at the policy. (O) **Management Response:** Agreed. As per recommendations 2 & 3, a formalised Programme is being prepared to better capture this review of local procedures as part of the periodic risk assessments. The identified documentation does not require significant updating, but will be reviewed nonetheless. **Responsible Officer:** Head of Health & Safety July 2018	
Current Findings 2	**Current Status of Implementation**
As part of the follow-up review, we retested the three sites that did not have local fire policies and procedures during the 2017/18 audit. We identified a similar position to the previous audit, with two of the three sites possessing out of date procedures. This audit identified that the Assessment and Treatment Unit has updated the local fire policy and procedure, although we have not been able to verify this.	Partially Implemented

Furthermore, 89% of policies and procedures in relation to fire safety throughout the Health Board were also out of date.

A dashboard has been produced, which monitors the local policies and procedures that require review and updating regarding fire safety. As at April 2019, the dashboard presented the following local policies and procedures as being out of date for review.

We were informed by the Health Board that there may be an opportunity to eliminate duplication of fire procedures at a local level, to reduce the number of documents that require updating. However, this is still being explored.

The table of our findings from the site visits is detailed below:

Location	**Last review date - info from 2017/18 audit**	**Planned review date - info from 2017/18 audit**	**Update Progress - 2019/20 Audit**
Grange House	Version observed on display dated March 2002	Not stated	The only policy visible within the reception was the same one mentioned in the 2017/18 audit – which is on the door to the Grange House.
Assessment & Treatment Unit	Document undated, but created in December 2015	Not stated	Within the red folder - issue date July 2012 and review date July 2015. On the front cover it said July 2016.

Ringland Health Centre	Document undated but created in August 2014. An earlier version of the policy dated 2011 was also in room 21	Not stated	The Practice Manager had no knowledge of local fire Policies and Procedures.

Since July 2018 the review and development of local fire safety policies and procedures has been incorporated into the three year rolling programme of risk assessments. The dashboard in place monitors compliance with local policies and procedures. As at April 2019, the following position was identified:

Total overdue: 326

Percentage overdue: 89%

Location of overdue policies / procedures	**Figures**
Overdue fire policies - Hospitals	281
Overdue fire policies - Health Centres / clinics	29
Over due fire policies - GP Surgeries	3
Overdue fire policies - Learning & Dev Homes	6
Overdue fire policies - offices	7

Current Recommendation 2	**Priority Level**
The local fire policies should be reviewed and updated as a matter of priority and assurance provided to the Health and Safety Committee.	**Medium**
Updated Agreed Management Action 2	**Responsible Officer/ Deadline**
It was agreed by the ABUHB Fire Safety Committee that a local fire policy and procedure would no longer be required where arrangements to manage fire safety already exist i.e. fire manual, evacuation strategy and local fire action notice. This decision was agreed at risk. The building fire strategy for health centres and clinics will eliminate the requirement for a fire policy and procedure in these type of premises.	Head of Health and Safety December 2019

2017/18 Recommendation: Fire Safety Audit Dashboard

Original Recommendation (Priority Rating: High)

The review/updating of local fire policies/procedures, fire manuals and risk assessments will be appropriately monitored and managed. (O)

Management Response:

Agreed.

A contributory factor to the recent backlog has been the long term sickness absence of one of the two fire officers – leading to increased backlog of risk assessment and documentation reviews. Additional resource has been identified for a fixed period to cover the sickness absence and is due to commence imminently; with specific focus on completing risk assessments.

This has led to the commencement of a wider review of the resource requirement and skill mix to better understand the demands of the service to improve service delivery and improve resilience.

Responsible Officer:
Head of Health & Safety
July 2018

Current Findings 3	Current Status of Implementation
The dashboard serves as a process for reporting overall performance and compliance to the Health and Safety Committee and the Strategic Fire Committee. It includes performance details of outstanding risk assessment, fire manuals and policies. However, the previous audit identified that this was not improving the overall compliance position, as poor performance continued. The follow-up review noted some progress had been made in completing patient care site risk assessments by December 2018. However, the compliance rates are still poor, with April 2019's dashboard detailing the following as outstanding, thus the dashboard is not achieving its objective: **Overdue item** / **Figure** Fire Policies / Procedures: 326 (89%) Fire Manuals: 39 (71%) Fire Risk Assessments: 103 (21%)	Not Implemented
Current Recommendation 3	**Priority Level**
The dashboard information should serve as a tool for assessing the current performance levels and the success of initiatives implemented to improve compliance.	**High**

The dashboard information should form a key component of the Health and Safety Committee's monitoring tools, with action taken against poor compliance. The dashboard should be reviewed to ensure the information reported still remains fit for purpose.	
Updated Agreed Management Action 3	**Responsible Officer/ Deadline**
The compliance recorded on the fire safety dashboard will be regularly monitored via the Fire Safety Team Meeting and ABUHB Fire Safety Committee. Sufficent information is available within the fire safety dashboard to manage any gaps for improvement. Following the successful recruitment of a new fire safety team in April 2019 significant progress has been made in reducing the backlog of fire risk assessments. Plans are in place to address the overdue fire manuals and local fire policies/procedures (see previous actions 1 and 2)	Head of Health and Safety January 2020 (Review of compliance against the fire safety performance indicators recorded on the dashboard)

2017/18 Recommendation: Completion of Actions	
Original Recommendation (Priority Rating: Medium) Action plans should be amended to include target dates for achievement. (D) Responsibility should be assigned to an appropriate forum to oversee effective monitoring and implementation. (D) **Management Response:** Agreed. It is intended that all risks will be recorded on DATIX to improve visibility of actions arising from risk assessments. This may initially result in an increased number of records, but this should reduce over time as the risks are mitigated. **Responsible Officer:** Head of Health & Safety July 2018	
Current Findings 4	**Current Status of Implementation**
The follow-up review found that fire risk assessments and action plans are emailed to the action owners, to help ensure actions are addressed.	Partially Implemented

The report in place monitors 'high' and 'extreme high' rated risks and is discussed in fire team meetings and the Strategic Fire Committee. However, a report for monitoring other risks has not yet been developed. The action plans reviewed (RGH Catering, Croesyceiliog Health Centre, NHH Pathology and Ty Siriol County Hospital) demonstrated that they have been updated with a target date for completion column. However, in the majority of cases, no specific dates are inserted into the plans. Instead, non-specific targets are included, for example, 'manage as usual' or 'to be completed immediately'. These descriptions are applied to all level of risks. As such, it is not possible to identify how the formal close out of these actions is being monitored. However, we were informed that discussions and monitoring is being completed as part of the Strategic Fire Safety Committee and the Fire Team meetings.	
Current Recommendation 4	**Priority Level**
The Health and Safety team should should review all outstanding actions and ensure that all action plans are dated, with a responsible individual named. The Health and Safety Committee should seek assurance at each meeting that actions from the action plans completed.	**Medium**

Updated Agreed Management Action 4	Responsible Officer/ Deadline
All fire safety risks are transferred from the fire risk assessment to the fire risk register (currently held on Datix). This includes a named lead for each risk and associated review dates. A plan to review all the high and extreme high fire safety risks has been developed and allocated to the relevant Fire Safety Advisor. Following implementation of the above a further plan will be developed based on the review date of the risk; this will provide an incremental approach to reviewing the risks as part of a longer term, risk based programme. The review status of fire safety risks will be included in the fire risk dashboard presented to the ABUHB Fire Safety Committee.	Head of Health and Safety December 2019 (Review of all high and extreme high fire safety risks) Head of Health and Safety January 2020 (Plan to review risks to be developed based on set criteria i.e. risk rating and time) Head of Health and Safety December 2019 (Review status of risks to be presented to ABUHB Fire Safety Committee)

2017/18 Recommendation: Fire Doors	
Original Recommendation (Priority Rating: Medium) Appropriate management action should be taken to ensure identified fire doors are kept closed at all times. (O) **Management Response:** Agreed. The respective fire warden(s) will be notified and to focus on such issues as part of their daily checks. **Responsible Officer:** Head of Health & Safety July 2018	
Current Findings 5	**Current Status of Implementation**
Following the previous audit, Ringland Health Centre were notified of the requirement to keep fire doors closed when not in use. During this audit, we found the same results, with the following noted: • the door (no 6 on the door) leading to consulting rooms on the right hand side of the reception area was wedged open; • the door to the kitchen was wedged open;	Partially Implemented

• the door (no 14 on the door) to the staff area with seats was wedged open; and • the door leading to consulting rooms 4,5 and 6 was wedged open with a wooden door stop. In each case, the door had a printed poster to say it was a fire door and that it should be closed. Furthermore, a fire warden is present at the Health Centre to oversee such matters.	
Current Recommendation 5	**Priority Level**
As in the last audit, appropriate management action should be taken to ensure identified fire doors are kept closed at all times. Fire wardens should be reminded to focus on these issues as part of their daily checks.	**Medium**
Updated Agreed Management Action 5	**Responsible Officer/ Deadline**
A Fire Safety Advisor attended Ringland Health Centre and discussed with the relevant persons the risks associated with the management of fire doors. It was identified that the doors being wedged open were not actually fire doors and the notices were removed. In addition to the original action to notify fire wardens we will produce a health and safety information sheet for circulation within the Health Board in relation to the management of fire doors.	Head of Health and Safety August 2019 (Fire Safety Advisor attended Ringland Health Centre to review management of fire doors) Head of Health and Safety December 2019

These actions will reinforce correct fire door procedures and allow the Fire Safety team to monitor and manage compliance but it will never guarantee 100% compliance.	(Develop and circulate H&S information sheet in relation to the management of fire doors)

2017/18 Recommendation: Training Compliance	
Original Recommendation (Priority Rating: Medium) An appropriate strategy should be developed to ensure that target compliance is achieved (e.g. increased provision of basic and additional fire training). (D) **Management Response:** Agreed. Work has already commenced to better capture and understand the data, e.g. by division/ directorate, area, grades etc. The intention is to better understand the risk to the organisation. Furthermore, the existing data does not differentiate between those who have never had training (high risk) against those that have recently expired (lower risk). Focus is also being given to improve the take-up and timely completion of refresher training. **Responsible Officer:** Head of Health & Safety July 2018	
Current Findings 6	**Current Status of Implementation**
There is now an educational framework in place and supplementary training for staff is available. In addition, there are mechanisms in place to target high risk areas across the Health Board and compliance has increased overall.	Partially Implemented

In addition, whilst training compliance is still not meeting the 85% target for each of the four statutory and mandatory modules, there has been improvement in compliance rates across each of them, as detailed below:

2017		**March 2019**	
Health & Safety	74%	Health & Safety	78%
Fire Safety	67%	Fire Safety	77%
Manual Handling	49%	Manual Handling	60%
Violence & Agression	70%	Violence & Agression	84%

Current Recommendation 6	**Priority Level**
The Health Board should develop a clear training needs analysis in order to help meet the 85% compliance rate on all areas of training. This should pinpoint high risk areas and address the issues / reasons which are contributing to the low compliance in certain areas. Targeted intervention should be undertaken in service areas where the training compliance is at its lowest. Time should be provided for staff to undertake the necessary training. The Health and Safety Committee should monitor the compliance rate of training in detail and seek further assurance if rates of compliance are not improving. Concerns should be escalated to the Quality and Patient Safety Committee as part of the established governance process.	**Medium**

Updated Agreed Management Action 6	Responsible Officer/ Deadline
Develop risk based training needs analysis for fire safety. Produce regular (proposal of monthly) performance reports in relation to fire safety training compliance and specifically identify high risk areas with low compliance. Provide the necessary support to identify the barriers to maintaining a acceptable level of compliance. Continue to monitor compliance with fire safety training requirements via the ABUHB Fire Safety Committee and implement improvement plans for Divisions/Directorates of poor compliance.	Head of Health and Safety March 2020 (Development of a fire safety training needs analysis document) Head of Health and Safety January 2020 (Produce monthly fire safety training performance reports) Head of Health and Safety December 2019 (Monitor fire safety training compliance at the ABUHB Fire Safety Committee)

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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Health and Safety Management Follow-up

Final Internal Audit Report

2019/20

Aneurin Bevan University Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Service

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5.4

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Executive sign off	Peter Carr, Director of Therapies & Health Science
Distribution	Scott Taylor, Head of Health & Safety
Committee	Audit Committee Health & Safety Committee

Quality and Patient Safety Committee

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

ACKNOWLEDGEMENT

NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review

1. Introduction and Background

The follow-up review of Health and Safety was completed in line with the 2019/20 Internal Audit Plan.

The review sought to provide assurance that Aneurin Bevan University Health Board (the 'Health Board') are operating in line with key health and safety policies and procedures.

2. Scope and Objectives

The purpose of the follow-up review was to assess and report whether the Health Board has implemented the Internal Audit recommendations made within the 2017/18 Health and Safety Management audit report issued in February 2018 which received a 'Limited Assurance'opinion.

The scope of this follow-up review does not aim to provide assurance against the full review scope and objective of the original audits. The 'follow-up review opinion' provides an assurance level against the implementation of the agreed action plans only. The recommendations made in the 2017/2018 audit and the current audit findings are set out in Appendix A.

Where significant improvement has taken place, we have recognised the recommendation as being implemented. There may be some areas where some progress has taken place, but the outcome is still yet to be fully implemented, if this is the case the recommendation has been recorded as partially implemented.

3. Associated Risks

The overall risk to consider in the follow-up review was failure to implement agreed audit recommendations and therefore continued:

- non-compliance with policies, procedures and legislation, resulting in harm to staff and users of the service and possible legal action; and
- financial and reputational implications associated with the failure to effectively manage health and safety risks.

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		**Follow up -** Progress on the majority of recommendations but insufficient progress on high priority recommendations to reduce risk to an acceptable level.

This follow-up audit has identified progress towards addressing the original audit findings, as illustrated within the Assurance Summary below. The Health and Safety team of 22 staff is close to full capacity, with two posts vacant and through the Health and Safety Priority Improvement Plan (the 'Plan'), audit recommendations (alongside other issues identified) are monitored and progress updates provided to the Health and Safety Committee.

The Plan describes progress completed since March 2018, which is also presented to the Health and Safety Committee, with further periodic updates throughout the last 12 months. Notable areas of progress since March 2019 include:

- the amendment of the delivery plan to reflect changes in risk;
- the establishment of a Task and Finish Group for further development of risk modules within Datix;
- a revision of the Occupational Health and Safety Policy; and
- identifying specific training needs analysis, in accordance with the Educational Framework.

However, a lack of sufficient progress with ensuring up to date health and safety inspections and risk assessments are in place has resulted in a limited

overall assurance opinion for this follow-up review. Further detail is provided in section 6 below.

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 2017/18 audit	Direction of travel	Classification 2019/20 audit
Finding 1: Regular Workplace Inspections	High	Some progress made, but insufficient to reduce risk to a lower priority.	High
Finding 2: Risk Assessments	High	Some progress made, but insufficient to reduce risk to a lower priority.	High
Finding 3: Policy	Medium	Recommendation fully implemented.	Closed
Finding 4: Educational Framework and Training Compliance	Medium	Some progress made, but insufficient to reduce risk to a lower priority.	Medium
Finding 5: Legislative Obligations	Medium	Recommendation fully implemented.	Closed

6. Summary of Audit Findings

1) Regular Workplace Inspections (High)

In the 2017/18 review, workplace inspections were not being completed. In addition, there was no documented approach in place for setting out the process for completing workplace inspections, including a programme of inspections covering all applicable areas within the Health Board.

We therefore recommended that a methodology/approach be developed for establishing and undertaking an annual programme of workplace inspections and that the programme is delivered in accordance with section 10.1 of the Occupational Health and Safety Policy.

Current Finding:

During this audit we identified that an inspection programme has been developed, but there remains a significant backlog of inspections yet to be completed. From 96 inspections that should have been completed by March 2019, only 31 have been completed and there is little evidence to suggest that the programme was prioritised according to risk.

Monitoring is completed through a submission of dashboards to the Health and Safety Committee, but in spite of the backlog presented, no challenge / resolution has been noted from the Committee. Overall, the progress has been insufficient to reduce the risk priority which calls into question the effectiveness of monitoring arrangements.

However, we were informed that during the last few months, the Health and Safety Committee has approved the restructure of the plan for completing outstanding workplace inspections. This is following the recent restructure of the Health and Safety Team.

We reviewed the quality of a sample of 13 completed workplace inspections, including: seven in Mental Health & LD, five in Scheduled Care and one in Unscheduled Care.

We found that the completeness and quality of the sample was satisfactory, with some minor exceptions noted:

- for two of the 13 sampled, it was not possible to confirm if they were reported onto Datix; and
- one of the 13 sampled still had an action to complete from April 2018, regarding training.

Current Status: Partially Implemented
Current Priority: High

2) Risk Assessments (High)

The 2017/18 review selected a sample of 16 service areas to test for the completion of risk assessments. We identified that 13 were either significantly out of date (greater than two years) or not present.

Furthermore, we were unable to obtain assurance that the process for monitoring the completion and quality of risk assessments was reviewed and reported into the Health and Safety Committee.

Finally, the list of health and safety co-ordinators within the Health Board was out of date.

We therefore recommended that each area complete an up-to-date health and safety risk assessment, by a trained coordinator and that the risk assessment process be overseen by the Health and Safety Team to ensure that it is completed in accordance with the Occupational Health and Safety Polciy.

Current Finding:

Our expectation was to be able to review a status report of risk assessments in order to establish whether our recommendation has been implemented. This is consistent with the original management response which stated that the status of risk assessments will be reviewed and compliance reported via a dashboard to the ABUHB Health and Safety Committee and relevant Divisional Forums.

However, we were informed that the Health and Safety Team do not collect data on the specific number of risk assessments that have been completed and are in date. We were therefore unable to establish whether all areas of the Health Board do have a completed up-to-date health and safety risk assessment.

As part of the follow-up audit we visited 20 wards/areas in order to establish whether an up to date risk assessment is in place. 15 did not and of the areas visited in the original 2017/18 audit, two areas were still without an up to date risk assessment.

We also reviewed a sample of seven completed risk assessments to test for completeness and quality. We identified that three were completed to a high standard, but four of them lacked information regarding follow-up assessments completed and evidence of logging the actions onto Datix.

Current Status: Not Implemented
Current Priority: High

3) Policy (Medium)

In the 2017/18 review, the Occupational Health and Safety Policy required local teams to develop their own local health and safety policy. However, we found that 13 of the 16 teams sampled were either not aware of the requirement to produce a local policy or the policies were out of date / in progress.

We therefore recommended that local policies are put in place for all areas in order to ensure that the Health Board's Occupational Health and Safety Policy is adhered to.

Current Finding:

The Occupational Health and Safety Policy has been reviewed, updated and approved by the Health and Safety Committee. The updated Policy has removed the requirement to develop local policies.

