Audit, Risk and Assurance Committee (Draft Accounts)

Tue 19 May 2026, 09:30 - 12:00

MS Teams

Agenda

09:30 - 09:30
0 min

1. Preliminary Matters

1.1. Welcome and Introductions

1.2. Apologies for Absence

1.3. Declarations of Interest

1.4. Draft Minutes of the last Meeting held on 28th April 2026

Chair

ARAC 20260519 1.4 20260428 Main Meeting Minutes - Chair Approved.pdf (9 pages)

1.5. Committee Action Log and Matters Arising

Chair

ARAC 20260519 1.5 20260428 Action Log - Chair Approved.pdf (3 pages)

09:30 - 09:30
0 min

2. Items for APPROVAL/RATIFICATION/DECISION

There are no items for inclusion in this section

09:30 - 09:30
0 min

3. Items for Discussion

3.1. To Review the Health Board's Annual Report (Overview & Performance Section) (Part 1)

Director of Corporate Governance

ARAC 20260519 3.1 Annual Report.pdf (5 pages)
ARAC 20260519 3.1 Annual Report Appendix A.pdf (66 pages)

3.2. To Review Draft/Final Accountability Report, including Annual Governance Statement (Part 2)

Director of Corporate Governance

ARAC 20260519 3.2 Accountability Report.pdf (107 pages)

3.3. To Review Draft/Final Annual Accounts and Financial Statements (Part 3)

Director of Finance and Procurement

ARAC 20260519 3.3 2025-26 Draft Annual Accounts Report VFinal.pdf (25 pages)
ARAC 20260519 3.3 ABUHB Draft 2025-26 Annual Accounts Appendix A.pdf (80 pages)

3.4. To Review Audit Enquiries to those charged with Governance and Management

Director of Finance and Procurement

- ARAC 20260519 3.4 Audit Enquiries Paper.pdf (3 pages)
- ARAC 20260519 3.4 Audit Enquiries Paper Appendix A.pdf (26 pages)

3.5. To Receive Report of Losses and Special Payment

Director of Finance and Procurement

- ARAC 20260519 3.5 Report of Losses and Special Payment.pdf (10 pages)

3.6. To Receive the Counter Fraud Annual Report and Agree the Counter Fraud Functional Standard Return Declaration

Director of Finance and Procurement

- ARAC 20260519 3.6 Counter Fraud Annual Report.pdf (3 pages)
- ARAC 20260519 3.6 Counter Fraud Annual Report 2025-26 Appendix A Final.pdf (34 pages)

3.7. To Receive Deep Dive of audit recommendations

Director of Corporate Governance

- ARAC 20260519 3.7 Deep Dive of Audit Recommendations.pdf (8 pages)
- ARAC 20260519 3.7 Appendix 2 Discharge Planning Recommendation Overview.pdf (8 pages)
- ARAC 20260519 3.7 Appendix 3 Total Live Digital Recommendations - 32.pdf (6 pages)
- ARAC 20260519 3.7 Appendix 4 Completed Digital Recommendations 4.pdf (1 pages)
- ARAC 20260519 3.7 Appendix 5 Remaining Live digital Recommendations 28.pdf (5 pages)
- ARAC 20260519 3.7 Appendix 6 Live Pre 2024 Recommednations (Not including digital or discharge planning) - 10.pdf (2 pages)
- ARAC 20260519 3.7 Appendix 7 Pre 2024 Completed Recommendations.pdf (1 pages)
- ARAC 20260519 3.7 Appendix 8 Remaining live pre 2024 recommedations.pdf (1 pages)

3.8. To Receive Strategic Risk and Assurance Report

Head of Internal Audit

- ARAC 20260519 3.8 Strategic Risk & Assurance Report.pdf (7 pages)
- ARAC 20260519 3.8 Strategic Risk Dashboard & Assessments Appendix A.pdf (44 pages)
- ARAC 20260519 3.8 Strategic Risk & Assurance Report Appendix B.pdf (1 pages)

3.9. To Receive Internal Audit Progress Report

Head of Internal Audit

- ARAC 20260519 3.9 202627 Internal Audit Planpdf.pdf (28 pages)
- ARAC 20260519 3.9 Internal Audit Progress Report.pdf (6 pages)

3.10. To Receive Internal Audit Reports

Head of Internal Audit

- ARAC 20260519 3.10 Final Internal Audit report 202526.pdf (3 pages)
- ARAC 20260519 3.10 Space Utilisation Final Advisory Report.pdf (10 pages)

3.11. Receive the External Audit Annual Audit Report

Audit Wales

- ARAC 20260519 3.11 External Audit Annual Audit Report.pdf (18 pages)

09:30 - 09:30
0 min

4. Items for Information

4.1. To receive Committee Programme of Business 2026/27

Chair

ARAC 20260519 4.1 Audit, Risk and Assurance Committee Forward Work Plan Cover Report.pdf (3 pages)
ARAC 20260519 4.1 Committee Work Programme 2026-27 Appendix A.pdf (6 pages)

4.2. To Receive the Audit Wales GMS Contract Challenges Report

Chair

ARAC20260519 4.2 GMS contract challenges.pdf (32 pages)
ARAC20260519 4.2 GMS contract challenges Appendix A.pdf (7 pages)

09:30 - 09:30
0 min

5. Other Matters

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

Chair

5.2. Any Other Urgent Business

Chair

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN/ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING MINUTES OF THE AUDIT RISK & ASSURANCE COMMITTEE

DATE OF MEETING	Tuesday 28th April 2026 09:30-11:30
VENUE	Microsoft Teams

PRESENT	Iwan Jones - Committee Chair – Independent Member Dafydd Vaughan - Independent Member Neil Patrick - Independent Member Helen Sweetland – Independent Member
IN ATTENDANCE	Rani Dash - Director of Corporate Governance Lucy Windsor – Head of Corporate Risk and Assurance Rob Holcombe – Director of Finance and Procurement Robert Jones – Assistant Director of Finance Gareth Lavington – Head of Counter Fraud Paul Solloway – Director of Digital Murry Guard – Auditor, Internal Audit Naomi Murtaugh – Head of Board Business Stephen Chaney - Head of Internal Audit Efion Jones – Deputy Head of Internal Audit Sara Utley - Performance Audit Lead, Audit Wales Julie Rees – Finance Audit Manager, Audit Wales Andrew Doughton – Audit Wales Harry Morris – Secreteriat Danielle Jackson - Secretariat
OBSERVING	None to note
APOLOGIES	Helen Sweetland – Independent Member

Minute Reference	Preliminary Matters
ARAC 0428/01	**Welcome and Introductions** The Chair welcomed everyone to the meeting.
ARAC 0428/02	**Apologies for Absence** Apologies were noted.

ARAC 0428/03	**Declarations of Interest** There were no declarations of interest raised to record.
ARAC 0428/04	**Minutes of the previous meeting** The minutes of the meeting held on the 12 February 2026 were agreed as a true and accurate record.
ARAC 0428/05	**Committee Action Log** The Committee reviewed the action log, noting actions completed, actions in progress, and actions not yet due. Iwan Jones (IJ), Committee Chair, highlighted a query relating to discharge planning actions, noting that there had previously been inconsistencies between reported positions and the audit log. IJ requested assurance that these would be reconciled. Lucy Windsor (LW), Head of Corporate Risk and Assurance, confirmed that this would be addressed within the forthcoming deep dive report. The Committee **AGREED** that completed actions could be removed from the Action Log.
ARAC 0428/06	**Revisit Records Management Internal Audit** Stephen Chaney (SC), Head of Internal Audit, presented an update on the Records Management audit. SC outlined that the previous review had been assessed as Limited Assurance and that a key action related to implementation of a new software solution. Rather than undertaking a standalone audit in 2026/27, SC advised that progress against the key actions would be reviewed within a wider digital project management audit. Paul Solloway (PS), Director of Digital, advised that a software development roadmap, including records management system improvements, would be presented to the Executive Committee to support prioritisation. Members acknowledged that records management remained a long-term programme with several actions still outstanding. The Committee **NOTED** the update.

	ITEMS FOR APPROVAL / RATIFICATION / DECISION
ARAC 0428/07	**To Approve reviewed and updated Financial Control Procedures** Robert Jones (RJ), Assistant Director of, presented the updated Financial Control Procedures (FCPs), noting two minor updates and confirming that all other procedures remained within review cycles. Iwan Jones (IJ), Committee Chair, sought assurance on delivery against key financial reporting milestones. RJ confirmed that all deadlines remained on track, and Julie Rees (JR), Audit Wales, confirmed no concerns from an external audit perspective. Dafydd Vaughan (DV), Independent Member, queried whether non-NHS clinical commissioning procedures covered GP services. Robert Holcombe (RH), Director of Finance and Procurement, clarified that the procedures applied specifically to secondary care. The Committee **APPROVED** the updated Financial Control Procedures; Financial Management System General Ledger and Commissioning Non-NHS Clinical Services
ARAC 0428/08	**To Agree the Counter Fraud Annual Work Plan 2026/27** Gareth Lavington (GL), Head of Counter Fraud, presented the annual work plan, noting that it remained broadly consistent but had strengthened alignment to the NHS Wales Counter Fraud Strategy. Neil Patrick (NP), Independent Member, queried the risk posed by artificial intelligence (AI) in fraud. GL advised that current concerns related primarily to recruitment fraud involving AI-generated applications. Paul Solloway (PS), Director of Digital, highlighted that guidance was available for managers on identifying AI use in recruitment. Robert Holcombe (RH), Director of Finance and Procurement, added that the counter fraud approach was increasingly risk-based, with stronger engagement from executive leads.

	The Committee **APPROVED** the Counter Fraud Annual Work Plan 2026/27.
ARAC 0428/09	**To Approve Audit Recommendation Tracking report.** Lucy Windsor (LW), Head of Corporate Risk and Assurance, presented the Audit Recommendation Tracking Report for Q4 December 31, 2026 – March 30, 2026, highlighting: • 29 recommendations completed • 27 revised deadlines • 80 live recommendations remaining LW advised that several older recommendations, particularly low-priority or digital-related items, were being reviewed for potential closure. Members raised concerns regarding the volume of deferred recommendations, particularly high-priority items. Iwan Jones (IJ), Committee Chair, emphasised the need for clearer action plans from responsible executives where deadlines were extended. Stephen Chaney (SC), Head of Internal Audit, provided context regarding low-priority recommendations and advisory reviews, noting these were not always intended for formal tracking. The Committee **APPROVED** the completed recommendations and revised deadlines, while requesting a detailed review of legacy recommendations to be presented at the next meeting. Action: Head of Corporate Risk and Assurance
	ITEMS FOR DISCUSSION
ARAC 0428/10	**To Receive Report of Losses and Special Payment** Robert Jones (RJ), Assistant Director of Finance, presented the report on losses and special payments. Members discussed potential financial impacts from changes in claims thresholds under "Putting Things Right". Robert Holcombe (RH), Director of Finance and Procurement advised that increased

	claim values could result in higher costs but may reduce longer legal processes. Members also discussed penalties arising from delays in "lessons learned" processes, noting broader financial implications, including potential impacts on Welsh Risk Pool contributions. Stephen Chaney (SC), Head of Internal Audit, confirmed that an audit of Welsh Risk Pool lessons learned processes was planned for 2026/27. The Committee **NOTED** the report.
ARAC 0428/11	**To Receive Report on the use of Single Tender Action.** Robert Jones (RJ), Assistant Director of Finance, presented the report outlining instances of single tender actions. It was noted that overall levels remained low relative to organisational scale, though one higher-value case had been included for transparency. A small number of cases were undergoing further review due to process compliance concerns. The Committee **NOTED** the report and the ongoing review of specific cases.
ARAC 0428/12	**To Receive Internal Audit Progress Report** Stephen Chaney (SC), Head of Internal Audit, presented the Internal Audit Progress Report, advising that audit work for the year was nearing completion, with only a small number of reviews outstanding. The Committee **NOTED** the progress report.
ARAC 0428/13	**To Receive Internal Audit Reports** Stephen Chaney (SC), Head of Internal Audit, presented four internal audit reports, all of which received Reasonable Assurance. SC summarised the key findings as follows: • The **Strategic Risk and Assurance Report** was positive overall, with only minor areas for improvement identified.

	• The **Capital Projects: Service Readiness Report** found generally sound arrangements, with improvements required around implementation dates and tracking. • The **Directorate Review – CAMHS** received reasonable assurance with no significant concerns raised. • The **Occupational Health Report** noted a recurring theme of performance pressures linked to workforce capacity, with concerns regarding service resilience and the timeliness of workforce planning actions. Iwan Jones (IJ), Committee Chair, raised concern regarding the absence of clear implementation dates within the Capital Projects report and requested that these be updated to enable effective tracking. **ACTION: HEAD OF INTERNAL AUDIT** IJ also highlighted concerns in relation to Occupational Health, particularly the delayed timescales for workforce development actions, which did not reflect the immediacy of the current service pressures. The Committee **NOTED** the reports.
ARAC 0428/14	**To Agree the Draft Internal Audit Annual Workplan 2026/27** Stephen Chaney (SC), Head of Internal Audit, presented the draft Internal Audit Plan. Neil Patrick (NP), Independent Member, suggested that staff experience and workforce issues should be considered within future audit work. Rani Dash (RD), Director of Corporate Governance, recommended aligning any further work with forthcoming Board discussions on staff survey findings. The Committee **APPROVED** the draft Internal Audit Annual Workplan 2026/27, subject to potential refinement following Board discussions on staff experience.
ARAC 0428/15	**To Review the Draft Internal Audit Opinion and Annual report 2025/26** Stephen Chaney (SC), Head of Internal Audit, presented the draft Internal Audit Opinion, indicating that it was likely to be Reasonable Assurance overall.

	SC confirmed that remaining audit work was close to completion and that the final opinion would be presented in May. The Committee **NOTED** the draft opinion and anticipated a final Reasonable Assurance opinion.
ARAC 0428/16	**External Audit Progress Report** Sara Utley (SU), Audit Wales, presented the External Audit Progress Report, outlining ongoing work on accounts and performance audit programmes. Julie Rees (JR), Audit Wales, advised that the audit of the Annual Accounts was due to commence imminently and remained on track, with a proposed audit opinion scheduled for the June Committee. No significant issues were reported at this stage. The Committee **NOTED** the report.
ARAC 0428/17	**External Audit Plan 2026/27** Julie Rees (JR), Audit Wales and Andrew Doughton (AD), Audit Wales, presented the External Audit Plan outlining planned financial and performance audit work. Key financial risks included management override and the organisation's financial position, consistent with prior years. AD highlighted planned performance work, including reviews of diabetes services and theatre efficiency, and structured assessment No concerns were raised by the Committee. The Committee **NOTED** the External Audit Plan 2026/27.
ARAC 0428/18	**Audit Wales Digital Transformation Report** Sara Utley (SU), Audit Wales, presented the Digital Transformation Report to the Committee Key findings included:

	• Progress in digital delivery despite limited funding • Need to strengthen governance and oversight of projects • Gaps in cyber assurance and digital workforce capability Paul Solloway (PS), Director of Digital, welcomed the report and confirmed actions were underway. The Committee **NOTED** the report and endorsed its findings and agreed that it should be referred to the Finance and Performance Committee for further scrutiny.
	ITEMS FOR INFORMATION
ARAC 0428/19	**Programme of Business** The Committee received the Programme of Business for information. The Committee **NOTED** the report.
ARAC 0428/20	**Regional Integration Fund Audit Wales Report** Sara Utley (SU), Audit Wales, presented the Regional Integration Fund report. Rani Dash (RD), Director of Corporate Governance, confirmed that the report would be considered by the Planning, Partnerships, Population Health Committee, and that local scrutiny arrangements would be reviewed. The Committee **NOTED** the report and agreed that it would be referred to the appropriate Committee for further consideration.
ARAC 0428/21	**Internal Audit Briefs** Stehen Chaney (SC), Head of Internal Audit presented four Internal Audit Briefs • Benefits Realisation Audit Brief • Overseas Recruitment Audit Brief • Professional Staff Registration • Cancer Referral Rates Audit Brief

	The Committee **NOTED** the briefs for information.
	Other Matters
ARAC 0428/22	**Items to be Brought to the Attention of the Board and Other Committees** • **Digital Transformation Report** to the Finance and Performance Committee • **Regional Integration Fund Report** to the Planning, Partnerships, Population Health Committee • **Occupational Health audit** to the People and Culture Committee
ARAC 0428/23	**Any Other Urgent Business** • Nothing reported.
ARAC 0428/24	**Date of the next meeting** • Tuesday 19th May 2026

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

Outstanding	In Progress	Not Due	Completed	Transferred to another Committee

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
October 2025	To Receive the National Fraud Initiative (NFI) 2024 - 25	Report back to the Committee on the outcomes of the NFI review once completed.	Head of Counter Fraud	May 2026	**Completed** Included within the Counter Fraud Annual report on the May Agenda
December 2025	**ARAC 1216/08** To Receive the Audit Recommendation Tracking report and Approve closing position.	Conduct a deep dive into all live digital related audit recommendations to ensure timelines are realistic.	Head of Corporate Risk and Assurance	April 2026	**Completed** Scheduled on the May Agenda
January 2026	**ARAC 0122/09** To Receive an Assurance Report on Systems and Processes to Improve Discharge	Conduct a review of all Discharge Planning audit actions be to ensure the audit	Head of Corporate Risk and Assurance and Director of Nursing	April 2026	**Completed** Scheduled on the May Agenda

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
	Performance, linked to Audit Recommendations.	tracker is entirely accurate.			
February 2026	**ARAC 0212/08** To Approve the Audit Recommendations Tracking Report	Complete a targeted review of all actions pre-2023 to confirm ongoing relevance, closure potential, and whether some actions sat outside the Health Board's direct control.	Head of Risk and Assurance	May 2026	**Completed** Scheduled on the May Agenda
April 2026	**ARAC 0428/13** Internal Audit Reports	Input clear numerical implementation dates against recommendations in the Capital Projects Report.	Head of Internal Audit and Director of Strategy, Planning and Partnerships.	June 2026	**Not Due**

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

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

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

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	19 May 2026
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Draft Annual Report 2025/26
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Rani Dash, Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Bryony Codd, Head of Corporate Governance

Pwrpas yr Adroddiad **Purpose of the Report**
Ar Gyfer Trafodaeth/For Discussion

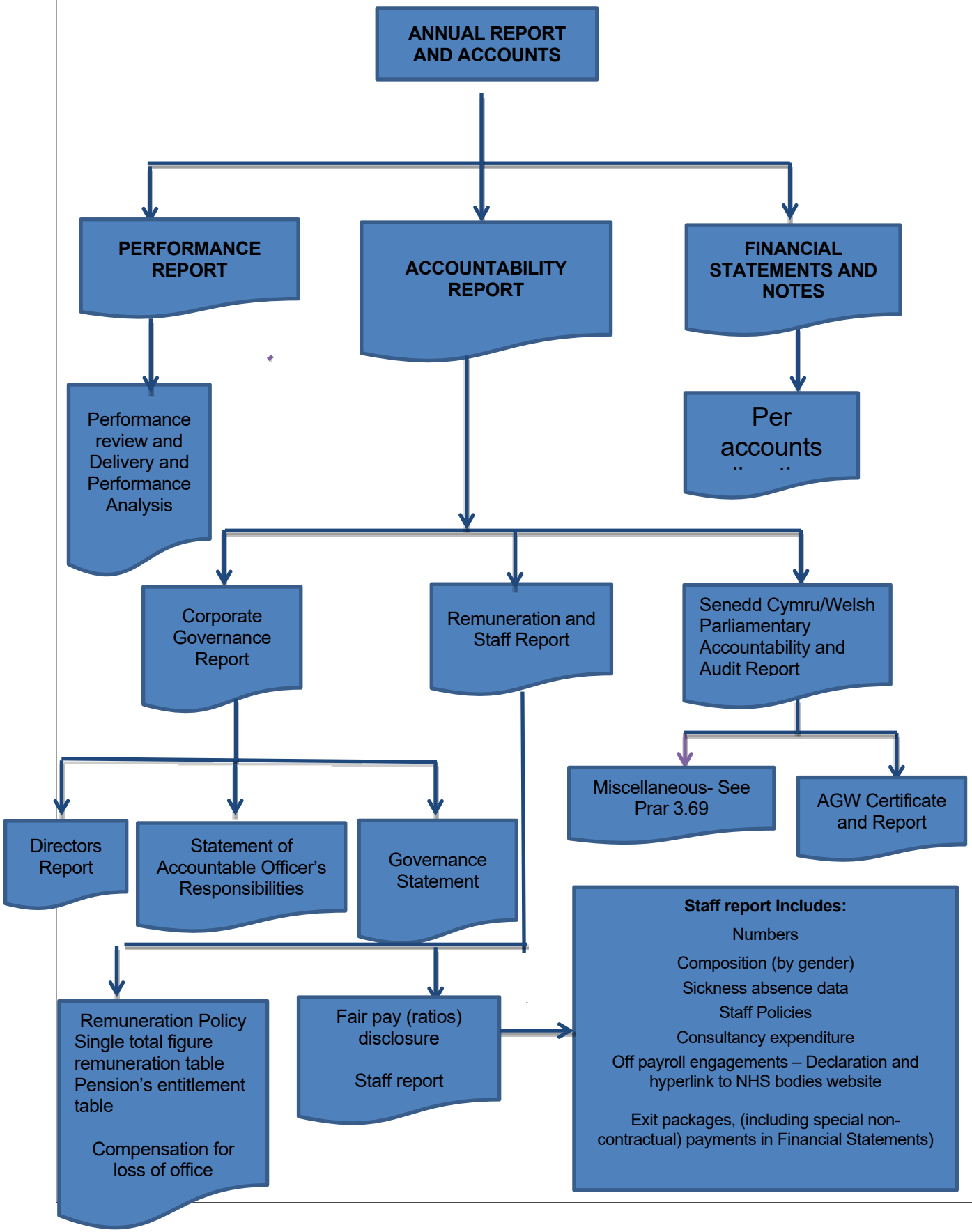
ADRODDIAD SCAA **SBAR REPORT**
Sefyllfa / Situation This paper presents to the Audit, Risk and Assurance Committee the first draft Performance and Accountability Reports 2025/26. In line with Chapter 3 of the Manual for Accounts: Annual Report and Accounts, the Health Board is required to publish, as a single document, a three part Annual Report and Accounts. Parts 1 and 2, the Performance Report and Accountability Report are provided for consideration by the Audit, Risk and Assurance Committee. The draft Accounts have been provided as a separate document.

Cefndir / Background
 	
This paper presents to the Audit, Risk and Assurance Committee the first draft Performance Report and Accountability Report 2025/26. In line with Chapter 3: Annual Report and Accounts, the Health Board is required to publish, as a single document, a three part Annual Report and Accounts which includes:
 	
• The Performance Report, which must include:
  ○ An overview.
  ○ Delivery and Performance analysis
 	
• The Accountability Report, which must include:
  ○ A Corporate Governance Report.
  ○ A Remuneration and Staff Report.

- Senedd Cymru/Welsh Parliament Accountability and Audit Report.

- The Financial Statements, including:
  - The Audited Annual Accounts 2025/26.

Outline Structure



Asesiad / Assessment

This report presents the first drafts of the Performance Report and Accountability Report.

The timetable for submission is outlined below:

Annual Reports 2025/26 - Key Dates	**2026**	
Draft Accounts to WG	**Fri**	**1-May**
Draft Performance Report Overview, Accountability Report and Remuneration Report to WG	**Fri**	**8-May**
Draft Reports to ARA Committee Members	**Tues**	**12-May**
ARA Committee meeting to Consider Draft Accounts and Draft Accountability Report	**Tues**	**19-May**
Final Accounts & Accountability Report to Audit Committee Members	Fri	19 June
ARA Committee meeting to Consider Final Accounts, and Accountability Report	**Tues**	**23-June**
Board meeting to approve Final Accounts and Accountability Report	**Wed**	**24-June**
Certification by Auditor General		
Final Annual Report Deadline for Submission to WG – Annual Report and Accounts as a single unified document	**Tues**	**30 June**
Annual General Meeting – to receive the Annual Report and Accounts	**Wed**	**15 July**

In line with the required timescales, the first draft report was submitted to Welsh Government and Audit Wales on 8th May 2026. These documents continue to be working documents, based on template guidance and are subject to ongoing refinement.

Members of the Audit, Risk and Assurance Committee are asked to consider the attached documents and provide comments for inclusion in the final draft of the report for consideration at their meeting on 23rd June 2026.

The final Chapter 3 of the Manual for Accounts confirms the requirement for a public meeting to be held no later than 31st July 2026, at which the Annual Report and audited accounts are presented.

Argymhelliad / Recommendation

The Audit, Risk and Assurance Committee is asked to consider and comment on the draft Performance Report and Accountability Report prior to preparation of the final reports for submission to the Committee on 23rd June 2026.

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

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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk

Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Not Applicable Choose an item.

2025 - 2026
Annual Report

Aneurin Bevan University Health Board

April 2026

Introduction

Our Annual Report is a suite of documents that tell you about our organisation, the services and care we provide and what we do to plan, deliver and improve healthcare for you. It provides information about how we performed in 2025/26, what we have achieved, how we plan to continue to improve next year and what out plans are.

This report also explains how important it is for us to work with you and listen to your views, to better deliver services that meet your needs, as close to your home as possible.

Our Annual Report for the period 1st April 2025 to 31st March 2026 includes:

- Our Performance Report which details how we have performed against our targets and the actions planned to maintain or improve our performance.
- Our Accountability Report which details our key accountability requirements and provides information about how we manage and control our resources, identify and respond to our risks, and comply with our own governance arrangements.
- Our Financial Statements and Annual Accounts which detail how we have spent our money and met our obligations.

Contact Us

You can contact the Health Board using the details below:

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Telephone; 01633 436700 or email abhb.enquiries@wales.nhs.uk
http://x.com/aneurinbevanUHB
https://www.facebook.com/AneurinBevanHealthBoard

Table of Contents

Part 1:

Performance Report

1st April 2025 – 31st March 2026

1. Reporting Requirements

The purpose of the performance section of this Annual Report 2025/26, as set out in the guidance provided in the NHS Wales 2025/26 Manual for Accounts, is to provide information on Aneurin Bevan University Health Board, its main objectives, Strategy and plans and the principal risks that it faces. The requirements are based on the matters required to be dealt with as set out in Chapter 4A of Part 15 of the Companies Act 2006, as adapted in the Financial Reporting Manual and NHS Wales Guidance Manual.

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

It should be noted that the Health and Social Care (Quality and Engagement) (Wales) Act 2020 legally requires Health Boards to publish an annual report regarding the Duty of Quality. This report will be prepared and published separately to this performance report. Further information is available in the Annual Accountability Report, Page XX.

2. Overview from the Chief Executive

Over the past year the Health Board has made significant progress in reducing waiting times for Planned Care and Mental Health, improving access to Primary Care and returning to levels of performance against several Urgent and Emergency care targets not reached since the early months of the Grange University Hospital opening. This progress reflects the organisation's commitment to improving patient outcomes and the

effectiveness of targeted non recurrent initiatives aimed at increasing capacity in key specialties to minimise delays in care.

Despite these advancements, within the year the Health Board was re-escalated by Welsh Government to Level 4 (Targeted Intervention) for Finance, Strategy, and Planning and to Level 4 for performance and outcomes related to urgent and emergency care. Through continued focused operational delivery, the organisation remains committed to achieving the necessary financial and operational standards required for de-escalation. This commitment is alongside the need to sustain critical service delivery, ensuring both service quality and patient safety are maintained at all times.

There have been notable achievements and improvements over the last 12 month in performance across the breadth of the Health Board's priorities. Key highlights include:

- Reducing the numbers of patients waiting over 52-weeks for a first outpatient appointment from 14,265 at the start of the year to 1,228 by year end across all RTT Specialties with only 5 out of the 28 specialties having patients waiting over 52 weeks.
- Significantly reducing the numbers of patients waiting over 104-weeks from referral to treatment to 21 at year end which is the lowest reported number since April 2020.
- Reducing the numbers of patients waiting over 8-weeks for a diagnostic to 223 despite high conversion rates from the implementation of a national targeted plan to reduce the number of outpatients waiting across Wales by 200,000
- The Pharmacist Independent Prescribing Service (PIPS) delivering above trajectory, with the March position representing 157% of the annualised target
- Optometry Services performance exceeding the IMTP (Integrated Medium Term Plan) trajectory by almost 20,000 patients (8%).
- For Urgent and Emergency Care March 2026 saw the best performance of the year (outside the Our Next Patient launch months) for Ambulance handovers within 45 minutes. Again, outside of the Sep-Nov 2025 period, this is the best performance on record since the February 2021.

- Leading the south-east Wales Regional Ophthalmology programme in delivery of over 25,000 cataract operations and elimination of 104 week waits for the region.
- The opening of the satellite radiotherapy centre in Nevill Hall Hospital providing advanced cancer treatment options closer to patients' homes.
- Continued Risk Adjusted Mortality Index (RAMI) below the Wales peer group average between Quarter 1 and Quarter 3 (Quarter 4 data not currently available due to coding) indicating improved mortality outcomes over time.
- DNA/CNA rates performance in February achieving a 2025/26 low of 4.9%, representing the lowest DNA rate on record since April 2019.
- C Difficile and MRSA rates per 100,000 lower than last year.
- Consultant Job planning compliance improving from the beginning of the year by 16%.
- Meeting Mental Health Part 1 and Part 2 targets across both Adults and CAMHS, with the services continuing to balance both demand and capacity to ensure continued compliance through the entirety of 2025/26.
- Publishing the new organisational Strategy Gwent 35 on which there is further detail provided later in this report
- Expenditure on Primary Healthcare Services, Healthcare received from other providers and Hospital and Community Health Services all increased from 2024/25 to 2025/26.

This report sets out further progress made by the organisation in 2025/26.

3. The Health Board

Aneurin Bevan University Health Board (ABUHB) was established in October 2009 and achieved University status in December 2013.

The Health Board's principal role is to ensure the effective planning and delivery of our local NHS system, within a robust governance framework, to achieve the highest standards of patient safety and public service delivery, improve health and reduce inequalities and achieve the best possible outcomes for our citizens, and in a manner that promotes human rights. To fulfil this role, we are required to work with our Partners and Stakeholders in the best interests of the population we serve.

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

The Gwent Joint Strategic Assessment 2025/26 Edition - Aneurin Bevan University Health Board provides a comprehensive overview of the health and well-being of the people of Gwent in an accessible way for anyone to view. The majority of the data is sourced from publicly available national data sources such as Stats Wales, Wales Public Health Outcomes Framework and the Office of National Statistics. The Assessment provides partners across Gwent with a shared intelligence source about the current, future and influences of health and well-being of the population of Gwent. An evidence-base to inform planning for local service delivery, that provides us with a picture of health for Gwent and provides us with a framework for building a fairer, safer and healthier Gwent.

3.1 Workforce

The Health Board has seen a significant growth in headcount over the last five years and currently employs 13,724 Whole Time Equivalents (WTE) (17,297 people; March 2025) and is the largest employer in Gwent. This is an increase of 264 WTE from last year, mainly in Nursing and Midwifery (146.24 WTE), and Medical & Dental (37.67wte).

The workforce demographic remains stable, with 20% of staff over 55 years old and 32% over 50 years old. From March 2025 to March 2026, turnover increased from 8.67% to 9.02% and sickness absence has increased from 6.44% to 6.55% with stress, anxiety, and depression accounting for a third of absences. All sectors, including the NHS have seen increases in sickness absence and the health and wellbeing of our staff remains a key priority of our People Plan.

The Health Board has significantly reduced Registered Nurse vacancies, and we are forecasting a zero vacancy position through student streamlining processes in 26/27. Medical and Dental vacancies have also reduced, although hard to fill posts in some medical specialties (e.g., Ophthalmology, General and Acute Medicine, Psychiatry, Public Health) remain. We will continue with dedicated recruitment and retention campaigns, as well as working with educational and national partners to address these issues. Long-term vacancies remain in non-clinical roles like Mechanical and Craftsperson positions, and we have designed career pathways to attract and future-proof these roles.

The priority is recruiting, developing, and retaining directly employed staff to build effective teams and provide a positive and qualitive staff and patient experience.

Our most recent records indicate that there are 1,329 WTE staff (2,094 headcount) working independently as GP practice staff, with 11% of GP staffing covered by Locums. In addition, 25% of GP partners are over the age of 55 years old, alongside 35% of the nursing workforce matching this age profile.

People Plan 2025 – 2030: The new 5-year plan People Plan was launched this year and is a core enable of our 10-year Health Board Strategy: 'Gwent 2035'. The plan was developed with engagement from staff, Trade Unions and partners, and supports our purpose and ambition by putting people at the heart of everything we do; creating the conditions for them to thrive, and enabling us to deliver outstanding, compassionate care while tackling health inequalities and building healthier futures for all.

The Plan sets three clear pillars of action for the next five years:

Better Health and Wellbeing: Our approach will be proactive, preventative and focused on resilience, valuing care for our people as much as care for our patients.
Better Future Workforce: By building digital skills, creating flexible roles and opening routes into NHS careers, we will ensure we have the right people, in the right roles, with the right skills for years to come.
Better Working Lives: We will invest in modern, flexible working arrangements, career development and recognition so that our people are motivated, engaged and able to reach their potential.

The Plan provides a strategic delivery programme set over the next 5-years. This includes further developing our achievements of the last People Plan (2022-2025), our key workforce performance indicators, and building on the achievements to date, which include:

- Ensuring all staff have a meaningful Performance Appraisal (PADR), with a target compliance of at least 85% (currently at 76.95%).
- Promotion of our staff survey, acknowledging the increased participation rate of 32.5% for 25/26 (previously 13.3%).
- Evaluation of a pilot staff recognition platform 'Share Given', that was implemented to provide an opportunity for patients (or their relatives) to say thank you and recognise the staff that made a difference to their care.
- Agreeing and implementing the recently refreshed Values and Behaviours Framework, following extensive staff engagement.
- Delivery and evaluation of a pilot strategic culture transformation project with consideration to how this approach can be applied across other teams and divisions.
- Continuation and development of our Leadership Development Programmes. Over the last year, 357 staff participated in a Leadership Development Programme and a further 339 managers attended masterclasses on subjects such as coaching, recognition and retention.
- Expanding retention initiatives across the Health Board following the success of the Nurse Retention plan including new starter surveys, a retention hub, talent and succession planning workshops.
- Further reducing time to hire, recognising this has consistently remained below the target of 71 days every month with lowest recorded average being 56.8 days.
- Reviewing our Nursing & Midwifery Workforce Strategy 2023-26, with a particular focus on Healthcare Support Worker development.
- Further roll out of innovative recruitment initiatives such as talent pools, lateral moves and rotational posts to support career development and promote retention across the Health Board. Through our talent pool approach, we have recruited to vacancies more efficiently, saving 25 days per vacancy in comparison to a traditional recruitment process.
- Further reduction of M&D vacancies by recruiting strategically to anticipated training gaps across a number of specialties where possible instead of recruiting to shorter gaps per specialty. We

achieved our lowest vacancies in December 2025 (59.6 WTE, compared to 203.72 WTE at its highest in August 2022).
- Improving our Occupational Health performance to support timely access and working towards achieving industry standard for Occupational Health Services.
- Integrating the ABUHB Post Incident Support Network and Clinical Pathway which was launched via our Employee Wellbeing Service

Our People Plan provides a strong platform to horizon scan and recognises the changing demands on healthcare and the demographics of our staff and population. This strategy, along with other national changes and priorities will take us forward to 26/27 and beyond.

3.2 Finance

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

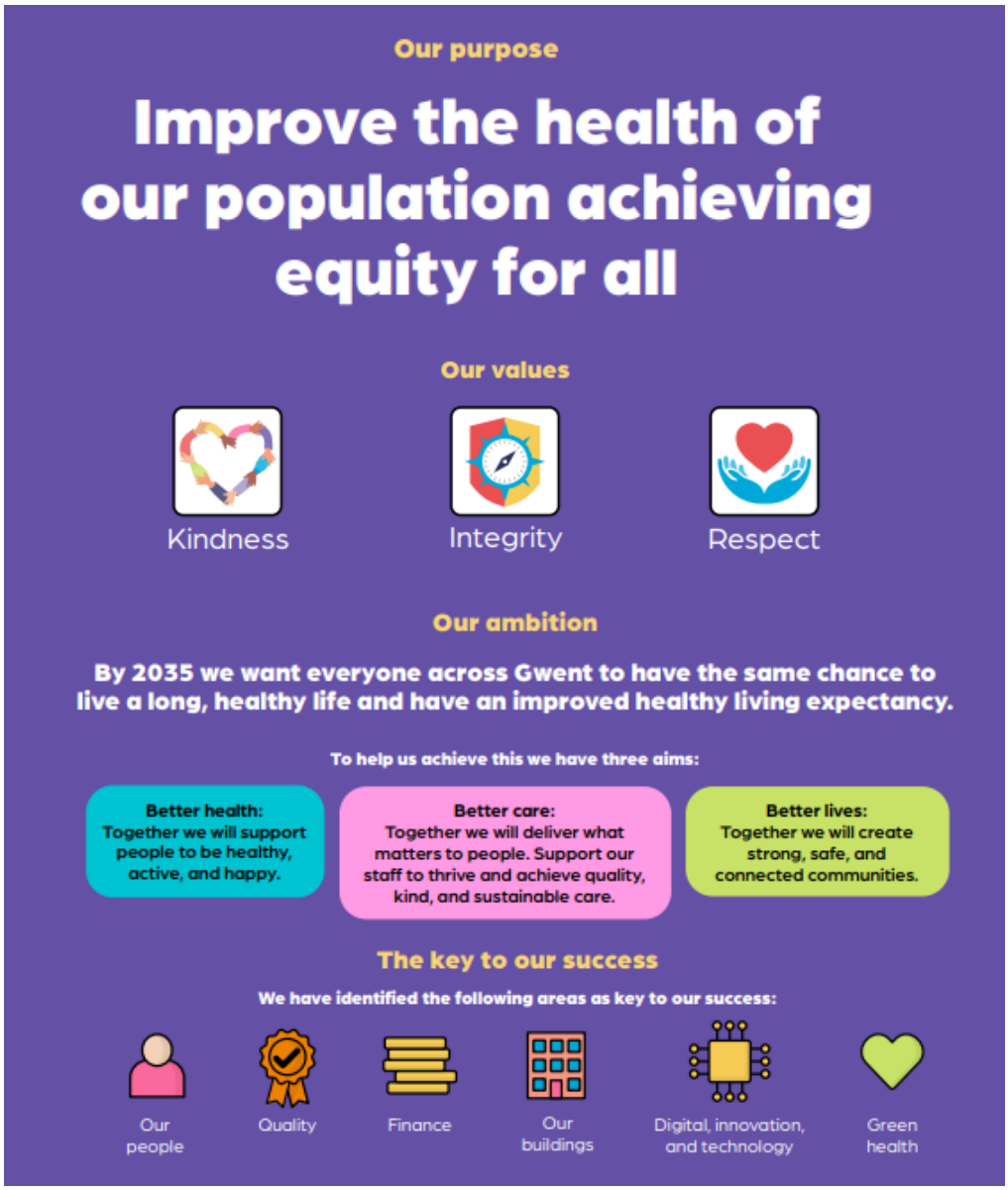
Detail on how the Health Board is governed is set out within the Accountability Report (Section 2 of the Annual Report and Accounts 2025/26).