Current Status: Implemented

4) Educational Framework and Training Compliance (Medium)

The 2017/18 review highlighted that there was no formal educational framework in place, which linked health and safety risks through to the needs and development of staff within the Health Board. In particular, we examined four statutory and mandatory training modules (Health and Safety, Fire Safety, Manual Handling and Violence and Agression). Whilst initiatives were being rolled out at the time of the last audit to improve the compliance rate, it was still less than the KPI of 85% completion, for each of the four modules.

We therefore recommended that mechanisms are developed to target higher risk areas and ensure supporting training is undertaken, either statutory and mandatory or supplementary training. In addition, we highlighted that it is important that the Health Board should address the downward trend of compliance with statutory and mandatory training.

We further recommended that the Health Board should consider implementing an education framework and that the Health and Safety Team work with each of the divisions to capture all key requirements. The management response was to develop a health and safety education framework, supported by training needs analysis, which is risk based.

Current Finding:

There is now an educational framework in place and supplementary training for staff is available. In addition, there are mechanisms in place to target high risk areas across the Health Board and compliance has increased overall.

In addition, whilst training compliance is still not meeting the 85% target for each of the four statutory and mandatory modules, there has been improvement in compliance rates across each of them, as detailed below:

2017		**March 2019**	
Health & Safety	74%	Health & Safety	78%
Fire Safety	67%	Fire Safety	77%

Manual Handling	49%	Manual Handling	60%
Violence & Agression	70%	Violence & Agression	84%

This progess should be continued, together with development of the training needs analysis in order to ensure that both overall compliance continues to increase and that areas of greater risk receive appropriate training and support.

Current Status: Partially Implemented
Current Priority: Medium

5) Legislative Obligations (Medium)

The 2017/18 review was unable to identify a legislation register within the Health Board, detailing all legal responsibilities. Therefore, there were no arrangements in place to ensure ongoing compliance with all relevant legislation.

Current Finding:

The follow-up review confirmed that a draft Health and Safety Legislative Assurance Framework has been completed and presented to the Health and Safety Committee for approval. The Framework details the legislative obligations, in addition to the actions arising and repsonsibile officers. This is hosted on the Health Board's intranet.

Current Status: Implemented

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.

Actions Implemented in Full	Actions Implemented in Part	Actions Not Implemented
2	**2**	**1**

2017/18 Recommendation: Regular Workplace Inspections (Design)

Original Recommendation (Priority Rating: High)

The Health Board should develop a methodology / approach for establishing and undertaking an annual programme of workplace inspections. In particular, it should set out:

- how service areas / wards are selected for an inspection, including risk analysis, previous findings, incidents and Datix reporting;
- the approach to the inspection, including which health and safety areas are included. For example, there may be numerous priorities from one year to the next;
- methodology for undertaking the inspection, i.e. the process for completing one from start to finish;
- how assurance is provided to the sub-committees of the Board over how the programme of work is devised and that it is completed on schedule or otherwise; and
- findings from the workplace inspections are identified and acted upon.

In addition, the Health Board should ensure that a programme of workplace inspections is developed and delivered in accordance with section 10.1 of the Occupational Health and Safety Policy. For example, the Health and Safety Committee may stipulate that all high risk areas are reviewed each year. Furthermore, if the programme is delivered late, then the Committee should receive assurances, together with an action plan for delivery to be returned to schedule.

Management Response:

An ABUHB health and safety monitoring manual will be developed. This will include a two year plan which outlines the audit/inspection delivery programme.

The manual, including programme will be presented at the ABUHB Health and Safety Committee in March 2018 for approval. The anticipated start date of the monitoring is 1st April 2018.

Future monitoring of the health and safety audit/inspection compliance will be presented via Divisional dashboards with an overview being presented at the ABUHB Health and Safety Committee.

Responsible Officer:
Head of Health and Safety / March 2018

Head of Health and Safety / April 2018

Current Findings 1	Current Status of Implementation
The Health and Safety Team has developed a two year audit / inspection programme, approved by the Health and Safety Committee. However, insufficient progress has been made against the programme, with only 31 out of 96 inspections completed by the end of March 2019. In particular, the following progress was identified: • 18 out of 54 Mental Health & LD inspections have been completed, where planned delivery was by November 2018; • two out of 42 Unscheduled Care inspections have been completed, where planned delivery was by March 2019; and • 11 out of 75 Scheduled Care inspections have been completed, where planned delivery was by July 2019.	Partially Implemented

We also tested the completeness of a sample of 13 inspections and found them to be complete with the following minor exceptions: • for two of the 13 sampled, it was not possible to confirm if they were reported onto Datix; and • one of the 13 sampled still had an action to complete from April 2018 regarding training. Monitoring is completed through a submission of dashboards to the Health and Safety Committee, but in spite of the backlog presented, no challenge / resolution has been noted from the Committee. Overall, the progress has been insufficient to reduce the risk priority.	
Current Recommendation 1	**Priority Level**
The inspections should be urgently completed. Priority should be given to the inspections that are longest past their delivery date and/or are in highest risk areas. The Health and Safety Committee should seek assurance each meeting over the ongoing completion of the programme of inspections. Where this is not the case, additional monitoring and support should be offered by the Committee to aid the timely recovery of the inspection deliverables. Oversight should be provided by the Quality and Patient Safety Committee in accordance with the governance process in place.	**High**

Updated Agreed Management Action 1	Responsible Officer/ Deadline
The ABUHB health and safety audit and inspection process has been reviewed in April 2019 and updated to achieve a sustainable level of monitoring. The revised programme of audits and inspections is delivered on a risk based approach. Criteria was set to identify those areas for audit and inspection during 2019/20. The criteria was based on current health and safety performance and included compliance with statutory and mandatory health and safety training and incident statistics. The programme commenced on 1 June 2019 and monitoring of the programme is undertaken via the Corporate Health and Safety Department, Divisional forums i.e. QPS Meetings and the Health Board Health and Safety Commiittee. The Corporate Health and Safety Department has successfully recruited Health, Safety and Fire Co-ordinators and allocated these as Business Partners to each of the Divisions to support the monitoring programme.	Head of Health and Safety December 2019 (Implementation of a sustainable process) March 2020 (Completion of the 2019/20 programme)

2017/18 Recommendation: Risk Assessments (Operation)

Original Recommendation (Priority Rating: High)

The Health Board should ensure that each area has completed an up-to-date health and safety risk assessment, by a trained co-ordinator. The risk assessment process should be overseen by the Health and Safety team, to ensure that it is completed in accordance with the Occupational Health and Safety Policy.

In addition, the Health Board should review and refresh the list of safety co-ordinators and continue to do so following the initial update.

The Health and Safety team should provide assurance and regular updates to the Health and Safety Committee over the status of risk assessments.

Management Response:

The monitoring of local risk management systems, including risk assessments will be included in the audit/inspection programme.

The status of risk assessments will be reviewed and compliance reported via a dashboard to the ABUHB Health and Safety Committee and relevant Divisional forums.

Further consideration is required to the utilisation of software to record and manage risk within the Health Board.

Responsible Officer:
Head of Health and Safety / April 2018

Current Findings 2	Current Status of Implementation
The review of the risk assessment process and risk management is a key objective of the Health and Safety audit / inspection programme. Non compliant risk assessments are recorded and monitored through the Datix platform. Currently, there is no collection of data on the specific number of risk assessments that have been completed and are in date. As part of the follow-up audit we visited 20 wards/areas in order to establish whether an up to date risk assessment is in place. 15 did not and of the areas visited in the original 2017/18 audit, two areas were still without an up to date risk assessment. As part of the follow-up audit we reviewed a sample of seven completed risk assessments to test for completeness and quality. We identified three that were completed to a high standard, but four of them lacked information: • four were not on Datix and as such, it is unclear how the risks will be followed up; • two were completed, but no responsible manager within the Health and Safety Team was identified; and • two used the old Gwent Healthcare Trust 1B forms and no review date or period was given. Following on from the last audit, risk assessment guidance sheets have been produced to assist staff with risk training.	Not Implemented

Current Recommendation 2	Priority Level
The Health Board should urgently ensure risk assessments are completed for each area, in accordance with the work programme in place. The Health Board should develop a system for monitoring the management and completion of risk assessments. The Health and Safety Committee should seek assurance at each meeting that risk assessments are being completed to a good standard and monitored regularly. Where this does not happen, additional monitoring by the Committee should take place. Oversight should be provided by the Quality and Patient Safety Committee in accordance with the governance process in place.	**High**
Updated Agreed Management Action 2	**Responsible Officer/ Deadline**
The status, including quality of risk assessments will be reviewed and monitored as part of the health and safety audit programme. The compliance will be reported to the ABUHB Health and Safety Committee and relevant Divisional forums i.e. QPS Meetings. A programme of transferring risks to digital format was agreed at the Risk Task and Finish Group (March 2019). Currently Divisional risks are being transferred to the Datix software. Three of the five Divisions have made the successful transfer and are now managing risks at a Divisional level via the Datix platform.	Head of Health and Safety March 2020 (Completion of the 2019/20 programme) Head of Health and Safety January 2020

A plan of digitalising local risks i.e. ward and department will be implemented in conjunction with the health and safety monitoring programme. Those areas identified for audit by the Corporate Health and Safety Department will engage in the process of transferring risks to Datix. The register of risk assessors within each area will be transferred from the current format (Excel) into a database (Access). The competence of each risk assessor will be reviewed proactively via the health and safety monitoring programme and re-actively via any ad-hoc visits i.e. incident investigations, risk assessments etc. Where necessary those assessors not fulfilling the role will be identified for re-fresher training.	(Upload of all Divisional risk registers to Datix) Head of Health and Safety March 2020 (Upload of all local risk assessments for those areas subject to a health and safety management audit in 2019/20) Head of Health and Safety March 2020 (Review the competence of risk assessors for those areas subject to a health and safety management audit in 2019/20)

2017/18 Recommendation: Educational Framework & Training Compliance (Design)

Original Recommendation (Priority Rating: Medium)

The Health Board should develop mechanisms to target higher risk areas and ensure supporting training is undertaken, either statutory and mandatory or supplementary training. This process should be linked to the risk assessment process, incorporate the use of business intelligence and be led by the Health and Safety team. For example, if sickness levels are higher than average, due to conditions caused by a lack of manual handling training, then the focus should be prioritised on this training module. Overall, it is important that the Health Board addresses the downward trend of compliance with statutory and mandatory training.

The Health Board should consider implementing an education framework to assist staff in the improvement of key skills and personal development. To achieve this, it is important that the Health and Safety team work with each of the divisions to capture all key requirements.

To support the above recommendations, the Health and Safety Committee should receive assurance that staff are being developed with the appropriate health and safety skills. In turn, the Committee should provide assurance to the Board members that sufficient education and training is being completed by all staff.

Management Response:

Develop a health and safety education framework, supported by training needs analysis, which is risk based.

Continue to monitor compliance with statutory and mandatory health and safety training requirements via the ABUHB Health and Safety Committee and implement improvement plans for Divisions/Directorates of poor compliance.

Responsible Officer:

Head of Health and Safety / September 2018

Head of Health and Safety / March 2018

Current Findings 3	Current Status of Implementation
There is now an educational framework in place and supplementary training for staff is available. In addition, there are mechanisms in place to target high risk areas across the Health Board and compliance has increased overall. In addition, whilst training compliance is still not meeting the 85% target for each of the four statutory and mandatory modules, there has been improvement in compliance rates across each of them, as detailed below:	Partially Implemented

2017		**March 2019**	
Health & Safety	74%	Health & Safety	78%
Fire Safety	67%	Fire Safety	77%
Manual Handling	49%	Manual Handling	60%
Violence & Agression	70%	Violence & Agression	84%

Current Recommendation 3	Priority Level
The Health Board should develop a clear training needs analysis in order to help meet the 85% compliance rate on all areas of training. This should pinpoint high	**Medium**

risk areas and address the issues / reasons which are contributing to the low compliance in certain areas. Targeted intervention should be undertaken in service areas where the training compliance is at its lowest. Time should be provided for staff to undertake the necessary training. The Health and Safety Committee should monitor the compliance rate of training in detail and seek further assurance if rates of compliance are not improving. Concerns should be escalated to the Quality and Patient Safety Committee as part of the established governance process.	
Updated Agreed Management Action 3	**Responsible Officer/ Deadline**
Develop risk based training needs analysis for all health and safety subject matters i.e. health and safety, fire safety, manual handling and violence & aggression. Continue to produce monthly performance reports in relation to health and safety training compliance and specifically identify high risk areas with low compliance. Provide the necessary support to identify the barriers to maintaining an acceptable level of compliance. Continue to monitor compliance with statutory and mandatory health and safety training requirements via the ABUHB Health and Safety Committee and implement improvement plans (agree an annual increase rate of improvement) for Divisions/Directorates of poor compliance.	Head of Health and Safety March 2020 (Development of specific training needs analysis) Head of Health and Safety January 2020 Head of Health and Safety January 2020 (Agree an annual increase rate of improvement)

Develop a training strategy to improve compliance for medical staff	Head of Health and Safety / March 2020

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.

5.4

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.

In the event that, pursuant to a request which the client has received under the Freedom of Information Act 2000, it is required to disclose any information contained in this report, it will notify the Head of Internal Audit promptly and consult with the Head of Internal Audit and Board Secretary prior to disclosing such report.

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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GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Audit Committee Thursday 5th December 2019 Agenda Item: 6.1

Audit Committee

Update on Governance, Financial Control Procedures, Technical Accounting Issues & Single Tender Actions

6.1

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

As required by the SFIs, the Audit Committee is asked to approve the FCPs outlined in section 2 below. The updated FCPs will then be published on the Intranet and relevant stakeholders informed.

The Audit Committee is requested to note the remainder of the report.

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

Executive Sponsor: Glyn Jones, Director of Finance and Performance

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

Report Received consideration and supported by :

Executive Team		**Committee of the Board [Committee Name]**	

Date of the Report: 19th November 2019

Supplementary Papers Attached:

Appendix 1 – Executive Report & Financial Control Procedures

Appendix 2 – Single Tender Actions

Purpose of the Report
To approve the FCPs and note the report.

Background and Context
This report includes a number of standing items that are to be reviewed in accordance with the Audit Committee's annual work plan which in turn has been developed from the terms of reference of the Committee. The report also includes a section relating to the Public Sector Payment Policy which the Committee has historically asked to be routinely reported.

Assessment and Conclusion

1. Review of Standing Orders, SFIs and Scheme of Delegation.

Standing orders:

Health Boards and Trust were recently issued under a Welsh Health Circular new model Standing Orders for the Health Board's adoption. The models have been reviewed and information included, as required, specific to the Health Board. The updated standing orders were also shared with Audit Committee for any comments prior to coming to the Board. The Standing Orders including those of WHSSC and EASC as Joint Committees of the Board were approved by the Health Board at its meeting on the 27th November 2019.

Standing Financial Instructions:

The review of all Wales Model SFIs is currently being undertaken as part of Directors of Finance (DoFs) Governance Work Stream through the Finance Academy.

The DoF for NHS Wales Shared Services Partnership (NWSSP) is Chair for the main SFI drafting group. The group includes finance representation from Welsh Health Boards and Trusts, NWSSP procurement and Richard Bevan, Chair of the all Wales Board Secretaries Group.

Drafts will be reviewed by finance and procurement review groups and submitted by the drafting group to the Governance Improvement Steering Group where they will be approved for official 'sign off'.

Following the work stream approval the updated model SFIs will be sent to Welsh Government for further comment. Directors of Finance and Board Secretaries will agree the final draft before obtaining Ministerial approval.

Adoption for ABUHB was originally estimated to be between February and March. The project is currently behind schedule, so are unlikely to be adopted before the Summer 2020.

2. Financial Control Procedures (FCPs)

The following procedures have been reviewed by the Executive Team and are submitted for approval by the Audit Committee.

- Payroll Financial Control Procedure
- Engaging Off Payroll workers

Appendix 1 includes a copy of the report that was presented to the Executive Team along with a copy of the procedures.

The Capital procedure is still under review and has not yet been presented to the Executive Team.

There are a further three procedures that are at the review stage which are:

- Accounts Payable
- Patients Property
- General Ledger

It is anticipated that all four procedures identified above will be presented for approval at the April 2020 Audit Committee meeting.

3. Technical Accounting Issues

IFRS16 Leases - update on action to date

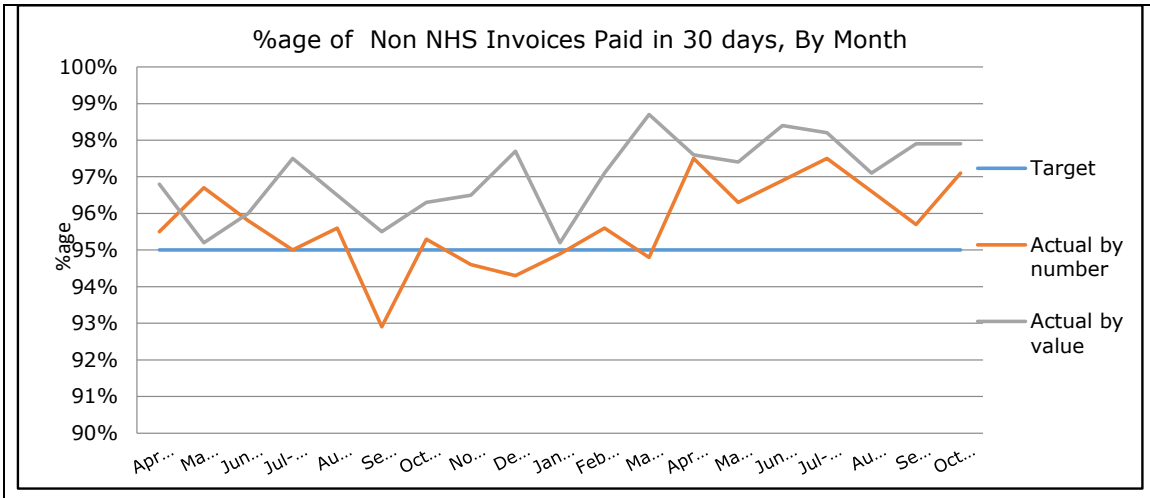
As reported at the last Audit Committee the Health Board submitted our estimated figures on 6th September in accordance with the requirements with the next submission to be made in early December.

Given the complexities of some of the all Wales contracts which are being reviewed by Ernst and Young on behalf of the Health bodies in Wales, the deadline for the next submission has been extended and is now likely to be February 2020.

We are continuing to work through the other issues that we raised as a Health Board when we submitted our initial return in September and will report back to the Audit Committee after the next submission.

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 October 2019. The target of 95% has been achieved on a year to date basis.



5. Single Quotation and Tender Actions – 25th September 2019 to 22nd November 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 consideration 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 9 requests submitted which have been approved during the period with an annual value of £699K.

Of these 9 approved requests, 7 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. There were 2 that were purchase of new / replacement equipment.

6. 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 63 payments in excess of £100,000 during the months of September and October 2019, totalling £109.055m. 48 of the payments were regular and specifically identified within the scheme of delegation. 15 payments were identified as requiring additional approvals prior to payment. Contracts were in place for all 21 payments made to private sector suppliers. Therefore there were no exceptional issues to report.

Recommendation
As required by the SFIs, the Audit Committee is asked to approve the FCPs outlined in section 2 above. The updated FCPs will then be published on the Intranet and relevant stakeholders informed. The Audit Committee is requested to note the remainder of the report.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	*SFI's. SO's, Financial controls and accounting systems and processes form the basis of many organisational controls without which the organisation would be exposed to significant financial and reputational risk.*
Financial Assessment	*No direct financial implications but the financial governance issues covered in this standard Audit Committee paper set a framework of key financial controls for the organisation.*
Quality, Safety and Patient Experience Assessment	*Not directly applicable to the report.*
Equality and Diversity Impact Assessment (including child impact assessment)	*No adverse impact*
Health and Care Standards	*This report will contribute to the Good Governance Standards in the Health and Care 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	
Glossary of New Terms	*FCP – Financial Control Procedure* *SFIs- Standing Financial Instructions* *SOs- Standing Orders*

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Executive Team 2019 Agenda Item: x.x

Executive Team

Payroll Policy and Financial Control Procedure
Policy for Engaging Off Payroll Workers

Executive Summary

This report presents the following:

- Payroll Policy and Financial Control Procedure
- Policy for Engaging Off Payroll Workers, updated for change in legislation and HMRC IR35 rules

The Executive Team is asked to approve the documents prior to Audit Committee on 5th December 2019

The Executive Team 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		**Committee of the Board**	None
Date of the Report: 12th November 2019			

Supplementary Papers Attached:
Appendix 1 – Payroll Policy and Financial Control Procedure
Appendix 2 – Policy for Engaging Off Payroll Workers

MAIN REPORT: No More than 5 pages.

Purpose of the Report

This report gives an overview of the financial policies and procedures to be submitted to Audit Committee on 5th December 2019.

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Background and Context

1. Background

Aneurin Bevan UHB has no current Payroll Policy and Financial Control Procedure. The document has been produced to support the Model Standing Financial Instructions as adopted by Aneurin Bevan UHB.

The Policy for Engaging Off Payroll Workers has been substantially re-written following a change in legislation and HMRC IR35 rules. The responsibility for establishing employment status for workers engaged through an intermediary now lies with public organisations. The Policy reflects the new rules and provides guidance on engaging all off payroll workers including those engaged through an intermediary.

2. Key Issues

2.1 Payroll Policy and Financial Control Procedure – This document has been written in collaboration with NHS Wales Shared Services Partnership – Payroll Services (NWSSP-PS) and Aneurin Bevan Workforce and Organisational Development department. The document has been widely circulated in the Finance Department and has been considered at the Workforce and Organisational Development Policy Group. The document has been sent to Internal Audit for comment.

2.2 Policy for Engaging Off-Payroll Workers – This document has been substantially re-written. Workforce and Organisational Development have been consulted and the policy and it has been considered at the Workforce and Organisational Development Policy Group. We have also received and included comments from our Taxation Advisers (Deloitte). The following summarises where the new policy differs from the 2014 version.

Introduction:

- Updated to reflect 2017 change in responsibility for employment status assessment (and applicability of IR35 rules)

Policy Statement:

- Updated to clarify the establishment of the HMRC rules relating to Off Payroll Workers under the Income Tax (Earnings & Pensions) Act 2003 (ITEPA)

Aims:

- Updated for clarification

Objectives:

- Updated for clarification

Scope:

- Updated to provide more information on definitions

Roles and responsibilities:

- New paragraph relating to public body responsibility for assessing employment status
- Recruiting manager: wording updated to reinforce the responsibility of the recruiting manager
- Medical staffing co-ordinators updated for clarification
- Finance: role updated to clarify responsibility for record keeping for HMRC inspection and the inclusion of BPA role
- WF&OD: slight word change, role of business partner included
- Procurement role: wording updated to reinforce responsibility
- Payroll: updated wording, including paying individuals via the payroll system and payroll's duty regarding statutory deductions and pay over to HMRC

Procedure and Process

- Re-written to reflect the current practice and 2017 legislation
- Provides more comprehensive guidance and procedure for assessment of employment status and treatment of the different outcomes of the assessment
- States consequences on non-compliance with HMRC rules

3. Next Stages and Action

Following consideration by the Executive Team , the approval for the documents will be as follows:

- Audit Committee on 5th December 2019.

Assessment and Conclusion

This report provides an overview of the Payroll Policy and Financial Control Procedure and the Policy for Engaging Off Payroll Workers.

Recommendation

The Executive team is asked to approve the documents.

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Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	*Sound governance of the Health Board ensures good financial management and reduces financial risk.*
Financial Assessment	*No impact.*
Quality, Safety and Patient Experience Assessment	*No impact.*
Equality and Diversity Impact Assessment (including child impact assessment)	*No impact.*
Health and Care Standards	*No impact*
Link to Integrated Medium Term Plan/Corporate Objectives	*No impact.*
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	*No impact*
Glossary of New Terms	*FCP - Financial Control Procedure.*

Aneurin Bevan University Health Board

Policy for Engaging Off Payroll Workers

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

Status: Draft
Approved by:
Owner: Finance Director

Issue date:
Review by date:
Policy Number:

Contents

1. Introduction

UK tax rules relating to taxation of off-payroll workers ("IR35") through certain types of intermediary (broadly companies and partnerships/LLPs in which the worker has a material interest) were changed in April 2017. The responsibility for assessing employment status of a worker providing services to a public body through such an intermediary now lies with the engaging organisation (Aneurin Bevan University Health Board). Prior to 6 April 2017, it was the responsibility of the intermediary in receipt of payment on behalf of the worker to determine employment status and whether IR35 rules applied. The IR35 rules ensure that workers who are paid through intermediaries and are deemed to hold employment status, pay broadly the same tax and NICs as if they were an employee under the Pay As You Earn (PAYE) system. The changes to the rules in April 2017 were introduced as a result of perceived widespread non-compliance amongst off-payroll workers providing services via intermediaries.

Engaging workers through an intermediary, changes the nature of the relationship from one of an employer/employee to a contractual relationship and presents a significant risk to the Health Board including:

- Potential breach of employment tax regulations, which can lead to financial penalties being imposed on ABUHB
- Reputational risk of being deemed to condone potential tax avoidance schemes
- Non-compliance with prevailing procurement legislation
- Lack of assurance that all necessary documents are in place for an individual employed through an intermediary e.g. professional registration and relevant background checks

2. Policy Statement

The Health Board is committed to ensuring that it is compliant with its duty in relation to payment of remuneration and deduction of taxation and national insurance as required by law. It is also committed to full compliance with prevailing procurement law and its internal procurement procedures when placing business with suppliers. The policy sets out the process for engaging workers under IR35 rules established in the Income Tax (Earnings & Pensions) Act 2003 (ITEPA).

3. Aims

To ensure:

- Compliance with HMRC legislation
- That employment status is established for all workers

4. Objectives

The purpose of this document is to outline the ABUHB responsibilities for engaging off-payroll workers.

This policy will provide guidance to the Health Board in identifying and correctly accounting for off-payroll workers to avoid non-compliance with Her Majesty's Revenue and Customs (HMRC) rules. The rules are encapsulated in IR35 as established in the Income Tax (Earnings & Pensions) Act 2003. They are in place to ensure that: "where an individual would have been an employee if they were providing their services directly, they pay broadly the same tax and National Insurance Contributions (NICs) as an employee"[1].[1]

5. Scope

This policy relates to workers who carry out work for the Health Board but are not employed by the Health Board, (broadly speaking, those individuals for whom we receive invoices for their services). It also relates to all staff engaged through an agency or other labour provider, where the agency/labour provider has itself engaged the worker via an intermediary. The Health Board is responsible for establishing the employment status of all workers.

There are some exemptions to the HMRC rules, but these are specific. Advice should be sought from Finance, Procurement or Workforce if necessary, before making a decision regarding employment status.

Note: An Office Holder (a role that is generally one which exists independently of the person fulfilling the role and would exist even if someone is not engaged to fill it) as defined by HMRC is always taxed as an employee.

Establishing employment status of sole traders supplied through an agency remains the responsibility of the agency. The policy relates

[1] HMRC. 2018. *Off-payroll working rules*. [ONLINE] Available at: https://gov.uk. [Accessed 31 October 2018].

to self-employed workers and sole traders under the basic employment status obligations that apply to the UHB.

The policy does not relate to staff who have an employment contract, or to ad-hoc workers e.g. bank staff engaged via 'terms of engagement' and subject to tax and National Insurance deducted under the Pay As You Earn system (PAYE). It does not apply to suppliers who are genuinely self-employed.

6. Roles and Responsibilities

As a public body, the Health Board must decide in all cases where a worker is paid through an intermediary whether HMRC off-payroll working rules apply. They must also tell the worker, agency or other provider in writing that they apply (from April 2020, this will need to be done through a "Status Determination Statement" (SDS). This must be done before the contract or work starts whichever is later.

From April 2020 the Health Board also has an obligation to have a dispute resolution process in place.

Where the off-payroll working rules apply the Health Board must ensure that Tax and National Insurance will be deducted from the VAT-exclusive invoice value paid to the intermediary. Deductions must be paid over to HMRC, within the timescales as set out by HMRC.

6.1. Recruiting Managers

It is primarily the responsibility of the person recruiting a worker to ensure that the law is complied with. All recruiting managers (usually the appointing officer) must establish whether the off-payroll working rules apply when engaging workers outside of the Payroll system.

Any staff not employed must be assessed individually. The recruiting manager must follow either the recruitment policy/process or procurement policy/process.

Recruiting managers have a responsibility to:

- Carry out an employment status check jointly with the Head of Financial Services and Accounting or their nominated deputy with reference to the worker's contract and working arrangements
- Use the HMRC 'Check Employment Status' online assessment for all individuals not directly employed
- Forward a copy of all documentation relating to the assessment to the Head of Financial Services and Accounting to allow inspection by HMRC in the event of a tax inspection
- Ensure that the resulting outcome is not contrived to arrive at a desired outcome
- Seek relevant advice from Workforce, Procurement and/or Finance business partner in all cases

Before seeking advice, the recruiting manager must ensure that all relevant information is available [See 7.3].

In all cases where an individual is engaged outside of the payroll system (including through an agency), the Procurement Department must be contacted for advice on procurement requirements and thresholds.

6.2. Medical Staffing Co-ordinators

Medical staffing co-ordinators may only engage off payroll workers through an agency. Workers supplied by an agency, but paid through an intermediary must be assessed for employment status. If there is any doubt, Finance and/or Workforce and/or Procurement, must be contacted for advice. The Procurement Department must be contacted for advice on procurement requirements and thresholds.

6.3. Accounts Payable Staff

NWSSP Accounts Payable staff must be aware of the off payroll rules. Staff must decline any payment requests (e.g. invoice) if there is no specific contract for services (e.g. purchase order).

6.4. Finance

Corporate finance must ensure that off payroll payments are recorded for mandatory annual disclosure to Welsh Government, and for inspection by HMRC where required.

Corporate Finance must regularly analyse the ledger for suppliers which may have the characteristics of an intermediary.

Corporate Finance will be responsible for jointly (with the recruiting manager) carrying out the HMRC 'check employment status'. They will to the best of their knowledge ensure that assessments are carried out accurately and in accordance with the law.

A copy of each employment assessment outcome, along with any supporting evidence (e.g. the contract, evidence of discussions with the worker and recruiting manager etc.), must be saved within the finance department.

Corporate Finance staff will ensure that this policy is available on the intranet to managers in NHS Wales Shared Services Partnership (NWSSP) Accounts Payable.

Business Partner Accountants (BPAs) must be aware of the rules relating to off payroll workers and support recruiting managers in obtaining the relevant advice.

6.5. Workforce and Organisational Development

Workforce and OD staff will ensure that this policy is available on the intranet to managers in the Health Board and to NHS Wales Shared Services Partnership (NWSSP) payroll services, recruitment services and to any departments involved in engaging medical or other staff.

Workforce business partners must be aware of the rules relating to off payroll workers and support recruiting managers in obtaining the relevant advice.

6.6 NWSSP Procurement Department

Procurement must ensure that the relevant contracting and procurement advice is given to recruiting managers for off-

payroll engagements. A list of framework agencies must be maintained, and all new framework agencies must be contacted annually (in writing) to ensure that they are compliant with the HMRC rules.

Procurement staff must be aware of the HMRC rules relating to off-payroll workers.

6.7 NWSSP Payroll Services

Payroll services must ensure that staff have full knowledge of this policy to enable them to provide the appropriate advice, should enquiries arise.

When informed by the recruiting manager, payroll services must enrol individuals assessed as holding employment status onto payroll on the IR 35 element. The individuals must be clearly and easily identifiable.

They must make the appropriate level of deductions for Tax and NI and prepare relevant information to enable pay over of deductions to HMRC.

7. Procedure for Engaging Staff in an Off Payroll Capacity

Changes in legislation introduced in 2017 placed responsibility on all Public Sector Organisations for determining employment status for all off payroll employees provided through an intermediary. An intermediary can be an individual e.g. partnership or limited company, or any other labour providing body. Where a worker is provided by an agency, the Health Board must establish whether they are directly employed by the agency (the IR35 rules do not apply in this case) or whether the agency is supplying the worker through an intermediary. Under previous legislation the responsibility for determining employment status was with the intermediary.

In all but the most exceptional cases (and on the express advice of HMRC), off payroll workers must be engaged and remunerated through the payroll system and be subject to tax and national insurance deductions at source, in line with tax and NI thresholds.

7.1. Process

7.1.1. Testing for Employment Status

When an (off payroll) individual is required, a test for employment status must always be carried out using the HMRC online tool. The test for employment status must be carried out jointly between the (ABUHB) recruiting manager and Head of Financial Services and Accounting or their nominated deputy.

A record of the outcome must be kept for reference and HMRC inspection regardless of the result. The HMRC tool can be accessed by clicking on the following link: Check Employment Status. This is an important step and must be carried out before the individual is engaged.

If it is determined that the rules apply, and Tax and NI must be deducted (calculated by Aneurin Bevan's payroll provider in accordance with HMRC PAYE rules). Both the individual and the intermediary must be informed of the decision immediately in writing. This must be done before the contract or work starts whichever is later.

If the off payroll rules are not complied with the Health Board will incur financial penalties in the following circumstances:

- If an individual who has been assessed by the Health Board as 'not employed' is then assessed by HMRC to hold employment status

- If the Health Board fails to test employment status and a worker is later assessed by HMRC to hold employment status. In such cases, the Health Board risks liability for the full cost of the employee's tax and NI contribution **plus** any penalty levied by HMRC

Penalties for not following the rules would only be avoided if the Health Board can evidence to HMRC that it had taken "reasonable care" in assessing the worker's status.

Employment status must be assessed by the Health Board for each role, however where groups of workers carry out largely the same function, it may be appropriate to carry out a 'mass' assessment. However if an individual requests to be tested

for employment status, the Health Board is obliged to carry out a test for employment status.

Any decision made on specific employees/groups of employees, must be reconsidered if any changes are made to the practices of the engagement. If any changes are made, the employment status check online tool must be used again.

7.2. Using the HMRC Employment Status Tool

To enable HMRC employment status assessments to be carried out before the contract or work starts, you must know the following details before contacting corporate finance:

- Contract of engagement
- The worker's responsibilities
- Who decides what work needs doing
- Who decides when, where and how the work's done
- How the worker will be paid
- If the engagement includes any benefits or reimbursement for expenses

The tool is designed to assess a number of factors, including:

- Control – right to control what the worker has to do, where it has to be done, when it has to be done and how it has to be done
- Personal services – Mutuality of obligation – obligation to pay the worker and the worker is obliged to provide work or a skill rather than send a substitute

The tool is intended to help an employer to ascertain whether the worker is an employee, for whom statutory deductions must be made. HMRC will honour the results of the test providing that that the information is accurate. It is vital that the answers provided reflect the written contract and how the working arrangement operates in practice. Any deviations from the contract will supersede the written contract for status determination. A record of all employee status checks, along with any supporting evidence, must be kept by corporate finance for inspection by HMRC, if needed.

If results are achieved through contrived arrangements to get a particular outcome, this would be treated as evidence of deliberate non-compliance and will attract higher penalties.

If an agency provides ABUHB with a worker who a sole trader, I.E. there is no intermediary it is the responsibility of the Agency to assess employment status.

7.3. When to use the HMRC Employment Status Tool

The first step must always be to understand the relationship between the organisation and the worker.

7.2.1 It is important to note that when directly engaging a self-employed person or sole trader, employment status must always be checked.

7.2.2 The Health Board must establish whether there is an intermediary. This can be:

- A company
- A partnership
- Other labour provider

Directly engaged off-payroll individuals must always be assessed under the IR35 rules

If none of the above apply, they may be exempt from the legislation. In any case the engaging manager must always seek advice from one of the departments below:

- Finance.
- Procurement.
- Workforce.

7.4. Procedure following HMRC Employment Assessment

7.4.1. Workers engaged through an intermediary via an Agency or Other Labour Provider

If an agency or any other labour provider supplies an individual or group of individuals assessed to hold employment status through an intermediary, you must confirm that they (the provider) deduct Tax and National Insurance as if they (the worker) were an employee.

You should pay the supplier invoice for providing the worker according to the contract with them.

The recruiting manager must always check with procurement that:

- The agency or labour provider is on a procurement framework
- If the agency or labour provider is not on a procurement framework, procurement must inform both the individual and intermediary in writing confirming the employment status of the worker before the contract or work starts.

7.4.2. Individuals assessed as employed

In cases where we pay an intermediary, but the individual is deemed as having employment status, they must be enrolled through payroll. All payment requests must be submitted to payroll (this will often be in the format of an invoice) electronically, providing them with all relevant information. Payroll will make the necessary deductions and supply the appropriate information to enable pay over of deductions to HMRC.

7.4.3. Sole Traders

If a sole trader is providing their services directly to ABUHB as an individual, an employment status check must always be carried out. If the HMRC tool returns a result of employed, they must also be enrolled on the payroll system and relevant deductions made.

7.4.4. Inconclusive Assessments

If the HMRC employment status tool returns an inconclusive result, the Health Board recruiting manager and Head of Financial Services and Accounting or their nominated deputy must undertake an in house employment status assessment. Where an inconclusive result has been returned, the Health Board will usually make the decision to assume employee status applies.

If the in-house assessment returns a self-employed status, all relevant documentation must be retained along with reasons for conclusions regarding employment status as evidence (e.g. contracts and correspondence with the individual or intermediary), in the event that HMRC make inquiries.