2025/26 was the second year of a three-year road map to sustainability based on the strategic aims of the Board which has been used as the reference document to drive financial improvement and service sustainability planning through its Value and Sustainability Board. There has been continued focus on reducing variable pay through effective workforce planning including roster efficiency, recruitment and retention and progressing other opportunities including reducing medicines waste, right sizing packages of care and consolidating Health Board estate.

4. Gwent 35 Strategy

In July 2025, the new strategy for the Health Board was approved by the Board, Gwent 35: Better Health, Better Care, Better Lives Gwent 35: Our Ten Year Strategy.

After listening to what is important to the people of Gwent, and learning from research, we developed three aims to ensure everyone in Gwent communities have the best healthcare, environment, and lifestyle to be healthy. We want everyone to have: better health, better care, and better lives.



The strategy signals a step change – fundamentally rebalancing focus towards healthy communities whilst setting out intent to become powered by innovation & improvement in all we do. It sets the ambition that by 2035 we want everyone to have the chance to live a long, healthy life & improved healthy life expectancy.

The values underpinning the strategy are an integral part of the strategic direction. The newly agreed values of — Kindness, Integrity, & Respect — are the foundation of the compassionate care provided, the relationships, & the culture required for the future. The outcomes to achieve our ambition for 2035 focus on:

- The reduction of the prevalence of preventable diseases & the factors that contribute to poor health & support healthy behaviours
- Improving the standards of care & access to local services to enable healthy days outside of hospitals
- Improve access to healthcare services for all communities, community connection & the proportion of budget spend on out of hospital services.

A delivery and deployment plan underpins the strategy in order that Gwent 35: Better Health, Better Care, Better Lives drives not only the direction of travel of services but shapes the "operating model" for the Health Board, embedding the intent of the strategy in all we do. An annual report of strategy delivery & deployment will be developed in September 26.

Strategy Delivery: What we do

The Strategy sets out the strategic actions for 2026/27 & beyond. This Plan and future IMTPs will be a key vehicle through which the strategy will be driven, outlining the actions over 3 year timeframes. There are two key elements that support strategy delivery. The outcomes framework & the strategic plans from the keys to success

Strategy Deployment : How we do it

Strategy deployment relates to "How" as an organisation we re-orientate, review & refresh how we work (our operating model) to ensure the intent, ambitions & goals of the strategy run through everything we do.

Work has commenced to review, test and strengthen the Health Board's Operating Model taking account of Culture & Ways of Working, Organisational Design, Technology & Infrastructure, Governance & Accountability, Processes and Partnerships. The detailed action plan can be found in Making it Happen, our strategy deployment & delivery plan. The actions are framed around the themes below. This action plan is a live document and will be updated to reflect the evolving Operating Model work plan.

5. Three year Plan 2025/26: Performance against trajectories

The Health Board's performance reporting is aligned to the commitments made in the 2025/26 Three Year Plan/IMTP, which are split between the following two components:

Ministerial Delivery Expectations

The Cabinet Secretary for Health and Social Services set out sixteen delivery expectations under five themes:

- Timely access to care
- Population Health & Prevention
- Building Community Capacity
- Mental Health Access (Adult and CAMHS)
- Women's Health

System Change Themes

Additional performance measures were set out against system change themes in the Integrated Medium-Term Plan (IMTP) 2025-28, drawn from the NHS Performance Framework, the Enabling Actions from the NHS Planning Framework and de-escalation conditions related to the Health Board's escalation status of Targeted Intervention for Urgent and Emergency Care.

The performance measures are grouped against the below IMTP system change themes:

- Embedding Prevention and Population Health in all that we do
- Progressing Place Based Models of Care and sustainability in Primary and Community Services
- Improving our Urgent and Emergency Care System focusing on experience, access and discharge pathways
- Continuing to prioritise Cancer, Urgent and the longest waiting patients for Planned Care
- Improving our Mental Health Services

A summary of the Health Board's Annual Performance is detailed below by System Change Theme noting the relevant, corresponding Ministerial Priorities of Ministerial Delivery expectation (MD), Targeted Intervention (TI) or Enabling Action (EA).

5.1 Embedding Prevention and Population Health in all that we do

Delivery Expectation	ABUHB commitment	Latest position	MD/TI/EA
% uptake of the COVID-19 vaccination for those eligible Spring Booster	**75%** (Jun-26)	**56.5%** (Jun-26)	**MD**
% uptake of the COVID-19 vaccination for those eligible Autumn Booster	**75%** (Mar-26)	**60.4%** (Mar-26)	**MD**
% uptake of the influenza vaccination amongst adults aged 65 years and over	**75%** (Mar-26)	**73.9%** (Mar-26)	**MD**
% children up to date with vaccinations by age 5	**95%** (Mar-26)	**83.8%** (Q3)	**MD**
% of children receiving HPV vaccination 1 dose by the age of 15	**90%** (Mar-26)	**70.6%** (Q3)	**MD**
Percentage of adult smokers who make a quit attempt via smoking cessation services	**5%** (Mar-26)	**3.9%** (Q3)	
Percentage of adult smokers who made a quit attempt via smoking cessation services who are CO-validated as quit at 4 weeks	**32%** (Mar-26)	**22.2%** (Q3)	
Percentage of well babies entering the new-born hearing screening programme who complete screening within 4 weeks	**90%** (Mar-26)	**93.2%** (Feb-26)	
Maintain physical examination at 6 weeks rates (Healthy Child Wales)	**90%** (Mar-26)	**94.5%** (Jan-26)	
Increase weight and measurement at 8 weeks rates (Healthy Child Wales)	**80%** (Mar-26)	**92.7%** (Q3)	
Increase in % of patients (aged 12 years and over) with diabetes who received all eight NICE recommended care processes	**47%** (Mar-26)	**47.3%** (Mar-26)	**MD**
Establishment of one Women's Health Hub in each health board area by March 2026	**Yes** (Mar-26)	**Established** (Mar-26)	**MD**

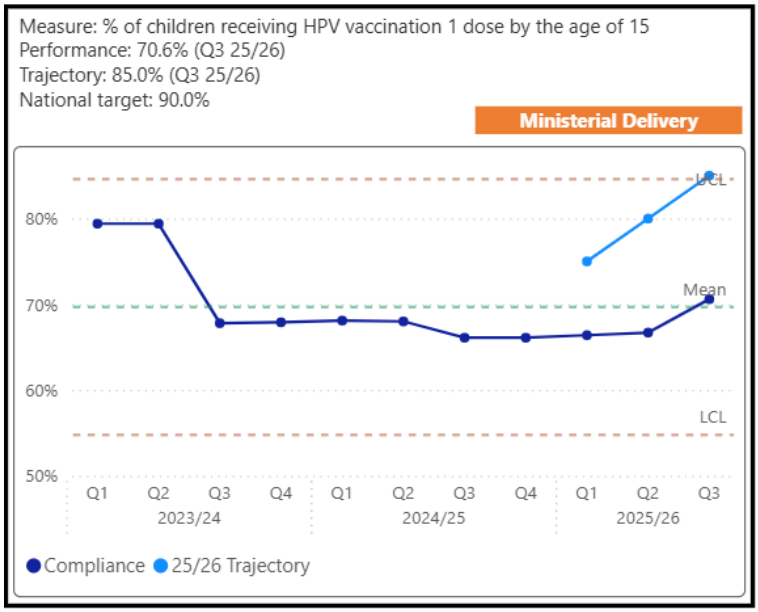
5.1.1 Vaccinations

A ministerial delivery expectation within this theme was the "achievement of vaccinations targets in the performance framework", as shown in the first five measures of the above table. COVID-19 vaccination fell significantly short of the national expectation in both the spring and autumn campaigns, a trend reflected nationally although the Health Board's performance was marginally higher than the 'all Wales' average. It should be noted that these measures have been removed from the 2026/27 NHS Wales Performance Framework.

Influenza vaccination rates in residents over 65 years old however was more positive, with performance at the end of the campaign achieving 73.9% coverage, which was an improvement from 72.9% in 2024/25. The Health Board undertook several actions through the course of the year to

improve uptake in seasonal vaccinations, including a review of booking processes and involvement in a PhD project to enhance uptake by exploring how to best remove barriers to uptake which will support further campaigns (e.g. use of text messaging services, improvement in letter wording to enhance engagement).

The number of children up to date with vaccinations by age 5 as well as those receiving HPV dose 1 by age 15 also did not meet the national targets (as of latest data available, Q3 2025/26). Vaccinations by age 5 had remained relatively stable at ~85% although there was a small decrease in the latest data to 83.8%. To support improved vaccination uptake by age five, a task and finish group has been established led by the Public Health Team and working in partnership with Health Visitors, the Vaccination Service and the Health Intelligence Team. The group will focus on targeted interventions in areas with lower uptake. A key initiative is the development of a 'live' dashboard to monitor uptake and assess the impact of interventions in real time. The initial pilot will prioritise MMRV vaccination and will be underpinned by Making Every Contact Count (MECC) principles during engagement with families. Staff involved in this work will be offered the newly developed Vaccine Brief Advice Awareness Training, delivered by the Health Protection Team, in line with recommendations from the Big Gwent Vaccination Conversation.

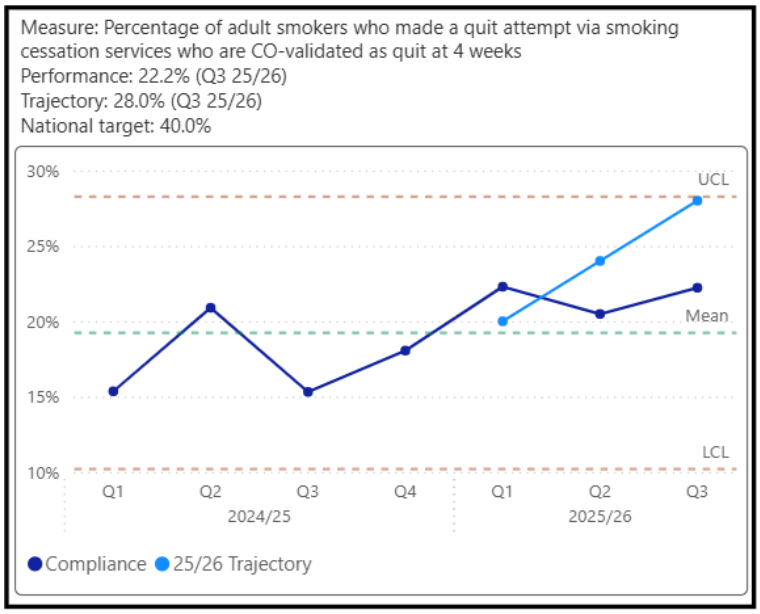


Progress has also been made in relation to HPV vaccination, with Q3 performance showing the first significant increase of the year, reaching 70.6%. Digital consent for school-aged vaccinations is being piloted with a small number of schools to support improved accessibility and uptake. Learning from the pilot will be used to inform further refinements prior to wider rollout, with the aim of increasing HPV vaccination coverage across Gwent. In addition, the Nye Be*VAN* mobile vaccination service has been deployed in areas with sub-optimal uptake, providing parents and young people with additional opportunities to access vaccination.

5.1.2 Smoking cessation

Smoking cessation measures, which covers both quit attempts and those who are Carbon Monoxide (CO) validated as subsequently having quit, show are borderline against trajectory as of the latest available data (Q3). The percentage of adult smoker who made a quit attempt via smoking cessation services and are CO validated as quit at four weeks has trended upwards since 2024/25, which is positive. Furthermore, the Q4 2025/26, unvalidated data indicates that there has been a seen a 69% increase in CO validated quitters in March 2026 compared to March 2025 (pending final, validated data submission).

As part of the Public Health commitment to delivering place-based care, behaviour change practitioners responsible for the Health Board's smoking cessation service have been aligned to localities and will form a core component of integrated neighbourhood teams. A comprehensive improvement programme is ongoing to optimise the service by reviewing and updating processes and placing greater emphasis on supporting individuals and groups to achieve carbon monoxide-validated quits at four weeks rather than just self-reported quits. This is being achieved by increasing community-based clinic capacity and ensuring that team members are given the opportunity to become embedded within their respective places and place-based teams.

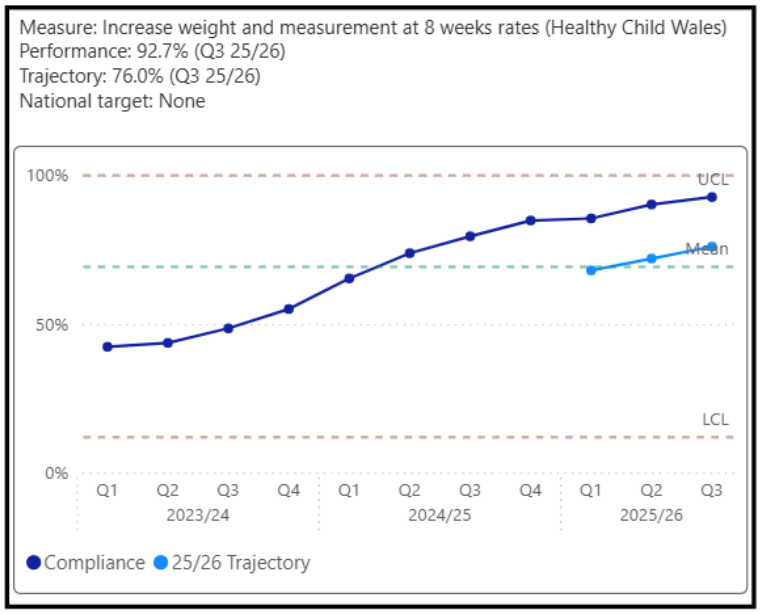


Work is also ongoing to ensure proportionate capacity is given to vulnerable populations at higher risk of tobacco related harm, e.g., those with mental health conditions, people with chronic conditions, pregnant women, and people at socio-economic disadvantage.

5.1.3 Newborn Babies

The three main measures for newborn babies:

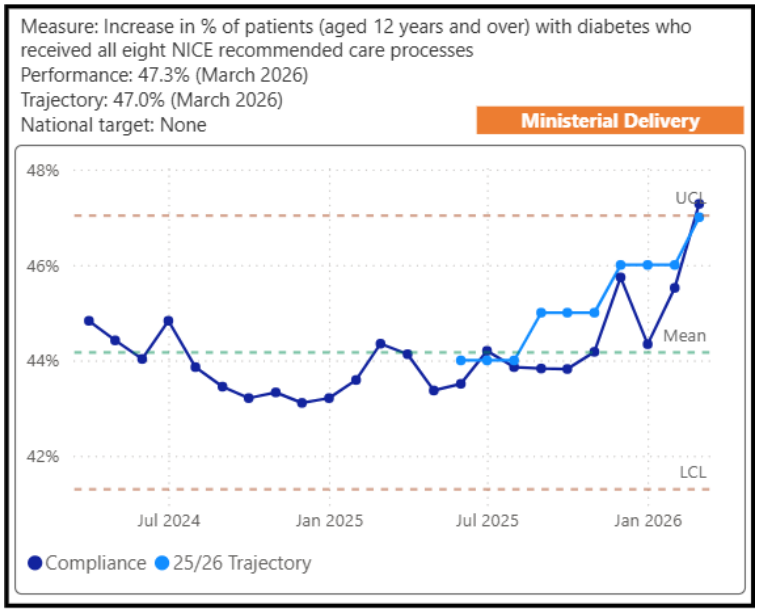
- hearing screening via the dedicated programme who complete screening within 4 weeks
- physical examination at 6 weeks rates
- weight and measurement at 8 weeks rates



have all performed strongly through the course of 2025/26 up to the latest available data and in excess of IMTP trajectory. Increase in the weight and measurement at 8 week rates (Health Child Wales) are most notable, having observable, quarterly improvement from the beginning on 23/24, with performance having reached 92.7% as of Q3 2025/26.

5.1.4 Diabetes

The ministerial delivery expectation to increase the percentage of patients (aged 12 years and over) with diabetes who received all eight NICE (National Institute of Clinical Excellence) recommended care processes also showed progress, closing the year at 47.3% and meeting the improvement trajectory set out in the IMTP. Significant progress has been delivered through the High Value Impact Pathway programme led by the Public Health Team, with a strong focus on improving quality and outcomes across diabetes care. Engagement materials supporting Urine ACR testing (which checks for early kidney damage) have been rolled out across all GP practices in Gwent and extended to wider



community and hospital settings, reaching primary care teams, community pharmacies and the public. This has supported improved clinical practice, with pilot sites achieving a 10% increase in compliance. Insights from process-mapping work across GP practices have informed the identification and sharing of high-value activities, and findings have been disseminated through GMS (General Medical Service) collaboratives to support system-wide improvement. The Urine ACR project is now concluding, with early evaluation indicating a potential improvement in compliance across the Health Board. In parallel, delivery of the footcare improvement work has continued, with timelines extended to ensure effective implementation and robust evaluation, while early scoping is underway to inform future improvement opportunities in areas such as gestational diabetes and transition to adult services.

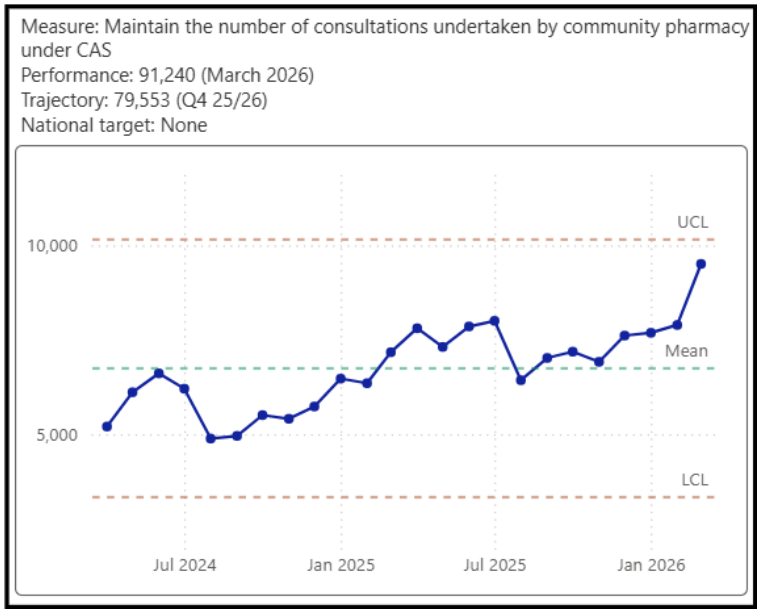
5.1.5 Women's Health Hub

The Health Board also delivered on its commitment to establish a Women's Health Hub. Launched in March, the online hub provides a trusted, accessible source of information, advice and support to help women and those accessing women's health services in making informed decisions about their health and wellbeing at every stage of life. The hub brings together guidance on maintaining a healthy lifestyle, information on local community groups and events, and clear signposting to further support from healthcare professionals when needed. This initiative forms part of a wider Welsh Government programme, including a national women's health website and directly supports delivery of the NHS Wales Women's Health Plan, a ten-year commitment to improving services and addressing health inequalities for women and girls across Wales.

5.2 Progressing place-based models of care and sustainability in primary and community services

Delivery Expectation	ABUHB commitment	Latest position	MD/TI/EA
100% of GP practices achieving all National Access Standards for In hours GMS	**100%** (Mar-26)	**Due** Jun-26	**MD**
Increase in people accessing PIPs where they would have visited their GP	**24,065** (Mar-26)	**37,789** (Mar-26)	**MD**
Maintain the number of consultations undertaken by community pharmacy under CAS	**79,553** (Mar-26)	**91,240** (Mar-26)	
Maintain the number of patients accessing NHS Optometry Services	**246,133** (Mar-26)	**266,125** (Mar-26)	
Number of patients accessing urgent emergency services - Dental	**43,153** (Mar-26)	**39,999** (Mar-26)	
Increase in capacity at the weekend of community nursing and specialist palliative care nursing to at least the required levels previously set for 2024/25	**128,347** (Mar-26)	**92,343** (Mar-26)	**MD**
Increase in capacity of Enhanced Community Care to at least the required levels previously set for 2024/25	**5,277** (Mar-26)	**6,545** (Mar-26)	**MD**
Maintain 95% of Palliative Care referrals assessed within 2 days	**95%** (Mar-26)	**94.0%** (Mar-26)	
Maintain proportion of GP referrals made to Rapid Response as a total of all medical assessments) for over 65s	**8.5%** (Mar-26)	**7.0%** (Mar-26)	

5.2.1 Pharmacy



Contacts to the Pharmacy Independent Prescribing Scheme (PIPS) and Common Ailment Scheme (CAS) services have continued to increase, reflecting both the expansion of clinical conditions managed by the service and the impact of a successful public awareness campaign. PIPs consultations finished the year at 157% of the annualised target, supported by the continued expansion of the service and an increase in participating community pharmacies from 49 to 67 over the

year. CAS activity also exceeded the IMTP trajectory, with March recording the highest monthly level of consultations to date at 9,510. Uptake continues to grow across newer clinical pathways, with UTI (Urinary Tract Infections) consultations almost doubling in the second half of the year to an average of just under 600 per month, and Sore Throat Test consultations showing both clear seasonal demand and a near-doubling year-on-year during the winter period, now exceeding 1,000 consultations per month. While further growth is anticipated, activity is expected to begin to moderate in future years as the service approaches capacity limits, particularly within CAS.

5.2.2 Optometry

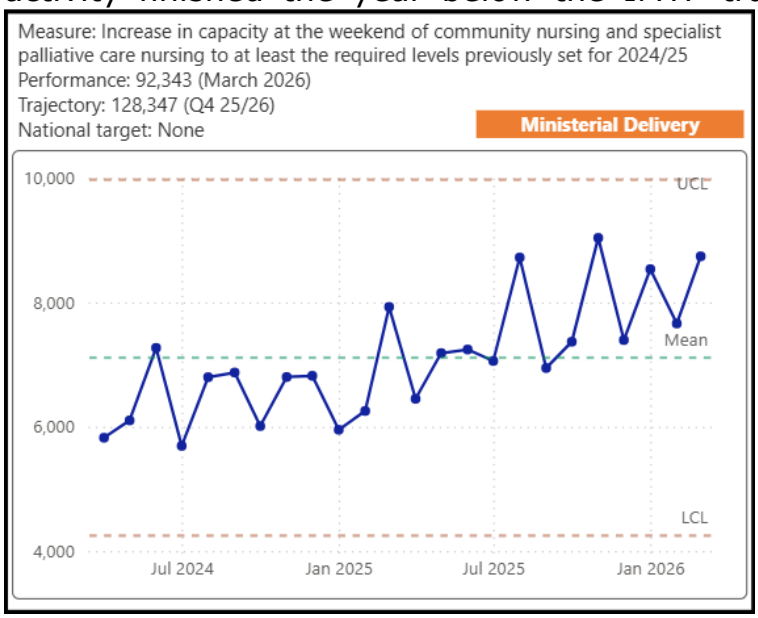
Optometry activity exceeded the IMTP trajectory by 8%, supporting almost 20,000 additional patients compared to plan, driven by implementation of the new WGOS (Wales General Ophthalmic Service) pathways and increased access to community-based care. Overall utilisation surpassed the total number of patients seen in 2024/25, despite some seasonal variability, with activity ranging from a low in January to a record high in October.

5.2.3 Dental Care

In contrast, Emergency Dental activity was slightly below trajectory, delivering 93% of planned activity, alongside a reduction in overall demand compared to the previous year. Performance was more variable across the year, with notable seasonal lows and a peak demand in January, reflecting ongoing pressures and changing patterns of urgent dental need.

5.2.4 Community Nursing

The Ministerial Delivery Expectation for weekend Community Nursing activity finished the year below the IMTP trajectory, delivering 72% of planned activity. However, a clear upward trend has been sustained, with average monthly contacts increasing by around 1,200 compared to 2024/25. While weekend activity continues to increase proportionally, meeting the ministerial ambition for weekend delivery of 80% of that of an average weekday, would require a significant rebalancing of service delivery.



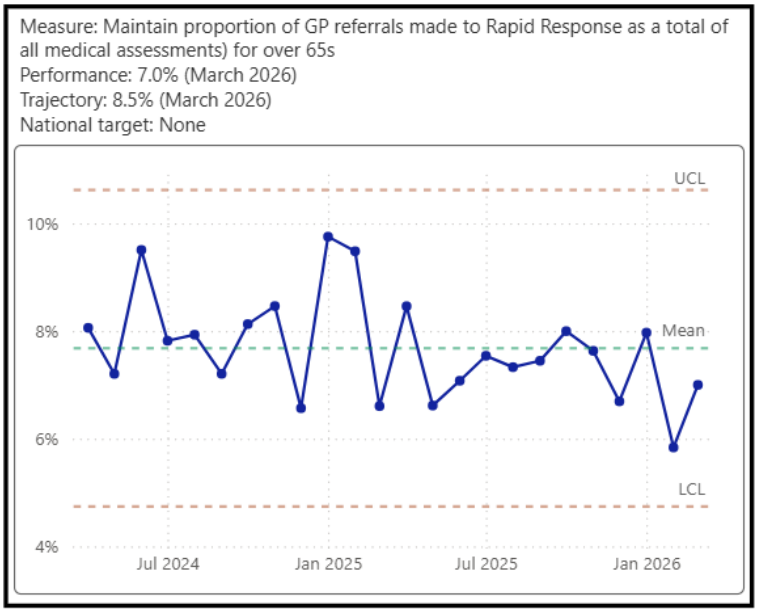
In contrast, Enhanced Community Care (ECC) performance, another Ministerial delivery expectation, exceeded forecast, with accepted referrals almost 25% above the IMTP trajectory, reflecting strong system utilisation of Rapid Response, Ready to Go Ward and Emergency Care at Home services.

5.2.5 Palliative Care

Palliative Care performance was marginally lower than the previous year, remaining consistently around 91% for much of the year and below the IMTP trajectory, primarily due to increased demand and periodic workforce capacity constraints. However, recovery in the final two months resulted in an end-of-year position of 94%, demonstrating improving resilience.

5.2.6 General Practice

GP referrals to Rapid Response services as a proportion of all medical assessments remained relatively stable throughout the year but were lower overall than in 2024/25 and largely below the IMTP trajectory, with seasonal variation and a more pronounced reduction in late winter.



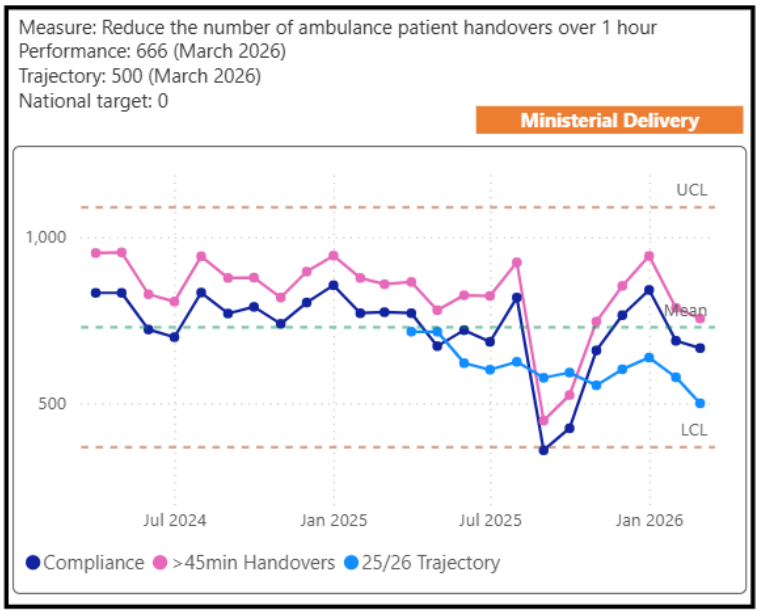
As part of the Urgent and Emergency Care transformation programme, the development of the Navigation Hub and Single Point of Access will seek to address access barriers and support improved utilisation of Rapid Response services, particularly for older people.

5.3 Improving our Urgent and emergency care system focusing on experience, access and discharge pathways

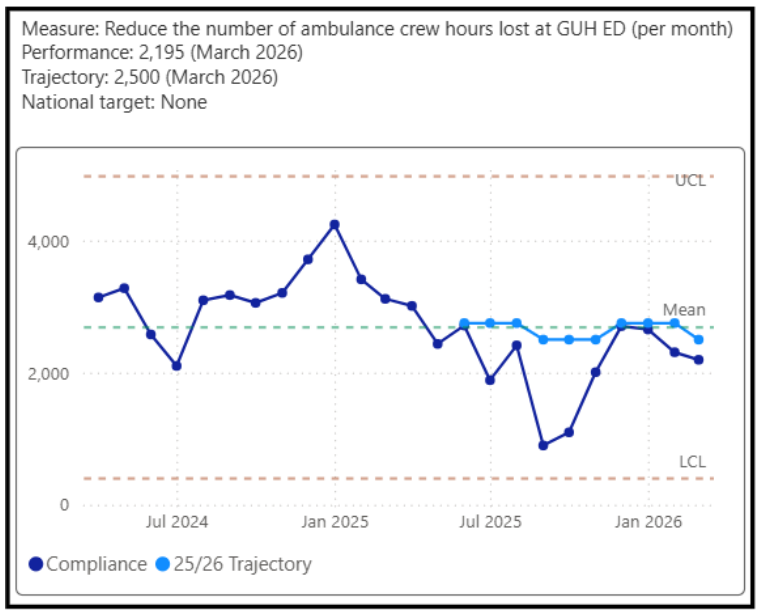
Delivery Expectation	ABUHB commitment	Latest position	MD/TI/EA
Reduce the number of ambulance patient handovers over 1 hour	**500** (Mar-26)	**666** (Mar-26)	**MD**
Reduce the number of ambulance crew hours lost at GUH ED (per month)	**2,500** (Mar-26)	**2,195** (Mar-26)	
Reduce the number of patients who spend 12 hours or more in all major and minor emergency care facilities from arrival until admission, transfer or discharge compared to the same month the previous year, building towards the national target of zero	**750** (Mar-26)	**1,184** (Mar-26)	**MD**
Increase and maintain national target of the percentage of patients waiting <4 hours in ED/MIU	**80%** (Mar-26)	**73.8%** (Mar-26)	
Reduction in time from arrival to ED triage - no waits over 60 minutes	**200** (Mar-26)	**528** (Mar-26)	
Median time from arrival at an emergency department to assessment by a clinical decision maker should not exceed 60 minutes and maintained for three months.	**60** (Mar-26)	**152** (Mar-26)	**TI**
Maintain the number of Urgent Primary Care contacts (inc. virtual)	**95,147** (Mar-26)	**95,304** (Mar-26)	
% of patients directly admitted to an acute stroke ward <4hrs of clock start	**20%** (Mar-26)	**21.1%** (Q3)	
% of unique stroke patients given thrombectomy (all stroke types)	**6%** (Mar-26)	**7.3%** (Q3)	
% Assessed by OT within 24 hours	-	**33.3%** (Feb-26)	
% Assessed by PT within 24 hours	-	**31.7%** (Feb-26)	
% Assessed by SaLT within 72 hours	-	**74.1%** (Feb-26)	
Deliver a 12-month reduction trend in the number of people who are delayed in hospital as measured by the Delayed Pathways of Care dashboard	**160** (Mar-26)	**178** (Mar-26)	**MD**
Deliver a 12-month reduction trend in the number of total days delayed in hospital as measured by the Delayed Pathways of Care dashboard	**6,437** (Mar-26)	**4,543** (Mar-26)	
Number of pathways of care delays due to awaiting completion of nursing / AHP / Medical / Pharmacy assessment	**12** (Mar-26)	**19** (Mar-26)	**TI**
Continuous reduction in the number of people admitted as an emergency who remain in hospital over 21 days since admission	**370** (Mar-26)	**385** (Feb-26)	**TI**

5.3.1 Ambulance handovers

Ambulance handover performance at the Grange University Hospital Emergency Department continued to improve during 2025/26. There were sustained reductions in both handover delays and associated lost hours. Lost hours remained below trajectory and, whilst not meeting the improvement trajectory set out on the IMTP, ambulance handovers over one hour showed marked improvement compared with the previous year, with around 100 fewer handover breaches and approximately 1,000 fewer lost hours over the same period.



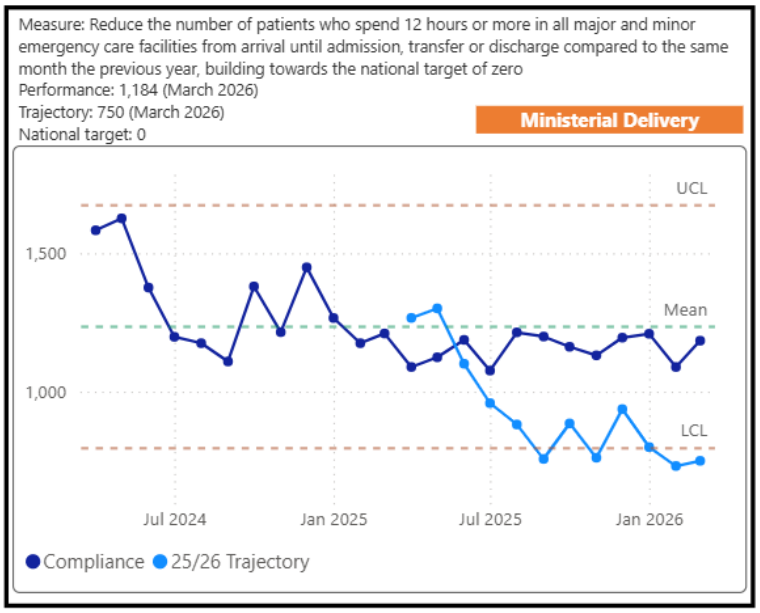
The March, year-end position delivered the strongest performance of the year outside of the initial Our Next Patient (ONP) launch period (September to November, record lows for all handover measures). In this context, March performance represents the best results seen since the early months of the hospital's opening, and 45-minute compliance reached 52%, closely approaching the 55% target set out in the Urgent & Emergency Care improvement plan and relaunch of the Our Next Patient initiative, which will underpin the improvement trajectories for 2026/27. Progress has been supported by a staged improvement programme, including a reset of standards and roles, clearer divisional ownership and executive oversight, and targeted actions to increase discharges and patient movement. All improvement actions are



benefits-mapped to ensure measurable system-wide impact on handover performance, patient flow, length of stay and patient experience.

5.3.2 12 and 4 hour targets

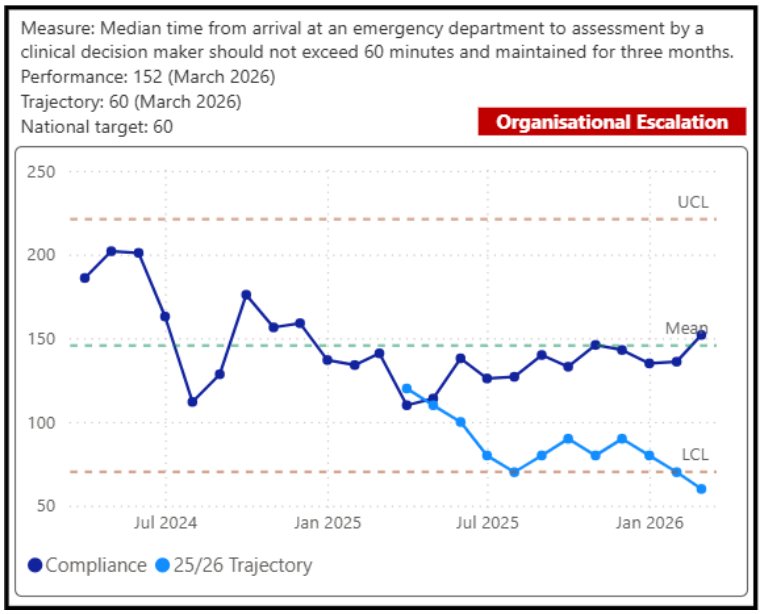
Performance against the 12-hour EDMIU and 4-hour standards showed improved consistency during 2025/26, despite ongoing system pressures. While the 12-hour IMTP trajectory was not fully achieved, performance represented a clear improvement on previous years, with breach volumes remaining within a narrow range throughout the year and significantly reduced volatility compared to historical patterns. 12-hour compliance was consistently strong, typically above 92%, with a post-Grange opening record high in July and year-end performance of 92.8%, narrowly below the targeted intervention de-escalation threshold of 93%. These improvements reflect greater operational stability, although weekly variation persists, driven by delayed specialty responses, high bed occupancy and constrained patient flow across the wider system.



4-hour performance was more challenged during the winter period, reflecting demand-led pressures across the urgent and emergency care system. Sustained improvement will continue to focus on earlier specialty decision-making, improved inpatient throughput and maintaining continuous flow through the Emergency Department and downstream assessment units and wards, supported by the relaunch of the Our Next Patient initiative and in line with the Urgent and Emergency Care (UEC) Improvement and Stabilisation plan.