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

It is important that recruiting managers are familiar with ABUHB policies for:

- Recruitment.
- Procurement.

Aneurin Bevan University Health Board

Payroll Policy and Financial Control Procedure

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

Status:
Approved by:

Issue date: dd/month/year
Review by date: dd/month/+3 years

Aneurin Bevan University Health Board
Payroll Financial Control Procedure
Owner: Director of Finance

ABUHB/Finance/

Contents:

1. Introduction

Payment of staff represents a high proportion of the Health Board's expenditure. The timely payment of staff, accurate calculation and payment of deductions to statutory bodies are essential.

2. Policy Statement

Aneurin Bevan University Health Board (ABUHB) is committed to ensuring that staff and workers are paid accurately and on time, that all voluntary and statutory deductions are made and paid over to the relevant body e.g. Her Majesty's Revenue and Customs (HMRC) and that all transactions are reflected accurately within the agreed timescale in its general ledger enabling accurate reporting internally and externally.

3. Aims

The aims of this procedure are to ensure that all employees are correctly paid in line with their terms and conditions, that any statutory income owed to the Health Board is identified and collected promptly, that salaries and deductions are calculated accurately and accounted for in full in the Health Board's ledger and that all third party payments are accurately calculated and paid over within deadlines to avoid penalties.

4. Objectives

- To pay all ABUHB employees and workers (e.g. self-employed or through an intermediary under IR35 rules) on time and within terms and conditions:
  - Ensure all staff and individuals are paid what is rightfully due to them within the published timetable.
  - To ensure that the correct deductions are made and reflect those that are statutory, voluntary, or duly authorised.
- To ensure that all statutory payments are received from government agencies by accurately recording employee absence. (e.g. in relation to statutory sickness pay and parental leave)
- To ensure that payroll (including employer cost and deductions) are accurately recorded within the agreed timescale in the Health Board's accounting ledger system and that the payroll system (ESR) and the accounting system (Oracle) are fully reconciled.
- Ensure that correct third party payments e.g. HMRC (Tax and National Insurance (NI)) and National Health Service Business Services Authority – NHSBSA (NHS pensions agency) are calculated

accurately and that the information is made available for payment in a timely manner to ensure that penalties are not incurred as a result of late payment.

5. Scope

The procedure covers all systems, processes and documentation relating to payment of staff and self-employed workers in ABUHB. It is relevant to all ABUHB staff and self-employed workers and those working through an intermediary under IR35 rules, NHS Wales Shared Partnership - Payroll Services NWSSP-PS including expenses, recruitment services and accounts payable (NWSSP).

6. Roles and Responsibilities

6.1 Workforce and Organisational Development (WF&OD)

- WF & OD are responsible for communicating NHS staff pay terms and conditions.
- They are responsible for communicating and publishing an annual timetable provided by NWSSP-PS widely within ABUHB to ensure that staff are aware of submission deadlines.

6.2 Managers

All information such as, notification of terminations, change in conditions etc must be submitted to NWSSP-PS immediately to ensure that staff are paid correctly. Managers must ensure that all employment documentation and ESR manager self-service (MSS) updates are:

  - Complete
  - Submitted within the published time table
  - Accurate
  - Appropriately authorised by delegated managers in line with the Authorised Signatory List (ASL).

- They must ensure that all policies relating to staff payments are followed including WF&OD policies, and Standing Financial Instructions and Financial Control Procedures.
- Must respond to NWSSP-PS queries in a timely manner to resolve any issues arising.
- Must ensure that all submissions including paper documents, electronic documents and system updates (ESR self-service, e-system dropdowns, timesheets or interfaces) to NWSSP-PS are:
  - Made within the published deadlines,

- Complete,
- Accurate and reflect the correct details including band, contracted hours and variable hours worked etc.
- Appropriately authorised by delegated managers in line with the ASL

6.3 Individuals

- Individuals must ensure that employment documentation is accurate, complete, submitted within the published time table, and appropriately authorised.
- They must ensure that all personal information including bank information, is up to date through ESR Self Service (ESS).
- Must review payslips and notify their manager if any discrepancies arise in respect of enhancements, overtime, contract hours, termination; other discrepancies.
- Must provide Payroll Services with the required documentation on commencement of employment – P45 (or P46 where P45 is not available).
- Review PAYE codes when notified by HMRC.
- Ensure that they have download their P60 and sufficient payslips for their individual needs. Requests for copies may incur a charge.

6.4 NWSSP-PS

- To work within the terms of any prevailing SLA between ABUHB and NWSSP-PS.
- To inform ABUHB WF&OD staff of any changes that require a change in ABUHB working practices.
- To pay all ABUHB employees and workers on time and within terms and conditions.
- NWSSP-PS will be responsible for the whole of the payroll process adhering to payroll processing best practice Payroll Services will adhere to payroll timetables.
- Providing a timetable to the Health Board containing the monthly payment dates for each complete financial year.
- Ensuring deductions (statutory, voluntary and other authorised deduction) are made in line with requirements.

- Payments to HMRC, Pensions Agency are made within deadlines, avoiding penalties.

6.5 Corporate Finance

- Ensuring that sufficient cash is in place to meet payroll commitments.
- Pay over of deductions for Tax, National Insurance and other third party deductions.
- Interfacing payroll files to the general ledger system.
- Processing urgent salary payments when requested.
- Correctly coding payroll elements to ensure proper accounting treatment.
- Performing reconciliations: the Oracle accounting system to the ESR payroll system (in conjunction with NWSSP-PS) and the Oracle accounting system to payments made.

7. Payment of Salaries

Employees and workers will be paid monthly via Bankers Automated Clearing Services (BACS) on the day(s) agreed between ABUHB and NWSSP Payroll Services (NWSSP-PS). Those paid weekly will be paid through BACS on the agreed day. Payment day(s) are subject to change following agreement between ABUHB and NSSSP-PS. Where the specified day falls on a weekend or public holiday payment will be made on the nearest working day (this may fall before or after the designated pay date).

NWSSP-PS will provide ABUHB with an annual timetable to include deadlines for payroll documentation (including electronic submission) to ensure variable pay is reflected accurately. ABUHB WF&OD will ensure that the annual timetable is published on the intranet.

7.1 Rates of pay

NWSSP-PS will make salary payments in accordance with prevailing terms and conditions and rates of pay. Where Welsh Government (WG) varies the rate of pay (e.g. pay awards), these will be applied to the Electronic Staff Record (ESR) system by the ESR managed service provider.

7.2 Non-standard rates of pay

Any non-standard rates of pay must follow the Policy for approval to offer salary outside of those nationally authorised by WG ministerial

correspondence. NWSSP-PS must be notified of any non-standard rates along with evidence that the policy has been adhered to.

7.3 Manual Payments

Manual payments will be made in exceptional circumstances. This would occur where an employee is in a no pay/substantially reduced pay situation and to ensure the employee is not unduly disadvantaged by waiting until the next payment run. Where this is the case payments may be made by faster payments or payable order.

If an employee has provided late bank account details or a replacement payment is required for the employee will incur a charge for the replaced transaction. If incorrect details are provided ABUHB is not obliged to provide a replacement until the original payment is received in the ABUHB bank account.

The following details must be forwarded by NWSSP-PS to (ABUHB) Treasury generic mailbox stating clearly the payment type (faster payment, or payable order).

- Payee name and payroll number.
- Bank name and address, sort code and account number (this should be substituted for payee full correspondence address in the case of payable order).
- Date of payment.
- Payment amount (words and figures).
- Detail/reasons for the payment.
- Signature and name of payroll officer completing the request.
- Signature and name of payroll officer checking the request.
- Signature, name and designation of payroll officer authorising the payment.

7.4 Advances of pay

In rare circumstances and where an employee would be otherwise unduly disadvantaged, NWSSP-PS may be requested, by a General Manager to make an advance of pay.

NWSSP-PS will provide ABUHB Treasury department with information as for manual payments clearly stating 'Payroll Advance'.

ABUHB Treasury department will make the payment and debit this payment to the Advance of Pay Control Account.

NWSSP-PS will recover the advance from the employees pay in the following month (this will credit the Advance of Pay Control Account).

The control account will monitored by the ABUHB Accountancy Manager each month to ensure all advances are fully recovered.

7.5 Incorrect payments to employees

7.5.1 General

All payroll submissions must be made within the timetable supplied by NWSSP-PS. If submissions are late, incorrect, incomplete or do not include the relevant authorised signature they may be returned to the originator. Correctly completed submissions will be updated for payment on the next main payroll run.

7.5.2 Underpayments

NWSSP-PS will confirm whether an employee has been underpaid, the balance owed will be paid on the next available main or supplementary payroll run.

7.5.3 Overpayments

NWSSP-PS will confirm whether an employee has been overpaid. Once confirmed NWSSP-PS and ABUHB staff will follow the Recovery of Overpayments to Employees policy.

7.6 Payroll Documentation

All payroll documentation relating to the payment of individuals, whether paper, electronic, or ESR direct system entry (ESS, MSS, e-Roster, etc.), including:

- Enrolment
- Terminations
- Changes
  - Personal changes
  - Employment changes

Must be submitted to NWSSP-PS in an agreed format and in a complete and timely manner to enable NWSSP-PS to make correct payments within the published timetable.

7.6.1 Variable pay

Enhancements, overtime, additional hours, bank shifts and other variable pay

NWSSP-PS will pay worked enhancements, overtime, additional hours, bank shifts and other variable pay on receipt of the agreed notification within the published timetable. The format of notification can be:

- E-systems. (e.g. bank, e-rostering etc.)
- Monthly or weekly workbook.
- Monthly or weekly paper timesheets. (**where variable pay is a regular requirement, managers must contact NWSSP-PS to arrange to submit monthly or weekly workbooks**)

All submissions must be completed in full, accurately reflect the work carried out and be appropriately authorised by delegated managers.

Where alterations to timesheets are made, staff should be informed.

All submissions (paper or electronic) must be received by NWSSP-PS within the published timetable to enable the correct payment to be made.

7.6.2 On-Call

Payment for on-call and call-out will be made in accordance to the all Wales On-Call agreement using the All Wales On-Call Claim Form, submitted in accordance to the monthly payroll timetable.

7.7 Deductions from pay

7.7.1 Statutory Deductions

NWSSP-PS will ensure that statutory deductions:

- Pay as you earn (PAYE)
- National insurance (NI)
- NHS pension
- National employment savings trust (NEST)

are assessed and correctly applied to each employee.

Employees must provide NWSSP-PS with a P45 or P46 on commencement of employment. Employees must review all personal correspondence from HMRC.

7.7.2 Attachment of Earnings Orders

On the receipt of an attachment of earnings order (AEO), NWSSP-PS will ensure that employee conditions are met to proceed with making deductions and will ensure that all parties are informed on any relevant facts relating to ability to pay.

NWSSP-PS will notify ABUHB corporate finance team to enable them to make the necessary arrangements to pay the resulting deductions over to the organisations requesting attachment of earnings.

Where an AEO cessation notice is received in NWSSP-PS after a payroll run has been completed, any refund of monies made under that order will be the responsibility of the requesting organisation.

7.7.3 Voluntary Deductions

All requests for voluntary deductions must be made to NWSSP-PS within the payroll timetable. Mandates must be appropriately authorised by a delegated manager in line with the ASL.

A schedule of third party deductions will be available at the end of each payroll run to ABUHB corporate finance team to enable them to make the necessary arrangements to pay the correct sums over to the relevant organisations.

7.7.4 Salary Sacrifice

All salary sacrifice schemes must be approved by ABUHB and comply with the ABUHB Salary Sacrifice Scheme FCP. Applications must be made, in line with the current scheme rules and must comply with HMRC rules and regulations.

A schedule of Salary Sacrifice deductions will be available at the end of each payroll period.

7.8 Employee Absence

7.8.1 Sick leave

Line managers must administer all aspects of sickness leave in line with ABUHB Sickness Absence Policy. Managers must accurately record all sickness absence dates on ESR to enable NWSSP-PS to manage statutory sick pay.

NWSSP-PS will manage payroll specific issues including:

- Management of statutory sick pay including the issue of SSP1 forms to employees.
- Assessment of eligibility for temporary injury payments.
- Recording of annual leave taken whilst on a period of sick leave on receipt of the application to utilise annual leave whilst on sick leave form (available on the intranet).

7.8.2 Parental Leave

Employees are required to submit fully completed and correctly authorised applications for parental leave according to the relevant parental leave policy. Copies must be forwarded to payroll to enable them to correctly manage statutory entitlements. NWSSP-PS will notify employees if statutory requirements are not complied with.

7.8.3 Career Breaks

Career breaks will be managed in accordance with the Employment Break Policy. NWSSP-PS must be notified of all agreed career breaks.

NWSSP-PS will make the necessary payroll adjustments and request payments (through debtor request to ABUHB Treasury Department) for NHS pension from the employee in line with the policy.

7.8.4 Annual Leave

The line manager will manage annual leave including all enquiries relating to leave entitlement.

Purchase of additional annual leave must be authorised by the delegated manager in line with the flexible working policy and the ASL and submitted to NWSSP-PS for calculation and deduction. The Payroll Services will notify ABUHB WF&OD of the leave claim. E-Systems will update the entitlement on ESR.

7.8.5 Changes and Terminations

NWSSP-PS must be informed in the appropriate format, including date of termination as soon as formal notice of resignation is received. Failure to inform NWSSP-PS in a timely manner will lead to overpayment.

All changes relating to terms of employment must be reported to NWSSP-PS in the correct format to ensure that correct payment can be made.

7.9 Payroll Processing

NWSSP-PS will process payroll payments, adhering to published timetables.

- NWSSP-PS must ensure **all concurrent** requests that form the payroll processing routine have completed with "normal" status.
- NWSSP-PS must notify abb_finsystems@wales.nhs.uk once the processing routine has been completed and indicate which payroll file has been processed. (e.g. week 25, Month 6, Month 6 Supp, etc.)
- NWSSP-PS must check the NHS Interface HUB notification has been received. (this provides conformation of successful file transfer to the NHS Interface HUB; if this email is not received, it indicates that issues have been encountered, requiring further attention by NWSSP-PS)

7.9.1 Payroll transfer to the Oracle Accounting System

Following receipt of the payroll general ledger file into the NHS ESR HUB, the ABUHB Systems Team will import the file

to Oracle ensuring that the correct number of lines are uploaded. The systems team will ensure that any coding errors are corrected prior to import and will send a notification to finance users on completion of posting the payroll file to the general ledger.

7.9.2 Cash management

The Head of Treasury will ensure that there are sufficient funds in the Health Board's bank account to meet the weekly and monthly payroll bill. The Head of Financial Services and Accounting or nominated deputy will authorise draw down of cash.

7.9.3 Payroll Reconciliations

- The general ledger must be reconciled to the payroll feed every month following ledger close. ABUHB staff will ensure the payroll interface file is compared with a download of the general ledger to ascertain whether there are any differences.
- ABUHB Financial Services and Accounting Department will review payroll/finance imbalances and notify NWSSP-PS of differences on a monthly basis.
- Where a difference is identified, the accountancy manager and relevant staff in NWSSP-PS must be informed. NWSSP-PS will investigate any differences in conjunction with ABUHB accountancy manager and provide ABUHB financial services staff with explanations to enable correction.
- ABUHB Treasury department will ensure that all balances on ledger deduction codes reconcile with actual payments subsequently made to HMRC and NHS pensions agency.
- NWSSP-PS will undertake reconciliation of ESR the gross to net report to the BACs/Cheque and costing report. Where it is identified that the reports do not reconcile, items will be investigated and remedial action will be taken to correct the files.
- NWSSP-PS will review, investigate and correct the differences where possible on the next available payroll run/earlier year update (EYU).
- ABUHB and NWSSP-PS will work closely with each other to ensure that all differences are resolved and corrected before the next payroll run.

7.10 Payment to HMRC

NWSSP-PS will make all statutory deductions in line with prevailing taxation regulations.

NWSSP-PS will:

- Provide information on liabilities of TAX, NI, NEST etc. (allowing for SSP, SMP etc.) to ABUHB Treasury department in sufficient time for Treasury to obtain authorisation to meet the HMRC deadline.

- Forward to NWSSP-Accounts Payable to enable them to include the payment on the BACS run in time for HMRC to receive payment by the 19th of the month following the payroll run. In cases where the 19th falls on the weekend or a bank holiday, payment must reach HMRC on the last working day before the 19th. The BACS must be made at least 3 working days before the payment is due.

7.11 Payment to NHS Pensions Agency

- NWSSP-PS will enter details of payment due to NHS Pension Agency on their system within the agreed timescales.

- NWSSP-PS will assess out of period overpayments, and inform Financial Services and Accountancy (following the payroll run) of any general ledger corrections necessary.

7.12 Enquiries

7.12.1 Employee Enquiries

General enquiries relating to hours worked and attendance (including annual leave and sickness), should be directed towards the line manager in the first instance.

Reference should be made to the intranet for Payroll Enquiries, including service standards and contact methods.

7.12.2 Payroll Enquiries to ABUHB

NWSSP-PS may raise an enquiry directly with the ABUHB manager in respect of any enquiries which would prevent an employee being correctly paid.

The manager must provide a response to the enquiry within 5 workings days unless otherwise indicated by Payroll Services to prevent an over/underpayment.

7.12.3 Enquiries to Payroll Services

NWSSP-PS will respond to enquiries made by managers or individuals from ABUHB within a reasonable time and in line with their standards, Service Level Agreement (SLA) and their customer charter. Payroll Services contact details can be found on the Payroll Services home page on ABUHB intranet. Shared Services information including the SLA and customer charter can also be accessed via a link on the Payroll Services home page.

8. Resources

This procedure must be read in conjunction with:

- Standing Orders.
- Standing Financial Instructions.
- Other relevant FCPs.
- Procedures relating to E-Systems. (e.g. E-roster, E-expenses E-bank etc.)
- The Health Board's recruitment and retention policy.

9. Equality

An Equality impact Assessment has been completed.

10. Audit

This policy will be subject to internal audit review from time to time.

11. Review

This policy will be reviewed every 3 years.

Appendix A - Summary of Single Tender/Quotation Actions

Date of Request	Type of Request	Reference No	Description	Anticipated Annual Value (ex VAT)	Supplier	Type	Reason for request	Advice from Procurement	pproved / Rejecte	CEO Approval Date
04/09/2019	Single Tender	ABU-STA-117678	Data Transfer to GP Clinical System Software	£32,000.00	Health Diagnostics	Services	Renewal of exisiting software	Extension of contract required to support business continuity	Approved	08/10/2019
17/09/2019	Single Tender	ABU-STA-42239	To oversee and act as project manager and to deliver specific discreet pieces of project work.	£15,750.00	Andy Terry	Services	To oversee and act as a project manager and to deliver specific discreet pieces of project work. This will be to work with clinicians to develop and implement clinical pathways for Fractured NOF, Back pain and the management of spinal emergency admission and ENT.	Short term contract until post is appointed via recruitment excerise	Approved	23/09/2019
08/07/2019	Single Tender	ABU-STA-42343	Organisational development programme Gwent RPB	£29,500.00	Bevan Commission	Services	The purpose of the work is to provide external capacity to deliver a programme of organisational development to the Gwent RPB. Specifically to develop an options paper for the delivery of inte rated services design and delivery at a regional, local and locality level, where collaboration between health and social care is required to achieve the best outcomes for people.	Nature of work can only be provided by organisations detailed - Bevan Commission will act as a lead party	Approved	07/08/2019
24/09/2019	Single Tender	ABU-STA-42935	Ophthalmology Outsourcing CCN	£475,000.00	Care UK	Services	Due to further pressures delivering RTT in the Ophthalmology service the commissioning team were requested to seek further oportunities to improve RTT performance. An additional 500 cases would be delievered in 2019/20 making a total of 1500 treatments.	Supports additional work with the ongoing outsourcing agreement which helps RTT's.	Approved	27/09/2019
19/09/2019	Single Tender	ABU-STA-117913	Whistance	£56,000.00	MRI Whistance	Services	Gritting Services - North Gwent - extension for current gritting & snow clearance as winter period starts on 1st October until 31th April 2020. Include NHH, Yab, YTC, NRC, Ebbw Vale Clinic. 5 year tender to be completed starting April 2020.	Short term contract until a 5 year tender exercise carried out	Approved	27/09/2019
06/11/2019	Single Tender	ABU-STA-43283	Dragon Voice Recognition Software - Histology	£55,600.00	GHG Software Developments Ltd	Goods	Dragon VR is specific to medical terminology and the technology has been improving for 15 years. There is no comparable VR system for medical dictation available.	No other supplier can offer this required service	Approved	08/11/2019
08/02/2019	Single Quotation	SQA312	Public Health	£5,200.00	Sunset Solar	Services	Loud speaker to promote smoke free environments at hospital entrances. System to be 6 push button pads at entrances to the Royal Gwent . Part of a co-ordinated activity to raise awareness of the smoke-free policy to patients, staff and visitors ahead of the legislation for early 2020	Appropriate course of action to support upcoming new legislation	Approved	08/10/2019
04/09/2019	Single Quotation	ABU-SQA-42767	Annual Platinum Service and Maintenance Contract for Optilite Analyser	£6,950.00	Binding Site	Services	Annual Platinum Service and Maintenance Contract for Optilite Analyser. Priced from Binding site 1 year quotation from 31.08.19 to 30.08.20	Supplier are the original equipment manufacturer and as such maintenance needs to be commissioned through this company.	Approved	23/09/2019
13/10/2019	Single Quotation	ABU-SQA-117909	Replacement Worktop	£23,159.20	Maindee Handyman Stores	Goods	Worktop to be supplied and fitted in large prep office in Online House, Cleppa Park	Only quote received on multiquote, have used this supplier previously and work was of a high standard.	Approved	08/10/2019

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Date of Request	Type of Request	Reference No	Description	Anticipated Annual Value (ex VAT)	Supplier	Type	Reason for request	Advice from Procurement	pproved / Reject	CEO Approval Date
04/09/2019	Single Tender	ABU-STA-117678	Data Transfer to GP Clinical System Software	£32,000.00	Health Diagnostics	Services	Renewal of exisiting software	Extension of contract required to support business continuity	Approved	08/10/2019
17/09/2019	Single Tender	ABU-STA-42239	To oversee and act as project manager and to deliver specific discreet pieces of project work.	£15,750.00	Andy Terry	Services	To oversee and act as a project manager and to deliver specific discreet pieces of project work. This will be to work with clinicians to develop and implement clinical pathways for Fractured NOF, Back pain and the management of spinal emergency admission and ENT.	Short term contract until post is appointed via recruitment excerise	Approved	23/09/2019
08/07/2019	Single Tender	ABU-STA-42343	Organisational development programme Gwent RPB	£29,500.00	Bevan Commission	Services	The purpose of the work is to provide external capacity to deliver a programme of organisational development to the Gwent RPB. Specifically to develop an options paper for the delivery of inte rated services design and delivery at a regional, local and locality level, where collaboration between health and social care is required to achieve the best outcomes for people.	Nature of work can only be provided by organisations detailed - Bevan Commission will act as a lead party	Approved	07/08/2019
24/09/2019	Single Tender	ABU-STA-42935	Ophthalmology Outsourcing CCN	£475,000.00	Care UK	Services	Due to further pressures delivering RTT in the Ophthalmology service the commissioning team were requested to seek further oportunities to improve RTT performance. An additional 500 cases would be delievered in 2019/20 making a total of 1500 treatments.	Supports additional work with the ongoing outsourcing agreement which helps RTT's.	Approved	27/09/2019
19/09/2019	Single Tender	ABU-STA-117913	Whistance	£56,000.00	MRI Whistance	Services	Gritting Services - North Gwent - extension for current gritting & snow clearance as winter period starts on 1st October until 31th April 2020. Include NHH, Yab, YTC, NRC, Ebbw Vale Clinic. 5 year tender to be completed starting April 2020.	Short term contract until a 5 year tender exercise carried out	Approved	27/09/2019
06/11/2019	Single Tender	ABU-STA-43283	Dragon Voice Recognition Software - Histology	£55,600.00	GHG Software Developments Ltd	Goods	Dragon VR is specific to medical terminology and the technology has been improving for 15 years. There is no comparable VR system for medical dictation available.	No other supplier can offer this required service	Approved	08/11/2019
08/02/2019	Single Quotation	SQA312	Public Health	£5,200.00	Sunset Solar	Services	Loud speaker to promote smoke free environments at hospital entrances. System to be 6 push button pads at entrances to the Royal Gwent . Part of a co-ordinated activity to raise awareness of the smoke-free policy to patients, staff and visitors ahead of the legislation for early 2020	Appropriate course of action to support upcoming new legislation	Approved	08/10/2019
04/09/2019	Single Quotation	ABU-SQA-42767	Annual Platinum Service and Maintenance Contract for Optilite Analyser	£6,950.00	Binding Site	Services	Annual Platinum Service and Maintenance Contract for Optilite Analyser. Priced from Binding site 1 year quotation from 31.08.19 to 30.08.20	Supplier are the original equipment manufacturer and as such maintenance needs to be commissioned through this company.	Approved	23/09/2019
13/10/2019	Single Quotation	ABU-SQA-117909	Replacement Worktop	£23,159.20	Maindee Handyman Stores	Goods	Worktop to be supplied and fitted in large prep office in Online House, Cleppa Park	Only quote received on multiquote, have used this supplier previously and work was of a high standard.	Approved	08/10/2019

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Audit Committee 5th December 2019 Agenda Item: 6.2

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 September and October 2019.

- **Background and context**
  Losses and Special payments are reported in the financial position monthly relating to cash payments for clinical negligence, personal injury claims, ex gratia payments and 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 October 2019 was £1,191k (inclusive of defence fees) which consisted of:

Clinical Negligence	£942k
Personal Injury	£234k
Minor Losses	£14k

- **Recommendation**
  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 and Performance			
Report Author: Estelle Evans, Head of Financial Services and Accounting			
Report Received consideration and supported by :			
Executive Team	**n/a**	**Committee of the Board [Committee Name]**	**n/a**
Date of the Report: 20th November 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 September to October 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 consists 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.

This report will provide information for the period 1st September to 31st October 2019.

6.2

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 31st October 2019 compared to the position reported at 31st August 2019 and 30th June 2019. It also identifies the outturn position for March 2019.

Table 1 – provision recorded on the Statement of Financial Activities (provided by NWSSP legal services)

Clinical Negligence & Personal Injury Provision				
	31-Mar-19 £000	30-Jun-19 £000	31-Aug-19 £000	31-Oct-19 £000
Clinical Negligence	120,797	136,354	139,849	154,513
Personal Injury	3,835	3,820	3,836	3,790
	124,632	**140,173**	**143,684**	**158,302**
Income From Welsh Risk Pool	-119,033	-134,482	-138,000	-152,701
Net Liability	**5,599**	**5,691**	**5,684**	**5,601**

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 31st October 2019 compared to the 31st August 2019 decreased slightly by £83k.
- There was an increase of £14,664k in the Clinical Negligence provision since August 2019 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.
  One Obstetrics case increased the provision by £15,780k as the possibility of a settlement was revised from possible to probable.

The number of cases provided for are shown in Table 2.

	31-Mar-19	30-Jun-19	31-Aug-19	31-Oct-19
	No. of cases	No. of cases	No. of cases	No. of cases
Clinical Negligence	240	248	244	235
Personal Injury	76	78	84	88
	316	**326**	**328**	**323**
Income from Welsh Risk Pool	99	111	113	117

Table 3 summarises the total amount charged to expenditure for the period to 31st October 2019:

YTD Expenditure Charged to the Accounts (incl Defence Fees)

	31-Mar-19	30-Jun-19	31-Aug-19	31-Oct-19
	£000	£000	£000	£000
Clinical Negligence	7,029	1,450	2,464	3,645
Personal Injury	404	105	179	258
Irrecoverable Debts	0	0	0	0
Other	285	11	11	14
	7,718	**1,566**	**2,654**	**3,917**
Income From Welsh Risk Pool	-5,925	-1,044	-1,763	-2,727

Net Expenditure	**1,793**	**522**	**890**	**1,191**

The net charge to the accounts from September to October 2019 was £301k.

Commentary on Table 3

During the period September to October 2019 the following payments have been made:

Payments have been made totalling £1,215k for Clinical Negligence cases. Some of these payments were above the Welsh Risk Pool threshold of £25k enabling the Health Board to accrue £959k of income. The provision required for outstanding cases has also reduced by £33K resulting in a net charge to expenditure of £222K for Clinical Negligence cases.

The £1,215k paid is analysed as follows:

- £700k (11 payments) – Settlements
  - £450k - related to two separate stroke related claims
  - £220k related to 8 payments ranging in value up to £85k.
- £416k (19 payments) – Claimants Solicitors Fees
  - £165k – related to a delay in diagnosing spastic paraparesis.
  - £251k related to 18 payments ranging in value up to £60k.
- £61k (45 payments) - Providing medical expertise.
- £25k (21 payments) – Counsel Fees incurred
- £12k (6 payments) – Professional fees incurred
- £3k (1 payment) – NWSSP Legal & Risk costs
- (£1k) (2 payments and 1 refund) Compensation Recovery Unit
- £1k (5 payments) – Other payments

Payments have been made totalling £61k for Personal Injury cases. Some of these payments were above the Welsh Risk Pool threshold of £25k enabling the Health Board to accrue £4k of income. The provision required for outstanding cases has also increased by £18K resulting in a net charge to expenditure of £75K for Personal Injury cases.

The £61k paid is analysed as follows:

- £24k (4 payments) - Settlements
- £36k (5 payments) - Claimants solicitors fees

- £1k (1 payment) – Counsel Fees

Other Losses

Minor losses recorded during the period September to October 2019 totalled £3k.

- £3k – 4 Ombudsman payments
- <£1k - 2 other minor losses relating to the loss of patients' property.

  Lessons learnt reviews have been undertaken for each case with the divisions and departments of the organisation actively responding to these reviews.

2.3 Redress

The NHS (Wales) Redress Measure 2008 and the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 enabled Health Bodies the opportunity to streamline the investigation of all concerns raised by patients, their families and staff. Any concern or complaint where the expected qualifying liability if established would be under £25k can be considered under the Redress Scheme by The Putting Things Right Team. This can substantially reduce legal costs and also reduces the amount of time taken to reach a conclusion.

The settlement and medical expert costs are reimbursable by NWSSP in full.

During the period September to October 2019, 8 payments were made in relation to redress cases totalling £35k. 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 £4k 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 – TBC* *Vice Chair – Shelley Bosson* *IM – Emrys Elias* *David Jones*	*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**	**8th Oct 2019**	
Quality & Patient Safety Committee	*Board*	*Chair – Professor Dianne Watkins* *Vice Chair – Frances Taylor* *IM –Emrys Elias* *Pippa Britton* *Louise Wright*	**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**	**16th Oct 2019**	QPS Committee was held in October 2019. The 'Putting Things Right' report and Public Services for Wales Annual Report and Accounts 2018/19 were presented.

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* *CEO - Judith Paget* *Medical Director - Dr Paul Buss* *Director of Nursing – Rhiannon Jones* *Director of Therapies and Health Science*	• 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**	**The planned committee 13th Nov 2019 was cancelled** **Next planned committee 19 Dec 2019**	Review of claims. Consideration of appeals for minor losses

Name of Committee	Reporting to	Membership	Role in Relation to Review of Losses and Special Payments	Meeting Frequency	Date of Last Meeting	Issues Highlighted
		– Peter Carr				
Quality & Patient Safety Operational Group	*Quality & Patient Safety Committee*	Operational group no non officer members	Highlight reports from each Division. Progress reports from Learning Committee, WRP and complaint /SI reports which need to be highlighted to the group for consideration re escalation	**Bi Monthly**	**6th Sept 2019, with the next meeting scheduled for 28th Nov**	During September compliance against the 30 day target for complaints was consistent with August at 71%. With Scheduled Care, Unscheduled Care and MH&LD all exceeding their trajectories. Unfortunately October dipped to 59% with only MH and LD exceeding their trajectory. Work is underway with support offered with Divisions to ensure November's compliance improves. Work has commenced with the Divisions to improve performance for Welsh Government closures. The overall compliance for September increased to 65%. Only 2

Name of Committee	Reporting to	Membership	Role in Relation to Review of Losses and Special Payments	Meeting Frequency	Date of Last Meeting	Issues Highlighted
						Divisions achieving their trajectories- Scheduled Care achieved 100% and Mental Health and Learning Disabilities achieved 88%.
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**		The Learning Committee /Forum is under review. A successful learning event took place in YYF during October, with a second event planned for December, focusing specifically on learning following a Serious Incident. A Learning event was also held on 20 November at Christchurch Centre, learning from complaints related to end of life care. The plan is to test a revised approach, ensuring effectiveness.

Name of Committee	Reporting to	Membership	Role in Relation to Review of Losses and Special Payments	Meeting Frequency	Date of Last Meeting	Issues Highlighted
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			

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	N/A
Financial Assessment	*Financial implications stated in Table 3 above*
Quality, Safety and Patient Experience Assessment	*See Appendix 1*
Equality and Diversity Impact Assessment (including child impact assessment)	*N/A*
Health and Care Standards	*See Appendix 1*
Link to Integrated Medium Term Plan/Corporate Objectives	*N/A*
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	*N/A*
Glossary of New Terms	*None*
Public Interest	*Report to be published in the public domain.*

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Audit Committee 5th December 2019 Agenda Item: 6.3

Aneurin Bevan University Health Board

Declarations of Interest

Executive Summary

It is a requirement within the Health Board's Standing Orders that all Board members and those employed by the Health Board declare any personal or business interests they may have, which may affect, or could be perceived to affect, the conduct of their role as a Board member of employee of Aneurin Bevan University Health Board.

It is a requirement of the Standing Orders that the Audit Committee review and report to the Board upon the adequacy of the arrangements for declaring, registering and handling interests. This report provides an update to the Audit Committee. A fuller report providing the current systems of declarations and the full Register of Interests will be submitted to the February Meeting of the Audit Committee to support the Committee's role in advising on the end of year reporting arrangements i.e. the Annual Accountability Report and the Annual Governance Statement.

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: Lucy Bennett, Executive Assistant

Report Received consideration and supported by :

Executive Team		**Committee of the Board [Committee Name]**	

Date of the Report: 27th November 2019

Supplementary Papers Attached: None

Purpose of the Report

The purpose of this report is to provide an update to the Audit Committee on the current position with regard to declarations of interest.

Background and Context

It is a requirement of the Health Board's Standing Orders that the Audit Committee review and report to the Board upon the adequacy of the arrangements for declaring, registering and handling interests.

Over recent years, the Health Board has sought to continue to extend the coverage of its current Register of Interests. This means that any staff with an actual or perceived conflict of interest in the roles that they discharge on behalf of the Health Board will have been required to declare this to the organisation. In support of this, the Health Board has a Staff Business Conduct Policy and the Audit Committee approved at its October 2019 meeting an updated version of this Policy. This policy is currently being rolled-out

again across the organisation and arrangements made for ensuring colleagues assess any conflicts and make the necessary declaration.

All Board Members annually declare their interests and these are reported in the Annual Accountability Report, Senior staff (the first three levels of Corporate and Divisional structures) and consultants (the Board secretary and Medical Director write directly to each consultant to make them aware of this requirement) are also asked to make annual declarations.

However, it is also recognised that we need to continue to extend this to all areas of the organisation. There are documents on the intranet and circulated within the organisation, which provide further information and guidance on what are interests and how people can declare them. Advice is regularly given by the Board Secretary to Corporate Departments and Divisions and regular personal enquiries are made directly to the Board Secretary for advice and guidance.

The Board Secretary holds the Register of Interests. This is updated during the year, as appropriate, to record any new interests or changes to the interests previously declared. An annual review is also undertaken to ensure that all Board members review their Declarations of Interest.

Declarations of Interest are also a standard agenda item at each Board and Committee meeting to enable individual Board members to declare any interests in relation to any specific aspect of the agenda. Any declarations made are formally recorded within the minutes of the meeting.

Currently the Register of Interests has 438 entries. These comprise:

- 28 Board Members or Board Level Staff
- 210 Consultants
- 200 staff members mainly from the top three tiers of management structures and targeted groups such as pharmacy, IT and works and estates staff.

Further work is underway to raise awareness and increase the number of declarations. Also, work is taking place at a national level via the Board Secretaries Group to develop an on-line declarations system which would facilitate declarations being made from all staff groups. It is anticipated this this will be available to all Health Boards and Trusts in 2020, as it is currently being piloted in a small number of organisations.

Recommendation

The Audit Committee is asked to note the arrangements in place and the current level of declarations on the register. Also, that a full report will be submitted in February as part of the preparations for end of year reporting.

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

Welsh Language Standards

Internal Audit Report
2019/20

Aneurin Bevan University Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Review reference:	ABU1920-04
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First Draft report issued:	4 November 2019
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Management response received:	21 November 2019
Final report issued:	21 November 2019
Auditor/s:	James Quance, Head of Internal Audit Steve Chaney, Deputy Head of Internal Audit, Rhian Gard, Principal Auditor
Executive sign off	Geraint Evans, Executive Director of Workforce and Organisational Development
Distribution	Sue Ball, Assistant Director of Workforce and Organisational Development Jill Evans, Senior Organisational Development Manager (Equality)

Ruth Evans, Workforce Organisational Development Senior Practitioner

Committee Audit Committee

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

ACKNOWLEDGEMENT
NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

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Please note:

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, approved by the Audit Committee.