5.3.3 Triage and Wait to be Seen

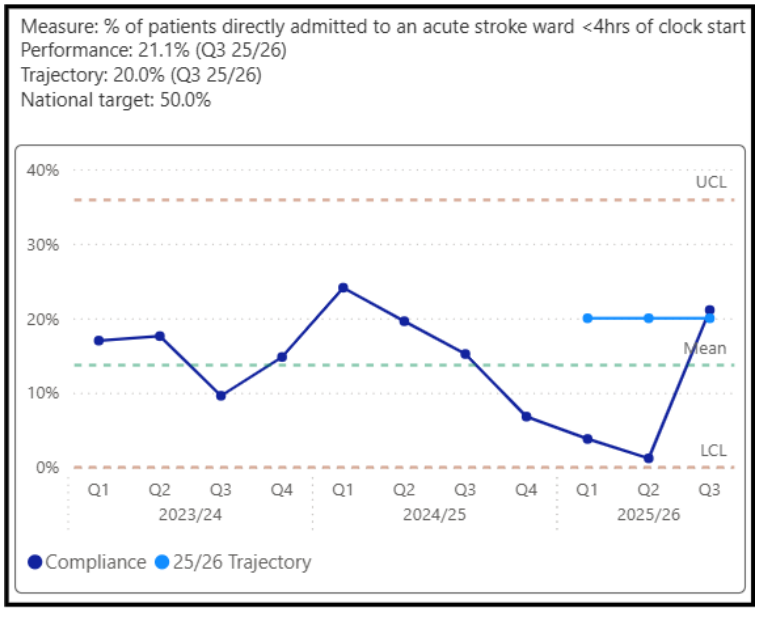
Triage and Wait to Be Seen (WTBS) performance during 2025/26 demonstrated improved control and stability compared with earlier years, while remaining sensitive to seasonal and operational pressures. Although triage performance tracked above trajectory following a winter peak, overall breach volumes remain significantly reduced, with 60-minute



breaches now approximately one-third of those seen during the early years of the Grange University Hospital. Triage improvement remains a core focus within the relaunch of the ONP initiative. Clinical Median Wait/WTBS performance has also improved year-on-year and shown greater consistency, although it has trended upwards through the course of the year and remains some way off achieving the IMTP trajectory which is aligned to the Health Board's targeted intervention de-escalation criteria. Sustained improvement actions are focused on strengthening daily operational huddles, enhancing early patient movement, optimising daytime assessment capacity through clinician role redesign and Senior Rapid Assessment and Treatment (SRAT) rostering, and protecting overnight cubicle capacity through robust escalation and boarding protocols to maintain flow and minimise delays.

5.3.4 Stroke services

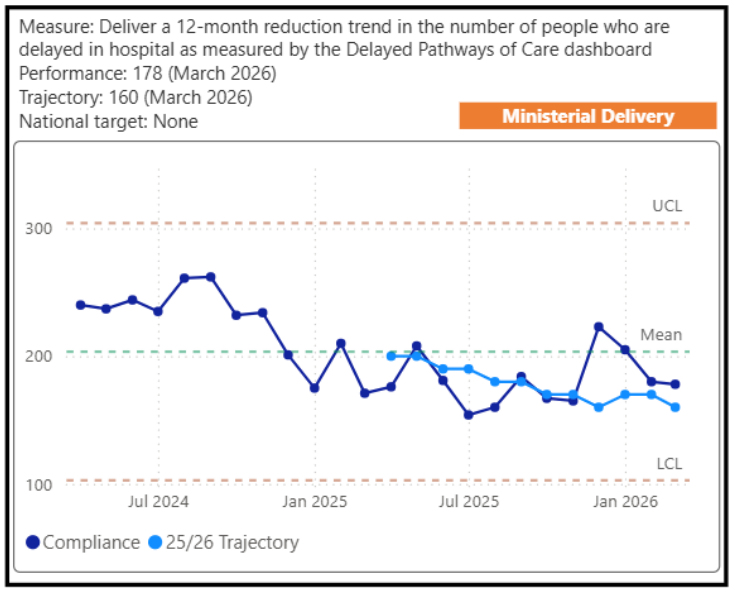
Stroke services demonstrated strong performance improvement during the year underpinned by corrected data processing, focused improvement actions and strengthened regional oversight. Following the resolution of a data processing error which severely impacted performance in the first half of the year, Q3 Sentinel Stroke National Audit Programme (SSNAP) results confirmed that performance against the stroke 4-hour standard exceeded the IMTP trajectory, with early analysis indicating this improvement has been sustained into Q4.

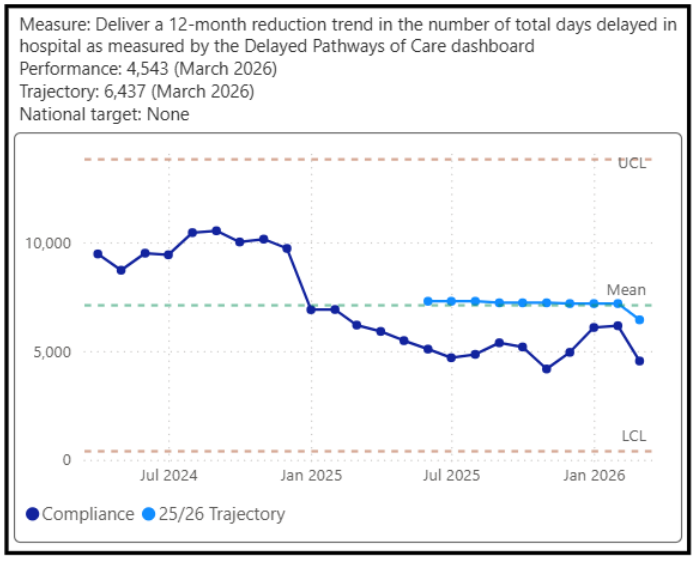


Thrombectomy performance also improved, with rates reaching 7.3% and meeting Q3 trajectory, supported by ongoing discussions with NHS Planning and Improvement and Joint Commissioning Committee colleagues to review commissioning arrangements and access to extended service hours. Progress has continued across the wider stroke pathway, with improved timeliness of physiotherapy and occupational therapy assessments and sustained improvements in speech and language therapy provision. An updated stroke improvement plan is in place to address outstanding GIRFT (Get it Right First Time National Programme) actions and align delivery with the NHS Wales Stroke Quality Statement, with performance oversight strengthening through the Urgent and Emergency Care Improvement Programme and enhanced regional governance arrangements, including Llais participation on the Stroke Regional Network Board.

5.3.5 Pathway of Care Delays

Pathway of Care Delays (POCDs) showed signs of sustained improvement towards the end of 2025/26 following a peak in system pressure during the winter. After reaching a high point in December of 223, total POCDs reduced for three consecutive months with the March, year-end position having reduced to 178. This was slightly above the planned trajectory of 160 and 4% higher than the equivalent position in the previous year (171), however the impact of delays has reduced more significantly, with total days delayed falling sharply to 4,543 in March which represents a 27% reduction compared with March 2025 and indicative of



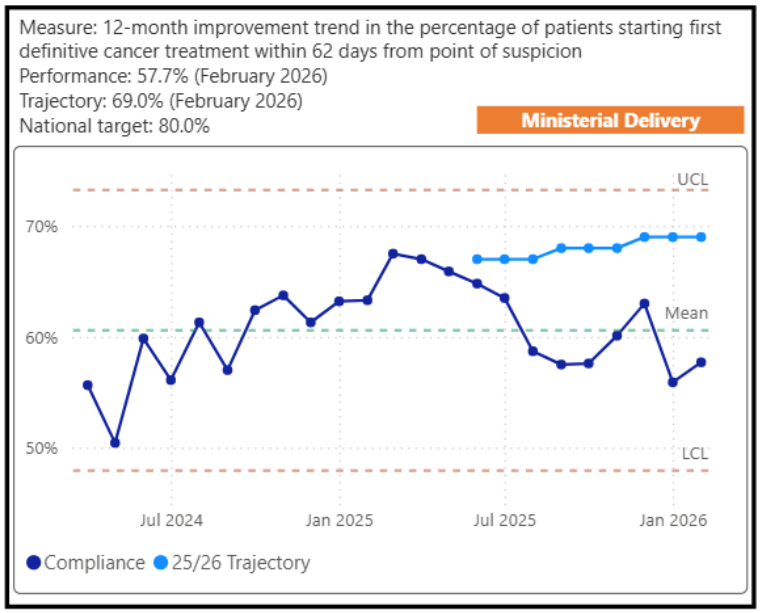


improved progression through discharge pathways, particularly for long-staying patients. Performance against the POCD subset measure, another measure as a result of the Health Board's escalation status for UEC, has remained on an overall downward trajectory since autumn, despite some month-to-month variation driven by assessment-related delays. Length of Stay for patients exceeding 21 days (the final UEC escalation measure) followed expected seasonal trends, peaking over winter before improving in February, supported by a renewed organisational focus through the Our Next Patient initiative. Continued improvement is being driven by a sustained focus on intensive review of the longest delays, alongside the introduction of strengthened divisional processes to improve the accuracy of Estimated Discharge Dates (EDDs) and clearer recording of the specific barriers preventing patients from moving to the next stage of discharge planning.

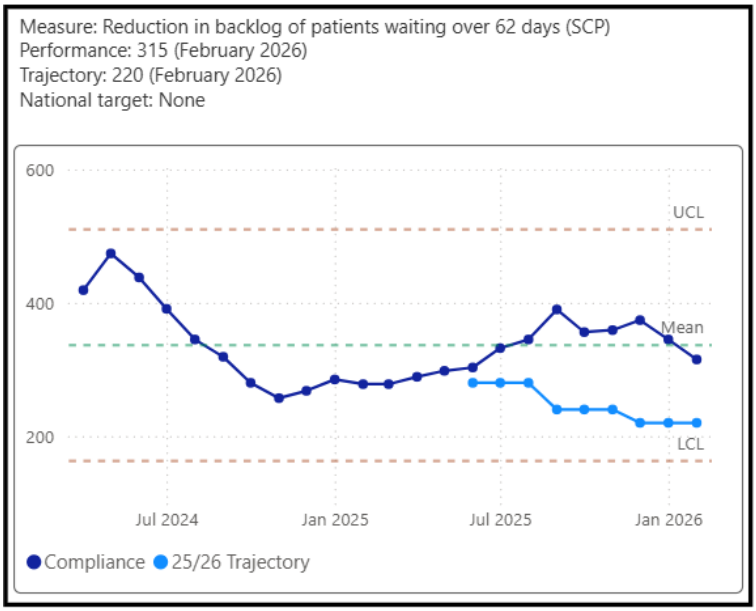
5.4. Continuing to prioritise Cancer, Urgent and the longest waiting patients for Planned Care

Delivery Expectation	ABUHB commitment	Latest position	MD/TI/EA
12-month improvement trend in the percentage of patients starting first definitive cancer treatment within 62 days from point of suspicion	**70%** (Mar-26)	**57.7%** (Feb-26)	**MD**
Reduction in backlog of patients waiting over 62 days (SCP)	**200** (Mar-26)	**315** (Feb-26)	
Reduction in backlog of patients waiting over 104 days (SCP)	**50** (Mar-26)	**108** (Feb-26)	
Increase in rate of treatments starting within 28 days of decision to treat	**75%** (Mar-26)	**90.8%** (Feb-26)	
Numbers of patients waiting over 104 weeks (all stages)	**0*** (Mar-26)	**23** (Mar-26)	**MD**
Number of patients waiting over 52 weeks for Outpatients	**1,834*** (Mar-26)	**1,228** (Mar-26)	
Reduction in the number of patients waiting 100% past Outpatient follow-up target date	**27,275** (Mar-26)	**30,850** (Mar-26)	
Increase in the rate of See On Symptom and Patient Initiated Follow-ups	**13.5%** (Mar-26)	**12.6%** (Mar-26)	
Monitoring DNA/CNA for every Outpatient clinic. When DNA >5%, overbooking to be implemented & monitored and reduction of CNA	**5%** (Mar-26)	**5.2%** (Mar-26)	**EA**
Reduction in the number of patients waiting more than 8 weeks for a specific diagnostic	**166*** (Mar-26)	**233** (Mar-26)	**MD**
Number of adults waiting more than 14 weeks for all audiology pathways	**5,440** (Mar-26)	**5,766** (Mar-26)	
Number of children waiting more than 6 weeks for all audiology pathways	**3,630** (Mar-26)	**780** (Mar-26)	
No patient waiting more than 14 weeks for a therapeutic assessment	**105** (Mar-26)	**350** (Mar-26)	
On 90% of days planned care inpatient/daycase/theatre recovery capacity should be protected from pressures and outliers	**90%** (Mar-26)	**95.4%** (Mar-26)	**EA**
Theatre Utilisation late starts to less than 20%	**25%** (Mar-26)	**38.2%** (Mar-26)	**EA**
Theatre Utilisation early finishes to less than 10%	**25%** (Mar-26)	**40.8%** (Mar-26)	**EA**
Theatre Utilisation session utilisation to 85%	**85%** (Mar-26)	**83.7%** (Mar-26)	**EA**
Deliver improvements in day surgery rates, achieving a BADS daycase rate	**55%** (Mar-26)	**77.9%** (Feb-26)	**EA**

5.4.1 Single Cancer Pathway

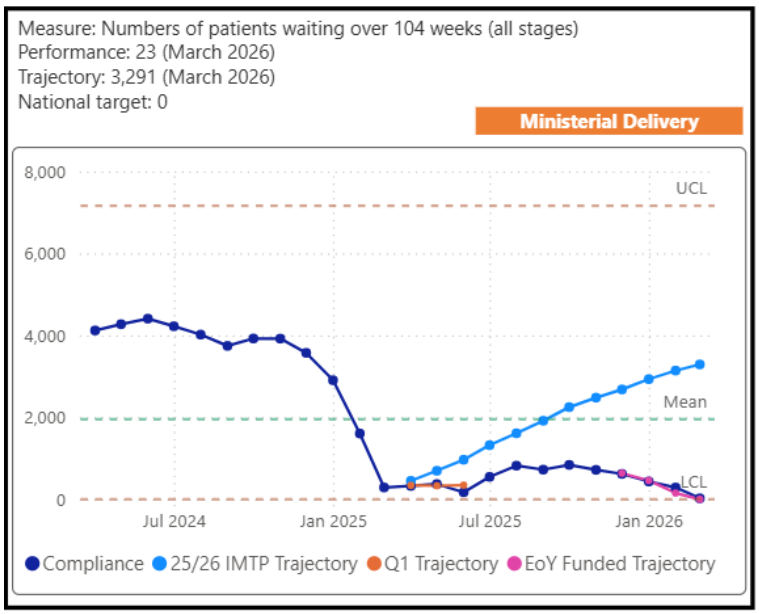


Delivery against the Single Cancer Pathway (SCP) standard during 2025/26 has been mixed and generally below the trajectory set out in the IMTP. SCP compliance improved marginally in February to 57.7% (the latest available data) with clear progress in specific pathways following the establishment of recovery planning meetings chaired by the Cancer Senior Responsible Officer (SRO) and supported by strengthened governance and targeted recovery actions across key tumour sites. Notable improvements are observed in gynaecological oncology, where SCP compliance increased from 37.5% in November to 73.3% in February, while Head and Neck pathways have seen backlog reduction following the resumption of weekly review meetings. Colorectal services remain a key focus, with a detailed recovery action plan now in place to address challenges at the initial diagnostic stage, including the ongoing impact of high DNA and short-notice cancellation rates within endoscopy. The 62-day backlog reduced steadily from a peak of around 390 in September, with the February position at 315 patients, equating to 9.5% of the total Patient Tracking List (PTL) and within the intended ~10% tolerance, albeit with continued focus required on Lower GI, Upper GI and Urology, which together account for over 75% of the backlog. The 104-day backlog has remained broadly stable over the past six months despite fluctuations in SCP census, with a clear priority to reduce this further through Q4 and into 2026/27. Performance against the 28-day

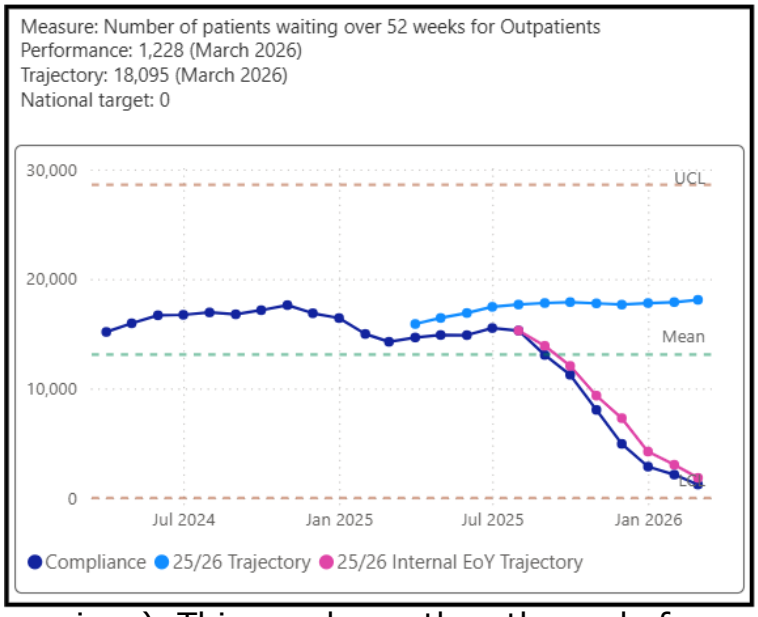


treatment start standard from decision to treat remained consistent throughout the year, ranging between 86.9% and 92.8%, and consistently above the mean, demonstrating sustained performance despite pathway pressures.

5.4.2 Planned Care



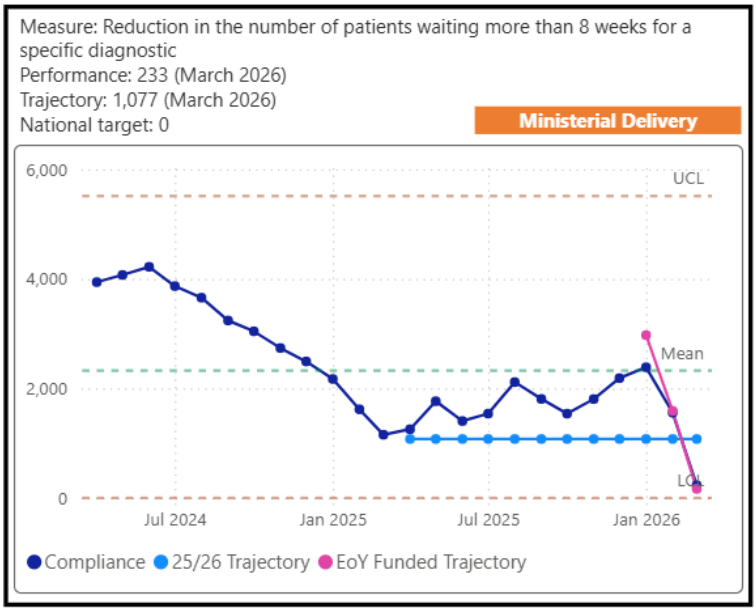
Planned care performance delivered a significant improvement during 2025/26, underpinned by strong organisational focus and targeted investment following national non-recurrent funding for both treatments (104 week waits) and Outpatients (national insourcing programme). The Health Board reduced waits over 104 weeks to 23 patients by March year end, the lowest position since April 2020. This represented a substantial achievement against a challenging trajectory that aimed for zero, with an acknowledged delivery risk of 30–40 patients in Orthopaedics. This outcome was enabled a substantial, cross divisional effort across multiple teams.

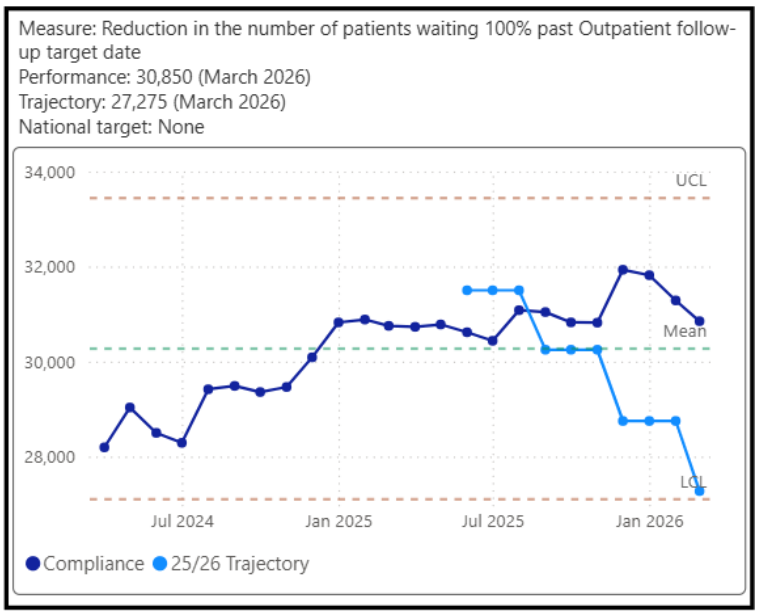


Performance against the 52-week new outpatient standard also improved, driven by the 26-week outpatient insourcing programme, which contributed to a sustained reduction from the August and delivered a year-end position of 1,228 patients over 52 weeks (down from 14,265 12 months previous). This was lower than the end of year forecast figure of 1,834 and represents the Health Board's lowest 52-week outpatient position since August 2020. Strong performance for the 26-week outpatient insourcing

programme was central to this reduction, with 33,203 appointments completed against a planned total of 33,612, equating to 98.8% contract delivery and demonstrating effective management of what was a hugely resource intensive programme to deliver within the Health Board.

Diagnostic performance against the 8 week standard improved markedly during the final quarter of 2025/26, following an intensive programme of recovery work supported by additional, non recurrent funding. This resulted in an exceptional reduction in 8-week diagnostic breaches, falling from 1,557 in February to just 233 at year end. While the initial assessment anticipated a closing position of 166 breaches, delivering this scale of improvement in the context of significant additional diagnostic demand arising from the 26-week outpatient insourcing programme represents a significant achievement. The outcome reflects sustained organisational focus and the collective efforts of a wide range of clinical, operational and support teams, whose contribution has been instrumental in delivering this milestone improvement in performance. The year end position saw zero breaches across several modalities, including endoscopy, neurophysiology and urodynamics, and a global 8-week compliance rate of 98.9%.

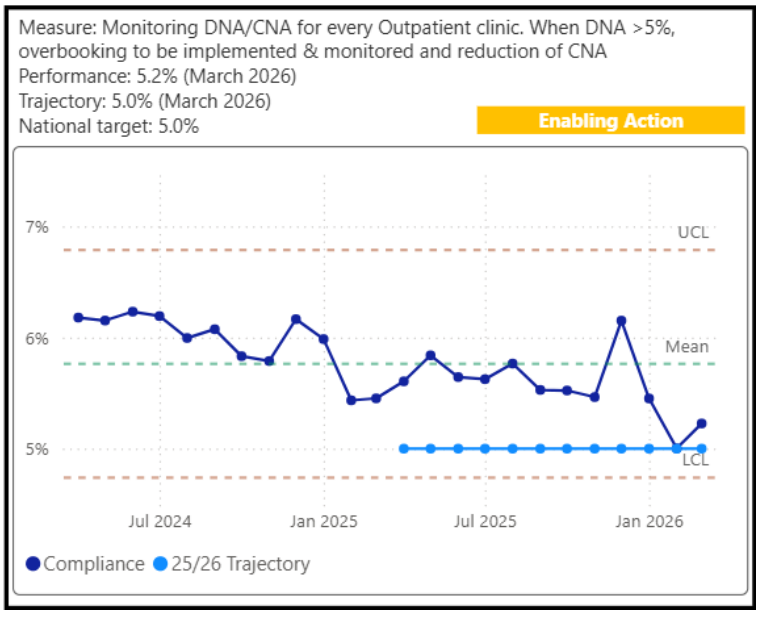




Delayed Follow Ups (100% past target) and rates of See on Symptom (SOS) and Patient Initiated Follow Up (PIFU) both ended the year not meeting the trajectories set out in the IMTP, although both trended in the right direction during the final quarter of the year and will remain key measures into 2026/27.

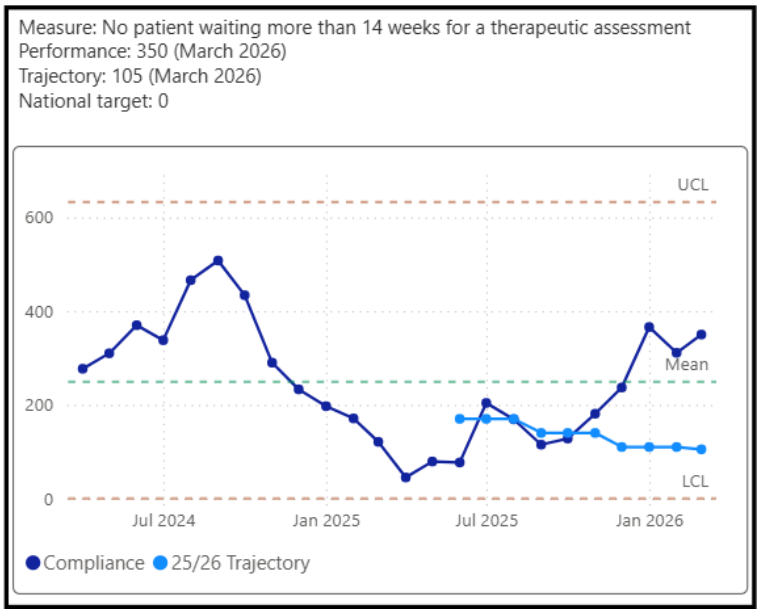
The Outpatient Transformation Programme continues to maintain a strong focus on managing patients with the longest follow-up waits, working closely with Directorates to ensure patients are appropriately booked, clerically validated or clinically reviewed. Local SOS and PIFU pathways were established across services, with further work underway to ensure consistent utilisation and identify additional opportunities. Retrospective application of SOS and PIFU pathways is planned for 2026/27 as part of the wider validation strategy. Targeted clinical validation has already begun, including within ENT services, resulting in patients being discharged or appropriately transitioned to SOS or PIFU pathways where clinically suitable.

Outpatient clinic 'Did Not Attend' (DNA) performance continued to show sustained improvement during 2025/26. February delivered the lowest DNA rate on record at 4.9% (based on available data since April 2019), with a marginal increase to 5.2% in March, slightly above the national target and IMTP trajectory (5%). Notwithstanding this small fluctuation, performance over the past 24 months demonstrates a clear and



positive trend. A targeted approach remains in place to address areas with persistently higher DNA and CNA rates, supported by the widespread implementation of text message reminders across the majority of clinics. In addition, work has commenced with Public Health colleagues to better understand cohort-specific factors influencing non-attendance within COTE services, helping to inform more tailored and preventative interventions going forward.

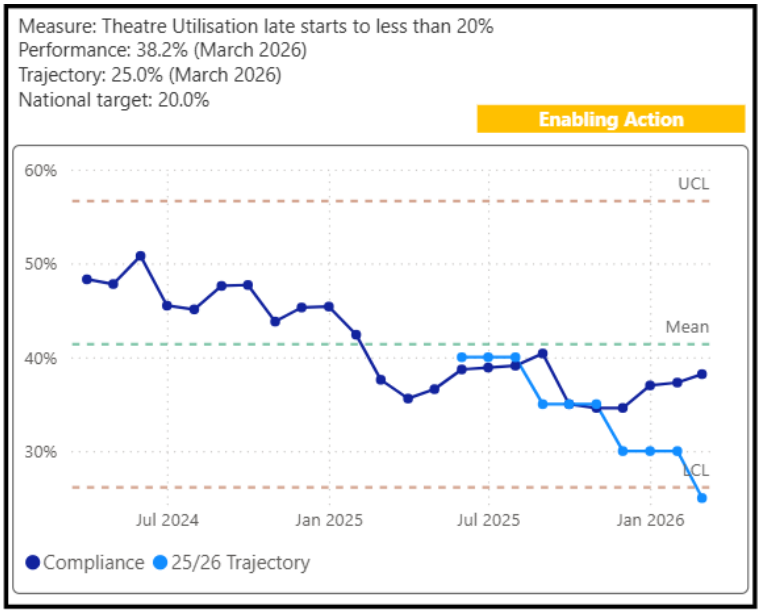
5.4.3 Audiology and Therapies

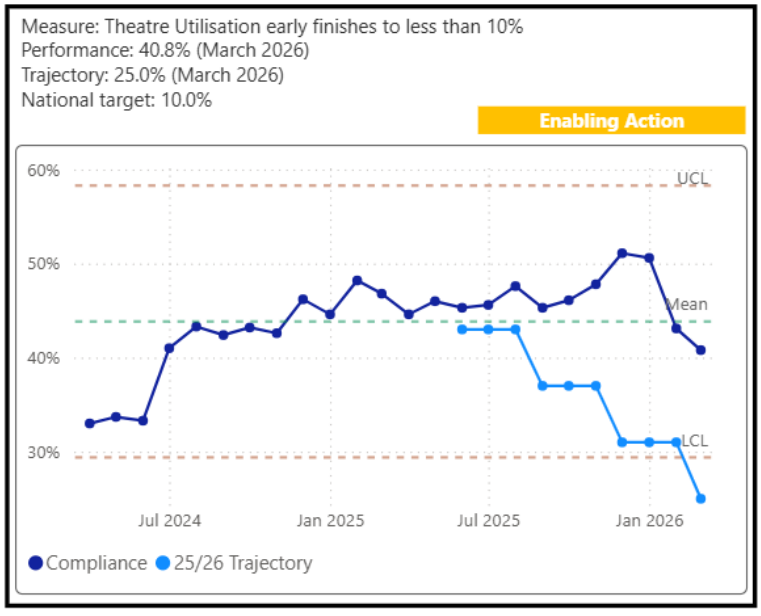


Audiology and therapy services experienced increased pressure during 2025/26 as a result of system-wide elective recovery activity and rising demand. Within adult audiology pathways, additional demand generated through the 26-week outpatient recovery programme in ENT led to increased referrals into Adult Hearing New and diagnostic pathways, resulting in 14-week breach numbers exceeding the IMTP trajectory as the service absorbed this surge within existing capacity. In contrast, paediatric audiology benefited from targeted end-of-year investment, enabling a reduction in breaches and delivering a year-end position lower than at the start of the year and well below planned levels. Across therapy services, 14-week performance deviated from the IMTP trajectory in the second half of the year, reflecting ongoing capacity challenges. Dietetic services continue to face workforce constraints, particularly within paediatrics and gastroenterology. Physiotherapy services have also seen increased demand due to higher volumes of spinal and knee referrals redirected from Orthopaedics, alongside a planned reduction in capacity to support delivery of the end of year 104-week RTT performance.

5.4.4 Theatres

Performance against key Theatre efficiency metrics during 2025/26 was variable across the suite of metrics, with some showing signs of improvements and others remaining relatively static. Elective theatre protection has been consistently maintained for the past 18 months, minimising disruption to planned care and continuing to demonstrate a key advantage of the service redesign with the opening of the GUH. Improvements in late starts have been delivered over the past two years, supported by the full implementation of Autosend and Golden Patient initiatives across all sites. These projects have helped standardise processes and improve readiness at the start of the day to maximise the time available. However, the additional improvement anticipated in the second half of the year was not fully realised, reinforcing the need for continued attention to list preparation, resource alignment and operational discipline. Early finishes remain a key challenge and continue to sit behind the IMTP trajectory; encouragingly, performance improved notably in the final two months of the year, with March recording the lowest early finish rate since June 2024. This indicates growing traction from optimisation actions, although further improvement is required to maximise productive theatre time. Session utilisation remained close to the national standard of 85% for most of the year, aside from expected seasonal variation. Day surgery performance has remained

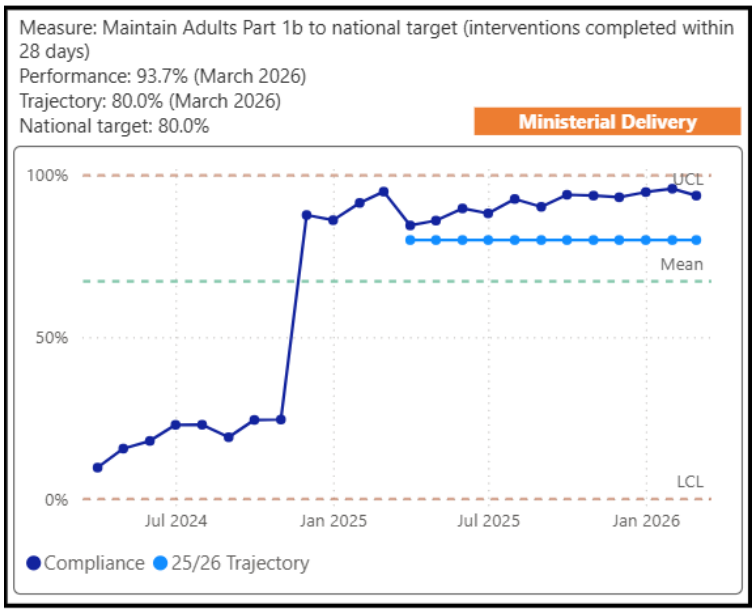




broadly aligned with national expectations, with BADS rates tracking near the 80% standard and ongoing maximisation meetings supporting delivery. Theatre optimisation, particularly reducing late starts and early finishes, remains a key organisational priority for 2026/27.

5.5 Improving our Mental Health services

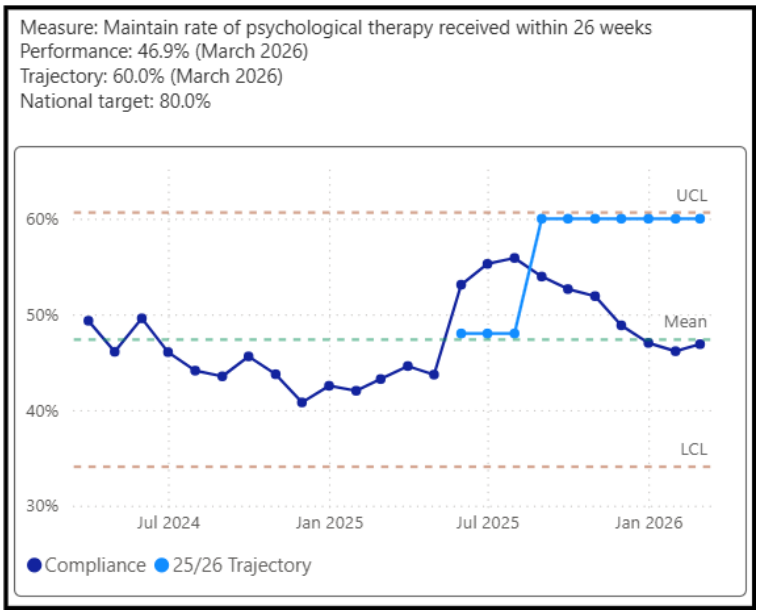
Delivery Expectation	ABUHB commitment	Latest position	MD/TI/EA
Maintain Adults Part 1a to national target (assessment completed within 28 days)	**80%** (Mar-26)	**86.6%** (Mar-26)	**MD**
Maintain Adults Part 1b to national target (interventions completed within 28 days)	**80%** (Mar-26)	**93.7%** (Mar-26)	**MD**
Maintain Adults Part 2 rates (number of individuals with a valid care and treatment plan)	**90%** (Mar-26)	**91.3%** (Mar-26)	
Maintain rate of psychological therapy received within 26 weeks	**60%** (Mar-26)	**46.9%** (Mar-26)	
Maintain CAMHS Part 1a national target compliance (assessment completed within 28 days)	**80%** (Mar-26)	**99.0%** (Mar-26)	**MD**
Maintain CAMHS Part 1b national target compliance (intervention completed within 28 days)	**80%** (Mar-26)	**80.4%** (Mar-26)	**MD**
Maintain CAMHS Part 2 national target compliance	**90%** (Mar-26)	**95.0%** (Mar-26)	
Improvement in Neurodevelopment waiting times compliance	**80%** (Mar-26)	**57.0%** (Mar-26)	
Maintain 80% compliance of Specialist CAMHS Choice Assessments within 28 days from referral	**80%** (Mar-26)	**94.5%** (Mar-26)	



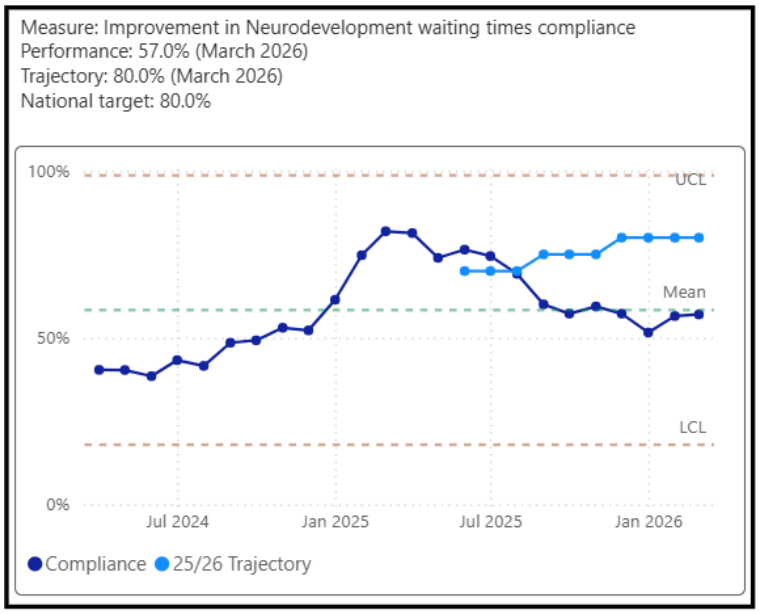
Mental health access standards performance during 2025/26 remained strong across the majority of core measures, reflecting effective demand and capacity management within both Adult and Children and Young People's services. Adult and CAMHS Part 1a and 1b standards were consistently achieved throughout the year. Adult and CAMHS 1a maintained continuous compliance with national requirements. Adult Part 2 performance exceeded the IMTP trajectory across the year and surpassing the national standard of 90% from August onwards. While ongoing data cleansing activity continues,

volumes of new Care and Treatment Plans (CTPs) and discharges are expected to stabilise, supporting sustained compliance.

Similarly, Specialist CAMHS Choice assessments have continued to perform well above the national standard of 80%, despite temporary capacity reductions earlier in the year, with improvement evident over the most final four months of the year. Within CAMHS Part 2, performance issues linked to non-compliance with CTP processes and data quality have been addressed through targeted audit activity, staff training, and the appointment of a dedicated CTP lead, resulting in a return to performance exceeding the national standard in the final four months of the year.



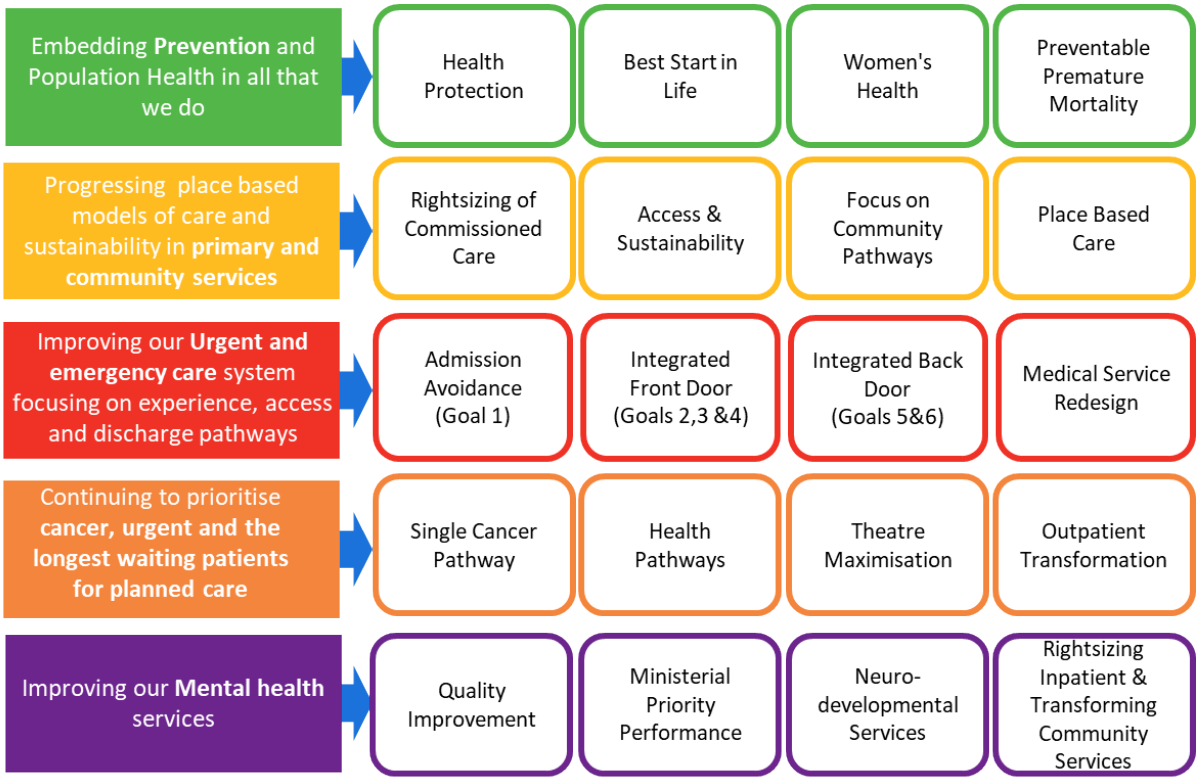
In contrast, some areas experienced increased pressure during the year, particularly within Psychological Therapies and CAMHS Neurodevelopmental pathways. Psychological Therapies performance declined during the second half of 2025/26, primarily because of workforce vacancies impacting capacity. In response, a revised divisional recovery plan has been developed to support delivery of the 2026/27 trajectory, with an ambition to improve performance to 62% by end of 2026/27. This is supported by the implementation of performance dashboards across all adult teams, completion of booking process mapping, and the development of improved future-state processes.



CAMHS Neurodiversity services remain under sustained pressure, with increasing referrals and growing waiting lists contributing to performance stabilising at around 57% through the second half of the year. While this has impacted the 26-week standard, the service has consistently maintained the ministerial requirement for longest waits to remain below 52 weeks. Strengthened screening processes and continued progress toward full implementation of the Neurodiversity Early Support Hub model are expected to support improved pathway consistency and capacity during 2026/27.

6. Delivering the IMTP Priorities 2025/26

This chapter updates on delivery against the five system change themes and the key priorities outlined in our Three-Year Plan 2025/26.



6.1 Embedding Prevention and Population Health in all that we do

In Gwent there is the largest gap in healthy life expectancy between our least and most deprived communities of any Health Board in Wales. Male predicted years in healthy life at birth varies from 55.6 years in Blaenau Gwent to 68.7 years in Monmouthshire. Female predicted years in healthy life at birth varies from 55.3 years in Blaenau Gwent to 69.3 years in Monmouthshire.

Our Director of Public Health's report on Preventable Premature Mortality called We are Gwent highlights that 1 in 3 deaths in Gwent between 2018-2022 happened prematurely, the three main causes are Cardiovascular Disease, Diabetes and Cancer which could have been preventable through regular physical activity, a healthy diet, not smoking, reducing alcohol consumption and through regular health checks.

Our Public Health Delivery Plan articulates how we work with partners and outlines our public health offer to them through five building blocks:

- Preventable Premature Mortality (including Women's Health)
- Best Start in Life
- Evidence Base
- Natural and Built Environment
- Resilient Communities (including Health Protection)

Under the system change theme of embedding prevention and population health in all that we do there were 4 key areas we committed to delivery against in our Plan for 25/26:

- **Resilient Communities & Health Protection:** Deliver the National Immunisation framework for Communities and accelerate action to embed community interventions that tackle the wider determinants of health recognising the local need and deprivation.
- **Best Start in Life:** Using the evidence developed in the Joint Strategic Needs Assessment to produce the Early Years Delivery plan with partnership commitment to deliver the actions.
- **Women's Health:** Working in partnership and understanding the gap in provision for Women implement the first Women's Health Hub in Gwent.
- **Preventable Premature Mortality:** Support our population to prevent premature mortality through targeted implementation of the Diabetes Prevention Programme and Hypertension Programme.

We made the following key achievements against these areas:

Embedding Prevention and Population Health in all that we do	
Priority	**Achievements**
Resilient Communities & Health Protection	• Plans successfully implemented to increase flu vaccination uptake in 2- & 3-years olds based on learning from the targeted programmes in Blaenau Gwent and Caerphilly • Delivered Vaccination Service to offer flu and COVID-19 vaccinations to care home residents ensured timely flu vaccination of housebound patients • Implemented the seasonal respiratory plan for all eligible cohorts coupled with an additional catch-up campaign for Respiratory syncytial virus (RSV) • Established vaccine equity task and finish group to ensure we provide targeted support to those who need it most • Implemented a Midwifery led quality improvement project to increase RSV vaccination uptake with support of the vaccination service in antenatal clinics • Integrated Wellbeing Network Leads have convened Well-being Collaboratives in specific communities which brings together Health Board services, local authority, third sector organisations, community groups, volunteers and community leaders • Driven actions to embed community-based interventions that address wider determinants of health as part of the ongoing partnership between Integrated Wellbeing Networks and Neighbourhood Care Networks ensuring activity remains aligned with local need and levels of deprivation
Best Start in Life	• Best Start in Life (BSiL) embedded as an area of focus for the Public Service Board (PSB) with a strategic Leadership Group to shape and steer an evidence-based regional delivery plan • A multi-agency workshop took place that agreed the approach and programme milestones required to improve outcomes in the first 1000 days • Agreed a Gwent wide BSiL definition and set of ambitions, as well as the proposed structure for the Early Years Delivery Plan, which will focus on programme assurance, priorities and developing a community of practice

	• Draft priorities for improvement were shared with the Best Start in Life (BSiL) Leadership Group in Q4, with further refinement now underway through the Regional Management Group. Priorities include a focus on improving preconception, pregnancy planning support, and increasing breastfeeding in Gwent through promotion of the Pump Loan Scheme and Peer Support Groups
Women's Health:	• Priorities and pathways agreed and mapping work has completed to assess the current service provision against the baseline within specification • The first tranche of funding from Welsh Government was successfully approved to progress implementation of training, engagement, accreditation and validation • An application was submitted for the second tranche of Welsh Government funding to support implementation of additional education and training, increased community presence and virtual signage of hub and spoke model • The Women's Health Discovery Report has been completed and translated into an action plan to inform future development of the pathfinder hub with the first pathfinder hub for Gwent successfully launching in April 26
Preventable Premature Mortality:	• Hypertension case finding service is up and running across Gwent in its first three months, over 1,100 blood pressure checks were completed and over 80 patients identified as hypersensitive • Commenced development of contract and service model with identified delivery partners for hypertension treat to target (TTT) service • Delivery of the 12-week behaviour change programme continues and in the first six month the total invited to participate was 4,354 with a total of 1,769 appointments issued • The Diabetes Prevention Programme has secured short term funding and planning continues for its integration into the Cardiovascular Disease service from September 2026.

6.2 Progressing Place Based Models of Care and sustainability in Primary and Community Services

Neighbourhood Care Networks (NCNs) were developed over 10 years ago within Gwent. In 2022 the Strategic Programme for Primary Care launched the Accelerated Cluster Development programme which aimed to broaden professional engagement in NCNs beyond GP practices to include Community Pharmacy, Optometry, Dental, Nursing and Allied Health Professionals.

Aligned with our strategy Gwent 35 it is important now more than ever, to plan for the redirection of resources towards helping people in Gwent maintain good health and well-being, so they can lead fulfilled and healthier lives for longer.

Place Based Care has long been recognised as the strategic approach for:

- Building resilient and connected communities
- Prevention and earlier intervention
- Reducing health inequalities
- Collaborative working through multi-disciplinary teams
- Providing are closer to home and streamlining access to specialist care
- Reducing preventable admissions and optimal hospital discharge through a Home First approach

Under the system change theme of progressing Place Based Models of Care and sustainability in Primary and Community Services, there were 4 key areas we outlined we would deliver against in our plan for 2025/26;

- **Rightsizing of Commissioned Care:** On-going review of all placements and addressing any areas where targeted support is needed to ensure we deliver value and sustainability in Continuing Healthcare.

- **Access & Sustainability:** Ensure sustainable GP Services across Gwent and implement of new pathways for Primary Care Optometry Services. In addition, increase the number of Pharmacies providing

Pharmacist Independent Prescriber Service and services through Common Ailments Service.

- **Focus on Community Pathways:** Working in partnership with Secondary Care Services develop prioritised workplan for pathway development that shifts care from an acute setting.

- **Place Based Care:** Working in partnership create a whole system Community Model based on need through multi-professional integrated neighbourhood making the necessary shift in resources and decision making from acute settings into our communities building community resilience.

Progressing Place Based Models of Care and sustainability in primary and community services	
Priority	**Achievements**
Rightsizing of Commissioned Care	• Continued to build on positive work to manage and reduce enhanced care in care home setting including introducing additional scrutiny on enhanced care and one to one placements • Community Health Care top 50 reviews were completed and associated actions taken forward resulting in efficiencies • 25-26 identified saving targets have been met with £306k of full year savings achieved for top the 50 placements and £305k full year savings for Funded Nursing Care assessment process
Access & Sustainability	• Following completion of supplementary and enhanced service mapping Neighbourhood Care Network Leads engaged with practices to improve equitable provision of supplementary and enhanced services • Continued robust management of GMS contractual changes including an updated Vacant Practice Policy reflective of the change in procurement regulations and ongoing Support for 3 practices under the Sustainability Assessment Framework • All five revised clinical pathways for optometry services have been developed and are available across Gwent including the successful transition of Primary Care providers previously commissioned through Ophthalmic Diagnostic Treatment Centre
Focus on Community Pathways	• Established Clinical Interface Groups underway in Mental Health, Urgent Care and Surgery to support the shift of acute services into community settings delivering care closer to home • Implemented programme management approach to progress the delivery of the Eye Care Plan through a series of workstreams with dedicated leads overseen by the Eye Care Collaboration Board • The Local Oral Health plan was revised in the context of the new General Dental Service Regulations, oversight will be led from the newly re-established Integrated Oral Health Group
Place Based Care	• Established work programme with agreed pilot areas of Blaenau Gwent and Torfaen as a federated local authority and Integrated Service Partnership Boards • Integrated Service Partnership Boards developed a costed implementation plan that articulates how the priorities will be addressed and identifying the key partners and stakeholders • Integrated Wellbeing Network Leads are now active members of the Neighbourhood Care Networks embedding social prescribing to utilise community assets

6.3. Improving our Urgent and Emergency Care System focusing on experience, access and discharge pathways

The six goals for Urgent and Emergency Care remained a significant priority with dedicated programmes coupled with targeted action to address Enhanced Monitoring in the Emergency Department at Grange University Hospital.

A strategic, coordinated approach was essential to ensure the system delivered timely, high-quality care. By focusing on improving Ambulance handovers, reducing prolonged stays, and addressing care delays, the system continued to progress in enhancing patient outcomes and operational efficiency.

Developed joined up place-based teams with the appropriate community infrastructure is necessary to tackle the complex and interrelated factors that affect health and well-being outcomes and health inequalities. An approach that solely relies on treating or providing care for individuals whilst ignoring the wider range of community assets in a 'place' will only achieve a partial response.

Under the system change theme of improving our Urgent and Emergency Care System focusing on experience, access and discharge pathways, there were 4 key areas we delivered against in our plan for 2025/26;

- **Admission Avoidance (Goal 1):** Ensure wider access to Community Hospitals from the community to avoid an acute admission is rolled out across all sites and deliver increased support to the Community and Care Homes.

- **Integrated Front Door (Goals 2,3&4):** Further develop our Emergency Care Models and improve experience in our Emergency Departments. In addition, take actions to reduce community falls.

- **Integrated Back Door (Goals 5&6):** Continue to embed the optimal Hospital flow across all sites and progress Trusted Assessor Model working with Local Authorities across Gwent.

- **Medical Service Redesign:** Implementation of Clinical Service Models that redesign our Medical Service across our Hospital sites.

Improving our Urgent and Emergency Care System focusing on experience, access and discharge pathways	
Priority	**Achievements**
Admission Avoidance (Goal 1)	• Extended weekday expansion of Community Resource Teams commenced in September 2024. Since going live, the average weekly referrals are up 26% and accepted up 25% versus 2023/24 • The Extended Weekend Frailty Service pilot ran for 10 weekends (25 January–30 March 2025) to reduce admissions and support winter pressures. During this period, 40 patients were identified, with 24 suitable for Frailty and 8 referred for interventions, alongside 37 Rapid Medical referrals accepted by Community Resource Teams • Upskillied care home staff to recognise red flags in residents with deteriorating diabetes supported through the development of a new Directory of Services, which outlines the support and training available to care • The Future Care Plan (FCP) facilitators have delivered training to 14 care homes across Gwent, with further sessions consistently booked through to July 2026. 92 care homes staff (from the 14 homes) have been trained with 48 NHS staff
Integrated Front Door (Goals 2,3 &4)	• Combined Same Day Emergency Care (SDEC) patient throughput has increased substantially in 2025 with 'SDEC first' principles embedded at The Grange University Hospital • Following the successful initial care home education and training initiative, a bid was submitted for National funding to increase the number of care home participation • Improved capacity of the enhanced community falls response service in Gwent and partnership working with Wels Ambulance Services Trust to maximize impact of the level 2 response • Frailty based MDT pilot implemented from November to March where 320 cases were reviewed resulting in 57% of patients remaining at home and 85% avoiding conveyance to the Grange University Hospital when community hospital admissions were included as alternative pathways

Integrated Back Door (Goals 5&6)	• Continued to embed the Optimal Hospital Flow Framework across all sites to support continuous flow model • Continued to monitor benefits and opportunities of the Transfer Lounge via Safety Flow
Medical Service Redesign	• Undertaken review of best practice models from Swansea, Leicester and Bristol • Stakeholder engagement continued to develop optimal model and clinical criteria • Older Person Pathway development progressed through working with clinical teams to define the clinical criteria at each stage of the pathway • 12-week public and staff engagement for Stroke was completed with additional sessions organised for Stroke patients groups across Gwent

6.4 Continuing to prioritise Cancer, Urgent and the longest waiting patients for Planned Care

Planned Care and Cancer Services have continued to focus on reducing waiting times, streamlining pathways, and enhancing patient outcomes.

From a strategic perspective, these areas must be approached with a dual focus: meeting current demand while planning for future capacity. Rising referrals and treatments place additional strain on existing resources, making it essential to implement innovative solutions that enhance operational efficiency. Forensic-level management of patients along the Single Cancer Pathway is crucial for sustaining improvements in performance, patient experience, and clinical outcomes. This includes data-driven approaches to track progress, optimise pathways, and identify opportunities to reduce delays.

Under the system change theme of continuing to prioritise Cancer, Urgent and the longest waiting patients for Planned Care, there were 4 key areas we outlined we would deliver against in our annual plan for 2025/26;

- **Single Cancer Pathway**: Working with Velindre University NHS Trust to deliver a new Satellite Radiotherapy Centre and Systemic Anti-Cancer Therapy Outreach Services in Gwent.

- **Health Pathways:** Achieve additional 50 localised Pathways live on Aneurin Bevan University Health Board local site.

- **Theatre Maximisation:** Theatres Service Model developed to inform the planning of a Day Case Centre of Excellence and delivery of improvements to increase Day Case activity.

- **Outpatient Transformation:** Ongoing monitoring of activity and opportunities for One-Stop Treatment Pathways in the Outpatient Treatment Unit and increased use of virtual clinics and identification of new pathways.

Continuing to prioritise Cancer, Urgent and the longest waiting patients for Planned Care	
Priority	**Achievements**
Single Cancer Pathway	• The Satellite Radiotherapy Centre in Nevill Hall Hospital opened in June 2025 for the first patient • Straight to test compliance has continued to progress across all tumour sites, with the exception of colorectal. For all tumour sites detailed recovery plans are in in place tp support this priority. • Systemic Anti-Cancer Therapy (SACT) outreach services has re-started at Nevill Hall Hospital in the Llanfoist suite following the closure of the Windsor suite due to RAAC • Work continues in partnership with Velindre NHS Trust on SACT outreach in line with new Velindre Cancer Centre opening in spring 2027 • Significant improvements within the Gynaecology Single Cancer Pathway, supported by the continuation of fortnightly Cancer Recovery Group meetings
Health Pathways	• 84 pathways are now live since 1st April 2025, this represents 188 pathways total • Page views have been consistently high throughout the year supported by dedicated education sessions increasing user traffic
Theatre Maximisation	• Planned Care Board workplan delivering key projects whilst also incorporating national priorities e.g. Clinical Implementation Network frameworks and Enabling Actions • A Theatres Service Model was developed to inform the planning of a Day Case Centre of Excellence as part of Nevill Hall Hospital Development Programme • Continued focus on day surgery maximisation to progress High-Volume Low Complexity lists • Successful implementation of golden patient in Grange University Hospital in September and is now rolled out across the Health Board • The Keeping Well Service continues to support patients who are experiencing long waits for planned care with a pilot to expand the service to incoming calls for Gynaecology in the new financial year
Outpatient Transformation	• Increased use of virtual clinics compared to the previous year and the identification of new pathways through scoping of opportunities in CIN and GIRFT recommendations

- Consistent communications in place to promote Consultant Connect, successful pilot of Neurology Epilepsy Patients Initiated Follow Up using Consultant Connect has resulted in opportunities in other specialties
- Attendances in Outpatient Treatment Unit 25-26 were 3921, an increase of 1120 compared to the previous year
- As part of the development of the one stop treatment pathways. The new one stop Gynae Heavy Menstrual Bleeding clinic is planned for 25-26 and scoping exercise is taking place for vasectomy procedures moving from daycase to treatment rooms.

6.5 Improving our Mental Health Services

Demand for Mental Health Services continued to increase highlighting the importance of finding ways to support people earlier with provision in the community with crisis prevention and recovery. The vision is to provide high quality, compassionate, person-centred Mental Health and Learning Disabilities Services, striving for excellent outcomes for the people for Gwent. There are several national strategic drivers including the Strategic Programme for Mental Health and National Programme for Suicide and Self harm Prevention.

Under the system change theme of improving our Mental Health Services there were four key areas we outlined we would deliver against in our plan for 2025/26:

1. **Quality Improvement:** Continue to engage with the work of the National Patient Safety Programme and embed and sustain the commitments within the Quality Improvement Plan.

2. **Ministerial Priority Performance:** Sustain progress of Part 1a and 1b for Adults and Children and improve measures for Psychological Services for Adults and start improvement project for Care Treatment Plans (CTP) for Children.

3. **Neurodevelopmental Services:** Complete Children's Neurodevelopmental Transformation Programme and deliver Single Neurodevelopmental Pathway for Adults.

4. **Rightsizing Inpatient & Transforming Community Services:** Develop model for Adult Inpatient, Community and Forensic Services. In addition, identify all access points into Mental Health Services and commence initial design options for Single Pathway.

Improving our Mental Health Services	
Priority	**Achievements**
Quality Improvement	• Fully engaged in the National Patient Safety Programme, contributing to the four national workstreams • Progressed the internal mock inspections for all wards throughout the year. All of Older Adult wards were complete and all of Adult wards apart from Carn Y Cefn have been completed. Feedback from wards that have completed the mock inspections was positive with staff finding the experience helpful and rewarding • Carn Y Cefn was subject to recent HIW inspection and therefore this audit will move into the 2026/27 financial year along with audits of all community teams • Embedded PROMS for adults and older adult functional services to ensure we act on what matters to individuals
Ministerial Priority Performance	• Increased triaging of referrals across Primary and Secondary Children & Adolescent Mental Health Services has supported a reduction in referrals which has enabled capacity to be flexed to meet both the 1A and 1B and support the waiting list for interventions despite having a significant rise in sickness absence • Care and Treatment Plan improvement has been delivered through a model change to commence aligned to the recovery plan for Part 2 improvement plan for Children and Young People • Psychological Therapies for Adults performance improved to 54% in October 2025, with a continued steady improvement since July 2025. Joint pathway work with Primary Care continues focusing on understanding the alignment between service areas • Part 1a and Part 1b progress was maintained throughout 2025/26 for Adults, with the service being consistently above the target of 80% in both Part1a (assessments completed within 28 days) and Part 1b (interventions completed with 28 days)
Neurodevelopmental Services	• Whilst National Funding for Adults ADHD service ceased in 25/26 we put plans in place to manage the caseload and secured funding for ADHD for 2026/27 and will be developing the strategic direction for the service going forward.

	• The Children & Young People needs-led model is embedding across teams, evidenced by a shift from universal to targeted support and improved appropriateness of referrals entering the specialist pathway • For Children & Young People RTT increased slightly to 56.51% in February, indicating early signs of stabilisation despite rising demand with RIF funding secured for 2026/27, maintaining existing staffing and helping stabilise waiting times • Website development and digital access pathways continue to progress as a key improvement action.
Rightsizing Inpatient & Transforming Community Services	• All Crisis services have been scoped as part of the work around a Single Point of Access and the development of our 111 press 2 Mental Health Service • Continue to work in partnership with NHS Wales Performance and Improvement Team to progress towards Open Access and the Stepped Care 2.0 model • Following completion of a review of the Learning Disability service model work is continuing to develop the models of care for learning disabilities, including a pilot reducing the number of beds within the inpatient unit • An implementation plan is being developed which will inform actions needed in 26/27 to deliver the models of care programme for Adults, Older Adults and Community services

7. Decarbonisation

The Health Board's Decarbonisation Programme which runs across all workstreams across the Health Board is well-established and aligned with Welsh Government's National Strategic Delivery Plan. Work continues to refine and mature the reporting framework so that progress can be tracked consistently across all workstreams, with an emphasis on understanding how decarbonisation benefits our communities and supports equity.

Key deliverables in 2025/26 include:

- **Strengthening staff communications and engagement**, helping increase awareness of and participation in decarbonisation and sustainability activities across the organisation.
- **Developing and implementing site-specific biodiversity plans** to enhance nature recovery and environmental value across Health Board estate locations.
- **Progressing the Refit energy-efficiency programme** and advancing work on alternative energy generation facilities to reduce long-term carbon emissions.
- **Reviewing prescribing and procurement practices** to support low-carbon, environmentally sustainable choices in line with emerging national priorities.
- **Embedding sustainable change within the newly established Waste Group**, ensuring decarbonisation is a core feature of both operational delivery and strategic planning.
- **Strengthening monitoring and reporting processes**, including prioritisation of viable initiatives, target setting, improved data collection to support accurate carbon calculations, and routine reporting of progress.
- **Publishing of the sustainable IV Paracetamol guidelines** following endorsement by the Medicines Management Programme Board and the Medicines and Therapeutics Committee for a targeted reduction in its use in favour of oral paracetamol whenever clinically appropriate which has a significantly lower carbon footprint

The workplan for 2026/27 includes bringing the Health Board up to full compliance with the new recycling regulations, developing mandatory sustainability training for staff and transitioning to reusable sharps containers.

8. Quality & Safety

The strong focus on improving the quality, safety and care of the services that we provide to our population continued throughout 2025/26 with the ongoing implementation of our *Quality Strategy 2023-26* ABUHB Quality Strategy 202326. The Strategy supports the Health Board's legal responsibilities under the Duty of Quality and Duty of Candour, ensuring that we are always open, transparent and focused on what is right for patients.

The Health Boards Quality and Safety Performance report which is produced for the Patient Quality, Safety and Outcomes Committee and the Board brings together intelligence drawn from established reporting systems, including patient feedback platforms, the Once for Wales Datix system, Qlik dashboards and validated infection surveillance data. This data is mapped against the Health Board's Six Pillars of Quality as set out below.

8.1 Patient Experience and Feedback

Overall patient satisfaction remains stable at 87% over the year. Friends and Family Test results are unchanged, with an overall score of 83% and a negative response rate of 10%. The lowest scoring experience question continues to relate to waiting times, with a noted decline in March, indicating an ongoing risk to patient experience. Work continues to expand feedback coverage, address areas with limited engagement, and embed new national surveys, including those aligned with the Listening to People regulations and accessible formats.

8.2 Concerns and Complaints

Putting Things Right and Listening to people Performance against the 30-day response target for formal concerns dipped in January, reflecting operational pressures and a significant increase in complaint volumes. Despite this, January was the first time the Health Board exceeded the national average for compliance.

Targeted work was put in place to reduce the backlog of overdue complaints continues, including enhanced oversight of cases exceeding nine months, divisional trajectories and deep-dive support. March saw the highest number of case closures this year with progress made in reducing cases over twelve months, although this work remains resource intensive and requires significant senior and Executive involvement.

Early Resolution performance has improved substantially compared to the previous year. The introduction of the Listening to People regulations, including a ten working-day Early Resolution timeframe, has encouraged

this and been supported by enhanced Putting Things Right training, twice weekly case reviews and dashboard monitoring.

8.3 Incidents and Patient Safety

Reported patient safety incidents continue to increase year-on-year. This growth is primarily driven by no-harm incidents, which are suggested to reflect improved reporting culture and awareness.

Falls data shows month-to-month variation but no evidence of sustained upward trend. The majority of falls continue to be assessed as resulting in no or low harm and falls rates per occupied bed day remain below the national benchmark. The Health Board introduced a revised process in year for reviewing falls with severe injury and published an updated Falls Policy for Hospital Adult Inpatients.

Pressure ulcer reporting shows a gradual reduction over time; however, interpretation is cautious due to delays in case closure and increased numbers of open incidents. Focused reviews for all grades of pressure damage are in place to improve the accuracy of avoidable v. unavoidable reporting.

Medication and IV fluid incidents show an upward trend, with administration errors remaining the most common category. Most incidents continue to result in no or low harm, and system improvements to enhance monitoring and targeted training are in progress.

The number of open Nationally Reportable Incidents has reduced over the past year, with improved compliance and a significant reduction in overdue cases. There has been a reduction in Early Warning notifications compared to 2024/25. Mental health-related incidents remain a prominent theme.

Reported Duty of Candour incidents have also fallen in 2025/26 compared to 2024/25 with cases continuing to be subject to the formal Duty of Candour process to support transparency and communication with those affected.

Learning from Events financial penalties have reduced significantly following service and divisional improvements. Open inquests remain high, generating pressure across the organisation, although there is positive use of written hearings.

8.4 Health Safety and Security

Improvements in safety compliance continue and there are ongoing workstreams in place both locally and nationally to improve this further.

Compliance against RIDDOR which is the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations to the Health & Safety Executive has increased with the improvement attributed to clearer guidance and additional training although there are still improvements to be made.

Health and Safety mandatory training remains around 85% compliance for Fire Safety, Violence Prevention and Reduction and Health and Safety but has reduced in year for manual handling training. A range of actions to improve this are being taken including onboarding additional manual handling trainers, applying a risk-based approach to training requirements based on what is most appropriate to staff roles and exploring further initiatives to address barriers such as staff release time.

8.5 Infection rates

Infection Prevention and Control Healthcare-associated infection rates show reductions in some areas, including C-Difficile and staphylococcal bloodstream infections. Winter ward closures due to norovirus continued in 2025/26 and highlight ongoing system pressures. Workforce shortages, isolation capacity and environmental cleaning challenges continue to affect resilience.

The Health Board is taking ongoing actions to address these challenges including rapid outbreak responses, isolation and cohorting where possible, implementing advanced cleaning techniques and progressing anti-microbial stewardship to promote the appropriate use of antimicrobials including antibiotics to present their future effectiveness, improve patient outcomes and reduce the development of resistance.

8.6 Safeguarding

This was the final year of the Gwent Safeguarding Board's strategic plan 2023-26 which covers both adults and children. The priorities of this multi-agency plan are to protect children and adults from neglect and harm, protect those at risk of exploitation and improve safeguarding arrangements across the region.

At a Health Board level, Child level 1 and 2 and Adult level 1 and 2 safeguarding training continue to report compliance around the 85% benchmark whilst compliance with Adult and Child level 3 training continues to rise, with the Health Board on track to achieve our compliance target by March 2028.

9. Equality, Diversity and Inclusion

The Health Board remains committed to promoting equality, diversity and human rights across its workforce and the services it provides to the population of Gwent. During the reporting period, the Health Board has continued to progress delivery of its Strategic Equality Plan (SEP) 2024–2028, strengthening the integration of equality, diversity and human rights considerations across workforce practice, service delivery and organisational governance. This work supports the organisation's statutory responsibilities under the Equality Act 2010, the Human Rights Act 1998, and the Public Sector Equality Duty (Wales) Regulations 2011.

Progress during the year has focused on embedding the Health Board's equality objectives across key organisational programmes, including the People Plan, workforce development initiatives and service improvement activity. Governance and oversight arrangements have also been strengthened to ensure greater organisational accountability for equality, diversity and human rights delivery. Regular assurance on EDI activity continues to be provided to the Board through the People and Culture Committee, including monitoring progress against the Strategic Equality Plan and associated action plans

The Health Board has also continued to develop initiatives to support a more inclusive organisational culture, including strengthening engagement with staff networks, promoting inclusive leadership and progressing work to improve accessibility and equity in communication and information for patients and staff. This includes ongoing work aligned with the All-Wales NHS Accessible Communication and Information Standards (ACIS).

The Health Board continues to meet its statutory equality reporting requirements, including the annual publication of Gender Pay Gap data, based on the workforce snapshot taken on 31 March each year in line with national reporting requirements. The Health Board has seen a decrease in the pay gap percentage for average hourly rates, from 24.71% in March 2024 to 23.8% in March 2025, which is a move in the right direction. The median hourly pay gap has also reduced, from 9.69% in March 2024 to 6.13% in March 2025.

Through these arrangements, the Health Board maintains appropriate control measures to support compliance with equality, diversity and human rights legislation and to promote an inclusive and equitable environment for staff, patients and the communities it serves.

10. Welsh Language Requirements

The Health Board publishes an Annual Report in relation to Welsh language service delivery on its website bilingually. This fulfils the Health Board's statutory duty to provide the Welsh Language Commissioner with an annual account of compliance with the Welsh Language Standards in accordance with the Welsh Language (Wales) Measure 2011. Prepared in line with Welsh Language Standard 120, the report outlines our progress, highlights key achievements, and sets out our strategy and future plans in this area.

Some of the notable points from our work in the last year include:

- The development and approval of the Health Boards 5-year plan to increase the offer of clinical consultations through the medium of Welsh in line with the requirements of Welsh language Commissioner's standard 110. In line with the guidance received from the Commissioner's office, this new plan focusses on a specific service.

- Development of a learning programme that matches the need of the member of staff with the appropriate learning mechanism. This includes digital learning tools as well as tutor led courses. A specific confidence building mechanism places a dedicated tutor to work one on one with individuals who had higher levels of Welsh language abilities but have lost confidence in those skills.

- A robust programme of engagement events has been established with learners throughout their education journey. This includes fluent Welsh speaking students and Welsh learners, ensuring the Health Board is the employer of choice when they have finished their studies.

- A Welsh language awareness workshop was delivered to divisional managers across the Health Board to look at bespoke action plans to improve compliance and provide a better service to our service users. The Welsh language unit also delivers awareness sessions in a number of the Health Boards key learning and induction programmes, such as the 'Leadership Development Programme' and both the 'Newly Registered Nurse, and Health Care Supporter' induction programmes.

As a Health Board, we collaborate with partners across NHS Wales via the Welsh Language Leads group to identify and progress areas of collective focus. We maintain constructive engagement with Welsh Government and are committed to upholding a strong, positive relationship with the Welsh Language Commissioner's Office, ensuring we deliver the best possible care for our Welsh-speaking population.

11. Financial Management and Performance

The Annual Accounts 2025/26 in Section 3 of the Annual Report page XX set out the detailed accounts for the full year to 31 March 2025 for Aneurin Bevan University Health Board. These accounts are prepared until International Financial Reporting Standards (IFRS).

The Health Board has two statutory financial duties:

- To breakeven over a rolling three year period; and
- To submit an IMTP to secure compliance with breakeven over three years

11.1 Revenue Resource Performance

The Health Board has not met its financial duty to break even against its Revenue Resource Limit over the three years 2023/24-2025/26. For the period 2025/26 the Board reported an overspend of XXX as shown in the table below:

3-year Revenue Breakeven duty	2023/24 £'000	2024/25 £'000	2025/26 £'000	Total £'000
Underspend against allocation	-49,766	-7,185	-18,282	-75,266

11.2 Capital Resource Performance

In additional to a revenue resource limit, the Health Board has a capital resource limit (CRL) that sets the target for capital expenditure. The Health Board met its financial duty to break-even against its Capital Resource Limit over the 3 years 2023-24 to 2025-26. The target is measured over a three year period as shown in the table below:

3-year Capital Resource duty	2023/24 £'000	2024/25 £'000	2025/26 £'000	Total £'000
Underspend against allocation	41	66	47	154

11.3 Long Term Expenditure Trends

The below table sets out the long term expenditure trends of gross operating costs across expenditure on Primary Healthcare Services, Healthcare from other providers and Hospital and Community services.

Analysis of gross operating costs

	£'000	£'000	£'000	£'000	£'000	£'001
Expenditure on Primary Healthcare Services	2020/21	2021/22	2022/23	2023/24	2024/25	**2025/26**
General Medical Services	108,993	112,524	116,217	122,671	132,671	**140,047**
Pharmaceutical Services	27,109	25,082	25,273	25,756	29,224	**29,396**
General Dental Services	33,079	38,030	39,817	39,870	44,444	**45,761**
General Ophthalmic Services	8,734	9,343	8,866	10,659	15,075	**17,251**
Other Primary Health Care expenditure	2,289	2,487	2,612	4,373	4,729	**3,715**
Prescribed drugs and appliances	106,852	106,282	114,331	121,947	125,771	**130,678**
Total	287,056	293,748	307,116	325,276	351,914	**366,848**

	£'000	£'000	£'000	£'000	£'000	£'001
Expenditure on healthcare from other providers	2020/21	2021/22	2022/23	2023/24	2024/25	**2025/26**
Goods and Services from Other NHS bodies	103,278	117,637	117,587	129,254	133,420	**149,448**
Goods and services from NHSW JCC	161,384	177,035	198,320	208,640	218,320	**232,273**
Continuing Care	81,347	83,675	86,006	99,136	99,904	**110,957**
Other	71,795	85,054	72,240	71,368	75,559	**81,912**
Total	417,804	463,401	474,153	508,398	527,203	**574,590**

Expenditure on Hospital and Community Health Services

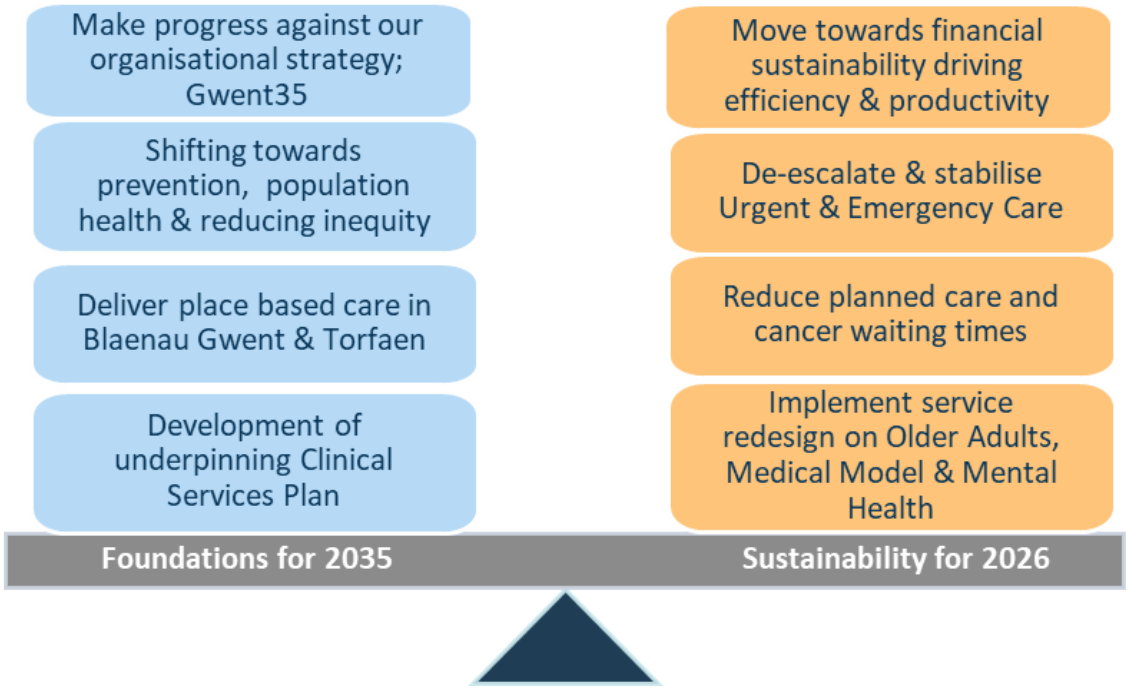
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	£'001
	2020/21	**2021/22**	**2022/23**	**2023/24**	**2024/25**	**2025/26**
Staff Costs	671,972	714,255	762,081	788,715	888,882	**958,465**
Non Pay	172,611	191,827	200,118	238,743	221,025	**224,509**
Depreciation and Impairments	96,361	31,056	30,804	59,994	49,908	**46,193**
Losses, special payments and irrecoverable debts	1,886	2,831	1,526	3,217	3,065	**8,725**
Other operating expenses	8,526	11,009	9,538	14,599	14,310	**15,138**
Total	**951,356**	**950,978**	**1,004,067**	**1,105,268**	**1,177,190**	**1,253,030**

12. Conclusion and Forward Look

Significant progress has been made as the organisation strives to deliver improvements in quality and performance and come out of areas of escalation. The organisation is proud of its achievements in 2025/26 which include:

- Significantly reducing the number of patients waiting over 104 weeks for treatment and waiting over 52 weeks for first outpatient appointments
- Achieving over 80% on mental health Part 1a and Part 1b targets for adults and children
- Markedly reducing the number of ambulance handover delays
- The Emergency Department in the Grange University Hospital achieving its highest compliance against the 12 hour target
- Sustaining progress with Pathway of Care Delays by continuing to reduce the volume & numbers of days patients are delayed
- Increasing the number of neonates that receive weight & measurement at 8 weeks throughout the year
- A continued shift of services into the community through common ailment services and independent prescribing in community pharmacies

Looking forward to next year's plan, the below sets out the commitments for 2026/27 and beyond as the organisation continues its path to sustainability whilst making progress in delivering our new organisational strategy Gwent 35: Better Health, Better Care, Better Lives and addressing the immediate financial, service and quality challenges and opportunities:



Next year's plan outlines the targeted actions we will take against the three strategic aims of:

1. **Better Health:** Together we will support people to be healthy, active, & happy
2. **Better Care:** Together we will deliver what matters to people – supporting our staff to thrive & achieving quality, kind, & sustainable care
3. **Better Lives:** Together we will create strong, safe, & connected communities

The diagram below outlines the four priorities against each of the strategic aims which will be progressed in 2026/27

Part 2:
Accountability Report

1st April 2025 –
31st March 2026

INTRODUCTION TO THE ACCOUNTABILITY REPORT

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

This Accountability Report has three sections:

1. Corporate Governance Report

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

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

2. Remuneration and Staff Report

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

3. Senedd Cymru/Welsh Parliament Accountability and Audit Report

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

Corporate Governance Report 2025/26

Including:

A: The Directors' Report

B (1): The Statement of the Chief Executive as the Accountable Officer

B (2): The Statement of Directors' Responsibilities in respect of the Accounts

C: The Annual Governance Statement

A: THE DIRECTORS' REPORT

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

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

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

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

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

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

Further detail on the Board's membership and composition during 2025/26 is available within Section C: The Annual Governance Statement.