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

1. Introduction and Background

The review of the Welsh Language Standards (the 'Standards') was completed in line with the 2019/20 Internal Audit Plan.

On 20th of March 2018, Assembly Members voted in favour of the Welsh Language Standards [No7.] Regulations 2018 (the 'Regulations'). The two key principles that underpin the Regulations are:

- in Wales, the Welsh Language should be treated no less favorably than the English Language; and
- persons in Wales should be able to live their lives through the medium of Welsh language if they choose to do so.

The financial penalty for non-compliance with the Standards could be a civil penalty of up to £5,000 per breach.

In July 2018, the Welsh Language Commissioner (the 'Commissioner') issued a draft compliance notice to all Welsh health organisations. After a twelve week consultation period, responses on the reasonableness and proportionality of implementing each standard were submitted to the Commissioner by all Welsh health organisations. Final compliance notices were issued in November 2018.

According to the final compliance notice, Aneurin Bevan University Health Board (the 'Health Board') is required to comply with 121 standards; out of which 103 standards required compliance by May 2019, 18 standards require compliance by November 2019 and the remaining two standards require compliance by November 2020.

The Health Board did query the delivery timeframe for 13 standards and the Commissioner responded in September 2019 agreeing to one variation, and two changes but the other 11 challenges were not accepted.

2. Scope and Objectives

The overall objective of the review was to evaluate and determine the adequacy of the systems and controls in place over the implementation of the Standards and in particular:

- how the Health Board has assessed the impact of the Regulations on the organisation;
- the process for creating implementation action plans to achieve compliance with the Regulations;

- the process for determining the resource requirements to deliver these action plans; and
- how staff are being made aware of the requirements of the Regulations.

3. Associated Risks

The risks considered in the review were as follows:

- the potential for financial penalties and reputational damage because the Health Board is unable to comply with the Regulations, within the timescales agreed with the Welsh Language Commissioner; and
- patients that request communication in the Welsh language are treated inequitably.

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 the Welsh Language 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 audit focussed on the controls in place to ensure compliance with the Standards and our findings are set out in the Summary of Audit Findings. At September 2019, 35 Standards were still recognised as red or orange RAG rated for delivery by 30th November 2019, i.e. less than 75%. Indeed,

13 standards were challenged, with a view to extending the implementation date. The Commissioner's letter, dated 16th September 2019, describes the 'lack of timely planning and preparation' as an unsuitable reason for an 'organisation's failure to prepare the implementation of a standard in itself means that the requirements of these standards as imposed are unreasonable or disproportionate'.

However, with further details from the Commissioner provided, the standard of compliance required was far less extensive than first anticipated. This prompted a refresh of the plan, which resulted in 14 Standards outstanding for implementation (as opposed to 35 Standards identified in the previous version).

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Impact assessment			✓	
2	Action plan creation			✓	
3	Resource requirements			✓	
4	Staff awareness			✓	

** 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 classified as a weakness in the system/control design for Welsh Language Standards.

Operation of System/Controls

The findings from the review have highlighted one issue classified as a weakness in the operation of the designed system/control for Welsh Language Standards.

6. Summary of Audit Findings

Our detailed findings are set out in the Management Action Plan in Appendix A.

The Health Board was required to implement the majority of the Standards by the end of May 2019 and an additional number by the end of November 2019 and November 2020. The table below illustrates the timeframes applicable and the current number still outstanding:

	May 2019	November 2019	November 2020
No. of Standards	103	17	4
Implemented	99	8	3
Outstanding	4	9	1

The Health Board has a Welsh Language Unit in place to support the delivery of the Standards, which is within the Workforce and Organisational Development Division. With the assistance of the Welsh Language Strategic Group the Welsh Language Unit is driving forward the implementation of the Standards to ensure they are embedded throughout the organisation.

Since May 2019 there has been increased activity towards the implementation of the Standards, with the appointment of additional staff, additional membership of the Welsh Language Strategic Group and further Standards implemented.

The previous version of the plan did identify 35 Standards still outstanding that were rated as red or orange. However, following engagement with the Welsh Language Commissioner this has reduced the totals within the table above. We selected a sample of eight Standards that reduced in RAG rating and verified that there was justification for the re-classification. Based on our additional sample, there were no issues identified with the recent amendments. However, 24 Standards that were scheduled for implementation by the end of May 2019 were still outstanding during September 2019.

Impact Assessment
The Regulatory Impact Assessment (RIA) was submitted to the Welsh Government during November 2016.

The process for completing the RIA included:

- liaising with colleagues throughout Wales that were part of the Welsh Language Officers Group to understand resource requirements;

- agreement at the Welsh Language Strategic Group on resource requirements;
- seeking advice from the Welsh Government and the Commissioner, including meetings with key staff members; and
- seeking feedback from Local Government personnel whilst recognising that the Standards operate in a different context.

Utilising the advice and information listed above a self-assessment for each Standard was completed to determine the overall impact. In particular, it sought to highlight the constraints on resource, time and ICT investment. The resulting assessment confirmed that additional staff were required, particularly regarding translation services. The resulting output was communicated to the Welsh Government.

Implementation of Action Plans

To deliver the Welsh Language Standards agenda, two action plans were formulated. One is a high level action plan specifically for the Board and the second, a more detailed plan, for operational purposes.

We found that the methodology used within the plans is a good approach and provides a RAG rating for compliance against each standard and a progress arrow, which estimates the extent that each standard is embedded throughout the Health Board.

We reviewed a sample of standards at varying degrees of progress (i.e. red, orange, yellow or green rated) to test the accuracy of the associated RAG ratings. We found that there was an accurate representation within the sample tested.

In addition to the above approach, the Health Board forwarded a challenge to the Commissioner during May 2019 for 13 Standards, with a view to extending the implementation date / level of implementation of each standard challenged. The Commissioner upheld two challenges, thus extending the timeframe from May 2019 until the end of November 2019. Furthermore, the Commissioner agreed to vary one standard and thus amended the level of implementation required.

However, in spite of the above progress, there were 24 Standards that required implementation by the end of May 2019, but were not implanted by that point. Indeed, they were still marked as outstanding during September 2019. A recent refresh of the plan now shows just four Standards still outstanding from May 2019. Furthermore, six Standards are in the process of being challenged on an All-Wales basis.

Whilst the Welsh Strategic Group convened on a regular basis until June 2019, there has only been one meeting since (September 2019). Overall, the Standards have not been embedded within the required timeframe.

In particular, a project plan was not compiled until March 2019 and the structure of the task and finish groups was still being discussed along recruitment requirements during April 2019 – one month prior to the first deadline for 103 Standards to be implemented.

Indeed, a review of the minutes of each meeting did not indicate a detailed plan, timeframes or steps to be taken to ensure complete compliance with the Standards. As at September 2019, the terms of reference for the Group were in the process of being ratified for the first time.

The above points have been raised as a **recommendation** within Appendix A.

Resource Requirements

An impact assessment of resource requirements was undertaken as part of the RIA alongside other aspects. ESR, staff resource and ICT investment were identified, as detailed below:

ESR

Health Board staff are required to update their level of Welsh competency, to assist with targeting specific areas for embedding the Standards.

Staff Resource

Within the RIA completed during 2016, cultural changes within the Health Board and an increase in staffing resource within the Welsh Language Unit were required, to support the implementation of the Standards. Initially, the Health Board focussed on recruiting staff for translating services, but following difficulties in recruiting, the emphasis was switched to project management and a regional solution for translating.

However, the recruitment and allocation of additional resource has only just recently been completed, with a Welsh tutor recruited during October 2019 and a project support officer during 2018 to implement the Standards.

To assist within the implementation and ongoing compliance with the Standards, a restructure exercise is underway within the Welsh Language Unit.

ICT Investment

We were informed that the Health Board is unable to print bilingual letters for specific matters (e.g. care plans within Mental Health and Learning Disabilities), as required by the Standards. The Standards also require simultaneous translation for public meetings and for individual meetings

when requested. However, in both cases, the Health Board has implemented suitable processes to ensure compliance with each of them.

Staff Awareness

There are a range of initiatives underway from a corporate level within the Health Board, including:

- staff emails regarding communication in Welsh;
- promotion of the Standards on the intranet;
- frequently asked questions around the Standards; and
- 'Diwrnod Shwmae' to coincide with the Rugby World Cup.

In addition, the Health Board has now incorporated standing agenda items at Divisional Management Team meetings. However, this has only very recently just commenced.

Furthermore, Welsh awareness sessions have only attracted 483 members of staff from a total of c.14,500. Although a Welsh tutor has recently been appointed to assist with the Standards agenda and show visibility across the Health Board this has only happened several months following the first imposition date of the Standards.

We also examined the implementation plan, to determine if it is clear what the impact and requirements were for each individual division and directorate. However, there was no individual impact analysis or requirements for each directorate. Instead, the implementation plan has been prepared from the perspective of each standard.

This has been raised as a **recommendation** within Appendix A.

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	**1**	**1**	**0**	**2**

Finding 1 Welsh Language Strategic Group (Operation)	Risk
The Welsh Strategic Group has a responsibility for co-coordinating the approach for the implementation of the Standards within the Health Board, of which the majority of the Standards were scheduled for delivery by the end of May 2019 and an additional number by the end of November 2019 and November 2020. The table below illustrates the timeframes applicable and the current number still outstanding: **May 2019** / **November 2019** / **November 2020** *No. of Standards*: 103 / 17 / 4 *Implemented*: 99 / 8 / 3 *Outstanding*: 4 / 9 / 1 However, during September 2019, 24 Standards were still past their implementation date from May 2019. Whilst we found that the Welsh Strategic Group convened on a regular basis from February until June 2019, there has only been one meeting since, at a key time for the implementation of the Standards. In addition, the attendance at each of the meetings did not provide a sufficient representation from throughout the Health Board, with operational and clinical staff representation not always present. Furthermore, the project plan for implementing the Standards was not compiled until March 2019 and the structure of the task and finish groups was still being discussed alongside recruitment requirements during April 2019 – one month	There is insufficient scrutiny of the process surrounding the implementation of the Standards. There is a lack of representation from throughout the Health Board to ensure all key areas are aware of the requirements of the Regulations. The Standards are not implemented on time. The plans in place are not achievable which will result in the Standards not being implemented in time.

prior to the first imposition deadline for 103 of the Standards to be implemented. Finally, the terms of reference for the Group were not ratified until September 2019.	
Recommendation 1	**Priority level**
The Health Board should ensure: • that the Welsh Strategic Group monitor and escalate significant non-compliance or delays with the delivery of the Standards implementation to the Executive Team. This should continue until each of the Standards are suitably implemented; and • there is suitable representation from throughout the Health Board, to include all divisions.	**High**
Management Response 1	**Responsible Officer/ Deadline**
We accept this recommendation and will put appropriate actions in place to progress.	Geraint Evans By next Strategic Group (9th January 2010)

Finding 2 Staff Awareness (Design)	Risk
There are a range of initiatives underway from a central level within the Health Board, including: • staff emails regarding communication in Welsh; • promotion of the Standards on the intranet; • frequently asked questions around the Standards; and • 'Diwrnod Shwmae' to coincide with the Rugby World Cup. Furthermore, Welsh awareness sessions have only attracted 483 members of staff from a total of c.14,500. Whilst there is an overall implementation plan in place for implementing each of the Standards, only recently, has the Standards been added to the Divisional Management Team meeting agendas. Consequently, engagement with individual divisions and directorates has commenced later than the required implementation dates. As such it's unclear whether there is sufficient resource in place within the Divisions to ensure the Standards are implemented.	Health Board staff are unaware of the requirements of the Regulations and in turn the impact it will have on the organisation and their work. If Health Board staff are unaware of the Regulations this will impact the implementation across the Health Board which may result in a penalty from the Welsh Language Commissioner if the Standards are not implemented. Standards are not fully embedded.

Recommendation 2	Priority level
The Health Board should: • allocate additional resource to raise the profile of the Standards throughout all areas of the organisation, particularly operational; and • escalate to the Executive Team non compliance / delays with the programme.	**Medium**
Management Response 2	**Responsible Officer/ Deadline**
We accept this recommendation: • a review and assessment of the current resources will be undertaken and any gaps identified will be presented to the Executive Team. • arrangements will be put in place in order to ensure that non-compliance/delays with the programme will be reported to the Executive Team.	Geraint Evans End of February 2020

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*

*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.

In the event that, pursuant to a request which the client has received under the Freedom of Information Act 2000, it is required to disclose any information contained in this report, it will notify the Head of Internal Audit promptly and consult with the Head of Internal Audit and Board Secretary prior to disclosing such report.

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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Charitable Funds

Internal Audit Report
2019/20

Aneurin Bevan University Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Alison Griffiths, Charitable Funds / PPM Manager

Committee

Audit Committee
Charitable Funds Committee

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

ACKNOWLEDGEMENT
NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Please note:

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, approved by the Audit Committee.

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

1. Introduction and Background

The review of Charitable Funds was completed in line with the 2019/20 Internal Audit Plan. The review sought to provide Aneurin Bevan University Health Board (the 'Health Board') with assurance that operational procedure is compliant with Health Board corporate policies.

Charitable Funds is the term given to money that is donated to the Health Board and which is administered through a registered charity, Aneurin Bevan University Local Health Board Charitable Fund and Other Related Charities (the 'Charity'). The Health Board is the Corporate Trustee of the Charity and has appointed the Charitable Funds Committee to oversee the management of its funds.

The Health Board has worked with CCLA (Churches, Charities and Local Authorities) Investment Management ('CCLA') since 2018. CCLA are appointed to manage investments in accordance with the Health Board's ethical, environmental and investment objectives and ensure that they are not in contravention of the aims of the Charity.

During the year ended 31 March 2019, the Charity received income of £871k, which comprised of donations (£407k), legacies (£43k), course fees and related income (£234k) and investment income (£187k).

For the same period, the Charity spent £1.017m on charitable expenditure, including patient education and welfare (£131k), redesigning rooms and notice boards to make them more patient friendly (£43k), equipment (£367k), staff education and welfare (£324k) and support / fundraising costs (£152k).

2. Scope and Objectives

The overall objective of the review was to evaluate and determine the adequacy of the systems and controls in place within the Health Board for the management of Charitable Funds, in order to provide assurance to the Health Board's Audit Committee.

The purpose of the review was to establish if the Health Board has appropriate processes in place to ensure that the Charitable Funds are appropriately managed and administered in accordance with relevant legislation.

We sought to provide reasonable assurance over the following areas:

Stewardship of the Funds

- funds held in Trust are appropriately monitored, managed and invested in accordance with the investment strategy;
- arrangements are in place to ensure the prudent management of investments (e.g. low risk), investments are reconciled regularly and that they are consistent with the objectives of the Charity;
- investment services are re-tendered every 3-5 years;
- fees and charges are consistent with the market average;
- dividends and interest are credited promptly to the Fund bank account;

Income

- to ensure that the Health Board has established procedures in place for receiving charitable fund income;
- that monetary donations, including funds raised by staff are receipted in line with the Charitable Funds Policy;
- to determine if charitable funds income received is banked promptly, securely and in full, appropriately recorded and accounted for correctly;
- to ensure that donations / legacies are not accepted where the terms of legacy/donation place unnecessary restrictions on the funds use;
- review the process for reclaiming Gift aid and ensure it is completed on a timely basis; and

Expenditure

- charitable funds expenditure is appropriate, authorised and within the terms of the relevant fund.

3. Associated Risks

The risks considered in the review were as follows:

- governance and stewardship of the Charitable Funds are insufficient resulting in inappropriate expenditure being incurred;

- investments not being held in secure investments leading to a potential financial loss;
- non-compliance with operational policies as well as legislation and the Charity Commission guidelines;
- increased management costs incurred;
- charitable funds income may be incorrectly recorded and / or accounted for;
- charitable funds income is not being maximised and
- charitable funds expenditure may be in appropriate, excessive or incorrectly recorded and not in line with the principles of the policy.

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 Charitable Funds 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.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Stewardship of the funds				✓
2	Income		✓		
3	Expenditure				✓

** 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 Charitable Funds.

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 Charitable Funds.

6. Summary of Audit Findings

The Charitable Funds Financial Control Procedure (FCP) sets out the process to be followed for the day to day management of charitable funds and the corporate responsibilities of the Health Board and in particular each of the following key audit objectives:

Stewardship of Funds

The Health Board has an investment strategy in place and the funds are monitored, managed and invested in line with the strategy. The Health Board's investments are maintained by an investment management service, CCLA, who provide services for charities, religious organisations and the public sector. The Health Board re-tender for the service every

three years with the assistance of Procurement Services from NHS Wales Shared Services Partnership (NWSSP). The last tender was during 2017.

We identified that the investment portfolio consisted of shares in a major alcohol beverage company, thus contravening the investment policy of the Health Board and the spirit of the Charity's objectives. However, the Health Board had already identified this exception and has reallocated the funds into an ethical investment fund. As a result, the Health Board no longer invests in alcohol or other goods / services excluded within the investment policy.

We found fees and associated charges for maintaining an investment portfolio to be favourable compared to other investment management companies i.e. CCLA – 0.6% versus market fees of between 0.75% and 1.25%.

Overall, we found the controls in place for the management of the funds and charity to be established and operating as expected.

Income

We tested a sample of 25 donations. 20 were selected from direct credits and five were from faster / electronic payments, to ensure that each were processed in accordance with the Financial Control Procedure Charitable Funds (FCP). We did not identify any exceptions.

We also visited 10 wards (16 donations) at the Royal Gwent Hospital, to ensure that the receipt of donations at a ward level are processed in accordance with the FCP. We identified donations on six of these wards for testing. In particular, we examined the:

- completeness of the receipt book;
- depositing of donations at the General Office;
- banking of cash and cheques received;
- claiming of gift aid (where applicable);
- legacy income to ensure that there are no restrictions attached;
- issuing of thank you letters and acknowledgements; and
- general awareness of the FCP and receipt books.

The main exceptions identified were:

- we were unable to identify whether 3 of 16 (across three wards) donations had been banked, including one donation for £450. Subsequent to the audit, the Charitable Funds Team visited the respective wards and located the donations, which have since been banked accordingly;

- 3 of 10 wards visited were unaware of the FCP or the charitable funds receipt book; and
- 11 of the 16 (across all six wards tested) donations examined had not completed the gift aid section fully. The total gift aid reclaimed back by the Charity during 2018/19 was £3,750 or 0.92% of donations received.

Two recommendations have been raised within Appendix A to address the exceptions above.

Expenditure

The Charity is able to authorise expenditure through a paper based process or automatically, through Oracle.

We tested 25 expenditure claims to ensure compliance with the FCP. We did not identify any exceptions. In addition, the Charitable Funds Team is encouraging staff to authorise expenditure payments through Oracle, to provide an automated audit trail.

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	**1**	**1**	**0**	**2**

Finding 1 Income - Donated Income (Operation)	Risk
We visited 10 wards at the Royal Gwent Hospital and selected a sample of 16 donations to test for compliance with the FCP. We identified donations for testing on six of the ten wards. The following exceptions to the procedure were identified: • eight instances (across five wards) where the white receipts remained within the charitable funds books, rather than being given to the donor as per the required process; • eight instances (across five wards) where it was unclear if donors had received a thank you letter / acknowledgment; • three instances (across three wards) where the pink receipts remained within the charitable funds books and there was no evidence that the money had been to taken to the General Office or banked. One of which was for £450 and the other two were for £25 and £20, respectively. Subsequent to our visit, Finance undertook visits to the respective wards and the donations were found and processed appropriately; • two instances (same ward) where donations were made out to "charitable funds" and "gift aid" by a ward, but it was not known where the money had come from. However, it was banked via the General office; and • three instances where the wards were not aware of charitable fund processes nor the charitable funds receipt book.	Donations are not properly receipted and banked in a timely manner. Non-compliance with the financial control procedure. There is an increased risk of misappropriation of charitable funds.

Recommendation 1	Priority level
The Health Board should complete the following recommendation steps. 1. Make staff aware of the Charitable Funds Financial Control Procedure. This may be completed by visiting wards on a regular basis to ensure the procedure is adhered to and assisting staff with related queries. This process should also be utilised to gain a further understanding of the reasons for non-compliance and to tailor the support accordingly. In particular, the Health Board should ensure that: • staff are aware of the Charity and its objectives, together with supporting processes; • all donors are given a receipt; and • all donations of cash or cheques should be taken to the General Office with the pink receipt to ensure it is banked promptly. 2. Retain a copy of the FCP with the charitable funds receipt book in a secure / known place (rather than in the back of a drawer under old paperwork). 3. Provide a completed example of a receipt with the charitable funds receipt book, to provide a point of reference for staff.	**High**

Management Response 1	Responsible Officer/ Deadline
Agreed. A revised FCP was issued in July 2019, which includes a new flow chart for the receipt of income. This FCP is available on the intranet and the link to this was included in the Charitable Funds newsletter issued in early November. A copy of the newsletter will also be sent to all fund holders by e-mail by the end of November. The Charitable Funds Team will be visiting fund holders and relevant staff over the next few months. At these visits we will provide a paper copy of the FCP together with a double sided laminated instruction sheet consisting of the donation flow chart and an example of a completed receipt.	Charitable Funds Manager /November 2019 Charitable Funds Manager /March 2020

Finding 2 Income – Gift Aid (Design)	Risk
On each receipt in the charitable funds receipt book there is a gift aid box to tick if it is being claimed, in addition to a clear declaration of what is being claimed: *"We are able to recover the tax on your donation which allows us to claim a further 25p for every £1 donated. In order that we can qualify for tax relief you must supply us with your full name, home address and postcode and tick the box below.* *The amount of income Tax / or Capital Gains Tax payment for each tax year must be at least equal to the amount of tax that the charity will reclaim on your gifts for that tax year.* *Please tick if you would like Aneurin Bevan Local Health Board Charitable Fund to treat this donation as a Gift Aid donation."* However, from a sample of 16 donations tested there were 11 instances where gift aid was not reclaimed on the donation and of these: • seven had not ticked the box for gift aid; and • four instances where the gift aid box had been ticked, but there was no address included on the receipt to allow the tax relief to be claimed. The total gift aid reclaimed back by the Charity during 2018/19 was £3,750 or 0.92% of donations received.	The Health Board is losing out on reclaiming additional money which can then be added to the relevant charitable funds.

Some of the reasons identified for the exceptions above include: • staff are not aware of the process and in turn do not ask the donor; and • staff do ask the donor and tick the box to agree, but do not obtain the donor's full address.	
Recommendation 2	**Priority level**
Staff should be made aware of the gift aid process to reclaim additional tax relief when it is appropriate to ask the donor. In doing so, the potential additional income should be highlighted.	**Medium**
Management Response 2	**Responsible Officer/ Deadline**
Agreed We will remind fund holders and relevant staff of the gift aid process by e-mail. The Charitable Funds Team will be visiting fund holders and relevant staff over the next few months. At these visits we will explain the gift aid process ensuring that the Gift Aid explanation card is present in the front of the receipt book and reissue them where necessary.	Charitable Funds Manager / December 2019 Charitable Funds Manager /March 2020

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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IT Service Management Follow-up

Final Internal Audit Report

2019/20

Aneurin Bevan University Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Service

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

ACKNOWLEDGEMENT
NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

1. Introduction and Background

The follow-up review of IT Service Management was completed in line with the 2019/20 Internal Audit Plan. The 2017/18 review sought to provide Aneurin Bevan University Health Board (the 'Health Board') with assurance that IT services were provided in an efficient and secure manner and that reflect the needs of the organisation.

Best practice for IT service management is set out within ITIL, formally an acronym for Information Technology Infrastructure Library. This is a set of detailed practices for IT service management that focuses on aligning IT services with the needs of the business. ITIL describes processes, procedures, tasks, and checklists which are not organisation-specific, but can be applied by an organisation for establishing integration with the organisation's strategy, delivering value, and maintaining a minimum level of competency.

2. Scope and Objectives

The purpose of the follow-up review was to assess and report whether the Health Board has implemented the Internal Audit recommendations made in the IT Service Management audit report in 2017/18, which received a 'Limited Assurance' opinion.

The scope of this follow-up review does not aim to provide assurance against the full review scope and objective of the original audit. The 'follow-up review opinion' provides an assurance level against the implementation of the agreed action plans only. The recommendations made during the 2017/2018 audit and the current audit findings are set out in Appendix A.

3. Associated Risks

The overall risk to consider in the follow-up review was failure to implement agreed audit recommendations and therefore the risks are as per the original audit:

- IT services provided do not suit the needs of the organisation;
- changes are enacted inappropriately; and
- the organisation does not get full value from external suppliers

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 plans only.

Considering the progress made against the action plan the follow up review opinion at this time is **Reasonable Assurance**.

RATING	INDICATOR	DEFINITION
Reasonable Assurance		**Follow up –** Sufficient progress in implementation of all recommendations.

It is relevant to highlight that the original audit was against certain aspects of best practice and as such the limited assurance opinion highlighted the areas where improvement was required in order to meet best practice. The response to the original audit recognised that the audit was useful to identify those areas to focus on and also recognised that those improvements represent a significant body of work. This follow-up audit has focussed on the management arrangements to ensure that improvements are planned.

We note that as part of an overall response ABUHB Informatics recruited a Specialist ICT Service manager in July 2019 whose task it is to oversee and improve IT Service Management. A good start has been made with an assessment of the 'as is' position made and a Service Management Landscape document (SML) produced; it has been accepted by the head of ICT and will be presented to the other heads of department within ICT on 27th November 2019.

The SML document contains a series of short / medium / long term tasks which are individually mapped to one or more audit recommendations. When completed they will complete all of the agreed recommendations in a holistic and comprehensive manner. The timescale to complete all of the currently identified tasks started August 2019 and is scheduled to end February 2021; which we consider reasonable and achievable giving the overall scope of the work planned. The SML document includes the recognition that this process is effectively perpetual, and in February 2021 another iteration of the cycle will begin.

The SML sets out the actions require to enable Informatics to align to the ITIL framework, and provided there is continued support for this process the Health Board will be able to demonstrate compliance.

The assurance rating provided is on the assumption that the work that has started on the SML tasks continues with appropriate support and resource to enable implementation.

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 2017/18 audit	Direction of travel	Classification 2019/20 audit
Finding 1: No SOPs for key functions	**HIGH**	Good progress progress made, with some work still required to fully implement the recommendation.	**Medium**
Finding 2: Service design	**HIGH**	Good progress made, with some work still required to fully implement the recommendation.	**Medium**
Finding 3: Knowledge Management	**HIGH**	Good progress made, with some work still required to fully implement the recommendation.	**Medium**
Finding 4: Change Advisory Board	**HIGH**	Good progress made, with some work still required to fully implement the recommendation.	**Medium**
Finding 5: Framework Alignment	**Medium**	Good progress made, with some work still required to fully implement the recommendation.	**Medium**
Finding 6: Service Level Management	**Medium**	Good progress made, with some work still required to fully implement the recommendation.	**Medium**
Finding 7: Service Performance	**Medium**	Good progress made, with some work still required to fully implement the recommendation.	**Medium**

Area	Classification 2017/18 audit	Direction of travel	Classification 2019/20 audit
Finding 8: Call Classification	**Medium**	 Good progress made, with some work still required to fully implement the recommendation.	**Medium**
Finding 9: Call Classification consistency	**Medium**	 Good progress made, with some work still required to fully implement the recommendation.	**Medium**
Finding 10: Problem Identification	**Medium**	 Good progress made, with some work still required to fully implement the recommendation.	**Medium**
Finding 11: Supplier Management	**Medium**	 Good progress made, with some work still required to fully implement the recommendation.	**Medium**

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6. Summary of Original Audit Findings

1) Standard Operating Procedures (SOPs) (High)

There are no formal SOPs in place for key functions within informatics:

- operating either of the service desks;
- change control; and
- release and deployment management for software

Current Finding:

The SML notes that a large amount of documentation is extant which is spread across various formats. In addition it notes that NWIS have an ITIL compliant document set. The actions included in the SML involve reviewing these, adapting NWIS procedures where possible, updating local documentation as required and migrating these to a new SharePoint site.

We consider that the actions contained within the SML provide an appropriate mechanism to enable the Health Board ensure that SOPs are provided for key functions.

Current Status: Partially Implemented with a coherent plan to progress
Current Priority: Medium

2) Service Design (High)

The services provided by Informatics have not been formally designed but have grown organically with the organisation. Due to this there has been no structured assessment of IT services need and demand levels within the organisation and there is no formal list of services provided.

Current Finding:

A stakeholder map has been drafted and there is the intent to use this to continue to build relationships within Informatics and across the wider Health Board and National communities.

The SML identifies further actions, with a focus on setting up a service management forum within Informatics with key stakeholders encouraged to participate. Exact membership and terms of reference is to be decided but it is envisaged that this group will greatly improve communication around service management issues, raise the profile of service management within the organisation and become a decision making body for adoption of future improvements. This group will also take responsibility for receiving information from and providing feedback to relevant service management boards, ensuring that the local organisation has a view on service management issues that affect them.

In the longer term the SML introduces Continual Service Improvement (CSI) and notes this is at the heart of the ITIL framework and provides a wrap around all other processes. It uses methods established within quality management to learn from past successes and failures to continually improve the effectiveness and efficiency of IT processes and services. It recommends that CSI be introduced within ICT such that it is built into the design of each and every service and all associated processes. A CSI policy and process will be developed and a CSI register be implemented to record and manage any suggested CSI initiatives.

We consider, that provided the actions continue to be implemented with appropriate support, then the SML provides an appropriate mechanism to provide a stronger link between Informatics and the user services.

Current Status: Partially Implemented with a coherent plan to progress

Current Priority: Medium

3) Knowledge Management (High)

There is no structured process for managing knowledge within Informatics i.e. no Service Knowledge Management System (SKMS). Information such as contracts records, work instructions etc. is kept in multiple locations, is siloed and not shared across departments.

Current Finding:

Informatics use SharePoint as a mechanism for storing and sharing key information and the use of this has been reviewed.

The SML uses this as a starting point for improvements and notes that this is to be used as a document repository for all service management related documents such as polices, processes, work instructions, reports etc. It notes that considerable thought needs to be given to how this is best structured as it will form the basis of a knowledge management system and not just function as a document repository. There is a separate group discussing this topic for Informatics overall with the following service management items being considered:

- A document library where all ICT documents are stored. This will make use of metadata and associated views so that information can be filtered, sorted and displayed to multiple users. Where possible, documents such as work instructions or procedures should be linked to relevant predefined templates with the service management tool.
- A public calendar used for the publication of the forward schedule of change. This should include all approved, planned changes so that there is a consistent and comprehensive view of all change related activity to allow better planning and minimising the disruption caused by change.
- A review and approval mechanism, so that documents within the repository are not allowed to become stale. Documents will be given a review timescale when they are uploaded and SharePoint will trigger reminders as reviews become due.

We consider that the actions contained within the SML provide an appropriate mechanism to enable Informatics the effectively share information about the services it provides between the different teams. Provided that the implementation of the actions continues with appropriate support and engagement then this issue will be resolved.

Current Status: Partially Implemented with a coherent plan to progress

Current Priority: Medium

4) Change Advisory Board (CAB) (High)

Currently there is no effective CAB operating for Informatics as a whole. This leads to the risk of teams operating in silos and enacting changes that conflict or cause problems elsewhere due to lack of effective communication and review of proposed changes.

Current Finding:

The SML notes that the current organisational structure is very defined, whereby individuals sit in a particular team and have little if any knowledge of the way in which other teams operate. There is a requirement for some resource to work cross functionally carrying out activities such as change management, problem management and incident management. Other areas where cross skilling would be useful would be within the service desk environment, and also participation in the on call rota.

As part of reviewing the current structure clear roles and responsibilities will be defined that fit with the tasks in hand and with the ITIL framework. Each

process will be allocated a process owner, who will assume full accountability for effective process execution. With reference to this recommendation the role of Change Manager has been identified as missing in the current structure. At present there is no one actively taking on the role of Change Manager. Change management duties are carried out on a very ad hoc and informal basis. Effective and controlled change management is absolutely critical to the success of any IT Service Provider so it is recommended within the SML that this role be recruited for on a permanent basis.

Following the review and adaptation of policy and process documents, key processes should be published, socialised and implemented covering Change Management. The process will be owned by the Change Manager who will set up a revitalised Informatics Change Advisory Board (CAB) on a regular basis. The CAB will consist of service management and technical subject matter experts, alongside key users from the wider community and will advise the Change Manager on the suitability of presented changes for approval. The Change Manager will also publish the Forward Schedule of Change on the Informatics share point and deal with any conflicts surrounding change scheduling.

Provided that there is continued support for the implementation of the SML actions, we consider that the actions contained within the SML provide an appropriate mechanism to enable the Health Board to ensure that change management us undertaken in a structured and controlled manner.

Current Status: Partially Implemented with a coherent plan to progress

Current Priority: Medium

5) Framework Alignment (Medium)

There is no formal alignment to any framework for IT Service Management within the Health Board and no definition of a Service Strategy or any formal assessment of demand.

There is some awareness of ITIL and its underlying concepts. However, this varies within Informatics, with the ICT team having provided training to some staff and the CAIST team having none. This variation feeds into the degree of move towards alignment, with the ICT team starting this process.

Accordingly there has been no dialogue with customers to define the value of IT Services or the desired outcomes in the service provision. The teams have taken a pragmatic approach with an aim to resolve queries at first point of contact if possible.

Current Finding:

The Health Board has committed to adopting the ITIL framework and has appointed a service management lead with a remit to facilitating this. In addition many staff have undertaken ITIL training and certification to foundation level and steps have been taken to align activities with the framework.

There is a caveat within the SML as it notes that the ITIL framework is very comprehensive and covers the full service lifecycle. Alignment to this framework will be a relatively lengthy journey but can be addressed incrementally so that key areas of concern can be addressed initially with lower priority tasks completed later.

We consider that the Health Board has made a demonstrable commitment to aligning Informatics activities with the ITIL framework and that there is a coherent mechanism to provide for this.

Current Status: Partially Implemented with a coherent plan to progress

Current Priority: Medium

6) Service Level Management (Medium)

There is no formal Service Level Management within Informatics. Consequently there are no SLAs with customers and no discussion with users regarding what the required service levels would be.

Current Finding:

As noted above the intent is to establish a Service Management Forum with key stakeholders to agree targets for performance measurement. The SML further notes other key actions to improve, with the development of a Sever Level Policy/Process being identified as a key item.

Provided that there is continued support for the implementation of the SML actions we consider that the actions contained within the SML provide an appropriate mechanism to enable Informatics to develop its Service Level Management process.

Current Status: Partially Implemented with a coherent plan to progress

Current Priority: Medium

7) Performance Management (Medium)

There is very little monitoring of performance of the service desks, with what monitoring there is being against volume and system type rather than service provision. In addition there is no reporting of this information to customers and no engagement with customers to seek feedback on the service received.

Current Finding:

The SML notes that Service Point should be retained certainly in the short term, but configured correctly to allow it to deliver maximum benefit. At present there is very little done in terms of reporting of service level targets, providing ICT Services with no way of ascertaining levels of performance and no way of ensuring that services are delivered within the terms of any agreements in place with service consumers.

There are arrangements in place that define targets for particular services in terms of response time, resolution time etc., but these have not been agreed and are not implemented on a routine basis. In addition there is a set of

national service level targets that exist, but again these have not been agreed by anyone within the Health Board.

The SML recommends that these targets are agreed within the Service Management Forum as fit for purpose and that they are implemented across every service within the service catalogue. Once these has been adopted, and reporting expanded within the Service Management tool, performance reports can be produced to gauge how well ICT meets its obligations, and also to provide a baseline of performance on which to build any proposed future service improvement plans. Subsequently a standard set of Key Performance Indicators should be agreed and implemented, this will ensure that all services are measured consistently and that metrics provide value to the organisation.

We consider that the actions contained within the SML provide an appropriate mechanism to enable Informatics to effectively monitor and report on its service provision.

Current Status: Partially Implemented with a coherent plan to progress

Current Priority: Medium

8) Classification Scheme (Medium)

Although calls are classified and assigned a priority, the scheme used is the national one. There is no formal classification scheme that has been considered by Informatics and agreed with users within the organisation.

Current Finding:

The SML notes that as part of drafting suggested KPIs and Targets, classification and categorisation of incidents and service requests will need to be clearly defined. Linked to the review of the processes and structures in place the SML notes that the role of incident / problem manager does not exist. Consequently it recommends providing a staff member to provide effective process management of Incident and Problem management.

Incident Management – The incident management process is to be owned by the Incident/Problem Manager and will govern how all incidents received by ICT will be recorded, managed, resolved and reported on. Management of Major Incidents and the On Call Procedures will also be in scope for this process.

Provided that there is continued support for the implementation of the SML actions we consider that the actions contained within the SML provide an appropriate mechanism to Informatics to classify and prioritise calls in a way that best fits with its users.

Current Status: Partially Implemented with a coherent plan to progress

Current Priority: Medium

9) Classification consistency (Medium)

A review of calls received by the CAIST team identified the following issues:

- there is inconsistency in using the call type definition with access issues being recorded under "functionality issue", "login/access issue", "request for change" and "standard request;"
- slow response under "functionality" and "slow response";
- there is no separate identification of service requests, incidents, problems; and
- the use of the priorities is inconsistent with the same call title having changing priorities.

These inconsistencies will make it difficult to effectively track performance and identify underlying reasons for calls.

Current Finding:

Following on from the point above, the revised incident management and request fulfilment process will allow for consistency of recording and Service Point is to be correctly configured to reflect this process.