Board Members' Interests

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

The document, which can be accessed in the link below, shows details of directorships of other organisations or other interests that have been declared by the members of the Board of Aneurin Bevan University Health

Board, and staff across the organisation, in line with the Standards of Business Conduct Policy, as at the 31st March 2026. This information is available on the Health Board's Internet site and can be accessed by following this link.

Personal Data Related Incidents

Information on personal data related incidents formally reported to the Information Commissioner's Office and "serious untoward incidents" involving data loss or confidentiality breaches are detailed on page 46 of the Annual Governance Statement at Section C.

Environmental, Social and Community Issues

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

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

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

The Health Board also complies with the Social Partnership Duty in Wales, established by the Social Partnership and Public Procurement (Wales) Act 2023, which mandates that the Health Board works with trade unions and other worker representatives when making strategic decisions about their well-being objectives.

The Board's Integrated Medium Term-Plan (IMTP) 2025-28 (approved by the Board March 2025) sets out the Board's strategic priorities which have been set within the context (environmental, social and community issues) in which the Health Board is operating within.

The Performance Report (Part A) of the Annual Report and Accounts 2025/26 provides greater detail in relation to the achievements of the Health Board in delivering the IMTP during 2025/26.

Statement for Public Sector Information Holders

In-line with the disclosure requirements set out by the Welsh Government and HM Treasury, the Health Board confirms that it has complied with the cost allocation and charging requirements set out in HM Treasury guidance during the 2025/26 year.

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

The Welsh Ministers have directed that the Chief Executive should be the Accountable Officer for Aneurin Bevan University Local Health Board. The relevant responsibilities of Accountable Officers, including their responsibility for the propriety and regularity of the public finances for which they are answerable, and for the keeping of proper records, are set out in the Accountable Officer's Memorandum issued by the Welsh Government.

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

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

As Accountable Officer, I confirm that the Annual Report and Accounts 2025/26 as a whole is fair, balanced and understandable. I take personal responsibility for the Annual Report and Accounts and the judgements required for determining it as fair, balanced and understandable.

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

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

_____

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

SECTION B(2): STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS FOR 2025/26

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

In preparing those accounts, the directors are required to:

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

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

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

By Order of the Board

Signed:

Andrew Morgan, Chair
Dated:

Nicola Prygodzicz, Chief Executive
Dated:

Robert Holcombe, Director of Finance and Procurement
Dated:

C: ANNUAL GOVERNANCE STATEMENT 2025/26

SCOPE OF RESPONSIBILITY

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

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

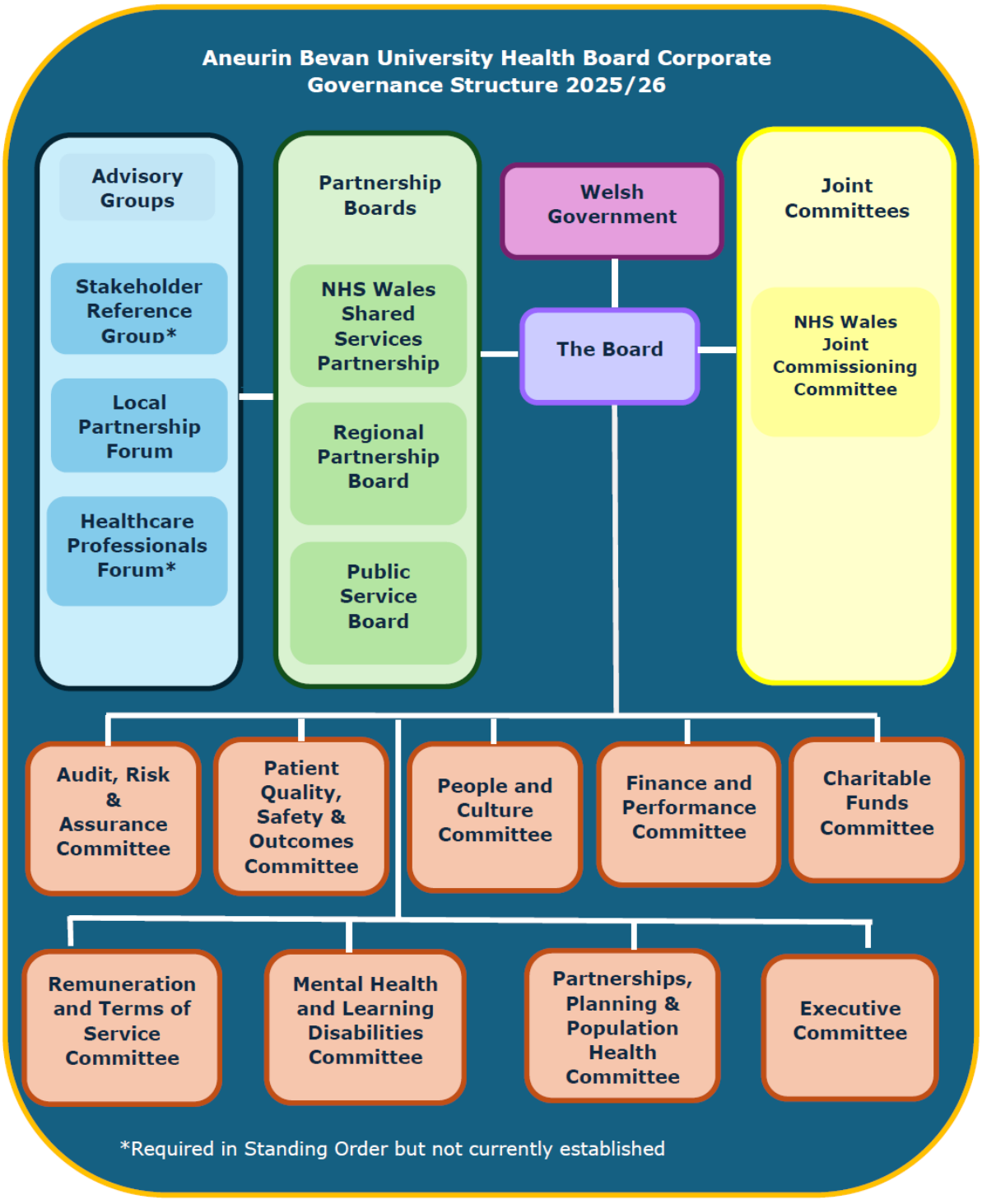
Welsh Government's Escalation and Intervention Arrangements for NHS Wales sets out the collective arrangements in place between the Welsh Government and external review bodies for identifying and responding to serious issues affecting NHS service delivery, quality and safety of care, and organisational effectiveness. As at 31st March 2026, Aneurin Bevan University Health Board was at Level 4 'Targeted Intervention' for Finance, Strategy and Planning and for performance and outcomes related to urgent and emergency care. The Performance Report (Part 1) of the Annual Report and Accounts for 2025/26 provides greater detail on the Health Board's performance and improvement actions in these areas.

OUR GOVERNANCE AND ASSURANCE FRAMEWORK

Aneurin Bevan University Health Board has agreed Standing Orders for the regulation of proceedings and business of the organisation. These are designed to translate the statutory requirements set out in the *Local Health Boards, NHS Trusts and Special Health Authorities (Constitution, Membership and Procedures) (Miscellaneous Amendments) (Wales) Regulations 2024*, which came into force on the 20 January 2025, and the *Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009*, into day to day operating practice. The Standing Orders, together with the adoption of a scheme of matters reserved to the Board, a scheme of delegation to officers and others and Standing Financial Instructions, provide the regulatory framework for the business conduct of

the Health Board and define its 'ways of working'. These documents, together with the Strategic Risk Register and a range of corporate policies set by the Health Board make up the Governance and Assurance Framework and arrangements of the organisation.

The diagram below outlines the corporate governance structure in place during 2025/26:



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

Membership of the Health Board and its Committees

Attachment 1 provides the Board's membership during 2025/26 and attendance at Board meetings for this period. The membership of the Board and changes during 2025/26, are outlined in Table 1 below:

Name	Designation	Dates (If not full year)
Executive Directors		
Nicola Prygodzicz	Chief Executive	
Hannah Evans	Director of Strategy, Planning and Partnerships	
Rob Holcombe	Director of Finance and Procurement	
Dr James Calvert	Medical Director and Deputy Chief Executive	Until 05/08/2025
Dr Andy Bagwell	Interim Medical Director	05/08/2025 until 26/10/2025
Dr Seema Srivastava	Medical Director	From 27/10/2025
Sarah Simmonds	Director of Workforce and OD	
Jennifer Winslade	Director of Nursing	Until 02/09/2025
Jennifer Winslade	Director of Nursing and Deputy Chief Executive	From 03/09/2025
Peter Carr	Director of Allied Health Professions and Health Sciences	
Tracy Daszkiewicz	Director of Public Health	
Leanne Watkins	Chief Operating Officer	
Independent Members		
Ann Lloyd	Chair	
Phil Robson	Vice Chair	
Louise Wright	Independent Member (Trade Union)	Until 10/04/2025
Vivek Goel	Independent Member (Trade Union)	From 02/06/2025

Name	Designation	Dates (If not full year)
Richard G Clark	Independent Member (Local Authority)	Until 19/09/2025
Helen Cunningham	Independent Member (Local Authority)	From 03/11/2025
Professor Helen Sweetland	Independent Member (University)	
Paul Deneen	Independent Member (Community)	
Iwan Jones	Independent Member (Finance)	
Dafydd Vaughan	Independent Member (Digital)	
Neil Patrick	Independent Member (Community)	
Penny Jones	Independent Member (Community)	
Akmal Hanuk	Independent Member (Third Sector)	From 02/06/2025
Directors in Attendance*		
Paul Solloway	Director of Digital	
Associate Members**		
Vacant	Chair, Stakeholder Reference Group	
Vacant	Chair, Health Professionals Forum	
Vacant	Director of Social Services	
Director of Corporate Governance***		
Rani Dash	Director of Corporate Governance	

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

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

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

The Board was chaired by Ann Lloyd, CBE, until 2nd April 2026. Andrew Morgan OBE, commenced as Chair on 5th May 2026. Phil Robson, Vice Chair, undertook the role of Acting Chair during the period 3rd April to 4th May 2026.

The Role of the Board

The Board has been constituted to comply with the *Local Health Board (Constitution, Membership and Procedures) (Wales) Regulations 2009* and the *Local Health Boards, NHS Trusts and Special Health Authorities (Constitution, Membership and Procedures) (Miscellaneous Amendments) (Wales) Regulations 2024*. The Board functions as a corporate decision-making body, Executive Directors and Independent Members being full and equal members and sharing corporate responsibility for all the decisions of the Board.

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

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

In summary, the Board:

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

Committees of the Board

Section 3 of Aneurin Bevan University Health Board's Standing Orders provides that "*The Board may and, where directed by Welsh Government must, appoint Committees of the Health Board either to undertake specific functions on the Board's behalf or to provide advice and assurance in the exercise of its functions*". In line with these requirements, the Health Board had in place a Committee Structure for 2025/26.

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

During 2025/26, the following Committees were in place:

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

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

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

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

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

Conducting Business with Openness and Transparency

Members of the public have been able to attend all Board meetings in person during 2025/26. In addition, all Board meetings were livestreamed and published to the Health Board's You Tube Channel.

Committee meetings were held virtually, which meant that public attendance was not facilitated. To maintain transparency and public accountability, from October 2025, the Health Board implemented an

alternative arrangement whereby summaries of Committee meetings were published on the Health Board's website. These summaries provide an overview of the key discussions, decisions and outcomes of each meeting, ensuring continued openness in the conduct of the Committee's business.

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

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

- All Board and Committee meeting agenda packs have been published to the Health Board's website in advance of meetings;
- Meetings of the Board have been livestreamed and published to the Health Board's You Tube Channel within 24 hours;
- The Health Board's Annual General Meeting in September 2025 was livestreamed, with in person attendance also permitted.
- Summaries of Committee business were published to the Health Board's website within 24 hours of the meeting.

The Health Board and its Committees have sought to undertake a minimum of its business in private sessions and ensure business, wherever possible, is published in the public domain. The Committees that do not publish information publicly is either because of the confidential nature of their business, such as the Remuneration and Terms of Service (RATS) Committee, or they are informal developmental type meetings such as the Board Development Sessions discussing plans and ideas often in their formative stages.

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

Items considered by the Board in 2025/26

During 2025/26, the Board held 6 scheduled meetings, as well as its Annual General Meeting on 24th September 2025.

All the meetings of the Board in 2025/26 were appropriately constituted and quorate. The key business and risk matters considered by the Board during 2025/26 are outlined below.

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

Business Cases:

- Approved the Outline Business Case for the **Transforming Access to Medicines (TRaM) South-East Wales Hub**.
- Approved the **Maternity and Neonatal Services Reconfiguration** Business Case.
- Approved the **Nevill Hall Hospital Strategic Outline Case** to address RAAC and long-term estate sustainability.
- Approved the Outline Business Case for the **Regional Orthopaedics Centre** (Llantrisant Health Park – Phase 2).
- Approved the **Digital infrastructure and AI oversight approach.**

Governance and Assurance:

- Received assurance in respect of arrangements for compliance with the **Nurse Staffing Levels (Wales) Act**.
- Approved the **Annual Report and Accounts 2024-25**.
- Approved the **Charitable Funds Annual Report and Accounts 2024-25**.
- **Received** the following **Annual Reports**:
  - Health, Safety & Fire Annual Report
  - Welsh Language Annual Report
  - Annual Quality Report
  - Annual Putting Things Right Report
  - Senior Information Risk Owner (SIRO) Annual Report
  - Strategic Equality Plan Annual Report
- Received the **Audit Wales Annual Audit Report** and **Structured Assessment 2025**.
- Received the **Public Services Ombudsman for Wales Annual Letter**.
- Approved interim changes to the **Standing Financial Instructions** and the **Scheme of Delegation – Delegated Limits**.
- **Noted** the **Pay Gap Reports 2025** (Gender Pay Gap and Ethnicity Pay Gap)

Plans/Strategies/Policies/Service Change:

- Noted progress in implementing the **Long-Term 10-Year Strategy** and associated outcomes framework.
- Approved the **Values and Behaviours Framework** (Kindness, Integrity, Respect).
- Approved the **People Plan 2025–28**.
- Approved the **Strategy Deployment Plan (Gwent 2035)**.
- Approved the **Winter Plan 2025/26** and noted the 2024/25 Winter Review.
- Noted updates on the **Nevill Hall Hospital Redevelopment Programme** and ongoing public engagement.
- Noted updates on **MSK / Community Therapy Transformation**.
- Noted progress and next steps on the **Digital, Data and Technology** modernisation programme.
- Noted the **Digital Programmes Update** and **Artificial Intelligence Review**.
- Endorsed the approach to **Quality Improvement**, including refreshed quality management structures.
- Approved the **Patient Safety Incident Reporting & Management Policy**.
- Received updates on **planned care performance**, including actions to reduce long waits and use Welsh Government funding for improvements.
- Noted development of **ReFit decarbonisation proposals**, funding uplifts and invest-to-save schemes.
- Endorsed improvement work across **urgent & emergency care**, including the Next/Your Next Patient flow initiatives.
- Noted updates on **Children and Young People's Services** including early pregnancy and gynaecology care improvements.
- Received the **Statutory and Mandatory Training Report** and **endorsed** actions to strengthen compliance.
- Received updates on implementation of the **NHS Wales Electronic Prescribing & Medicines Administration (ePMA)** programme.
- Approved service decisions relating to **General Medical Services**.

Routine Business:

- Ratified **actions taken by the Chair**, on behalf of the Board, to seal documents affixing the Health Board's Common Seal.
- Considered and discussed the Health Board's **financial performance** and the related risks being managed by the organisation.
- Considered the **Board's performance** against key local and national targets and the actions being taken forward to improve performance.
- Considered performance against the Health Board's **Quality Outcomes Framework**.
- Received assurance reports from the **Committees and Advisory Groups** of the Board.
- Received update reports from the **Executive Team** in respect of key issues locally, regionally and within NHS Wales.
- Reviewed the **Corporate Risk Register** and sought assurance on the management of mitigating actions.
- Noted progress on **Women's Health Hub development** and alignment with the national Women's Health Plan.
- Noted updates on **Respiratory and General Medicine Service Model** changes at the Grange University Hospital.
- Approved the **Capital Programme 2026/27**, including invest-to-save and discretionary schemes.
- Noted the community diagnostic hub **Llantrisant Health Park OBC** (regional, for information only).
- **Approved** the **Integrated Medium-Term Plan (IMTP) 2025–2028** for submission to Welsh Government.
- **Approved** the **Budget Delegation Proposal for 2026/27**.
- **Noted** updates on **Primary and Community Care development**, including Community by Design initiatives.
- **Noted** progress on **Dementia improvement**, including the Dementia Friendly Hospital Charter and refreshed three-year improvement plan.
- **Approved** the **Violence Prevention and Reduction Strategic Plan**.
- **Noted** the findings and priority actions arising from the **Maternity and Neonatal National Assurance Assessment**.

Patient Experience and Public Engagement:

Patient experience remained a core component of Board agendas, with powerful presentations demonstrating the impact of service developments and personal stories. Presentations during 2025/26 included:

- **Cryoablation and robotic innovation** in cancer and interventional radiology.
- **Early pregnancy and emergency gynaecology**: improvements introduced following a patient's experience of miscarriage care.
- **Knee osteoarthritis embolisation service**: showcasing innovative alternatives to surgery with strong outcome data.
- **Arts in Health** Programme for perinatal mental health, showing strong benefits for confidence, emotional regulation and social connection.
- **Closed loop insulin pump therapy** significantly improving quality of life for patients with Type 1 diabetes.
- **Dementia Care** highlighting learning and improvement actions across hospital and community services.

Throughout 2025/26, **Llais, Gwent Region** attended meetings of the Board to provide an overview of recent issues of concern and positive observations or public feedback being addressed by Llais in relation to the planning and delivery of health services in Gwent.

Items considered by Committees of the Board

During 2025/26, Board Committees considered and scrutinised a range of reports and issues, in line with the matters delegated to them by the Board. These included a range of internal and external audit reports and reports from other review and regulatory bodies, including Healthcare Inspectorate Wales.

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

An overview of the key roles and responsibilities, membership and areas considered by the Committees of the Board is provided below:

Audit, Risk and Assurance Committee		
Roles and Responsibilities	The Committee has been established to enable the scrutiny and review of matters related to audit, financial accounting, assurance, and risk management, to a level of depth and detail not possible in Board meetings. The purpose of the Committee is to support the Board and Accounting Officer by reviewing the comprehensiveness and reliability of assurances on governance, risk management, the control environment and the integrity of financial statements and the annual report. Terms of Reference	
Chair	Iwan Jones, Independent Member (Finance)	8/8
Members and Attendance	Dafydd Vaughan, Independent Member Neil Patrick, Independent Member Helen Sweetland, Independent Member - from September 2025 Richard Clark, Independent Member - to June 2025 Paul Deneen, Independent Member -January 2026 only	8/8 8/8 4/5 1/3 1/1
Regular Executive Attendance	Rani Dash, Director of Corporate Governance Robert Holcombe, Director of Finance and Procurement *(Attendance not required January 2026)*	7/8 7/7
Number of Meetings per year	8	
Items Considered	Among the key issues considered by the Committee during 2025-26, as outlined in the Committee's Work Programme, the following were also considered: • An overview of **financial governance and control arrangements**, including updates on Financial Control Procedures and Standing Financial Instructions self-assessment, payment performance, banking	

arrangements, and losses and special payments, together with routine monitoring of Single Tender Actions.

- An overview of **internal audit** activity, covering plan delivery and reports across areas such as clinical audit (local and national), job planning, discharge planning (follow-up), business continuity, divisional governance, mental health and learning disabilities, maternity, GUH Emergency Department extension, health & safety, Electronic Document and Records Management System, contract management, performance management framework, waiting list management, medical equipment & devices, and managed GP practices.
- An update on **external audit** work, including progress on the financial statements audit, Structured Assessment, Audit Fees consultation, and thematic reviews (e.g., Eye Care Services, Planned Care, Discharge Planning at Health Board and regional levels) and the National Fraud Initiative.
- An overview of meetings relating to the **Annual Report and Accounts**, considering Part 1 (Performance), Part 2 (Accountability and Annual Governance Statement), and Part 3 (Financial Statements), including processes to validate performance and financial data and recommendations to the Board for approval.
- Updates on **organisational risk, governance and compliance**, including risk maturity development, movements in strategic risks (e.g., industrial action, financial sustainability), and improvements to compliance with Welsh Health Circulars and Ministerial Directions with clearer escalation routes.
- An overview of **clinical audit** governance, including the Committee's continued emphasis on the absence (earlier in the year) of an approved local clinical audit plan, subsequent actions to strengthen corporate local clinical audit arrangements, and mid-year reporting on national audit participation.
- Updates on **job planning**, noting persistent challenges (e.g., expired plans, digital completion, local enforcement and training), with oversight aligned to the People & Culture Committee and a strengthened management approach.
- An overview of **discharge planning and urgent care performance**, noting improvements in delayed discharge metrics, documentation, real-time dashboards, and pathway redesign, while recognising ongoing system-wide challenges across partner organisations and digital systems.
- Updates on **quality governance, patient safety and assurance**, including follow-up of Quality Governance recommendations, safeguarding training compliance, the Post-Payment Verification annual programme and expanded scope, and counter-fraud performance and benchmarking across NHS Wales.

Further information is available in the Audit, Risk and Assurance Committee Annual Report 2025/26. [link to be added in May once approved by Board]

Patient, Quality, Safety and Outcomes Committee		
Roles and Responsibilities	The scope of the Patient Quality, Safety and Outcomes Committee encompasses all areas of patient experience, quality and safety relating to patients, carers and service users, within directly provided services and commissioned services. Full Terms of Reference	
Chair	Helen Sweetland	5/5
Members and Attendance	Penny Jones Philip Robson - from June 2025 Paul Deneen Vivek Goel - from October 2025 Helen Cunningham – from February 2026	5/5 4/5 5/5 3/3 1/1
Regular Executive Attendance	Jennifer Winslade Seema Srivastava – from December 2025 Peter Carr James Calvert - to October 2025	5/5 2/2 3/5 2/2
Number of Meetings per year	6 – July meeting was cancelled resulting in 5 taking place.	
Items Considered	Among the key issues considered by the Committee during 2025-26, as outlined in the Committee's Work Programme, the following were also considered: • **An overview of quality outcomes and performance reporting**, including regular Quality Outcomes Reports aligned to the six Pillars of Quality. These reports provided assurance on patient and staff experience, complaints and concerns, patient safety, clinical effectiveness, health and safety, infection prevention and control, and safeguarding. The Committee considered trends in mortality, falls, pressure ulcers, medication safety, complaints performance, infection rates and safeguarding activity, and reviewed areas requiring targeted improvement. • **An overview of the development and implementation of the Quality Management System**, including the establishment and ongoing role of the Quality Management Group. The Committee received assurance on the alignment of quality governance arrangements with national requirements, the Duty of Quality and Duty of Candour, and the Health and Care Quality Standards. • **An update on maternity and neonatal services**, including workforce, safety, culture and performance. The Committee reviewed maternity and neonatal quality reports, neonatal service improvement activity, culture and listening exercises, infection prevention and control arrangements, medicines management, workforce capacity and training compliance, and received assurance on ongoing improvement plans and leadership oversight. • **An overview of patient experience, concerns and complaints management**, including the Patient Advice and Liaison Service (PALS), Putting Things Right (PTR) performance, and preparations for the	

	implementation of the new *Listening to People* framework. The Committee considered early resolution performance, equity of access, resource implications, regulatory changes, and risks associated with implementation without additional national funding. • **Updates on inspection and regulatory activity**, including Healthcare Inspectorate Wales (HIW) inspections, Audit Wales findings, Health and Safety Executive (HSE) interventions, and actions taken in response. The Committee monitored progress against inspection recommendations, reviewed assurance arrangements through the Assurance Monitoring and Tracking system, and considered learning and escalation where required. • **An overview of specific risk and improvement programmes**, including safeguarding training compliance, health and safety leadership and workforce capacity, infection prevention and control, nutrition and hydration, mortuary and Care After Death services, learning from deaths, clinical audit activity, commissioning assurance, and the management of strategic risks delegated to the Committee. Further information is available in the Patient Quality, Safety and Outcomes Committee Annual Report 2025/26. [link to be added in May once approved by Board]

Partnership Population, Health & Planning Committee		
Roles and Responsibilities	The purpose of the Partnerships, Population Health and Planning Committee is to seek assurance on: • The robustness of the Health Board's approach, systems and processes for developing strategies and plans, including those developed in partnership; • Plans and arrangements for the following matters are adequate, effective, and robust and achieving intended outcomes: Joint committee and partnership planning; Engagement and communication; and Civil Contingencies and Business Continuity; • That partnership governance and partnership working is effective and successful; and • that those arrangements in place to improve population health and wellbeing are robust and effective and delivering intended outcomes. Full Terms of Reference	
Chair	Ann Lloyd, until April 2025 Phillip Robson, from July 2025	1/1 3/3
Members and Attendance	Phillip Robson, until July 2025 Dafydd Vaughan Penny Jones Richard Clark, until October 2025 Akmal Hanuk, from July 2025 Neil Patrick, provided IM Committee Support	0/1 4/4 3/4 2/2 1/3 1/1
Regular Executive Attendance	Hannah Evans, Director of Strategy, Planning and Partnerships, Tracy Daszkiewicz, Director of Public Health	4/4 2/4

Number of Meetings per year	4	
Items Considered	Among the key issues considered by the Committee during 2025-26, as outlined in the Committee's Work Programme, the following were also considered: • **An overview of the development and approval status of the Integrated Medium Term Plan (IMTP),** including the early development of the 2026/27 IMTP. • **An overview of priority programmes and transformation activity**, including planned care, urgent and emergency care, place-based care, population health, cancer services, mental health transformation, decarbonisation and digital foundations. • **An update on regional planning and collaboration**, including ophthalmology, orthopaedics, diagnostics, endoscopy, radiology and wider regional service models. • **An overview of meetings of the Regional Partnership Board and Public Services Boards**, with focus on priority setting, alignment of structures, winter pressures, and strengthening collaboration across system partners. • **Updates on population health, prevention and health protection**, including vaccination programmes, communicable disease response, health protection system maturity, and learning from incidents and national exercises. • **An overview of estates and infrastructure planning**, including the development of an updated Estates Strategy, rationalisation of St Woolos Hospital and development proposals for Nevill Hall Hospital. • **Updates on business continuity, emergency planning and digital resilience**, including preparedness for cyber incidents, business continuity assurance, and alignment with wider emergency planning and response arrangements. • Committee **risk report**. Further information is available in the Partnership, Population Health and Planning Committee Annual Report 2025/26. [link to be added in May once approved by Board]	

People & Culture Committee		
Roles and Responsibilities	The purpose of the People and Culture Committee is to provide assurance to the Board on: • all matters relating to staff and workforce planning of the Health Board; • plans to enhance the environment that supports and values staff in order to engage the talent and nurture the leadership capability of individuals and teams working together to drive the desired culture throughout the Health Board to deliver safer better health care; • the direction and delivery of Organisational Development and other related frameworks to drive continuous improvement and to achieve the objectives of the Health Board. Full Terms of Reference	
Chair	Paul Deneen	3/3
Members and Attendance	Helen Sweetland Philip Robson Vivek Goel	3/3 3/3 2/3
Regular Executive Attendance	Sarah Simmonds	3/3
Number of Meetings per year	3	
Items Considered	Among the key issues considered by the Committee during 2025-26, as outlined in the Committee's Work Programme, the following were also considered: • An overview of **workforce performance**, including sickness absence, turnover, workforce supply, recruitment timelines, job planning compliance, statutory and mandatory training, occupational health performance and variable pay, through regular review of the Workforce Performance Dashboard. • An overview of the Health Board's **People Plan 2025–2030**, including its strategic pillars, delivery measures, success indicators and governance arrangements, alongside confirmation of refined outcome-focused measures to support effective implementation and assurance. • An update on **staff experience and engagement**, including the NHS Wales Staff Survey approach, response rates, outcomes and the development of divisional and organisational action plans, as well as efforts to reduce survey fatigue and strengthen staff voice. • An overview of **equality, diversity and inclusion** assurance, including progress against the Strategic Equality Plan and the Welsh Government's Race Equality Action Plan for Wales, with particular focus on workforce data quality, recruitment and progression inequalities, staff networks and Board-level leadership and oversight. • Updates on **employee relations activity**, including suspensions, disciplinary cases, employment tribunal claims and learning from complex cases, alongside implementation of new policies and frameworks such as Respect and Resolution and anti-sexual harassment arrangements.	

	• An overview of **workforce governance** and assurance, including Disclosure and Barring Service compliance, workforce risk management, establishment control, workforce planning and organisational change, and the monitoring of delegated strategic workforce risks. • Updates **on professional workforce frameworks and reforms**, including arrangements for speciality doctors, locally employed doctors and clinical fellows, medical revalidation, job planning systems, and preparations for the Resident Doctors contract reform. • An overview of **workforce safety and wellbeing initiatives**, including the Speaking Up Safely framework, violence prevention and reduction strategy, staff safety measures and organisational responses to concerns raised by staff. Further information is available in the People and Culture Committee Annual Report 2025/26. [link to be added in May once approved by Board]

Finance and Performance Committee		
Roles and Responsibilities	The purpose of the Finance & Performance Committee is to provide assurance to the Board on the achievement of the Board's aims and objectives as set out in its Integrated Medium-Term Plan. In doing so, the Committee will seek • ongoing development of an improving performance culture which continuously strives for excellence and focuses on improvement in all aspects of the health board's business, in line with the Board's Performance Management Framework; • that arrangements for financial management and financial performance are sufficient, effective and robust; • that services are improving efficiency and productivity and financial plans are being delivered; • there is timely and appropriate access to health care services to achieve the best health outcomes within agreed targets, for directly provided and commissioned services; and • risks are suitably identified, mitigated, residual risks controlled, and corrective actions are taken as required to sustain or improve performance. Full Terms of Reference	
Chair	Richard Clark (Until July 2025) Neil Patrick (From September 2025)	2/2 5/5
Members and Attendance	• Iwan Jones, Independent Member • Dafydd Vaughan, Independent Member • Akmal Hanuk, Independent Member	4/5 5/5 4/4
Regular Executive Attendance	• Paul Solloway, Director of Digital • Hannah Evans, Director of Strategy, Planning and Partnerships • Robert Holcombe, Director of Finance	4/5 5/5 5/5

Number of Meetings per year	5
Items Considered	Among the key issues considered by the Committee during 2025/26, as outlined in the Committee's Work Programme, the following were also considered: An overview of the **Committee Risk Report**, including strategic risks relating to financial sustainability, performance management, digital infrastructure, estates compliance, and carbon reduction, with ongoing consideration of risk tolerance, mitigation effectiveness, and interdependencies between workforce absence, operational pressures, and financial risk. An overview of **organisational performance and escalation arrangements**, including national and internal escalation frameworks, progress against de-escalation criteria, and sustained challenges in Urgent and Emergency Care, Planned Care, Mental Health, and Financial Performance. An update on the **Integrated Performance Report**, including performance against Ministerial Priorities, covering prevention and population health, Primary and Community Care, Urgent and Emergency Care, Planned care, Cancer and Diagnostics, Mental Health services, and Workforce productivity, alongside consideration of system-wide pressures and national supply constraints. An overview of **financial performance** through the Monthly Finance Report and Monitoring Returns, including in-year deficit forecasts, savings delivery, cost pressures, income risks, capital expenditure, cash management, and engagement with Welsh Government on funding and financial risk mitigation. Updates on **value, sustainability, efficiency, and productivity programmes**, including assurance from the Value and Sustainability Board, efficiency opportunities in theatres, beds, outpatients, medicines management, non-pay expenditure, and planned care productivity, recognising the distinction between performance improvement and cash-releasing savings. An overview of **major service and transformation developments**, including ophthalmology diagnostic hub progress, outpatient transformation, theatres efficiency, stroke service improvement, benefits realisation from business cases, commissioning arrangements, and the alignment of service redesign with quality, safety, workforce, digital readiness, and financial sustainability. An overview of **digital, data, information governance, and cybersecurity assurance**, including progress on major digital programmes, electronic patient records, digital prescribing, data standards, information governance compliance, and the management of digital and cyber risks.

	An overview of **estates compliance and infrastructure assurance**, including statutory compliance, backlog maintenance, estate condition risks, workforce challenges within estates services, and the prioritisation of investment based on clinical and safety risk. Further information is available in the Finance and Performance Committee Annual Report 2025/26. [link to be added in May once approved by Board]

Charitable Funds Committee		
Roles and Responsibilities	The purpose of the Charitable Funds Committee is to ensure the stewardship and effective management of funds which have been donated, bequeathed and given to the Aneurin Bevan Health Charity for charitable purposes by making and monitoring arrangements for the control and management of the Health Board's Charitable Funds. Full Terms of Reference	
Chair	Paul Deneen	4/4
Members and Attendance	Neil Patrick Richard Clark (Until June 2025) Akmal Hanuk (Since June 2025) Nicola Prygodzicz Robert Holcombe	4/4 1/1 2/3 4/4 4/4
Regular Executive Attendance	N/A	
Number of Meetings per year	4	
Items Considered	Among the key issues considered by the Committee during 2025-26, as outlined in the Committee's Work Programme, the following were also considered: • An overview of the **Finance and Performance position**, including quarterly financial performance, income and expenditure trends, investment valuation movements, management of fund balances, and the approval of new charitable funds to support specific initiatives and services. During the year, the Committee also considered the impact of market volatility on charitable investments and agreed actions to strengthen future assurance, including enhanced scrutiny of investment performance, engagement with investment managers, and preparation for the re-tendering of investment arrangements. • An overview of **funds available to the Committee**, including updates on general-purpose funds, legacy receipts, commitments, and the level of discretionary funding available to support bids and grant applications. The Committee recognised the importance of balancing the active use of charitable funds with the long-term financial sustainability of the charity. • An update on **bids and Small Grant Scheme applications**, including the approval of multiple small grants and larger funding bids, consideration of affordability and future commitments, and the	

	establishment of strengthened governance arrangements. This included the operation of a bids and grants sub-group to enhance consistency, transparency, and alignment with charitable objectives, alongside agreement to improve application requirements and introduce proportionate monitoring of funded activity. • An overview of **legislative and regulatory changes**, including updates on the Charities Statement of Recommended Practice (SORP), assurance that the charity was prepared for forthcoming requirements, and confirmation that no material impacts were anticipated for the organisation. • Updates on the **management of slow-moving funds**, including attendance from fund holders, review of spending plans, encouragement of timely and appropriate use of charitable funds, and agreement to strengthen oversight where funds had remained unspent for extended periods. • An overview of **investment composition and performance**, including updates from the charity's investment managers, consideration of market conditions, and assurance regarding the ongoing suitability and monitoring of investment arrangements. • An update on the **priority plan to raise the profile of the charity and support future fundraising**, including approval of a refreshed charity brand identity, registration with the Fundraising Regulator, development of new fundraising mechanisms, and early engagement with potential corporate supporters and patronage opportunities. • An overview of **governance and assurance matters**, including approval of the Committee's Programme of Business, Terms of Reference, administration charge for 2025/26, and the review and approval of the Annual Accounts, Annual Report, and related audit documentation. Further information is available in the Charitable Funds Committee Annual Report 2025/26. [link to be added in May once approved by Board]

Mental Health and Learning Disabilities Committee		
Roles and Responsibilities	The purpose of the Mental Health and Learning Disabilities Committee is to advise the Board to assist it in discharging its functions and meeting its responsibilities with regard to mental health, learning disabilities and CAMHS issues; and especially the Health Board's compliance with the Mental Health Act 1983, Mental Capacity Act 2005, Equality Act 2010 (where relevant) and associated legislative and statutory frameworks. Full Terms of Reference	
Chair	Penny Jones	5/5
Members and Attendance	Paul Deneen Philip Robson	5/5 4/5

	Dafydd Vaughan	4/5
Regular Executive Attendance	Leanne Watkins, Chief Operating Officer Jennifer Winslade, Director of Nursing Seema Srivastava, Medical Director (from November 2025) Tracey Daszkiewicz, Director of Public Health	3/5 3/5 0/2 1/5
Number of Meetings per year	5	
Items Considered	Among the key issues considered by the Committee during 2025/26, as outlined in the Committee's Work Programme, the following were also considered: • An overview of **Mental Health Act compliance**, including activity trends under the Act, use of Sections 4, 135 and 136, rectifiable and unlawful detentions, Community Treatment Orders, Hospital Managers' hearings, and multi-agency working. • An overview of **Mental Health services performance, quality, safety and activity**, including assurance on Adult Mental Health, learning disabilities and Child and Adolescent Mental Health Services. • An update on **service transformation and improvement**, including psychological therapies, neurodevelopmental services, CAMHS recovery and sustainability, community-based models of care, and the redesign of pathways to support demand management, earlier intervention and more sustainable delivery. • An overview of **restrictive practice**, including restraint, enhanced observations and segregation, alongside actions to reduce restrictive interventions through SafeWards, Safety Pods, improved training, strengthened policies, thematic reviews and divisional oversight arrangements. • Updates on **Mental Capacity Act and Deprivation of Liberty Safeguards**, including training compliance, audit findings, backlog pressures, governance arrangements, and preparation for future Liberty Protection Safeguards requirements, recognising ongoing legal, workforce and financial challenges. • An overview of **Right Care, Right Person**, including phased implementation, multi-agency collaboration, crisis pathways, transport and conveyance challenges, and ongoing development of integrated models to ensure individuals receive the appropriate response at the right time. • An overview of **Dementia assurance**, including progress against the All-Wales Dementia Standards, community hubs, carers' support, workforce development, memory assessment pathways, dementia-friendly environments and sustainability risks associated with future funding. • An overview of **quality improvement and inspection activity**, including Healthcare Inspectorate Wales inspections, internal audits, action plans, governance reviews, leadership visibility, and learning from incidents, complaints and external scrutiny. • An overview of **digital enablement and maturity**, including digital process improvement, robotic process automation, electronic patient record readiness, data quality, and the findings of the Mental Health Digital Maturity Assessment.	

	Further information is available in the Mental Health and Learning Disabilities Committee Annual Report 2025/26. [link to be added in May once approved by Board]

Remuneration and Terms of Service Committee		
Roles and Responsibilities	The Committee considers and approves the remuneration and terms of service for the Chief Executive, Executive Directors and other very senior staff within the framework set by the Welsh Government, on behalf of the Board. The Committee seeks assurance in respect of objectives for Executive Directors and other Very Senior Managers and the associated performance assessment; agreeing actions on behalf of the Board where required. Full Terms of Reference	
Chair	Ann Lloyd, Chair	3/3
Members and Attendance	Philip Robson, Vice Chair Iwan Jones, Independent Member	3/3 3/3
Regular Executive Attendance	Sarah Simmonds, Director of Workforce and OD	3/3
No Meetings per year	Quarterly, as required	
Items Considered	The Committee received updates on: • Chief Executive and Executive Director Performance • Executive and Senior Manager Secondments • Settlement Agreements • Progress with AFC non pay collective agreement and other pay related issues (national discussions)	

Board Development and Briefing

Board members took part in a number of development and briefing sessions through 2025/26. Topics covered at these sessions included:

- Long Term Strategy Development
- Organisational Priorities and Parameters
- Service Development Business Cases
- Financial Plan 2025/26
- Welsh Government Priorities and Requests
- Annual Update from the Joint Commissioning Committee (JCC)
- Place Based Care, Including Primary Care Model
- Board Development Programme Delivered by Good Governance Institute (GGI)
- Records Management Update

Self Assessment and Evaluation

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

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

The Health Board commenced its Board Development Programme, delivered in partnership with the Good Governance Institute (GGI), during 2025/26. This work remains ongoing to support continuous improvement.

This programme focused on core concepts such as governance, risk, culture and effective decision-making and leadership – these are components drawn directly from the principles which underpin high performing boards and organisations and the opportunity to better understand and improve our performance in these areas will ensure a more effective board and better outcomes for patients and service users.

Committees of the Board undertook self-assessment during November and December 2025. In undertaking these assessments, committee members considered their composition, establishment and ways of working, the outcomes of which informed a review of Committee Terms of Reference. The revised Terms of Reference for each Committee were approved by the Board in May 2026.

Compliance with Standing Orders

A review of compliance has been undertaken against the Health Boards Standing Orders; Reservation and Delegation of Powers. Although further work is identified to strengthen arrangements in a number of areas, three (3) key areas have been identified where the Health Board is not currently compliant with the Standing Orders. These are:

Section 5 – Advisory Groups	*The LHB's Advisory Groups include a Stakeholder Reference Group, Healthcare Professionals' Forum and Local Partnership Forum.* [Local Partnership Forum is established]
Section 7 - Meetings	*The availability of papers in English and Welsh languages and in accessible formats, such as Braille, large print, easy read (where requested or required) and in electronic formats;*

Actions will be put in place to address each of these areas during 2026/27.

ADVISORY GROUPS AND JOINT COMMITTEES

Advisory Groups

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

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

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

Stakeholder Reference Group (SRG)

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

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

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

In view of these evolving engagement arrangements and given that the Stakeholder Reference Group last met in October 2021, a decision was taken to disband the SRG in its current form in October 2022, whilst the Health Board reviewed and redesigned the role and constitution of the Group, ensuring it is fit for purpose and fully effective. A proposal for re-establishment of the SRG will be considered by the Board in 2026.

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

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

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

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

The Health Board runs a comprehensive community engagement program that ensures communities can speak directly with Health Board staff and share their views on health services.

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

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

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

Healthcare Professionals' Forum (HPF)

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

The Health Board is continuing to develop its Quality Management System and as a part of this a review and design of the Healthcare Professional's Forum will be undertaken, ensuring it is fit for purpose and fully effective and does not duplicate other aspects of the Health Board's clinical engagement mechanisms. A proposal for re-establishment of the HPF will be considered by the Board in 2026.

In the absence of a formal HPF, the Board also continues to engage clinical professionals through its professional executive directors (Medical Director, Director of Nursing, Director of Therapies and Health Sciences and Director of Public Health) and existing professional management groups, such as the Clinical Directors Forum and System Leadership Group. The Board also engages with primary care providers through its cluster arrangements.

In addition, in 2024/25, the Health Board established a Clinical Advisory Forum, which is a non-executive advisory group that provides advice to the Executive Team and onwards to the Board where relevant. The Clinical Advisory Forum a is multi-professional advisory group which offers advice or recommendations on new treatments, Quality Impact Assessments and processes and services within the Health Board.

NHS Wales Joint Commissioning Committee

The NHS Wales Joint Commissioning Committee (NWJCC) is a formal committee representing all seven Health Boards in Wales. While each Health Board plans and delivers services for its own local population, some services are so specialist, complex, or low-volume that they need to be commissioned once for the whole of Wales.

NWJCC brings the Health Boards together to do this, ensuring that nationally commissioned services are planned consistently, collaboratively, delivered safely, and available equitably to everyone, wherever they live in Wales.

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

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

Further detail in respect of the Joint Commissioning Committee is available on their website

Statutory and Strategic Partnerships

Gwent Regional Partnership Board

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

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

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

The Regional Integration Fund (RIF) is hosted by Aneurin Bevan University Health Board on behalf of the Gwent Regional Partnership Board and is a standing agenda item on the Regional Partnership monthly meetings. All matters in relation to the RIF are discussed and approved within the partnership forum. Information is cascaded throughout the partnership structures for transparency. Where needed, the RPB accommodates special meetings to sign off RIF investment plans where meetings schedules do not align with reporting or development timeframes.

Aneurin Bevan University Health Board Members included in the membership of the Regional Partnership Board in 2025/26 were:

- Ann Lloyd, Health Board Chair

- Nicola Prygodzicz, Chief Executive
- Tracy Daszkiewicz, Director for Public Health
- Hannah Evans, Director of Strategy, Planning & Partnerships
- Phil Robson, Vice Chair

Further detail in respect of the Gwent RPB can be found on the RPB's website.

Gwent Public Services Board

The Gwent Public Services Board (PSB) is the statutory body established by the Well-being of Future Generations (Wales) Act 2015 which brings together the public bodies in Gwent to meet the needs of Gwent citizens present and future. The aim of the group is to improve the economic, social, environmental and cultural well-being of Gwent. Working in accordance with the five ways of working, the Board has published its Well-being Assessment and Well-being Plan.

The Health Board contributes to achieving these objectives through the delivery of the Clinical Futures Strategy and the Integrated Medium-Term Plan (IMTP).

Aneurin Bevan University Health Board Members included in the membership of the Public Services Board are:

- Ann Lloyd, Health Board Chair
- Nicola Prygodzicz, Chief Executive
- Tracey Daszkiewicz, Executive Director for Public Health

Further detail in respect of the Gwent PSB can be found on the PSB's website.

NHS Wales Shared Services Partnership

NHS Wales Shared Services Partnership (NWSSP) was established in November 2010 to deliver economies of scale; efficiencies and consistency of quality and process for the business and professional services that were directly managed and delivered by local NHS bodies.

As a hosted organisation, NWSSP operates under the legal framework and Establishment Order of Velindre University NHS Trust. The Managing Director is the designated Accountable Officer for Shared Services in line with The Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012 and is accountable to the Director General/CEO of NHS Wales, Health Boards, Special Health Authorities and Trusts through the Shared Services Partnership Committee (the Partnership Committee). The Partnership Committee meets bi-monthly and is chaired by Professor Tracy Myhill OBE. The membership is comprised of representatives from each NHS organisation, including Aneurin Bevan University Health Board.

The Partnership Committee is responsible for exercising the Velindre NHS Trust's functions in relation to shared services, including the setting of policy and strategy and the management and provision of shared services to Local Health Boards, Special Health Authorities and Trusts. Several committees and advisory groups have been established to help support the governance arrangements that underpin how NWSSP operates.

Further detail in respect of NHS Wales Shared Services Partnership can be found on NWSSP's website.

Partnership working with other Health Boards

The Health Board is fully committed to active collaboration where this delivers added value to clinical service delivery, access, and sustainability.

The Health Board meets on a regular basis with other Health Boards in South Wales to agree common approaches to strategic challenges, progress ongoing regional collaborative programmes, share experience / best practice and to consider future opportunities for closer working to mutual benefit.

In addition, the Health Board, Cardiff and Vale University Health Board, Cwm Taf Morgannwg University Health Board and Velindre University NHS Trust have agreed to work together on a portfolio of regional opportunities that at the time of writing includes Orthopaedics, Ophthalmology, Diagnostics, Stroke, Cancer and the development / implementation of a single regional clinical strategy for South-East Wales. A Regional Portfolio Oversight Board has been established to oversee the portfolio of work. Each Health Board / Trust is represented on this forum via its Chief Executive, Director of Planning and Chief Operating Officer.

Directed by the Cabinet Secretary for Health and Social Care, Aneurin Bevan University Health Board, Cardiff and Vale University Health Board, and Cwm Taf Morgannwg University Heath Board have established a Joint Regional Committee to exercise the facilitation and oversight of regional planning to drive effective collaboration and regional working.

THE PURPOSE OF THE SYSTEM OF INTERNAL CONTROL

As Chief Executive and Accountable Officer, I have overall responsibility for maintaining a sound system of internal control that supports the achievement of the Health Board's policies, aims and objectives, while safeguarding public funds and assets.

The system of internal control is designed to manage risk to a reasonable level rather than eliminate all risks; it can therefore only provide reasonable and not absolute assurances of effectiveness.

The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place for the year ended 31 March 2026 and up to the date of approval of the annual report and accounts

Governance Framework and Capacity to Handle Risk

The Health Board has established a clear governance framework to support effective risk management and internal control.

The Board is supported by its committees, in particular:

- The Audit and Risk Assurance Committee, which provides independent assurance on the adequacy of governance, risk management and internal control
- The Patient Quality, Safety and Outcomes Committee, which oversees risks relating to quality and safety
- The Executive Committee provides a forum for the identification, review and escalation of risks, ensuring that emerging risks are actively managed and reported through the governance structure.

Responsibility for risk is clearly defined and delegated to Executive Directors, ensuring appropriate expertise and accountability across key domains including operational delivery, workforce, digital and patient safety.

The Risk Management Framework

The Health Board operates a comprehensive Risk Management Framework (RMF), approved by the Board and subject to annual review. The framework supports a consistent and structured approach to risk identification, assessment, mitigation and review.

Risk management is embedded within organisational processes, including planning and performance management, and aligned to the Integrated Medium-Term Plan (IMTP) and Gwent 35 Strategy.

Staff are supported through training and development to ensure that risk management is understood and applied consistently across the organisation, and aligned with the Board's Risk Appetite Framework.

An Internal Audit review undertaken during 2025/26 concluded a reasonable assurance opinion on the effectiveness of the Strategic Risk Register and associated processes.

Opportunities for improvement were identified in relation to consistency and clarity, but these do not detract from the overall effectiveness of the framework.

Risk Appetite Determination

The Health Board's Risk Appetite Framework defines the level of risk the organisation is willing to accept in pursuit of its strategic objectives. The framework is informed by consideration of operational pressures, stakeholder expectations, regulatory requirements and the broader risk environment in which the Health Board operates.

The Board adopts a balanced and proportionate approach to risk-taking. Whilst there is recognition that some level of risk is inherent in delivering healthcare services and driving improvement, the Board maintains a low tolerance for risks relating to patient safety, quality of care and regulatory compliance, and a cautious approach in relation to financial sustainability.

The Risk Appetite Framework supports:

- Informed decision-making and prioritisation of resources
- Clear articulation of acceptable levels of risk exposure
- Structured escalation and oversight of risks operating outside of appetite

The Board explicitly recognises that, in the current operating environment, some risks will remain outside of appetite in the short to medium term. However, this does not represent a position of acceptance. Rather, such risks are subject to enhanced scrutiny, with a clear expectation that action is taken to reduce risk exposure to within acceptable levels as far as is reasonably practicable.

The table below summarises the Health Board's position in relation to its risk appetite and tolerance levels. The full Risk Appetite Statement is available separately here

	Risk Theme	Risk Appetite Level	Risk Appetite Description	Risk Appetite Thresholds
RISK APPETITE	Aneurin Bevan University Health Board Activities (Compliance & Safety)	Minimal	Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurrence of the risk after application of controls	Score 8 and below
	Aneurin Bevan University Health Board Activities (Service Delivery)	Open	Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure	Score 17 and below
	People	Open		
	Transformation and Partnership working	Open		
	Financial Sustainability	Cautious	Preference for safe, though accept there will be some risk exposure: medium likelihood of occurrence of the risk after application of controls	Score 13 and below

Risk Profile and Principal Risk

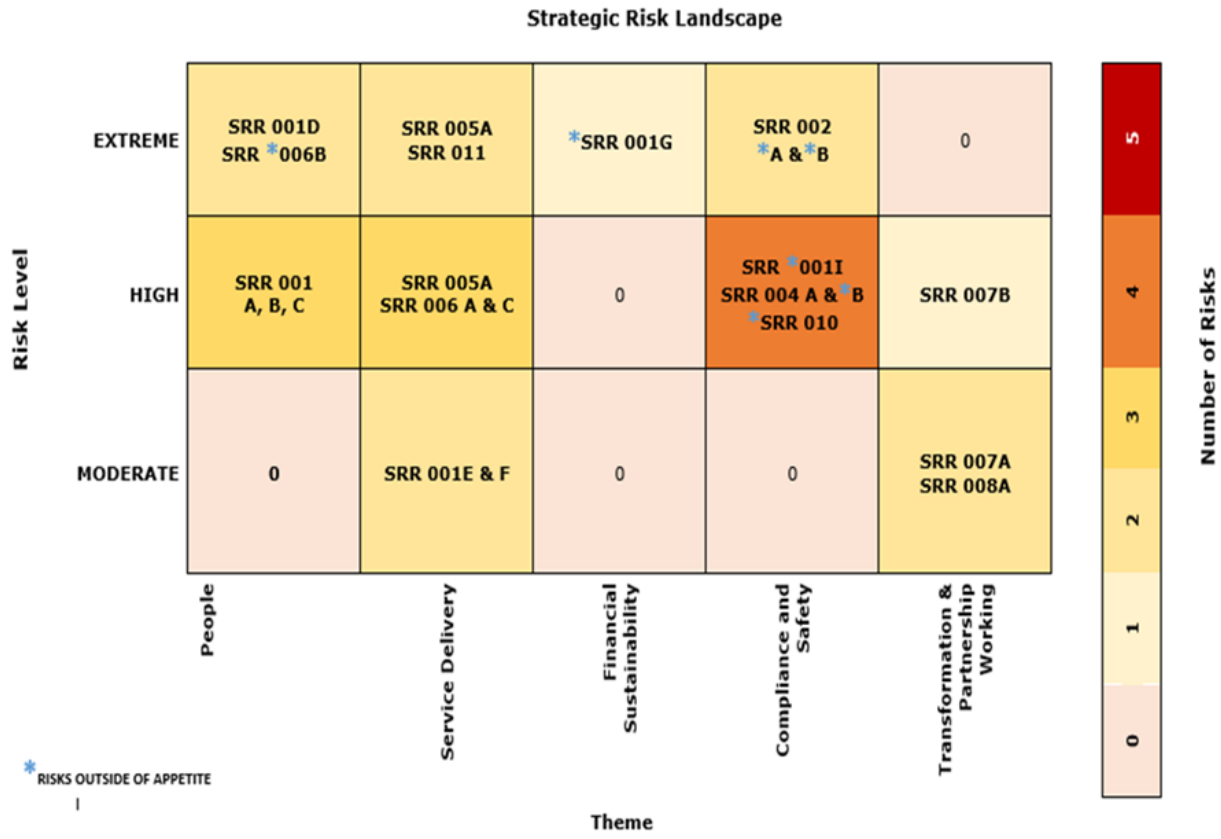
The Health Board maintains a Strategic Risk Register (SRR) which identifies and manages the principal risks to the achievement of its objectives. A copy of the latest Strategic Risk Report, presented to the Board in May 2026, is available on the Health Board's **to be added.**

The overall risk profile during 2025/26 remained stable within a high-risk operating environment. The majority of strategic risks are assessed as high, with a smaller number rated as extreme.

Key principal risks include:

- Financial sustainability
- Workforce capacity
- Service performance and operational resilience
- Patient safety and quality

The Board recognises the interdependencies between these risks and their potential cumulative impact on organisational performance and service delivery.



Six of the strategic risks, highlighted with a blue Asterix, remain outside the Board's defined risk appetite and are subject to enhanced monitoring, scrutiny and management action.

Assurance Framework (Three Lines of Assurance)

The Health Board applies the three lines of assurance model to support a structured and transparent approach to assurance.

First line: Operational management and internal controls
Second line: Oversight functions including governance, risk and compliance
Third line: Independent assurance from Internal Audit and External Audit

The Audit, Risk and Assurance Committee receives regular reports on the effectiveness of this framework, including:

- Adequacy of controls
- Progress against mitigating actions
- Identification of gaps in assurance

Sources of assurance include Internal Audit, External Audit, performance and financial reporting, quality and safety information, and management assurances.

Significant Issues, Risks and Control Challenge

During 2025/26, the Health Board has continued to operate in a challenging environment, with a number of risks remaining outside risk appetite, particularly in relation to:

- Financial sustainability
- Workforce constraints
- Operational performance and demand pressures
- Infrastructure and estate resilience

These represent ongoing system pressures rather than failures of control but require continued focus and management action.

Actions taken to address control issues

In response to these challenges, the Health Board has taken steps to strengthen its control environment, including:

- Enhanced financial governance and oversight
- Targeted service improvement and recovery actions
- Strengthened workforce planning
- Improved oversight of digital and infrastructure risks
- Development of business continuity arrangements

In addition, actions are underway to:

- Strengthen Executive oversight of the Strategic Risk Register
- Improve the quality and consistency of risk reporting
- Enhance alignment between risk management and strategic planning

Overall Assurance Conclusion

Based on the sources of assurance outlined above, I can confirm that the Health Board has in place an effective system of internal control that supports the management of risk to a reasonable level.

While some risks remain outside the Board's defined appetite due to the external operating environment, these are clearly identified, actively managed and subject to enhanced scrutiny.

I am therefore able to provide reasonable assurance that the Health Board's arrangements for governance, risk management and internal control are operating effectively.

Public and Stakeholder Engagement

The Health Board engages with patients, the public and external stakeholders to inform its approach to risk management. This includes:

- Public consultation and engagement activity
- Collaboration with patient advocacy organisations, including Llais
- Partnership working with regulators, emergency services and local authorities

These arrangements support improved identification of emerging risks and strengthen organisational responsiveness.

Emergency Planning

In accordance with the statutory duties of the Civil Contingencies Act (2004) and Emergency Planning Guidance issued by Welsh Government the Health Board have in place emergency plans, business continuity arrangements, health protection response plans and supporting documents. These plans were considered by the Board's Partnerships, Population Health and Planning Committee in July 2024. The plan is currently undergoing a review in readiness for its 3 yearly review in 2027.

An internal business continuity audit was undertaken in October 2025 providing reasonable assurance. Within the scope of the audit the effectiveness of business continuity management system in place and identified as being substantial. A recommendation from the audit was for services to test and exercise their local plans, to address this the emergency planning team have scheduled dates throughout the year to facilitate exercising these plans.

There has, additionally, in accordance with the Act, been collaborative planning and exercising with Local Resilience Forum (LRF) partners throughout the year aligned to the LRF Risk Register, and shared and collaborative response to incidents.

THE CONTROL FRAMEWORK

Patient Safety, Quality, Experience and Learning

In 2025/26, Aneurin Bevan University Health Board continued to strengthen its quality governance arrangements to ensure effective oversight of clinical risk, patient safety, experience and clinical effectiveness. The Duty of Quality and Duty of Candour remained embedded as the golden thread from ward to Board, supported by the Quality Management Framework (2025–2028) and a maturing Quality Management System (QMS).

The QMS provides a structured and consistent approach to quality planning, quality control, quality improvement and assurance, enabling the Board to

understand risk, variation and learning through triangulation of incidents, audit, outcomes, mortality, patient experience and staff feedback. Quality intelligence flows through divisional governance to the Quality Management Group (QMG), Executive Committee and Patient Quality, Safety and Outcomes Committee (PQSOC), providing assurance to the Board.

Further integration of corporate quality functions during 2025/26 (Quality and Patient Safety, Putting Things Right, Clinical Legal Services and Quality Improvement) strengthened escalation routes, reduced duplication and improved the reliability of movement from insight to action and assurance.

Quality Outcomes Framework (QOF) and Assurance Reporting

During 2025/26, the operating discipline of the QMS was strengthened through refreshed Quality Outcomes Framework (QOF) reporting. Quarterly submissions to PQSOC became more standardised, with clearer narrative, improved visualisation and stronger alignment to the six pillars of quality.

Run-chart data for key safety indicators (including falls and pressure ulcers) improved visibility of variation and supported earlier intervention at divisional and service level. These developments enhanced the Board's ability to gain assurance on quality performance and risk.

Clinical Effectiveness, Mortality and Clinical Audit

The Six Pillars of Quality continue to provide the assurance spine for the Health Board. In 2025/26, Pillar 3 – Clinical Effectiveness was strengthened to improve visibility of clinical outcomes, audit, benchmarking and adherence to evidence-based practice.

The Annual Clinical Audit Plan underpinned participation in the National Clinical Audit Programme alongside local priority audits. Audit findings were reviewed through the Clinical Standards and Effectiveness Group (CSEG) and escalated to PQSOC where required. All actions arising from audit are recorded and tracked via the Audit Management and Tracking (AMaT) system, providing clear accountability and oversight.

Learning from Deaths processes were strengthened through more consistent templates, improved data validation and enhanced triangulation with audit, safety and outcome data. Thematic outputs now inform CSEG, QMG and PQSOC, supporting a more integrated view of harm and variation.

Clinical Risk Management and Deteriorating Patients

Clinical risk is identified and managed through multiple sources including incident reporting, mortality reviews, audit findings, complaints, claims and patient feedback. Risks are reviewed within divisional governance structures and escalated through QMG and PQSOC as required, aligned to the Board Assurance Framework.

In 2025/26, a key area of focus was the deteriorating patient agenda and sepsis. Significant progress was made in implementing national deterioration tools (NEWS2, PEWS and NEWTT2) and preparing for Call 4 Concern (Martha's Rule). Training delivery was supported through ESR reporting and local training packages, with coordinated oversight via the Deteriorating Patient Health Board Group.

The Big Conversation on Sepsis strengthened governance focus by incorporating lived experience from patients, families, clinicians and leaders, reinforcing the importance of early recognition, escalation and reliable systems of care.

Patient Experience, Putting Things Right (PTR) and Learning Systems

PTR governance continued to strengthen in 2025/26 through earlier acknowledgement, more consistent initial contact, Datix validation dashboards and targeted improvement work, particularly within Medicine. Patient and staff stories were increasingly used within governance forums to support compassionate, just learning and improvement.

These arrangements improved transparency, data quality and timeliness, and strengthened the role of lived experience within quality assurance and improvement.

Infection Prevention and Control (IPC)

IPC governance was strengthened through enhanced surveillance, standardisation of policies and active oversight of infection risks. Integration of IPC metrics into QMS dashboards improved early identification of infection-related risks and strengthened divisional accountability and assurance.

Health and Safety

Health and safety governance was reinforced through improved RIDDOR oversight, policy standardisation and focused fire safety close-out. The early development of the Violence Prevention and Reduction Strategy strengthened links between staff safety, patient outcomes and organisational culture. Integration of health and safety metrics into QMS dashboards improved consistency of assurance.

End of Life Care and Bereavement (GRACE)

End of life and bereavement care continued to develop through the rollout of the GRACE model, aligned to the National Bereavement Framework. Governance arrangements supported the establishment of a single point of contact, People Participation Panels and Graces' Places across boroughs, improving continuity of bereavement care and early support for families.
Stronger multidisciplinary coordination, clearer pathways and early Grief Awareness training improved system visibility and consistency of care.

Overall Assurance

In 2025/26, the Health Board's quality governance arrangements provided a coherent and increasingly mature system for managing clinical risk, overseeing clinical audit and effectiveness, and assuring the quality and safety of care. The continued development of the QMS strengthened the Board's ability to triangulate intelligence, escalate risk appropriately and gain assurance that improvement actions are implemented and sustained.

Information Governance

Information is a critical asset, essential for both the clinical management of individual patients and the efficient management of services and resources. Information Governance (IG) involves establishing high standards for handling this information and equipping the organisation with the necessary tools to achieve these standards.

The Health Board has designated several key roles with specific responsibilities related to the information it holds, uses, and shares. The Medical Director serves as the Caldicott Guardian, the Director of Digital is the Senior Information Risk Owner (SIRO), and the Assistant Director of Digital Governance & Assurance is the Data Protection Officer (DPO).

Throughout 2025/2026, the Health Board continued to enhance its forums to address information governance requirements consistently. These forums facilitate processes and communications to ensure compliance with Data Protection obligations. Dashboards are produced to support and assist in training compliance, complaint handling, incident, and breach management. Annual reports detailing progress are disseminated to relevant divisions and boards.

The organisation continued to demonstrate a strong information governance and data protection control environment through its performance against the Information Governance Toolkit, achieving a compliance score in excess of 96% and meeting all essential criteria. This performance provides assurance of alignment with national data security and protection standards.

The Senior Information Risk Owner (SIRO) report was published which provided an overview of the organisation's information governance activities and performance. It informs senior management about the organisations efforts in managing information risks and ensuring compliance with relevant regulations.

The Wales Accord on the Sharing of Personal Information (WASPI) framework is firmly embedded in the Health Board's practices for sharing relevant information with partner organisations.

In 2025/2026, the Information Governance Department received a total of 224 Subject Access Requests (SAR's) from individuals seeking access to personal information held about them. These requests were separate from and did not include Access to Health Records requests.

The number of Subject Access Requests (SAR's) processed under the Access to Health records provisions increased by 3.9% rising from 7,568 in 2024/2025 to 7,862 in 2025/2026.

There was also a 22% increase in Information Governance (IG) incidents reported by staff, from 555 incidents in 2024/2025 to 676 incidents in 2025/2026.

During the reporting period, a total of 82 Information Governance related complaints were received from members of the public. Of these, 4 complaints were referred to the Information Commissioners Office (ICO), with 3 not upheld and 1 pending a final outcome at the time of writing.

In 2025/26, the Health Board reported no serious lapses in data security to the ICO.

Quality of Data

The Health Board makes every attempt to ensure the quality and robustness of its data and has regular checks in place to assure the accuracy of information relied upon. However, it is recognised that the multiplicity of systems and data inputters across the organisation means that there is always the potential for variations in quality, and therefore always scope for improvement. We have an on-going data quality improvement approach which routinely assesses the quality of our data across key clinical systems. Good quality clinically coded data plays a fundamental role in the management of hospitals and services. Coded data underpins much of the day to day management information used within the NHS and is used to support healthcare planning, resource allocation, cost analysis, assessments of treatment effectiveness and can be an invaluable starting point for many clinical audits.

The Board relies upon independent and objective assurances, such as those provided by auditors and inspectors, to comment upon the effectiveness of the Board's assurance system. This assurance system includes reporting on financial performance, operational performance and quality of and associated outcomes.

The Corporate Governance Code

The Corporate Governance Code currently relevant to NHS bodies is 'The corporate governance in central government departments: code of good practice' (published 21 April 2017). The Health Board, like other NHS Wales organisations, is not required to comply with all elements of the Code,

however, the main principles of the Code stand as they are relevant to all public sector bodies. The Corporate Governance code is reflected within key policies and procedures. Further, within our system of internal control, there are a range of mechanisms in place that are designed to monitor our compliance with the Code. These include Self-assessment; Internal and External Audit; and Independent Reviews.

The Board is clear that it is complying with the main principles of the Code and is conducting its business openly and in line with the Code, and that there were no departures from the Code as it applies to NHS bodies in Wales. A copy of the current self-assessment against the code is provided as **Attachment Three**.

Planning Arrangements

In March 2025, the Board approved a balanced Integrated Medium-Term Plan (IMTP) for 2025-28 in line with section 175(2A) of the National Health Service (Wales) Act 2006 (as amended by NHS Finance (Wales) Act 2014) and in accordance with the NHS Planning Framework.

This was subsequently approved by the Cabinet Secretary for Health and Social Care (the Cabinet Secretary) in July 2025, however the Welsh Government's Collective Review process concluded that the IMTP carried a number of risks that would need to be actively managed and mitigated and was therefore approved subject to a range of accountability conditions.

On 16 December 2025, the Cabinet Secretary announced that, in-line with the NHS Wales Oversight and Escalation Framework, and due to a deterioration in the financial position, failure to deliver the approved IMTP, and waiting times at the Grange University Hospital emergency department: finance, strategy and planning would be escalated from level 3 to level 4; and performance and outcomes related to urgent and emergency care at the Grange University Hospital emergency department would be escalated from level 3 to level 4 and be widened to include the whole urgent and emergency care system. Consequently, the Cabinet Secretary informed the Health Board that a decision had been taken to revoke the approval status of the Health Board's IMTP with immediate effect.

Throughout the year the Board and its Finance and Performance Committee has maintained a focus on overseeing delivery of the commitments set out by the Health Board within the IMTP for 2025/26.

In March 2026, the Board approved its Annual Plan (with a Three-Year Intent) for 2026/27, forecasting a financial deficit of £43.7m, which did not fully comply with section 175(2A) of the National Health Service (Wales)

Act 2006 (as amended by NHS Finance (Wales) Act 2014) and the NHS Planning Framework.

On 22 April 2026, the Health Board received confirmation from Welsh Government that as the Annual Plan 2026/27 represented a deteriorating financial and performance position, the Plan was considered by Welsh Government to be unacceptable and unsupportable. At the time of writing, the Health Board is expected to consider and address feedback received from Welsh Government and provide a response which demonstrates tangible improvements to the Plan in relation to performance and finance by 29 May 2026.

MANDATORY DISCLOSURE STATEMENTS

Equality, Diversity & Human Rights

The Health Board remains committed to promoting equality, diversity and human rights across its workforce and the services it provides to the population of Gwent. During the reporting period, the Health Board has continued to progress delivery of its Strategic Equality Plan (SEP) 2024–2028, strengthening the integration of equality, diversity and human rights considerations across workforce practice, service delivery and organisational governance. This work supports the organisation's statutory responsibilities under the Equality Act 2010, the Human Rights Act 1998, and the Public Sector Equality Duty (Wales) Regulations 2011.

Progress during the year has focused on embedding the Health Board's equality objectives across key organisational programmes, including the People Plan, workforce development initiatives and service improvement activity. Governance and oversight arrangements have also been strengthened to ensure greater organisational accountability for equality, diversity and human rights delivery. Regular assurance on Equality, Diversity and Inclusion (EDI) activity continues to be provided to the Board through the People and Culture Committee, including monitoring progress against the Strategic Equality Plan and associated action plans.

The Health Board has also continued to develop initiatives to support a more inclusive organisational culture, including strengthening engagement with staff networks, promoting inclusive leadership and progressing work to improve accessibility and equity in communication and information for patients and staff. This includes ongoing work aligned with the All-Wales NHS Accessible Communication and Information Standards (ACIS).

The Health Board continues to meet its statutory equality reporting requirements, including the annual publication of Gender Pay Gap data, based on the workforce snapshot taken on 31 March each year in line with national reporting requirements. The Health Board has seen a decrease in the pay gap percentage for average hourly rates, from 24.71% in March

2024 to 23.8% in March 2025, which is a move in the right direction. The median hourly pay gap has also reduced, from 9.69% in March 2024 to 6.13% in March 2025.

Through these arrangements, the Health Board maintains appropriate control measures to support compliance with equality, diversity and human rights legislation and to promote an inclusive and equitable environment for staff, patients and the communities it serves.

Pensions Scheme

I can confirm that as an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employers' contributions and payments into the Scheme are in accordance with Scheme rules and that the member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations. Further detail in this regard is included within the provisions note within the 2025/26 Financial Statements (Note 20).

Carbon Reduction Delivery Plans

The Health Board is able to confirm compliance with the following statement:

"The organisation has undertaken risk assessment and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements as based on UKCIP 2009 weather projections to ensure that the organisation's obligation under the Climate Change Act and the Adaptation Reporting requirements are complied with."

Counter Fraud, anti-corruption and anti-bribery matters.

Aneurin Bevan University Health Board is committed to reducing the level of fraud, bribery and corruption within the NHS to an absolute minimum and keeping it at that level, freeing up public resources for better patient care.

The Health Board's Counter Fraud Team undertake proactive/preventative work with the intention of safeguarding the organisation from economic crime. Further information on the valuable work undertaken is available in the Counter Fraud Annual Report 2025/26. [Link to be added when published end of May]

Ministerial Directions & Welsh Health Circulars

The Welsh Government has previously issued Non-Statutory Instruments and reintroduced Welsh Health Circulars (WHCs) in 2014/15. Details of these and a record of any ministerial directions given is available on the Welsh Government website. A full detail of the WHCs and Ministerial

Directions issued to the Health Board in 2025/26 and the Health Board's responding action is included at **Attachment 2**.

There was one Ministerial Direction issued in December 2019, to address the operational challenges arising as a consequence of pension tax arrangements. Further detail in this regard is included in provisions within the 2025/26 Financial Statements (Note 20).

Modern Slavery Act 2015 – Transparency in Supply Chains

The Health Board is fully committed to the Welsh Government Code of Practice Ethical Employment in Supply Chains. This has been established by the Welsh Government to support the development of more ethical supply chains to deliver contracts for the Welsh public sector and third sector organisations in receipt of public funds.

NHS Wales Shared Services Partnership (NWSSP) Procurement Services, on behalf of the Health Board, commits to ensure that any parts of our supply chain comply with all elements of the code of practice including:

- Modern slavery & human rights abuses;
- Blacklisting;
- False self-employment;
- Unfair use of umbrella schemes and false self-employment; and
- Paying the living wage.

NWSSP Procurement Services has:

- Embedded the Code of Practice in standard operating procedures, including terms and conditions of contract;
- Provided training to those involved in buying/procurement on modern slavery and ethical employment practices, through various training mediums;
- Aligned the Code of Practice within our broader Sustainable Procurement Code of Practice;
- Developed standard questions that ensure ethical employment practices are considered as part of the procurement process;
- Became a signatory to the Transparency in Supply Chains (TISC) register, and published the NWSSP Ethical Employment Statement; and
- Encouraged our suppliers sign up to the TISC register, and publish their own modern slavery/ethical employment policies and statements;
- Engaged with wider NHS Scotland, NHS Northern Ireland and NHS England colleagues to continue to develop and share best practice.

NWSSP Procurement Services will continue to:

- Conduct appropriate and targeted engagement with our bidders, to ensure that the way in which we work does not contribute to the use of illegal or unethical employment practices within the supply chain;
- Maintain and share knowledge of ethical employment issues and themes, ensuring continuing support of fair and decent work;

- Leverage our tender processes to encourage our suppliers to sign up to the commitments of Ethical Employment in Supply Chains Code of Practice and also to the TISC register, to publicise their commitments and their Modern Slavery/Ethical Employment Statements;
- Assess our expenditure to identify areas of high risk, and continue to address any issues of modern slavery, human rights abuses and/or unethical employment practice.

The NWSSP Ethical Employment statement and more information can be found on the NWSSP Website

REVIEW OF EFFECTIVENESS OF SYSTEM OF INTERNAL CONTROL

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the system of internal control is informed by the work of the internal auditors, and the executive officers within the organisation who have responsibility for the development and maintenance of the internal control framework, and comments made by external auditors in their audit letter and other reports.

The Board has adopted a structured approach to risk management, whereby risks are identified, assessed and controlled, and if appropriate, escalated or de-escalated through the governance mechanisms of the organisation.

During 2025/26, the Board's Audit, Risk and Assurance Committee and, Patient Quality, Safety and Outcomes Committee played a key role in monitoring the effectiveness of internal control and the process for risk management. During 2025/26 work has continued to embed the Risk Management Framework and the Board's Quality Strategy ensures that the work of all regulators, inspectors and assurance bodies is mapped and evidenced in our assurance framework so that the Board is fully aware of this activity and the level of assurance it provides. We will also continue to strengthen arrangements for monitoring and reporting progress in implementing recommendations arising from the work of auditors.

The Health Board also uses reports from Healthcare Inspectorate Wales, the Welsh Risk Pool and other inspectorates and regulatory bodies to inform the governance and assurance approaches established by the organisation. A tracking mechanism for these recommendations is also in place and progress in delivering these recommendations is overseen by the Patient Quality, Safety and Outcomes Committee via updates in respect of Inspections.