Current Status: Partially Implemented with a coherent plan to progress

Current Priority: Medium

10) Known Errors (Medium)

There is no record of known errors in place. The lack of a known error record leads to inefficiencies in dealing with calls relating to these and the service desks are heavily reliant of staff knowledge. In addition, there is no process in place for reviewing calls for identifying underlying problems in order to fix / escalate / record as known errors. This is due mainly to the lack of ability to extract information from Service Point.

Current Finding:

As referenced above, the SML notes that a problem management process is to be defined and owned by the Incident / Problem Manager. Ensuring that the known error database within Service Point is populated and linked to incident templates is part of this.

Provided that there is continued support for the implementation of the SML actions we consider that the actions contained within the SML provide a mechanism for Informatics to manage problems and the associated knowledge in an appropriate manner.

Current Status: Partially Implemented with a coherent plan to progress

Current Priority: Medium

11) Supplier Management (Medium)

Although there is a record of external suppliers kept, there is minimal active managing of services received, with no formal leads for monitoring / liaising with each supplier / contract, no active monitoring of supplier risk and no consistent monitoring of contract performance and associated activation of penalty clauses.

Current Finding:

The current position has not significantly changed, with a record of external suppliers maintained.

The SML considers supplier management and contains actions for improvement. The intent is for a review of current suppliers with a mechanism for regular service review meetings be introduced where provided services can be reported and discussed to ensure compliance with the contracts that govern that service.

A nominated lead contact within ICT is to be defined for each supplier who will assume responsibility for conducting these service review meetings, ensuring performance targets are met and also for developing ongoing relationships.

Provided that there is continued support for the implementation of the SML actions we consider that the actions contained within the SML sets out a framework for ensuring supplier management is undertaken in an appropriate manner.

Current Status: Partially Implemented with a coherent plan to progress

Current Priority: Medium

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 progress is outlined below.

Actions Implemented in Full	Actions Implemented in Part	Actions Not Implemented
0	**11**	**0**

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.

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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Divisional Review - Scheduled Care

Internal Audit Report
2019/20

Aneurin Bevan University Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Executive sign off	Claire Birchall, Executive Director of Operations
Distribution	Glyn Jones, Executive Director of Finance and Performance Glenys Mansfield, Divisional Manager Scheduled Care

Andy Bagwell Clinical Director, Scheduled Care

Committee Audit Committee

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

ACKNOWLEDGEMENT
NHS Wales Audit & 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 Scheduled Care Division (the 'Division') was completed in line with the 2019/20 Internal Audit Plan. The review sought to provide Aneurin Bevan University Health Board (the 'Health Board') with assurance over compliance with policies and procedures and the management of risk within the Scheduled Care Division.

2. Scope and Objectives

The internal audit assessed the adequacy and effectiveness of internal controls in operation in the Scheduled Care Division. 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 main areas reviewed were to ensure that:

Governance Arrangements

- appropriate governance structures, committees and groups are in place with clear reporting lines that support the key operational functions of finance, workforce, planning and performance and quality and patient safety;
- business partners provide appropriate support for the Division's key operational functions;
- policies and procedures within the Division are owned and are up to date;
- there are appropriate mechanisms in place to ensure new legislative and regulatory information received is disseminated and actioned on a timely basis; and
- declarations of interest (or nil returns) are submitted for all relevant staff and the division is aware of the declarations made.

Planning and Performance

- the Division has appropriate arrangements in place to ensure that its Integrated Medium Term Plan (IMTP) is developed in accordance with the Health Board's corporate planning framework;
- budget holders and other relevant staff are appropriately engaged in the development of the IMTP, including service change plans;

- the Division has appropriate non-financial performance measures and key performance indicators in place that cover relevant service delivery and cross-cutting themes, such as workforce. These are formally reviewed and reported on a regular basis;
- the Division has arrangements in place to generate and capture quality and patient data as a means of identifying areas for improvement;
- the Division has appropriate action and recovery plans in place, where required, in relation to both financial and non-financial activities. For example, should performance targets begin to show an adverse variance; and
- demand and capacity plans are used as 'day to day' business planning tools for managing the Division and are monitored to ensure they remain fit for purpose.

Risk management processes are audited separately annually and therefore were not reviewed in detail as part of this audit.

During the audit, we sampled three directorates; Radiology, Trauma and Orthopaedics and Anaesthetics.

3. Associated Risks

The potential risks considered in the review were as follows:

- the Division is not appropriately governed which could result in a service that is not being delivered safely and effectively;
- services are not effectively planned;
- management arrangements in the division are not effective; and
- objectives within the Division are not achieved as a result of demand and capacity data failing to be properly used and monitored.

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 within the Divisional Review - Scheduled Care 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.

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5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Governance structures			✓	
2	Business partners			✓	
3	Policies and procedures		✓		
4	Dissemination channels			✓	
5	Declarations of interest		✓		

Assurance Summary					
6	Development of directorates IMTP investment schemes			✓	
7	Performance monitoring of IMTP deliverables			✓	
8	Patient safety and quality			✓	
9	Performance/ recovery plans			✓	
10	Demand and capacity plans			✓	

** 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 classified as weaknesses in the system/control design for Divisional Review – Scheduled Care.

Operation of System/Controls

The findings from the review have highlighted three issues that are classified as weaknesses in the operation of the designed system/control for Divisional Review – Scheduled Care.

6. Summary of Audit Findings

(i) Governance Structures

The Health Board does not prescribe the structure that its divisions are required to adopt, but each are set up to support the monitoring and delivery of divisional activities. We observed that oversight groups operate at division and directorate levels and that generally speaking these do so with an appropriate level of formality in terms of documentation and evidence. That said, we noted the absence in some cases of documented

terms of reference to support the management groups and this is raised as **recommendation 2.**

(ii) Business Partners

The Division operates with the assistance of finance and workforce business partners. The business partners are members of the Divisional Management Team and advise on and support the development of strategic plans, business cases, IMTP and key divisional projects. We identified that appropriate support is provided by the business partners to the division.

(iii) Policies and Procedures

The Division's activities are wide ranging through the provision of clinical care. The need for clear and accessible policies and procedures is paramount. Testing our sample of directorates indicated a lack of clarity over ownership and responsibility of these documents as well as what is prescribed by the Health Board for their update and maintenance.

The policy and procedure documents that we tested revealed a wide variety of different formats in use as well as widespread deficits in document control features i.e. status/ serial number/ document date/ document version/ author/ approver/ review date etc. and as a result, a high priority recommendation has been made to tighten controls in this area, as raised within **recommendation 1.**

(iv) Dissemination Channels

Directorates generally disseminate policy, procedure or technical materials that reach them from the Division or professional/ clinical groups via pre-defined group e-mails to appropriate staff. Cascade routes vary across directorates but in general, alerts or notices are passed down through the Division and directorate management structures to directorate staff. Additionally intranet, speciality web pages and forums, newsletters and document management systems e.g. Q-Pulse all serve to achieve the sharing/ distribution of key materials.

However, whilst key information is typically cascaded as listed above, there is no formal measure to ensure that this happens at each management or team meeting. Therefore, we have raised a recommendation (**recommendation 5**) to implement a standing agenda item for each relevant meeting to discuss any significant changes on the horizon, for example, legislative changes.

(v) Declarations of Interest

Where a member of the Board, its staff or individuals working with the organisation has a controlling or significant financial interest in a business or organisation to which the Health Board may be awarding business or making financial grants there is a requirement to declare that interest. The

Health Board policy requires that entries (either disclosure or if none, a 'nil return') are made in the register provided and reviewed annually.

Exceptionally, for General Managers and Heads of Department, this responsibility falls on the Divisional Director (for all other groups the co-ordination of this review is the responsibility of the Board Secretary and therefore out of the scope of this audit), but we found no evidence that this was taking place within the Division and have therefore raised a finding accordingly, as **recommendation 3.**

(vi) Development of Directorate IMTP Investment Schemes

Directorates complete an investment scheme schedule setting out a list of proposed development initiatives for the forthcoming years. These are submitted to the Division and selected initiatives are included within the Division's IMTP. Divisional IMTPs are consolidated into a Health Board level IMTP document (not in the scope of this audit) which is submitted to Welsh Government.

Delivery of IMTP initiatives is monitored through a range of management oversight groups. We tested a sample within these records and corroborated the status of their delivery from information provided by directorate and group members.

(vii) Performance Monitoring of IMTP Deliverables

The Division has a wide range of comprehensive performance monitoring and reporting activity tools. The IMTP records targets and how these will be achieved, together with numerous delivery boards and groups – including:

- Planned Care Programme Board;
- Theatres Programme Board;
- weekly special measures and cancer delivery meetings; and
- weekly Divisional Management Team meetings.

The audit examined evidence of performance monitoring of RTT and KPI measures and we did not identify any issues.

(viii) Patient safety and quality

Quality and patient safety is monitored through the Divisional Patient Safety and Quality meeting (DPSQ). The DPSQ is a nursing led monthly meeting with a standing agenda, papers, minutes and actions, and outcomes of the Division level meeting feed into the corporate level Patient Safety & Quality Operations Group (PQSOG).

Clinical practice throughout the Health Board is prescribed by principles within the Health and Care Standards, with a perpetual cycle of in-house compliance audits conducted by the Quality and Patient Safety team. Whilst outcomes at a summary level are shared with the Division at DPSQ and

directly with individual teams, there is no forum within the Division for ensuring themes / actions are addressed. As such, recurring weaknesses in ward based patient level documentation may not be addressed. This has been raised as **recommendation 4.**

(ix) Performance and Recovery Plans

Directorates contribute performance material into a divisional level monthly assurance report that goes to the Chief Operating Officer for the monthly divisional assurance meetings.

These reports, based on a standard format, cover the following broad core features (although the detail of the full report varies each period according to issues prevailing):

- concerns and serious incidents;
- patient safety and quality;
- finance;
- referral to treatment (RTT) updates;
- cancer update;
- workforce performance; and
- Clinical Futures updates.

Recovery plans are required for a directorate where RTT delivery is falling short of that planned and we noted that in the Trauma and Orthopaedics directorate, additional activity has been hindered by the impact of changes to tax levels on consultants' pay and consequently, delivery against RTT plans has fallen sharply. The Directorate has submitted a recovery plan to the Division to address the issues.

(x) Demand and Capacity plans

Directorates submit demand and capacity plans against RTT delivery objectives during the IMTP planning phase. Capacity is determined (using the 'Team effectiveness' model) by reviewing staffing levels and, using conversion rates, deriving the case volumes that these equate to. Demand is based on prior year volumes enhanced by forecast factors. Gaps are seen where case demand exceeds capacity to deliver.

Directorates' Sustainability/ Transformation Action Plans, which are submitted to Executives, set out efficiency, demand management and a range of other measures that will be adopted to address gaps indicated by demand and capacity assessments. Directorates of the division with RTT targets closely monitor service delivery with detailed weekly activity trackers and, informed by these, the division participates in the weekly RTT meeting (not minuted) led by the Chief Operating Officer.

Directorates where actual activity levels being achieved fall significantly below delivery plan targets are required to revise their delivery plan model and submit recovery plans that set out what actions will be taken to improve recovery and delivery.

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	**1**	**3**	**1**	**5**

Finding 1 Policies and Procedures Governance (Design / Operation)	Risk
We noted an absence of directorate level control schedules, logs or registers of the policies and procedures owned in two of the three sample directorates examined in the audit, and an absence of any process/ cycle of update or programme for refreshing of these. As a result, there were no definitive directorate records we could test to assess controls around currency or completeness of this key document set. Health Board policy stipulates controls in this area and in particular: *'Each Directorate or Division will put in place a robust controlled documentation system to ensure that records of distribution of policies and other written control documents are maintained',* and *'policy documents must be reviewed no later than three years after initial approval and regularly reviewed on the same basis thereafter. Documents will be reviewed more frequently if changes in legislation or the service requires it'*. We examined a sample of policy and procedure documentation in the directorates of Radiology and Anaesthetics (we could not establish a set of policies and procedures associated with the third sample directorate, Trauma and Orthopaedics, so were unable to sample their records) and found the following themes: • policies and procedures are not drafted on the standard corporate template and formats were seen to vary widely; • in many cases examined there were deficits observed in some/ all of the document control features i.e. status/ serial number/ document date/	Risk that documented policies and procedures are inaccurate, incomplete, outdated and out of alignment with actual practices.

document version/ author/ approver/ review date etc. (note Radiology documents held in the Q-Pulse document management system had a lesser instance of deficit); and • many documents listed, where this was recorded, had passed their review date.	
Recommendation 1	**Priority level**
We recommend that policies and procedures owned by the directorates are managed in local registers and that a consistent process is put in place across all directorates to address the document refresh and control weaknesses noted in the finding.	**High**
Management Response 1	**Responsible Officer/ Deadline**
Agreed. Request out to all Directorate Managers, Senior Management and Nursing Teams have been sent a list of Standard Operating Policies and procedures. The list is to include: title, date of review and document owner; to be reviewed by the end of November. Division is exploring options for a Quality Management System (QMS), including the current QMS in use in Radiology and Pathology (Q-Pulse). Once an evaluation of the available systems is complete, recommendations for the most appropriate will be made to DMT for procurement and implementation by the end of the financial year.	Glenys Mansfield 30/11/19 Gwawr Evans 31/3/20

Finding 2 Division and Directorate Governance (Operation)	Risk
The Division and its directorates have a framework of management oversight groups/ teams/ committees/ boards/ meetings that oversee and monitor controls and delivery. The level of formality varies across these in terms of agendas/ papers/ minutes/ action logs that they operate, but these features were found to be in place for the key divisional management team meetings. Whilst, the following observations were made in examining this area, we found that the overall control more than adequately compensated for any additional risk: • excepting the Divisional Patient Safety & Quality Group, terms of reference documents were not available for the Division/ directorate level management groups examined. As such, it was not possible to establish their formal intended purpose, responsibilities, delegated decision making powers, quoracy, membership, etc.; • formal quarterly IMTP meetings between the Division and directorate managers had not taken place over the period of review (but we noted were being reinstated from July 2019); • there were gaps in the regular monthly directorate management meetings because there had been periods when Radiology and Anaesthetics directorate manager posts were vacant.	Risk that governance structures may not be in line with Health Board/ best practice standards. There is an increased risk of inefficient utilisation of resources. The Division is slow to respond to issues arising.

Recommendation 2	Priority level
We recommend that terms of reference documents are developed and ratified for the key management / oversight groups within the Division. In particular, to ensure appropriate membership and quoracy requirements are in place to support the objectives of the respective group.	**Medium**
Management Response 2	**Responsible Officer/ Deadline**
Agreed. Full Divisional review, by Directorate by all Directorate teams to establish a list of meetings, standard agenda and Terms of reference These, including the Divisional meetings will be collated and a full review of meeting purpose and reporting will be established. Gaps in availability of Terms of Reference will be identified and the owner of the meeting will be required to complete Terms of Reference sharing purpose and accountability.	Glenys Mansfield 31/12/19 Glenys Mansfield 28/02/20

Finding 3 Declarations of Interest (Operation)	Risk
The Health Board requires that staff assessed as being at risk of having potential conflicts of interest complete an annual review of their declarations or confirm their 'nil return'. Under policy rules (*Policy for Standards of Business Conduct Incorporating Declarations of Interest and Receipt of Gifts and Hospitality*), divisional directors are required to co-ordinate the annual process and ensure General Managers and Heads of Department in their division have made an annual declaration/ nil return. However, we could find no evidence that the Division maintains any records to demonstrate compliance with these requirements as applicable to the Division.	Risk that undisclosed conflicting interests compromise the Health Board's integrity, impartiality and transparency.
Recommendation 3	**Priority level**
We recommend that records of an annual review of relevant staff declarations are maintained by the Division to evidence compliance.	**Medium**

Management Response 3	Responsible Officer/ Deadline
Agreed. Request submitted to the Board secretary to obtain confirmation that the medical staff across the Division have their declarations kept corporately. Divisional Senior Management Team and Directorate Management Teams emailed asking them to read and be aware of the Policy for Standards of Business Conduct. Divisional review of all declarations and baseline establishment of all General Managers and Heads of Departments for exceptionality against the referenced guidance to be undertaken. Declaration form shared across the Division for completion by the end of December.	Glenys Mansfield 28/11/19 Andy Bagwell 24/12/19 Gwawr Evans 24/12/19

Finding 4 Patient Safety & Quality Review Actions (Design)	Risk
We noted a wide reaching programme of assessments in operation, based on the Health and Care Standards framework and spanning all areas of the Health Board's clinical activities. Actions arising from Health and Care Standards Assessment (HaCi) audits are captured in the DATIX 'Actions' module and prompts to action are then automatically e-mailed to action owners. However, neither the DPSQ nor any other team or group is tasked with monitoring delivery and closure of these actions. At the time of the audit, 24 actions were overdue. Additionally, the key current recurring theme emerging from HaCi audits is weaknesses in ward based patient documentation, but we were advised that	Risk that key actions to address control weaknesses revealed by assessment activities are not implemented.

there is no forum where these themes are reported or for actions to resolve them. We were unable to obtain evidence that they are being progressed.	
Recommendation 4	**Priority level**
We recommend that processes to monitor delivery of remedial actions and to address themes emerging from HaCi audits are implemented to progress improvements to standards.	**Medium**
Management Response 4	**Responsible Officer/ Deadline**
Agreed. The Divisional's Patient Safety and Quality Group will develop a tracker of the outstanding actions logged which will cover , Ombudsman actions, Complaint actions /changes , HaCi assessments and External Inspections. This will allow themes to be clearly identified and discussed at DPSQ to agree next steps and this forum will also review effectiveness of actions	Linda Jones 31/12/19

Finding 5 Clinical and Legislative Updates (Design)	**Risk**
Directorates generally disseminate policy, procedure or technical materials that reach them from the division or professional/ clinical groups via pre-defined group e-mails to appropriate staff. Cascade routes vary across directorates but in general, alerts or notices are passed down through the Division and directorate management structures to directorate staff. Additionally intranet, speciality web pages and forums, newsletters and document management	There is an increased risk that upcoming changes are not disseminated sufficiently in advance.

systems e.g. Q-Pulse all serve to achieve the sharing/ distribution of key materials. However, whilst key information is typically cascaded as listed above, there is no formal measure to ensure that this happens at each appropriate management or team meeting.	
Recommendation 5	**Priority level**
The Division should ensure that key management meetings hold a standing agenda item regarding clinical and legislative changes, to serve as a tool for identifying upcoming changes in advance and implementing the necessary action.	**Low**
Management Response 5	**Responsible Officer/ Deadline**
Agreed. Each Directorate meeting and Divisional Management Team to have included an agenda item on legislative changes, this will also be on the DPSQ and Divisional Management Team operational agenda. Co-ordination of key changes will be owned and disseminated by the General Managers office.	Glenys Mansfield 31/12/19

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*

*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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