INTERNAL AUDIT

Internal audit provides me as Accountable Officer and the Board, through the Audit, Risk and Assurance Committee with a flow of assurance on the system of internal control. I have commissioned a programme of audit work which has been delivered in accordance with public sector internal audit standards by the NHS Wales Shared Services Partnership. The scope of this work is agreed with the Audit, Risk and Assurance Committee and is focussed on significant risk areas and local improvement priorities.

The overall opinion by the Head of Internal Audit on governance, risk management and control, is a function of this risk-based audit programme and contributes to the picture of assurance available to the Board in reviewing effectiveness and supporting our drive for continuous improvement.

The Head of Internal Audit is satisfied that there has been sufficient internal audit coverage during the reporting period in order to provide the Head of Internal Audit Annual Opinion. In forming the Opinion, the Head of Internal Audit has considered the impact of the audits that have not been fully completed.

The assurance sections that follow provide a brief summary of the scope of the Internal Audit Reviews that have been completed and received by the Committee during the financial year 2025-26.

Substantial Assurance
In the following review areas, it was reported that the Board could take **substantial assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. The few matters that required attention were compliance or advisory in nature with low impact on residual risk exposure.
Standing Orders Compliance 2025/26 The overall objective of the audit was to assess Aneurin Bevan University Health Board's (the 'Health Board') adherence to the Model Standing Orders (Reservation and Delegation of Powers) and Standing Financial Instructions, as determined by the Welsh Government (WG). **Welsh Intensive Care Information System 2025/26** To ensure lessons learnt and / or any associated actions regarding the work completed to date on the Welsh Intensive Care Information System (WICIS) are appropriately addressed by Aneurin Bevan University Health Board. This audit focussed on the steps taken by the Health Board to incorporate lessons learnt / actions identified following the pausing of the WICIS Programme. It did not assess or review the ongoing suitability of WICIS for the Health Board or the

appropriateness of the actions taken during the initial rollout of the Programme. Instead, this review focussed on risks that have been identified by the Health Board and subsequent remediation / lessons learnt identified.

Reasonable Assurance

In the following review areas, it was reported that the Board could take **reasonable assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively.

Some matters required management attention in either control design or operational compliance and these had low to moderate impact on residual risk exposure until resolved.

Divisional Governance Arrangements 2024/25

The review assessed whether the governance arrangements in place within the Primary Care and Community (PCC) Division ensure key risks and matters arising were escalated and managed effectively. This review was completed in line with the Aneurin Bevan University Health Board 2024/25 Internal Audit Plan.

Mental Health and Learning Disabilities 2024/25

The review assessed the arrangements from the 90-day Plan for the Mental Health and Learning Disabilities division to ensure that these have been embedded.

Maternity Services Improvement Plan 2024/25

This review followed the 2023/24 internal audit of the Maternity Services Action Plan, assessing whether previously raised external recommendations were being effectively implemented on schedule and appropriately monitored.

Staff Survey 2024//25

A review of the actions underway to influence change following on from the Employee Experience Survey (staff survey) results.

GUH Emergency Department Extension 2024/25

The audit was undertaken to review the management arrangements established to progress the extension of the Grange University Hospital Emergency Department.

Health Board Managed Practices 2024/25

The review examined the letting of a group of five Health Board managed GP practices that were let to a single partnership in early 2024 (one that commenced operation from 1 January 2024 and four from 1 April 2024) and which were subsequently returned to the Health Board's management in 2025. The review was to ensure that the Health Board had an appropriate process in place to assist in managing the return of a Managed Practice to Independent Contractor status, including the application and shortlisting processes.

Performance and Accountability Framework 2024/25
The review examined the adequacy of the Performance and Accountability Framework arrangements put in place at Aneurin Bevan University Health Board. The review assessed the appropriateness of the Framework implemented, rather than the associated performance recorded.

Technical Continuity 2024/25
To review the enactment of technical resilience and awareness of fault domains and to ensure that Aneurin Bevan University Health Board is maximising the potential for resilience within the architecture.

Medical Equipment and Devices 2024/25
This audit assessed the controls in place for the management of a sample of medical equipment and devices within the Health Board. The term medical device includes all products, except medicines, used in healthcare for the diagnosis, prevention, monitoring or treatment of illness or disability but the scope of this audit was limited to electronic patient connected medical equipment, excluding ultrasound devices, which were the subject of a similar audit during 2023/24.

Newport East Health and Wellbeing Centre 2024/25
The audit was undertaken to evaluate whether the Health & Wellbeing Centre, as commissioned, had achieved the desired objectives and whether issues raised at prior audits have been addressed. This was the third audit of the project (the previous review in April 2024 having determined Reasonable Assurance).

Waiting List Management 2024/25
The review focused on adult weight management, which has Health Board derived targets in the absence of national targets.

Electronic Document and Records Management Solution (EDRMS) 2024/25
To review the effectiveness and appropriateness of the electronic document and records management solution (EDRMS) in use for the management of digital health records and the provision of scanning services within Aneurin Bevan University Health Board.

Financial Sustainability 2024/25
To determine if appropriate recovery plans were in place to achieve a sustainable financial position, including the impact of any associated reduction in non-recurrent funding. The audit provided assurance over the establishment, implementation and tracking of financial savings targets, in relation to the recovery plans.

Safeguarding 2025/26
The audit sought to provide assurance that key policies and procedures are in place within Aneurin Bevan University Health Board to ensure compliance with safeguarding regulations.

Business Continuity Plan 2025/26
As a Category 1 responder, with key emergency response duties under the Civil Contingencies Act (2004), the Health Board is required to ensure that it has robust plans in place for emergency preparedness, resilience and response. The audit examined and assessed the adequacy and completeness of business continuity plans and response protocols in a sample of the services within the Health Board's divisions. IT disaster recovery testing was not covered within this review, as it is assessed separately.

Cyber Security 2025/26
To assess Aneurin Bevan University Health Board's governance process for cyber security, associated risk statements and the management and delivery of improvement plans. In addition, the Cyber Incident Response Plan was also assessed.

RGH Central Decontamination Unit 2025/26
The overall objective of this audit was to evaluate the progression and delivery of the project against the key business case objectives and to assess the adequacy of the systems and controls in place to support the successful delivery of the project.

Strategic Risk and Assurance 2025/26
To determine and evaluate whether the Aneurin Bevan University Health Board's (the Health Board) governance and strategic oversight of risk and assurance are effective, aligned with organisational goals, and support long-term objectives.

Capital Projects – Service Readiness 2025/26
An evaluation of a sample of projects was completed over the preparedness of services for operational deployment, to ensure a timely commencement of the new / revised operations.

Directorate Review – Child and Adolescent Mental Health Services 2025/26
To ensure that appropriate arrangements are in place for the management of risk and performance within the Health Board and CAMHS Directorate.

Occupational Health 2025/26
To provide assurance over the arrangements and controls in place for the management of the Occupational Health Service within the Health Board.

Limited Assurance

In the following review areas, it was reported that the Board could take **only limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, were suitably designed and applied effectively.

More significant matters required management attention with moderate impact on residual risk exposure until resolved.

The Management response and action plan to respond to the issues and weaknesses identified, which form part of the final reports, are considered by the Audit, Risk and Assurance Committee. The Committee monitor progress in line with agreed timescales via the Audit Recommendations Tracker.

In addition for all limited assurance rated reports, executive leads attend the Audit, Risk and Assurance Committee to provide assurance on the actions identified.

Embedding of Policies 2024/25
The review assessed whether the Speaking up Safely: A Framework for the NHS in Wales has been fully implemented.

The Framework was released in December 2024 and work remained ongoing to address the gaps. Monitoring the effectiveness of the new process would continue. Follow Up audit included in the 2025/26 Internal Audit Plan.

Job Planning 2024/25
To provide assurance that arrangements are in place and operating effectively for consultant job planning.

A robust process was in place, with actions to increased compliance with job planning. The main challenge lay in the uptake and completion of job plans. Regular updates on progress provided to ARAC and People and Culture Committee.

Health and Safety 2024/25
To review how key health and safety risks were managed in accordance with the Health Board policies and procedures, including RIDDOR reporting.

Significant work had been undertaken since audit fieldwork concluded, with improvements made, but governance remained in development, with a review of divisional accountability underway.

Subject Access Requests 2025/26
To ensure the Health Board is complying with legal and regulatory obligations with effective processes and that the system for managing Subject Access Requests (SARs) is robust, secure, and efficient. The audit only looked at information held by the Health Board and did not include information managed by other parties e.g. GP practice records maintained by NWSSP. In addition, the quality of records that were issued to the requestor was not assessed.

Despite the limited assurance outcome, the team's operational performance was exceptionally strong, with more than 99% of SARs processed within statutory timescales and a high monthly volume of 600–700 requests being managed effectively. The limitation in assurance arose from control weaknesses, rather than performance. Improvement actions have been put in place to address this.

Speaking up Safely
The audit noted that the current approach is manual, time-consuming and does not reliably capture all activity undertaken to progress / manage cases. As a result, a limited assurance opinion was concluded, reflecting recurring issues from the previous audit.

The GUH Emergency Department
The audit of the Grange University Hospital Emergency Department Extension project for 2025/26 concluded limited assurance due to significant delays, contractor performance issues, and financial uncertainties, with Phase 1 delayed by 45 weeks and Phase 2 removed for re-tendering in 2026/27. Key management actions include undertaking a lessons-learnt review, improving financial reporting, managing contractual changes timely, and revising the benefits realisation plan, while governance and quality assurance were deemed reasonable but with room for improvement in reporting and operational planning.

Assurance Rating Not Applicable

The following reviews were undertaken as part of the audit plan and reported or closed by correspondence without the standard assurance rating indicator, owing to the nature of the audit approach.

Contract Management 2024/25
The review assessed whether appropriate contract management arrangements were in place within the Health Board. This review had been undertaken further to the advisory review of Contract and Procurement at Betsi Cadwaladr University Health Board (BCUHB), completed at the request of Welsh Government in 2023/24, which identified several areas of concern and non-compliance with the organisation's Standing Financial Instructions. Through inclusion within NHS Wales Organisations 2024/25 Internal Audit plans, this review has compared and contrasted the appropriateness of contract management arrangements across eight more organisations, with common issues and challenges noted.

Follow up of previous Audit Recommendations 2024/25
To assess whether a sample of high and medium priority internal audit recommendations have been implemented by Aneurin Bevan University Health Board

Health Board Managed Practices 2024//25
A follow up to the audit report listed above (in reasonable assurance). This supplementary report included additional considerations for the Health Board to consider, which are in addition to the expectations specified within the existing control environment (i.e. applicable regulations, Welsh Health Circular and/or Vacant Practice Policy).

Public Health 2025/26
To determine if the Health Board had effective controls in place to ensure that public health objectives are being met at a local level, in support of the IMTP and the requirements of the Wellbeing of Future Generations (Wales) Act 2015, whilst recognising the responsibilities of Public Health Wales. A number of items were raised aimed at improving internal controls and/or compliance. These will need to be considered against other priorities and available financial / non-financial resources.

The following three reports included in the 2025/26 Internal Audit Plan have been deferred to 2026/27:

- Clinical Audit
- Six Goals Programme
- Directorate Review – Ophthalmology/ENT

The following **6** reports form the 2025-26 audit schedule will be presented at Committee meetings during Quarters 1 and 2 of 2026-27.

- Divisional Budgetary Control
- Benefits Realisation (Excluding digital)
- Professional Staff Registration
- Cancer Referral Rates
- Estates Assurance – Space Utilisation
- NHH Regional Satellite Centre

Monitoring and Implementation of Audit Recommendations

The Audit, Risk and Assurance Committee maintains oversight of the monitoring and implementation of audit recommendations. Over the past year, the Health Board has strengthened its internal audit guidance, including the development of formalised procedures and supporting documentation. This has established a consistent framework for tracking both internal and external audit recommendations, reinforcing effective monitoring to support organisational learning, strengthen governance, and provide assurance.

During 2025/26, further progress has been made in enhancing the maturity and effectiveness of audit recommendation management. Targeted action

has been taken to improve the timeliness of implementation, with particular emphasis on addressing longstanding recommendations (pre-2023) and those previously delayed due to factors outside the Health Board's control.

In-year, a series of focused "deep dive" reviews were undertaken in key areas, including discharge planning and digital. These reviews identified a number of longstanding recommendations that remained unimplemented and highlighted areas where there was overlap across recommendations, as well as instances where management responses had extended beyond the original scope of the recommendation. This work has provided greater clarity on prioritisation, improved alignment between recommendations and actions, and strengthened oversight of delivery.

Work is also underway to strengthen the reliability, visibility, and control of the tracking process through the transition from an Excel-based system to Microsoft Lists. All post-2023 recommendations are now managed within the new system. Once the remaining pre-2023 recommendations (20 in total) have been implemented and closed, the Health Board will complete the transition to a single, standardised digital platform. This will enhance data accuracy, improve version control, and provide a clearer audit trail, while also supporting the efficiency and robustness of Internal Audit's annual review process.

In addition, the development and implementation of an Audit Handbook, alongside an embedded quality assurance process, has further strengthened the Health Board's approach. This has improved the consistency and quality of management responses, ensuring they meet audit standards and are specific, measurable, achievable, relevant, and time-bound (SMART).

To provide independent assurance to the Committee and the Board, Internal Audit undertakes an annual review of the implementation of audit recommendations, with particular focus on those assessed as high priority. The review assesses whether appropriate and timely action has been taken and considers any residual risks arising from delays in implementation. Although this is an advisory audit, it is an important tool that supports organisational learning and provides valuable insight to strengthen the future management of audit recommendations.

At the end of the 2025/26 financial year, the Audit Recommendations Tracker recorded 80 outstanding recommendations across 34 audit reports. This reflects continued focus on implementation to support improvements in quality, safety, and governance across the Health Board.

Number of Live Recommendations on the Corporate Audit Tracker by Priority Rating				
High	**Medium**	**Low**	**Not Rated***	**Total**
20	**35**	**2**	**23**	**80**

*Not rated covers External Audit recommendations which are not given a priority rating as well as Internal Audit Advisory Reports

Head of Internal Audit's Opinion for 2025/26 (DRAFT)

The purpose of the annual Head of Internal Audit opinion is to contribute to the assurances available to the Accountable Officer and the Board of Aneurin Bevan University Health Board which underpin the Board's own assessment of the effectiveness of the organisation's system of internal control.

The overall opinion is based primarily on the outcome of the work undertaken during the 2025/26 audit year. We also consider other information available to us such as our overall knowledge of the organisation, the findings of other assurance providers and inspectors, and the work we undertake at other NHS Wales organisations. The Head of Internal Audit considers the outcomes of the audit work undertaken and exercises professional judgement to arrive at the most appropriate opinion for each organisation.

A quality assurance review process has been applied by the Director of Audit & Assurance and the Head of Internal Audit in the annual reporting process to ensure the overall opinion is consistent with the underlying audit evidence.

The scope of my opinion covers both those areas examined in the risk-based audit plan which has been agreed with senior management and approved by the Audit, Risk and Assurance Committee, and other information obtained during the year that we deem to be relevant to our work. The Head of Internal Audit assessment should be interpreted in this context when reviewing the effectiveness of the system of internal control and be seen as an internal driver for continuous improvement. The Head of Internal Audit opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control is set out below.

Reasonable assurance		The Board can take reasonable assurance that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.

EXTERNAL AUDIT: AUDIT WALES STRUCTURED ASSESSMENT

The Audit Wales 2025 Structured Assessment work reviewed the Health Board's corporate governance and financial management arrangements, particularly the progress in implementing recommendations from previous structured assessment reports and the Audit Wales 2024 report on cost savings.

Overall, the Audit Wales report stated:

"The Health Board's Board and committee governance arrangements are stable and generally effective. However, given its financial and performance challenges, the Health Board's development of a new long-term strategy and delivery of its three-year route map are crucial to enabling the organisation to transform services to meet current and future demand."

The report went on to say that:

- **Board transparency, effectiveness, and cohesion** – "Despite reasonably effective Board and committee arrangements, the Health Board should increase the number of patient safety leadership walk rounds and improve committee chairs' reporting to Board."

- **Corporate systems of assurance** – While the Health Board is strengthening its assurance arrangements and its performance management approach is improving; further work is needed."

- **Corporate approach to planning** – "The Health Board has generally effective arrangements for developing strategic plans built on good engagement. Developing a new long term strategy is a clear priority for the Health Board. However, it needs to ensure clinical services plans are developed in consultation with all relevant stakeholders and fully reflect the changes needed to further deliver sustainable clinical service models."

- **Corporate approach to managing financial resources -** "The Health Board is improving its financial controls and has a stronger focus on value and savings delivery. However, its significant ongoing financial challenges suggest that it needs a longer term and detailed financial strategy aligned to sustainable care models."

The Annual Audit Report for the Health Board is available on the following link. This report summarises the findings from Audit Wales' 2025 audit work at Aneurin Bevan University Health Board undertaken to fulfil their responsibilities under the Public Audit (Wales) Act 2004.

Copies of all reports produced by Audit Wales can be accessed via Audit Wales Publications.

CONCLUSION

As Accountable Officer for Aneurin Bevan University Health Board, based on the assurance process outlined above, I have reviewed the relevant evidence and assurances in respect of internal control. I can confirm that the Board and its Executive Directors are alert to their accountabilities in respect of internal control and the Board has had in place during the year a system of providing assurance aligned to corporate objectives to assist with identification and management of risk.

During 2025/26, the Health Board proactively identified areas requiring improvement and requested that Internal Audit undertake detailed assessments in order to manage and mitigate associated risks. Work will continue in 2026/27 to ensure implementation of recommendations arising from audit reviews, in particular where a limited assurance rating is applied. Work will also continue in 2026/27 to further embed and mature risk management and assurance arrangements at a corporate and operational level. Implementation of further improvements identified by External Audit will see a further strengthening of the Board's effectiveness and the system of internal control in 2026/27.

This Annual Governance Statement confirms that Aneurin Bevan University Health Board has continued to mature as an organisation and, whilst there are areas for strengthening, no significant internal control or governance issues have been identified. The Board and the Executive Team has had in place a sound and effective system of internal control that provides regular assurance aligned to the organisation's strategic objectives and strategic risks. Together with the Board, I will continue to drive improvements and will seek to provide assurance for our citizens and stakeholders that the services we provide are efficient, effective and appropriate, and are designed to meet patient needs and expectations and that our governance framework continues to develop and mature.

It is disappointing that in 2025/26, the Health Board has remained under enhanced escalation and intervention arrangements in some areas with Welsh Government. Significant progress has been made, and we will continue to progress at pace towards sustainable improvements that enable de-escalation to routine monitoring arrangements.

It is widely known that the demands on the health and care system remain significantly pressured, increasing health inequalities, and sustained economic and cost of living challenges. The health and care landscape in Gwent is rapidly changing. The Health Board has an agreed long-term strategy, *'Gwent 2035: Better Health, Better Care, Better Lives',* which articulates our joint commitments with the population of Gwent through to 2035. This strategy will continue to guide the Health Board in all we do to achieve our ambition that by 2035 everyone has the same chance to live a long healthy life.

Signed:

Nicola Prygodzicz
Chief Executive
Dated: XX 2026

Attachment One

The Board has been constituted to comply with the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009. In addition to responsibilities and accountabilities set out in terms and conditions of appointment, Board members also fulfil Champion roles where they act as ambassadors for these matters.

Name	Designation	Dates (If not full year)	Attendance at Board Meetings	Champion Role
Independent Members				
Ann Lloyd	Chair		7 out of 7	
Philip Robson	Vice Chair		6 out of 7	Mental Health
Louise Wright	Independent Member (Trade Union)	Until 10/04/2025	0 out of 0	
Vivek Goel	Independent Member (Trade Union)	From 02/06/2025	4 out of 6	
Richard Clark	Independent Member (Local Authority)	Until 19/09/2025	2 out of 3	
Helen Cunningham	Independent Member (Local Authority)	From 03/11/2025	3 out of 3	
Professor Helen Sweetland	Independent Member (University)		6 out of 7	Research
Paul Deneen	Independent Member (Community)		7 out of 7	Children and Young People
Iwan Jones	Independent Member (Finance)		7 out of 7	Welsh Language
Dafydd Vaughan	Independent Member (Digital)		7 out of 7	
Neil Patrick	Independent Member (Community)		7 out of 7	Armed Forces
Penny Jones	Independent Member (Community)		7 out of 7	Speaking Up Safely
Akmal Hanuk	Independent Member (Third Sector)	From 02/06/2025	5 out of 6	

Name	Designation	Dates (If not full year)	Attendance at Board Meetings	Champion Role
Executive Directors				
Nicola Prygodzicz	Chief Executive		7 out of 7	
Hannah Evans	Director of Strategy, Planning and Partnerships		7 out of 7	Emergency Planning
Rob Holcombe	Director of Finance and Procurement		7 out of 7	
Dr James Calvert	Medical Director / Deputy Chief Executive	Until 05/08/2025	1 out of 3	Caldicot
Dr Andy Bagwell	Interim Medical Director	05/08/2025 to 26/10/2025	1 out of 1	
Dr Seema Srivastava	Medical Director	From 27/10/2025	3 out of 3	Caldicot
Sarah Simmonds	Director of Workforce and OD		6 out of 7	Raising Concerns Welsh Language
Jennifer Winslade	Director of Nursing		7 out of 7	
Peter Carr	Director of Allied Health Professions and Health Sciences		5 out of 7	Fire Safety Violence and Aggression
Tracy Daszkiewicz	Director of Public Health		7 out of 7	
Leanne Watkins	Chief Operating Officer		5 out of 7	
Directors in Attendance				
Paul Solloway	Director of Digital		7 out of 7	
Director of Corporate Governance				
Rani Dash	Director of Corporate Governance		7 out of 7	

Membership and attendance at Committees of the Board is provided on pages 17-28

Quoracy of Meetings

	Quorate	Non-Quorate

Board	21 May 2025	25 June 2025	16 July 2025	24 September 2025	26 November 2025	28 January 2026	25 March 2026	
Patient Quality, Safety and Outcomes Committee	31 March 2025	3 June 2025	29 July 2025 (meeting cancelled)	1 October 2025	2 December 2025	17 February 2026		
Audit, Risk and Assurance Committee	22 April 2025	20 May 2025	24 June 2025	18 September 2025	21 October 2025	16 December 2025	22 January 2026	12 February 2026
Charitable Funds Committee	4 June 2025	30 September 2025	7 January 2026	22 April 2026				
Partnerships, Population Health and Planning Committee	2 April 2025	1 July 2025	7 October 2025	27 January 2026				
Mental Health and Learning Disabilities Committee	9 April 2025	17 June 2025	9 September 2025	20 January 2025	24 March 2025			
Finance and Performance Committee	8 April 2025 (meeting cancelled)	17 June 2025	31 July 2025	29 September 2025	15 December 2025	23 February 2025		
People and Culture Committee	11 June 2025	15 October 2025	10 February 2026					

Remuneration and Terms of Service Committee	**19 May 2025**	**3 September 2025**	**4 February 2026**					

Attachment Two

Welsh Health Circulars

WHC No	Date Issued	Name of WHC	Rating
WHC/2025/004	14/04/2025	NHS Wales National Clinical Audit and Outcome Review Plan 2025 to 2026	Complete
WHC/2025/006	06/05/2025	Recording of Mental Health Outcome Measures	In Progress
WHC/2025/008	25/06/2025	Introduction of a National Mandatory Licensing Scheme for Special Procedures in Wales	In Progress
WHC/2025/010	11/04/2025	Changes to prescribing antiviral and antibody treatments for COVID-19	Complete
WHC/2025/011	11/04/2025	Identity Verification for Digital Health Services in Primary Care	Complete
WHC/2025/012	29/05/2025	Interim changes to NHS Model Standing Financial Instructions	Complete
WHC/2025/013	24/04/2025	NHS Wales Financial Monitoring Return Guidance 2025 to 2026	Complete
WHC/2025/015	22/04/2025	People's Experience framework	Complete
WHC/2025/016	06/05/2025	Update on NHS Wales Vaccination programme against respiratory syncytial virus (RSV)	Complete
WHC/2025/017	06/05/2025	Tranexamic acid use: Recommendation 7a of the Infected Blood Inquiry (IBI)	In Progress
WHC/2025/018	09/05/2025	Tirzepatide (Monjouro) for the management of obesity and overweight	Complete

WHC No	Date Issued	Name of WHC	Rating
WHC/2025/019	12/05/2025	Changes to the routine childhood vaccination schedule and to the selective hepatitis B vaccination programme	Complete
WHC/2025/020	06/06/2025	National Influenza Vaccination Programme 2025-26	In Progress
WHC/2025/021	03/06/2025	Introduction of routine vaccination programmes for prevention of mpox and gonorrhoea	In Progress
WHC/2025/022	26/06/2025	National Covid 19 Vaccination Programme autumn 2025	In Progress
WHC/2025/023	13/06/2025	PPE Stockpile volumes in Wales	Complete
WHC/2025/024	11/12/2025	NHS Wales hearing care: future approach to audiology services	In Progress
WHC/2025/025	11/07/2025	Overseas Visitors' Eligibility to Receive Primary Care	In Progress
WHC//2025/026	04/08/2025	The safe and responsible adoption of ambient voice technologies ('AI Scribes') in clinical and practice settings	In Progress
WHC/2025/027	16/07/2025	All-Wales gluten free subsidy card scheme (WHC/2025/027) | GOV.WALES	In Progress
WHC/2025/028	09/07/2025	Expansion of the shingles immunisation programme for severely immunosupressed individuals aged 18-49	In Progress
WHC/2025/029	14/07/2025	Introduction of new RSV passive immunisation from autumn 2025	Complete
WHC/2025/031	26/09/2025	Data standards notice of change for Waiting Well Single Point of Contact	Complete
WHC/2025/034	25/09/2025	Data Standards notice of change for Planned Care Referrals	In Progress

WHC No	Date Issued	Name of WHC	Rating
WHC/2025/037	25/09/2025	Infected Blood Inquiry: Implementing recommendation 7e, Shot Reports	In Progress
WHC/2025/038	22/09/2025	Accessible Communication and Information Standards in healthcare	In Progress
WHC/2025/039	23/10/2025	Antimicrobial resistance and healthcare associated infection Improvement goals for 2025-2027	In Progress
WHC/2025/042	20/10/2025	Update: NHS Wales national clinical audit and outcome review plan 2025 to 2026	Complete
WHC/2025/043	23/10/2025	New clinical pathway for treating and managing obesity	In Progress
WHC/2025/044	04/02/2026	Code of Practice Quality Assurance and Performance Management, Escalating Concerns, and Closure of Regulated Care and Support Services	In Progress
WHC/2025/045	30/10/2025	Changes to Standing Orders for the Joint Commissioning Committee	Complete
WHC/2025/046	31/10/2025	Routine varicella (chickenpox) vaccination programme for young children in Wales from 1 January 2026	Complete
WHC/2025/049	15/12/2025	Patient Travel Policy	Complete
WHC/2025/051	08/12/2025	Safety netting discharge leaflets for adults and children	In Progress
WHC/2025/052	15/01/2026	COVID 19 Spring Vaccination Programme 2026	Complete
WHC/2025/053	02/02/2026	Expansion of RSV vaccine eligibility to adults aged 80+ and residents in care	Complete

WHC No	Date Issued	Name of WHC	Rating
WHC/2025/054	17/12/2025	Pneumoccal vaccination product change	Complete
WHC/2025/055	19/12/2025	2026-27 Health Boad Allocation	Complete
WHC/2026/001	08/01/2026	Call4Concern: timelines and responsibilities	In Progress
WHC/2026/002	04/03/2026	Data standards notice of change for planned care activity	In Progress
WHC/2026/004	26/03/2026	Refreshed Intellectual Property guidance for NHS Wales Organisations.	In Progress
WHC/2026/007	24/02/2026	**Critical UK-wide Bone Cement Shortage - Immediate National Requirements for NHS Wales**	In Progress
WHC/2026/008	10/03/2026	NHS Research and Development Finance Policy	In Progress
WHC/2026/006	27/03/2026	Listening to people: The amended NHS Wales complaints, incidents and redress process	In Progress
WHC/2026/011	01/04/2026	Maternity Reporting Data Set (MR ds) - Data Requirements	In Progress
WHC/2026/017	31/03/2026	Welsh health Circular enabling community pharmacies to supply medicines ordered by optometrists as part or providing NHS care in Wales	Complete

Ministerial Directives

Date Issued	Ministerial Direction	Progress
22/04/2025	Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 2) Directions 2025 | GOV.WALES	**Implemented**
19/05/2025	The Primary Medical Services (Intra-Periarticular Injections) (Directed Supplementary Services (Wales) Directions 2025 | GOV.WALES	**Implemented**
19/05/2025	The Primary Medical Services (Minor Surgery) (Directed Supplementary Services (Wales) Directions 2025 | GOV.WALES	**Implemented**
30/05/2025	The Primary Care (Contracted Services: Immunisations) (Influenza) Directions 2025 | GOV.WALES	**Implemented**
09/06/2025	Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 3) Directions 2025 | GOV.WALES	**Implemented**
24/06/2025	Amendments to Model Standing Orders and Model Standing Financial Instructions – NHS Wales (WHC/2023/032) | GOV.WALES	**Implemented**
23/07/2025	Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 4) Directions 2025	**Implemented**
08/08/2025	Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 5) Directions 2025	**Implemented**
13/08/2025	The Primary Medical Services (Type 2 Diabetes Mellitus Care Scheme for Adults (Directed Supplementary Service) (Wales) (Amendment) Directions 2025 | GOV.WALES	**Implemented**
13/08/2025	The Primary Medical Services (Type 2 Diabetes Mellitus Care Scheme for Adults) (Directed Supplementary Service) (Wales) Directions 2024 | GOV.WALES	**Implemented**
04/09/2025	The Directions to Local Health Boards as to the General Dental Services Statement of Financial Entitlements (Wales) (Amendment) (No.4) Directions 2025	**Implemented**
04/09/2025	https://www.gov.wales/directions-local-health-boards-personal-dental-services-statement-financial-entitlements-wales	**Implemented**
30/09/2025	The directed supplementary services directions and specification for people living with severe frailty in their own homes 2025 | GOV.WALES	**Implemented**
14/10/2025	The Primary Care (Contracted Services: Outpatients Waiting Lists First Appointment Scheme) Directions and Specification 2025 | GOV.WALES	**Implemented**
11/11/2025	Statement of general ophthalmic services remuneration and fee directions: 2025 | GOV.WALES	**Implemented**
02/12/2025	Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 6) Directions 2025 | GOV.WALES	**Implemented**
03/12/2025	Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2026 | GOV.WALES	**Implemented**

Date Issued	Ministerial Direction	Progress
16/12/2025	Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 7) Directions 2025 | GOV.WALES	**Implemented**
22/12/2025	The Primary Medical Services (Minor Surgery) (Directed Supplementary Services (Wales) Directions 2025 | GOV.WALES	**Implemented**
23/12/2025	The Directions to Local Health Boards as to the General Dental Services Statement of Financial Entitlements (Wales) (Amendment) (No 5) Directions 2025 | GOV.WALES	**Implemented**
05/01/2026	Mental Health Review Tribunal for Wales (Membership) Bill | GOV.WALES	**Implemented**
14/01/2026	The Nursery Milk Scheme (Wales) Directions 2026 | GOV.WALES	**Implemented**
16/01/2026	The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 2) Directions 2026 | GOV.WALES	**Implemented**
04/02/2026	Code of Practice Quality Assurance and Performance Management, Escalating Concerns, and Closure of Regulated Care and Support Services 2026 | GOV.WALES	**Implemented**
04/02/2026	Code of Practice Quality Assurance and Performance Management, Escalating Concerns, and Closure of Regulated Care and Support Services (WHC/2025/044) | GOV.WALES	**Implemented**
04/02/2026	The Directions to Local Health Boards and NHS Trusts in Wales on Quality Assurance and Performance Management, Escalating Concerns, and Closure of Regulated Care and Support Services 2026 (NWSI 2026 No.17) | GOV.WALES	**Implemented**
05/02/2026	The Primary Care (Contracted Services: Immunisations) (RSV) Directions 2026 (NWSI 2026 No. 18) | GOV.WALES	**Implemented**
23/02/2026	The Primary Care (Contracted Services: Immunisations) (RSV) Directions 2024	**Implemented**
06/03/2026	The Wales Infected Blood Support Scheme (Amendment) Directions 2026 | GOV.WALES	**Implemented**
11/03/2026	Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 3) Directions 2026 | GOV.WALES	**Implemented**
13/03/2026	The Directions to Local Health Boards and NHS Trusts in Wales on Quality Assurance and Performance Management, Escalating Concerns, and Closure of Regulated Care and Support Services 2026 (NWSI 2026 No.17) | GOV.WALES	**Implemented**
19/03/2026	The Primary Medical Services (People Living with Severe Frailty in their own Homes) (Directed Supplementary Service) (Wales) (Amendment) Directions 2026 | GOV.WALES	**Implemented**
24/03/2026	https://www.gov.wales/mental-health-review-tribunal-for-wales-membership-act-2026#description-block	**Implemented**

Attachment Three

Corporate governance in central government departments: code of good practice 2017

Aneurin Bevan University Health Board Assessment 2025/26

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
2.1 2.2	Each organisation should have an effective board, which provides leadership for the business, helping it to operate in a business-like manner. The board should operate collectively, concentrating on advising on strategic and operational issues affecting the department's performance, as well as scrutinising and challenging departmental policies and performance, with a view to the long-term health and success of the Trust.	The Board meets in public on a bi-monthly basis. A forward work programme of Board Business is in place and approved on an annual basis. The work of the Board is guided and determined by its Standing Orders, Standing Financial Instructions and Schemes of Delegation. This provides the framework for delegation and decision making within the Health Board. The Board receives, as standing items to each meeting, finance, performance and corporate risk reports.	Comply	Board and Committee Minutes – demonstrate Scrutiny and support Audit Wales Structured Assessment 2025
2.3	The Board does not decide policy or exercise the powers of the ministers. The department's policy is decided by ministers alone on advice from officials. The board advises on the operational implications and effectiveness of policy proposals. The Board will operate according to recognised precepts of good corporate governance in business: • Leadership – articulating a clear vision for the department and giving clarity about how policy activities contribute to achieving this vision, including setting risk appetite and managing risk • Effectiveness – bringing a wide range of relevant experience to bear, including through offering rigorous challenge and scrutinising performance	The Board provides leadership and direction to the organisation and has a key role in ensuring that the organisation has sound governance arrangements in place. The Board seeks an open culture and high standards in the ways in which its work is conducted. Board Members share corporate responsibility for all decisions and undertake a key role in monitoring the performance of the organisation. Progress on the development and delivery of the Health Board's Integrated Medium-Term Plan 2026–29 is presented to the Board on a regular basis. The Health Board's Standing Orders and Standing Financial Instructions are designed to translate the	Comply	Standing Orders and Standing Financial Instructions Audit Wales Structured Assessment 2025 IMTP Value and Behaviours Framework

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
	• Accountability – promoting transparency through clear and fair reporting. • Sustainability – taking a long-term view about what the department is trying to achieve and what it is doing to get there.	statutory requirements into day to day operating practice, and, together with the adoption of a Schedule of Decisions reserved to the Board of Directors; a Scheme of Decisions to Officers and Others; and Standing Financial Instructions (SFIs), they provide the regulatory framework for the business conduct of the Health Board. These documents form the basis upon which the Health Board's governance and accountability framework is developed and, together with the adoption of the Health Board's Values and Behaviour Framework, is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.		
2.4 3.10	The Board should meet on at least a quarterly basis; however, best practice is that boards should meet more frequently. The Board advises on five main areas: • Strategic Clarity • Commercial Sense • Talented People • Results focus • Management information	The Board meets at least six times a year and in addition holds an Annual General Meeting. Discussions, actions and decisions of all meetings of the Board and its Committees are formally recorded as minutes or action notes. The Board's role, as set out in its Standing Orders, is to: • Set the strategic direction for the organisation • Hold the organisation to account for performance and delivery • Set the tone and culture of the Board and the organisation The Board's business is therefore structured in this way and encompasses the five main areas set out in point 2.4.	Comply	Standing Orders and Standing Financial Instructions Audit Wales Structured Assessment 2025 Board and Committee Agenda and Meeting Papers
2.7	The Board also supports the accounting officer in the discharge of obligations set out in Managing Public	The Board approves the Accountability Report, following scrutiny by the Audit, Risk and Assurance Committee, on an annual basis which includes the Statement by the	Comply	Accountability Report

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
	Money for the proper conduct of business and maintenance of ethical standards.	Accountable Officer assuring the Board on the System of Internal Control.		
2.12	Where Board members have concerns, which cannot be resolved, about the running of the department or a proposed action, they should ensure that their concerns are recorded in the minutes.	Any concerns raised at Board and Committee meetings are formally recorded in the minutes. The role of the Director of Corporate Governance is responsible for ensuring these matters are effectively managed, recorded and resolved where possible.	Comply	Board and Committee Agenda and Papers Role of the Director of Corporate Governance
3.1 3.11 3.12 3.13	The Board should have a balance of skills and experience appropriate to fulfilling its responsibilities. The membership of the board should be balanced, diverse and manageable in size.	Constitution is set out in the Health Board's Establishment Orders and the Health Board abides by this composition. The Health Board's Standing Orders also outlines the composition of the Board. The Board has a range of skills and expertise. Individuals are appointed to Independent Member or Executive roles based on their particular backgrounds and specialist knowledge. All Independent Member appointments including the Chair and Vice Chair are appointed by Welsh Government and the appointment processes are managed by the Public Appointments Department of Welsh Government. The appointment panels for all Executive appointments, although organisation appointments, will have external independent assessors and Welsh Government representation. All Executive Directors are appointed to permanent NHS contracts. Independent Members are appointed for up to four years at any one time and can be re-appointed	Comply	Health Board Establishment Orders Standing Orders Board Member Induction checklist

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
		up to a maximum of eight years in the organisation. This is controlled by Welsh Government as they are Ministerial appointments. The Board is provided with a range of information including performance information at Board and Committee Meetings. The format and content of these is informed by national standards and requirements and also locally requested information. Independent Member membership on Board Committees are rotated at appropriate times to ensure there is mix and balance of experience across all meetings		
3.2	The roles and responsibilities of all board members should be defined clearly in the department's board operating framework.	The Board is constituted in accordance with the Health Board's Establishment Orders and Standing Orders	Comply	Health Board Establishment Orders Standing Orders
3.3	The Finance Director should be professionally qualified.	The Director of Finance and Procurement is professionally qualified	Comply	Recruitment and appointment documentation for the Director of Finance and Procurement
3.5	Independent Members will exercise their role through influence and advice, supporting as well as challenging the executive	The Structured Assessment 2025 concluded that: *The Health Board has an effective Board supported by strong governance arrangements, with clear and high-quality information enabling the Board to discharge*	Comply	Audit Wales Structured Assessment 2025

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
		its duties. Board and committee meetings are well chaired, with Independent Members participating fully and providing appropriate scrutiny and challenge, particularly in relation to performance, finance and quality matters. Executive Directors were found to be open and transparent about the organisation's challenges and priority areas for action, and Board discussions were described as open and constructive, particularly when considering areas of risk and organisational pressure. The Health Board has robust arrangements in place to support Board capability and continuous improvement. There is a national programme of induction for Board members, coordinated by Health Education and Improvement Wales, alongside a locally tailored induction programme for new Independent Members. These arrangements are supported by an ongoing programme of Board Development Sessions, Board Briefings and targeted training. During 2025–26, the Board has been supported by the Good Governance Institute through a comprehensive Board development programme, focusing on how the Board works together, effective relationships, scrutiny and governance, and the provision of strategic, risk-based assurance. These development activities are used to strengthen Board effectiveness and collective leadership on an ongoing basis.		Independent Member Induction Pack
3.15	The Board should agree and document in its board operating framework a *de minimis* threshold and	A forward work programme of Board Business is in place and approved on an annual basis.		Board Forward Work Programme

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
	mechanisms for board advice on the operation and delivery of policy proposals.	The Terms of Reference Operating Arrangements for the Board Committees articulate their remit. A forward work programme for each Committee is in place and approved on an annual basis.		Committee Forward Work Programmes Committee Terms of Reference
4.1	The Board should ensure that arrangements are in place to enable it to discharge its responsibilities effectively, including: 1. formal procedures for the appointment of new board members, tenure and succession planning for both board members and senior officials 2. allowing sufficient time for the board to discharge its collective responsibilities effectively 3. induction on joining the board, supplemented by regular updates to keep board members' skills and knowledge up-to-date 4. timely provision of information in a form and of a quality that enables the board to discharge its duties effectively 5. a mechanism for learning from past successes and failures within the departmental family and relevant external organisations 6. a formal and rigorous annual evaluation of the board's performance and that of its committees, and of individual board members 7. a dedicated secretariat with appropriate skills and experience	All Independent Member appointments including the Chair and Vice Chair are appointed by Welsh Government and the appointment processes are managed by the Public Appointments Department of Welsh Government. All Executive appointments, although internal appointments have external independent assessors on the panels and also Welsh Government representation. The Director of Corporate Governance monitors the terms of office of Independent Members to ensure succession planning is timely and managed in conjunction with the public appointments unit. Agenda Setting meetings are held with the Chair, Chief Executive and Director of Corporate Governance to plan the agenda and ensure sufficient time is allocated to the right things at Board meetings. Board Induction programme in place (as previously referenced), supplemented by ongoing Board Briefing and Board Development sessions. The Chair undertakes regular one to ones and annual Personal Appraisal and Development Reviews with all Independent Members.		Terms of Reference and Operating Arrangements for Board and Committees Board and Committee Forward Work Programmes

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
		Agenda and papers for Board meetings are published one week prior to the meeting. Report templates are in place to support the provision of appropriate and relevant information. The Board's Quality Strategy and Quality Assurance Framework ensure learning as a key pillar of quality, embedded across the organisation. The Board undertakes an assessment of its effectiveness using the NHS England and NHS Improvement (NHSE and NHSI) Well-led Framework for Leadership and Governance Developmental Reviews. Committees undertook self assessments for 2025/26 during January which will inform the Board's end of year assessment.		
4.5	The terms of reference for the nominations committee will include at least the following three central elements: • scrutinising systems for identifying and developing leadership and high potential • scrutinising plans for orderly succession of appointments to the board and of senior management, in order to maintain an appropriate balance of skills and experience • scrutinising incentives and rewards for executive board members and senior officials, and advising on the extent to which these arrangements are effective at improving performance	The Terms of Reference and operating arrangements are based on the model Standing Orders and ensure that roles and responsibilities of Board Committees capture scrutiny and assurance roles. The Chair reviews the membership of Committees on an annual basis to ensure the appropriate balance of skills and expertise and support succession planning.	Comply	Terms of Reference for Board Committees Standing Orders
4.6	The attendance record of individual board members should be disclosed in the governance statement and	The Annual Governance Statement provides details on the membership of the Board and Committee and the attendance record of individuals at these meetings.	Comply	Annual Governance Statement

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
	cover meetings of the board and its committees held in the period to which the resource accounts relate.			
4.10	Where necessary, board members should seek clarification or amplification on board issues or board papers through the board secretary. The board secretary will consider how officials can best support the work of board members; this may include providing board members with direct access to officials where appropriate.	Independent Members of the Board have direct access to members of the executive team in order to seek further information or clarification on issues as and when they arise. Regular Board Development sessions and Board briefings are also held to ensure that Board members are kept up to date on the breadth of issues. The Director of Corporate Governance acts as an independent voice within the organisation to advise and support the Board on governance matters and its approach to openness and transparency. The Director of Corporate Governance is responsible for developing the programmes of work for the Board and Committees of the organisation. Ensuring that agenda and papers are developed and reviewed prior to publication to ensure the quality or reports and maximum transparency and openness in the way in which the organisation conducts its business.	Comply	Board Secretary role profile
4.11	An effective board secretary is essential for an effective board. Under the direction of the permanent secretary, the board secretary's responsibilities should include: • developing and agreeing the agenda for board meetings with the chair and lead non-executive board member, ensuring all relevant items are brought to the board's attention • ensuring good information flows within the board and its committees and between senior management and non-executive board members, including:	The Director of Corporate Governance undertakes these roles as Board Secretary for the Health Board	Comply	Board Secretary role description Standing Orders

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
	• challenging and ensuring the quality of board papers and board information • ensuring board papers are received by board members according to a timetable agreed by the board • providing advice and support on governance matters and helping to implement improvements in the governance structure and arrangements • ensuring the board follows due process • providing assurance to the board that the department: • complies with government policy, as set out in the code • adheres to the code's principles and supporting provisions on a comply or explain basis (which should form part of the report accompanying the resource accounts) • acting as the focal point for interaction between non-executive board members and the department, including arranging detailed briefing for non-executive board members and meetings between non-executive board members and officials, as requested or appropriate recording board decisions accurately and ensuring action points are followed up • arranging induction and professional development of board members (including ministers)			
4.14	Evaluations of the performance of individual board members should show whether each continues to contribute effectively and corporately and demonstrates	Individual annual assessment of Board Executive Directors is undertaken by the Chief Executive and Independent Members by the Chair, with the former	Comply	Appraisal documentation and process

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
	commitment to the role (including commitment of time for board and committee meetings and other duties).	reported to the Remuneration and Terms of Service Committee.		
4.15	All potential conflicts of interest for non-executive board members should be considered on a case by case basis. Where necessary, measures should be put in place to manage or resolve potential conflicts. The board should agree and document an appropriate system to record and manage conflicts and potential conflicts of interest of board members. The board should publish, in its governance statement, all relevant interests of individual board members and how any identified conflicts, and potential conflicts, of interest of board members have been managed.	Board Members complete annual Declarations of Interest, with a 6 monthly validation check, and this register is available on the Health Board's website. Declarations of Interest in relation to items on the agenda are also sought at each Board and Committee meeting and are formally recorded within the minutes. Standards of Business Conduct for Employees in place and details responsibilities for declarations of interests.	Comply	Declarations of Interest Register Standards of Business Conduct for Employees Policy
5.1 5.8	The board should ensure that there are effective arrangements for governance, risk management and internal control for the whole departmental family. Advice about and scrutiny of key risks is a matter for the board, not a committee. The board should be supported by: • an audit and risk assurance committee, chaired by a suitably experienced non-executive board member • an internal audit service operating to Public Sector Internal Audit Standards1 • sponsor teams of the department's key ALBs	The Health Board has established an Audit, Risk and Assurance Committee, chaired by the Independent Member Finance lead. NWSSP Internal Audit Services are appointed as the Health Boards Internal Auditors. The Health Board and its Committees monitor the management of risk considering the risks profile and actively engaging in its management.	Comply	Terms of Reference and Operating Arrangements for the Audit, Risk and Assurance Committee Accountability Report Audit Wales Structured Assessment
5.2 5.13	The board should take the lead on, and oversee the preparation of, the department's governance statement for publication with its resource accounts each year.	The Audit, Risk and Assurance Committee is responsible for reviewing the system of governance and assurance established within the Health Board and the arrangements for internal control, including risk management for the organisation and, in particular,	Comply	Accountability Report

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
	The annual governance statement (which includes areas formerly covered by the statement on internal control) is published with the resource accounts each year. In preparing it, the board should assess the risks facing the department and ensure that the department's risk management and internal control systems are effective. The audit and risk assurance committee should normally lead this assessment for the board.	advises on the Annual Governance Statement signed by the Chief Executive. The Governance Statement is included within the Accountability Report which is considered by the Audit, Risk and Assurance Committee prior to approval by the Board.		
5.3 5.10	The board's regular agenda should include scrutinising and advising on risk management.	The Health Board approve the Risk Management Framework. The Health Board and its Committees monitor the management of risk considering the risks profile and actively engaging in its management. A Strategic Risk Register is maintained and considered at each Board Meeting, and by the Audit, Risk and Assurance Committee. Each Committee monitors risks associated with its portfolio and provides assurance reports on these to the Board.		Board and Committee Agendas and papers Risk Management Strategy Board Assurance Framework Strategic Risk Register
5.4 5.9 5.11 5.12 5.14 5.15	The key responsibilities of non-executive board members include forming an audit and risk assurance committee. The board and accounting officer should be supported by an audit and risk assurance committee, comprising at least three members. An audit and risk assurance committee should not have any executive responsibilities or be charged with making	An Audit, Risk and Assurance Committee is established. The Terms of Reference and Operating Arrangements for the ARA Committee are clear in relation to authority and delegated responsibilities. These Terms of Reference are published on the Health Board's website. Full secretariat support is provided by the Corporate Governance Team.	Comply	Terms of Reference and Operating Arrangements for Audit, Risk and Assurance Committee Board Assurance Framework

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
	or endorsing any decisions. It should take care to maintain its independence. The audit and risk assurance committee should be established and function in accordance with the *Audit and risk assurance committee handbook.* The board should ensure that there is adequate support for the audit and risk assurance committee, including a secretariat function. The terms of reference of the audit and risk assurance committee, including its role and the authority delegated to it by the board, should be made available publicly. The department should report annually on the work of the committee in discharging those responsibilities Boards should ensure the scrutiny of governance arrangements, whether at the board or at one of its subcommittees (such as the audit and risk assurance committee or a nominations committee). This will include advising on, and scrutinising the department's implementation of, corporate governance policy.	The Board Assurance Framework is scrutinised by the Audit, Risk and Assurance Committee.		
5.5	The head of internal audit should periodically be invited to attend board meetings, where key issues are discussed relating to governance, risk management processes or controls across the department and its ALBs.	The role of Head of Internal Audit is clearly set out in the Health Board's Standing Orders. The Head of Internal Audit attends all meetings of the Audit, Risk and Assurance Committee. Audit Wales and Internal Audit have a routine invite to all Board and Committee meetings.	Comply	Standing Orders Terms of Reference for the Audit, Risk and Assurance Committee

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
5.6 5.7 5.10	The board should assure itself of the effectiveness of the department's risk management system and procedures and its internal controls. The board should give a clear steer on the desired risk appetite for the department and ensure that: • there is a proper framework of prudent and effective controls, so that risks can be assessed, managed and taken prudently • there is clear accountability for managing risks • Departmental officials are equipped with the relevant skills and guidance to perform their assigned roles effectively and efficiently. The board should also ensure that the department's ALBs have appropriate and effective risk management processes through the department's sponsor teams Advising on key risks is a role for the board. The audit and risk assurance committee should support the board in this role.	The Health Board has an agreed Risk Management Strategy which articulates a clear risk escalation pathway. A Risk Management Community of Practice is in place, led by the Head of Risk and Assurance.	Comply	Risk Management Strategy Strategic Risk Register

Remuneration and Staff Report 2025/26

The Treasury's Government Financial Reporting Manual (FReM) requires that a Remuneration Report shall be prepared by NHS bodies providing information under the headings in SI 2008 No 410, made to the extent that they are relevant. The Remuneration Report contains information about senior managers remuneration. The definition of 'Senior Manager' is: "those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS body. This means those who influence the decisions of the entity as a whole rather than the decisions of individual directorates or departments."

This section of the Accountability Report meets these requirements.

The Remuneration and Terms of Service Committee

Remuneration and Terms of Service for Executive Directors and the Chief Executive are agreed, and kept under review, by the Board's Remuneration and Terms of Service Committee. The Committee also monitors and evaluates the annual performance of the Chief Executive and individual Directors (the latter with the advice of the Chief Executive). In 2025/26, the Remuneration and Terms of Service Committee was chaired by the Health Board's Chair, Ann Lloyd CBE, and the membership included the following Members:

- Philip Robson, Vice Chair of the Board;
- Iwan Jones, Chair of Audit, Risk and Assurance Committee

Meetings are minuted and decisions fully recorded.

Independent Member Remuneration

Remuneration for Independent Members is determined by the Welsh Government, along with the tenure of appointments. Details of Independent Members' remuneration for the 2025/26 financial year, together with comparators are given in Tables below.

Directors' Remuneration

Details of Directors' remuneration for the 2025/26 financial year, together with comparators are given in Tables below. The norm is for Executive Directors and Senior Managers salaries to be uplifted in accordance with the Welsh Government identified normal pay inflation percentage. In 2025/26, Executive Directors received a pay inflation uplift, in-line with Welsh Government's Framework.

The Remuneration and Terms of Service Committee also reviews objectives set for Executive Directors and assesses performance against those objectives when considering recommendations in respect of annual pay uplifts. It should be noted that Executive Directors are not on any form of performance related pay. All contracts are permanent with a three-month notice period. Conditions are in line with those set by Welsh Government as part of the NHS Reform Programme of 2009.

The Remuneration and Terms of Service Committee considers issues of equality and diversity when evaluating and setting remuneration for Directors', particularly in relation to gender and ethnicity in pay levels, in line with Welsh Government's Framework.

Salary and Pension Disclosure Table: Salaries and Allowances (Audited position)

Salary and Pension entitlements of Senior Managers Remuneration

		2025-26					2024-25				
Name	**Title**	**Full Year Equivalent Salary (bands of £5,000)**	**Salary (bands of £5,000)**	**Benefits in kind (to nearest £100)**	**Pension Benefits**	**Total (bands of £5,000)**	**Full Year Equivalent Salary (bands of £5,000)**	**Salary (bands of £5,000)**	**Benefits in kind (to nearest £100)**	**Pension Benefits**	**Total (bands of £5,000)**
		£000	**£000**	**£00**	**£000**	**£000**	**£000**	**£000**	**£00**	**£000**	**£000**
Executive Directors											
Nicola Prygodzicz	Chief Executive	245 - 250	210 - 215	23	94	305 - 310	240 - 245	200 - 205	16	175	380 - 385
Dr James Calvert	Medical Director (Until 04.08.25) Deputy Chief Executive (Until 04.08.25)	230 - 235	80 - 85	0	0	80 - 85	225 - 230	225 - 230	0	92	315 - 320
Dr Andy Bagwell	Interim Medical Director (From 05.08.25 Until 26.10.25)	210 - 215	45 - 50	5	41	85 - 90					
Dr Seema Srivastava	Medical Director (From 27.10.25)	210 - 215	85 - 90	5	111	200 - 205					
Robert Holcombe	Director of Finance and Procurement	170 - 175	170 - 175	0	65	235 - 240	165 - 170	165 - 170	0	68	235 - 240
Hannah Evans	Director of Strategy, Planning and Partnerships	160 - 165	155 - 160	0	56	210 - 215	155 - 160	155 - 160	0	38	190 - 195
Jennifer Winslade	Director of Nursing Deputy Chief Executive (From 03.09.25)	170 - 175	155 - 160	18	66	220 - 225	155 - 160	140 - 145	12	20	160 - 165
Sarah Simmonds	Director of Workforce and Organisational Development	160 - 165	150 - 155	23	56	210 - 215	155 - 160	145 - 150	15	55	200 - 205
Peter Carr	Director of Therapies and Health Sciences	140 - 145	135 - 140	0	85	220 - 225	130 - 135	130 - 135	0	99	230 - 235
Tracy Daszkiewicz	Director of Public Health and Strategic Partnerships	155 - 160	150 - 155	0	44	195 - 200	150 - 155	150 - 155	0	44	195 - 200
Chief Operating Officer											
Leanne Watkins	Chief Operating Officer	160 - 165	150 - 155	22	88	240 - 245	155 - 160	140 - 145	17	59	205 - 210
Other Directors											
Rani Dash	Director of Corporate Governance	130 - 135	125 - 130	16	43	170 - 175	130 - 135	120 - 125	10	28	150 - 155
Paul Solloway	Director of Digital	135 - 140	125 - 130	16	44	170 - 175	130 - 135	120 - 125	9	150	270 - 275

Independent Members

Ann Lloyd CBE	Chair	70 - 75	70 - 75	0	0	70 - 75	65 - 70	65 - 70	0	0	65 - 70
Pippa Britton	Vice Chair (Until 30.11.24)						55 - 60	35 - 40	0	0	35 - 40
Philip Robson	Vice Chair (From 01.04.25) Special Advisor to the Board (Until 31.03.25)	55 - 60	55 - 60	0	0	55 - 60	15 - 20	15 - 20	0	0	15 - 20
Martin Blakebrough	Independent Member (Third Sector) (Until 08.06.24)						15 - 20	0 - 5	0	0	0 - 5
Akmal Hanuk	Independent Member (Third Sector) (From 02.06.25)	15 - 20	10 - 15	0	0	10 - 15					
Prof. Helen Sweetland	Independent Member (University)	15 - 20	15 - 20	0	0	15 - 20	15 - 20	5 - 10	0	0	5 - 10
Richard Clark	Independent Member (Local Authority) (Until 19.09.25)	15 - 20	5 - 10	0	0	5 - 10	15 - 20	15 - 20	0	0	15 - 20
Helen Cunningham	Independent Member (Local Authority) (From 03.11.25)	15 - 20	5 - 10	0	0	5 - 10					
Paul Deneen	Independent Member (Community)	15 - 20	15 - 20	0	0	15 - 20	15 - 20	15 - 20	0	0	15 - 20
Neil Patrick	Independent Member (Community)	15 - 20	15 - 20	0	0	15 - 20	15 - 20	15 - 20	0	0	15 - 20
Penny Jones	Independent Member (Community)	15 - 20	15 - 20	0	0	15 - 20	15 - 20	15 - 20	0	0	15 - 20
Dafydd Vaughan	Independent Member (Digital)	15 - 20	15 - 20	0	0	15 - 20	15 - 20	15 - 20	0	0	15 - 20
Iwan Jones	Independent Member (Finance)	15 - 20	15 - 20	0	0	15 - 20	15 - 20	15 - 20	0	0	15 - 20
Louise Wright	Independent Member (Trade Union) (Until 10.04.25)	0	0	0	0	0	0	0	0	0	0
Vivek Goel	Independent Member (Trade Union) (From 02.06.25)	0	0	0	0	0					

	2025-26	
	Pay	Ratio
Band of Highest paid Director's Total Remuneration £000	245 - 250	
25th percentile pay £	29,758	8.3:1
Median pay £	38,364	6.5:1
75th percentile pay £	49,046	5.0:1

	2024-25	
	Pay	Ratio
Band of Highest paid Director's Total Remuneration £000	240 - 245	
25th percentile pay £	29,484	8.2:1
Median pay £	37,030	6.5:1
75th percentile pay £	48,530	5.0:1

Salary has been reported as gross pay, after deduction of any salary sacrifice schemes. The following salary was sacrificed.

	2025-26			
	Lease Car Scheme	Home Electronics Scheme	Pensions Advice	Annual Leave Purchase
	£'000	£'000	£'000	£'000
Nicola Prygodzicz	9			
Dr Andy Bagwell	2			
Dr Seema Srivastava	2		<1	
Hannah Evans				3
Jennifer Winslade	12			
Sarah Simmonds	8			
Tracy Daszkiewicz				3
Leanne Watkins	8	1		
Rani Dash	9			
Paul Solloway	9			

	2024-25			
	Lease Car Scheme	Home Electronics Scheme	Pensions Advice	Annual Leave Purchase
	£'000	£'000	£'000	£'000
Nicola Prygodzicz	9		<1	
Dr Andy Bagwell				
Dr Seema Srivastava				
Hannah Evans				
Jennifer Winslade	12			
Sarah Simmonds	8		<1	
Tracy Daszkiewicz				
Leanne Watkins	11	1		
Rani Dash	9			
Paul Solloway	9			

The amount of pension benefits for the year which contributes to the single total figure is calculated using a similar method to that used to derive pension values for tax purposes and is based on information received from NHS BSA Pensions Agency.

The value of pension benefits is calculated as follows:
(real increase in pension* x20) + (real increase in any lump sum) – (contributions made by member)
*excluding increases due to inflation or any increase of decrease due to a transfer of pension rights

This is not an amount which has been paid to an individual by the Health Board during the year, it is a calculation which uses information from the pension benefit table. These figures can be influenced by many factors e.g. changes in a persons salary, whether or not they choose to make additional contributions to the pension scheme from their pay and other valuation factors affecting the pension scheme as a whole.

Ann Lloyd 2025-26 salary includes £1k backpay.

Prof. Helen Sweetland has been remunerated since 1st September 2024.

Former Chief Executive Andrew Goodall has been seconded to Welsh Government since 8th June 2014. Welsh Government Accounts has disclosed remuneration received, the Health Board was reimbursed for the employment costs incurred. The salary for Andrew Goodall for 2025-26 was between £250,000 to £255,000 (£240,000 to £245,000 2024-25).

Remuneration Report continued

Salary and Pension entitlements of Senior Managers Pension Benefits

Name	Title	Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31 March 2026 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2026 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2026 £000	Cash Equivalent Transfer Value at 31 March 2025 £000	Real increase in Cash Equivalent Transfer Value £000	Employer's contribution to stakeholder pension £00
Nicola Prygodzicz	Chief Executive	5.0 - 7.5	2.5 - 5.0	90 - 95	235 - 240	2,140	1,974	106	0
Dr James Calvert	Medical Director / Deputy Chief Executive	0.0	0.0	95 - 100	235 - 240	2,361	2,404	0	0
Dr Andy Bagwell	Interim Medical Director	2.5 - 5.0	2.5 - 5.0	60 - 65	150 - 155	1,413	1,174	44	0
Dr Seema Srivastava	Medical Director	5.0 - 7.5	10.0 - 12.5	65 - 70	165 - 170	1,443	1,138	111	0
Robert Holcombe	Director of Finance and Procurement	2.5 - 5.0	2.5 - 5.0	65 - 70	165 - 170	1,596	1,474	75	0
Hannah Evans	Director of Strategy, Planning and Partnerships	2.5 - 5.0	0.0 - 2.5	50 - 55	115 - 120	1,055	964	54	0
Jennifer Winslade	Director of Nursing / Deputy Chief Executive	2.5 - 5.0	2.5 - 5.0	65 - 70	160 - 165	1,573	1,449	81	0
Sarah Simmonds	Director of Workforce and Organisational Development	2.5 - 5.0	0.0 - 2.5	45 - 50	100 - 105	939	852	53	0
Peter Carr	Director of Therapies and Health Sciences	2.5 - 5.0	5.0 - 7.5	55 - 60	135 - 140	1,245	1,118	91	0
Tracy Daszkiewicz	Director of Public Health and Strategic Partnerships	2.5 - 5.0	0.0	20 - 25	0	344	288	32	0
Leanne Watkins	Chief Operating Officer	5.0 - 7.5	5.0 - 7.5	60 - 65	155 - 160	1,339	1,212	88	0
Rani Dash	Director of Corporate Governance	2.5 - 5.0	0.0 - 2.5	35 - 40	75 - 80	643	585	33	0
Paul Solloway	Director of Digital	2.5 - 5.0	0.0 - 2.5	50 - 55	125 - 130	1,109	1,029	47	0

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

Pensions tax annual allowance – Scheme Pays arrangements 2019/20

In accordance with a Ministerial Direction issued on 18 December 2019, the Welsh Government have taken action to support circumstances where pensions tax rules are impacting upon clinical staff who want to work additional hours, and have determined that:

Clinical staff who are members of the NHS Pension Scheme and who, as a result of work undertaken in the 2019-20 tax year, face a tax charge on the growth of their NHS pension benefits, may opt to have this charge paid by the NHS Pension Scheme, with their pension reduced on retirement.

Welsh Government, on behalf of the Aneurin Bevan University Health Board, will pay the members who opt for reimbursement of their pension, a corresponding amount on retirement, ensuring that they are fully compensated for the effect of the deduction.

This scheme will be funded directly by the Welsh Government to the NHS Business Services Authority Pension Division, the administrators on behalf of the Welsh claimants.

Clinical staff had until 31 March 2022 to opt for this scheme and the ability to make changes up to 31 July 2026.

The Health Board have included a Scheme Pay provision of £689,932 (£685,920, 2024-25) as notified by Welsh Government within these accounts.

Remuneration Relationship (Audited position)

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director/employee in their organisation and the 25th percentile, median and 75th percentile remuneration of the organisation's workforce.

Total Pay and benefits				**£'000**				**£'000**
Chief Executive Total pay and benefits range				**245-250**				**240-245**
Highest paid Director Total pay and benefits range				**245-250**				**240-245**
		2025-26	**2025-26**	**2025-26**		2024-25	2024-25	2024-25
		£'000	**£'000**			£'000	£'000	
Total pay and benefits mid-point		**Chief Executive**	**Employee**	**Ratio**		Chief Executive	Employee	Ratio
	25th percentile pay ratio	**245 - 250**	**30**	**8.3:1**		240 - 245	29	8.2:1
	Median pay	**245 - 250**	**38**	**6.5:1**		240 - 245	37	6.5:1
	75th percentile pay ratio	**245 - 250**	**49**	**5.0:1**		240 - 245	49	5.0:1
Salary component of total pay and benefits								
	25th percentile pay ratio	**245 - 250**	**30**			240 - 245	29	
	Median pay	**245 - 250**	**38**			240 - 245	37	
	75th percentile pay ratio	**245 - 250**	**49**			240 - 245	49	
Total pay and benefits mid-point		**Highest Paid Director**	**Employee**	**Ratio**		Highest Paid Director	Employee	Ratio
	25th percentile pay ratio	**245 - 250**	**30**	**8.3:1**		240 - 245	29	8.2:1
	Median pay	**245 - 250**	**38**	**6.5:1**		240 - 245	37	6.5:1
	75th percentile pay ratio	**245 - 250**	**49**	**5.0:1**		240 - 245	49	5.0:1
Salary component of total pay and benefits								
	25th percentile pay ratio	**245 - 250**	**30**			240 - 245	29	
	Median pay	**245 - 250**	**38**			240 - 245	37	
	75th percentile pay ratio	**245 - 250**	**49**			240 - 245	49	

In 2025-26 14 (2024-25, 15) employees received remuneration in excess of the highest-paid director.

Remuneration for all staff ranged from £17k to £371k (2024-25, £17k to £459k).

The all staff range includes directors with the exception of the highest paid CEO Director as appropriate and excludes the non-executive directors and excludes pension benefits of all employees.

Financial Year Summary

The 2025-26 pay ratio is comparable with 2024-25 with minimal variation. The median pay ratio for the relevant financial year is consistent with the pay, reward and progression policies for the entity's employees taken as a whole.

9.6.2 Percentage Changes		2024-25 to 2025-26	2023-24 to 2024-25
% Change from previous financial year in respect of Chief Executive		%	%
	Salary and allowances	2	7
	Performance pay and bonuses	0	0
% Change from previous financial year in respect of highest paid director			
	Salary and allowances	2	7
	Performance pay and bonuses	0	0
Average % Change from previous financial year in respect of employees takes as a whole			
	Salary and allowances	1	5
	Performance pay and bonuses	0	0

STAFF REPORT

Staff Numbers (Audited position)

9.2 Average number of employees	Permanent Staff	Staff on Inward Secondment	Agency Staff	Specialist Trainee (SLE)	Collaborative Bank Staff	Other	Total	2024-25
	Number	Number	Number	Number	Number	Number	Number	Number
Administrative, clerical and boarc	2,800	8	11	0	0	0	2,819	2,722
Medical and dental	890	5	39	447	0	13	1,394	1,339
Nursing, midwifery registered	4,180	0	111	0	0	0	4,291	4,121
Professional, Scientific, and tech	455	0	10	0	0	0	465	433
Additional Clinical Services	2,910	0	23	0	0	0	2,933	2,903
Allied Health Professions	981	5	14	0	0	0	1,000	982
Healthcare Scientists	258	0	2	0	0	0	260	257
Estates and Ancilliary	1,081	0	25	0	0	0	1,106	1,054
Students	3	0	0	0	0	0	3	6
Total	13,558	18	235	447	0	13	14,271	13,817

The data above represents an average over 52 weeks of the year and includes agency workers and specialist trainees. There has been a small increase in staff in post overall. The strategic work to reduce agency over the past 12 months has been successful along with reducing vacancies.

Turnover has increased to 9.02% compared to the previous year of 8.67%.

In the last 12 months staff in post has increased by 2.18%. The largest increases have been within Medical & Dental staff increased by 4.36% and Nursing and Midwifery increased by 3.63%.

Retirements Due to Ill Health

This note discloses the number and additional pension costs for individuals who retired early on ill-health grounds during the year. These additional pension costs have been calculated on an average basis and will be borne by the NHS Pension Scheme.

9.3. Retirements due to ill-health

	2025-26	2024-25
Number	15	16
Estimated additional pension costs £	962,243	1,456,012

Staff Composition

The table below provides the breakdown of staff numbers split by Directors and all other staff within the Health Board.

The gender breakdown for all staff groups as of 31 March 2026 is provided below:

	2025-26			2024-25			2023-24		
	Directors	WTE	%	Directors	WTE	%	Directors	WTE	%
Female	7.85	10,901	79.54%	7.85	10,682	79.67%	8.00	10,413	76.60%
Male	3.00	2,804	20.46%	3.00	2,742	20.33%	4.00	2,669	20.40%
Total	**10.85**	**13,705**		**10.85**	**13,424**		**12.00**	**13,082**	

Sickness Absence Data

The Health Board's sickness absence rate for 2025/26 was 6.55%. This is an increase from 6.44% in 2024/25 and 6.10% in 2023/24. During the period sickness absence remained above 6% from June 2025 to February 2026 reducing to 5.94%, in March 2026. December 2025 recorded the highest in month sickness absence rate at 7.46%.

The table below provides the sickness absence trend data for the Health Board over the last eleven years.

Sickness Absence	Data Calculations	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
WTE Days Lost (Short Term <28 days)	The WTE days Lost due to sickness calculates the impact of sickness absence based on the employees contracted hours **WTE days lost x FTE by the number of calendar days absent**	61261	53097	60406	54759	68229	60411	79761	98573	85948	86029	86865
WTE Days Lost (Long Term >28 days)		144562	147711	153345	162684	194289	188778	203781	205131	207218	223369	237875
Total WTE Days Lost		205823	200808	213751	217443	262518	249189	283542	303704	293166	309398	324740
Sickness Absence %		5.23%	5.26%	5.23%	5.29%	5.79%	6.51%	6.51%	6.73%	6.21%	6.44%	6.55%
Total Staff Years	**WTE days lost / 365 days per year**	564	550	586	596	719	683	777	832	803	848	890
Average Working Days Lost	**WTE days lost / headcount**	14.7	14.2	15.2	15.2	15.2	16	17.2	18	17.5	18.08	18.71
Total staff employed in period (headcount)	**Avg headcount as at March each year**	14020	14155	10412	14334	14835	15528	15863	16245	16735	17111	17352
Total staff employed with no absence (Headcount)	**Avg headcount without absence/headcount available**	5608	5803	5852	5016	5340	6055	5710	5035	5188	5133	5379
Percentage staff with no sick		40%	41%	37%	35%	36%	39%	36%	31%	31%	30%	31%
Source: Electronic Data Record (ESR) All data has been sourced via ESR BI Reports												

The Sickness Absence Focus Group supports the People Plan and Health Board objectives by reviewing attendance trends and identifying ways to reduce sickness absence. The work is taken forward through its subgroups:

- Education and Training
- Stress, Anxiety & Depression
- Data Analysis
- Communications & Engagement

Staff Policies

Aneurin Bevan University Health Board has a robust framework of Policies and Procedures to enable appropriate action in order to discharge its statutory requirements and appropriate accountability for:

- Giving full and fair consideration to applications for employment made by disabled persons or other protected characteristics, having regard to their particular aptitudes and abilities;
- Continuing the employment of and for arranging appropriate training for employees, who have become disabled persons during the period when they were employed by the company;
- For the training, career development and promotion of staff with protected characteristics persons employed by the Health Board.

Staff policies renewed or newly applied during the reporting period 01 April 2025 to 31 March 2026 include:

- All Wales Procedure for Staff to Raise Concerns (review)

- All Wales Anti Sexual Harassment Policy (new)
- All Wales Flexible Working Policy (review)
- All Wales Organisational Change Policy (review)
- Internal Lateral Transfer Scheme (new)
- Neonatal Care Leave and Pay Policy (new)
- Manual Handling Policy (review)
- Nursing and Midwifery Professional Regulation Policy (review)
- People in Positions of Trust (PiPoT) (new)
- The use of Restrictive Physical Intervention (RPI) Policy (review)
- Using the Welsh Language Internally Staff Policy (review)
- Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) Policy (review)
- Violence Prevention and Reduction Policy (review)
- All Wales Reserve Forces Training and Mobilisation Policy (review)
- Employment Break Scheme (review)
- Unpaid Parental Leave Policy (review)
- Paternity Leave Policy (review)
- Roster Policy (review)
- Adverse Weather (review)
- Health and Safety Policy (review)
- Professional Regulation Policy (review)
- Preceptorship Policy (review) Recruitment and selection policy (new)
- Keeping of Personal Records Policy (review)
- Maternity and Adoption Leave Policy (review)
- Annual Leave and Statutory Holidays Policy for Non -Medical and Dental Staff (review)

Between 01 April 2025 and 31 March 2026, the following policies were identified as being superseded by All Wales policies previously implemented within the Health Board and were therefore decommissioned Banding of New Posts Policy

- Re-evaluation of Existing Posts Policy

All policies are developed in partnership with Trades Union colleagues and are assessed via an Equality Impact Assessment to ensure that every policy is fair and does not present barriers to participation or disadvantage any protected groups from participation.

Employee Relations Matters

Details of the number of disciplinary cases between 01 April 2025 to 31 March 2026 is provided below:

Disciplinary Cases	Dismissals	Appeals	Employment Tribunals	Upholding Professional Standards in Wales	Respect and Resolution	Capability
71	6	3	9	5	34	11

The Health Board has continued to apply the principles of its avoidable employee harm programme of work to disciplinary investigations, to consider the impact on the people involved and improved application of process. Work is ongoing to embed the avoidable employee harm approach in the management of Respect and Resolution cases.

Improved initial assessments of situations have supported proportionate and appropriate management of misconduct that emphasises opportunities for learning and continuous improvement. Where applicable, alternative policies have been applied, resulting with an increase in the application of alternative policies and procedures such as respect and resolution and capability.

Payment to Past Directors (Audited position)

No payments have been made to any person who was not a director at the time the payment was made, but who had been a director of the Health Board previously.

Expenditure on Consultancy

Supplier	**Services provided**	**Amount**
		£p
Boo Coaching & Consulting Ltd	Coaching Consultancy Support for the Board	11,400
Dorset Software Services Ltd	G Cloud Focus Consultancy Services	588,539
Ernst & Young LLP	VAT Consultancy & Advisory Services	29,806
Supportive Care UK	Consultant Support to the Specialist Palliative Care Service	18,900
Total Consultancy 2025/26		**648,645**

Expenditure on Temporary Staff

	£000
Administrative, Clerical and board members	436
Medical and dental	10,528
Nursing, midwifery registered	8,242
Professional, Scientific, and technical staff	1,159
Additional Clinical Services	1,440
Allied Health Professions	1,495
Healthcare Scientists	250
Estates and Ancillary	1,333
Total	**24,883**

Tax Assurance for Off-payroll Engagements

Table 1: For all off-Payroll engagements as of 31 March 2026, for more than £245 per day

No. of exisiting Engagements as of 31 March 2026	**2**
Of which, the number that have existed:	
for less than one year at time of reporting	0
for between one and two years at time of reporting	1
for between two and three years at time of reporting	0
for between three and four years at time of reporting	0
for four or more years at time of reporting	1

Table 2: For all new off-Payroll engagements between 1 April 2025 and 31 March 2026, for more than £245 per day

Number of new engagements between 1 April 2025 and 31 March 2026	2
Of which...	
No. assessed as caught by IR35	0
No. assessed as not caught by IR35	2
No. engaged directly (via contracted to department) and are on the departmental payroll	0
No. of engagements reassessed for consistency/assurance purposes during the year	0
No. of engagements that saw a change to IR35 status following the consistency review	0

Exit Packages and Severance Payments (Audited position)

9.5 Reporting of other compensation schemes - exit packages				
9.5.1 Exit Packages Costs and Numbers				
	2025-26	2025-26	2025-26	2025-26	2024-25
Exit packages cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures	Total number of exit packages	Number of departures where special payments have been made	Total number of exit packages
	Whole numbers only	Whole numbers only	Whole numbers only	Whole numbers only	Whole numbers only
less than £10,000	0	0	0	0	1
£10,000 to £25,000	0	0	0	0	0
£25,000 to £50,000	0	0	0	0	0
£50,000 to £100,000	0	3	3	3	0
£100,000 to £150,000	0	1	1	1	0
£150,000 to £200,000	0	0	0	0	0
more than £200,000	0	0	0	0	0
Total	0	4	4	4	1

	2025-26	2025-26	2025-26	2025-26	2024-25
Exit packages cost band (including any special payment element)	Cost of compulsory redundancies	Cost of other departures	Total cost of exit packages	Cost of special element included in exit packages	Total cost of exit packages
	£	£	£	£	£
less than £10,000	0	0	0	0	7,500
£10,000 to £25,000	0	0	0	0	0
£25,000 to £50,000	0	0	0	0	0
£50,000 to £100,000	0	204,086	204,086	204,086	0
£100,000 to £150,000	0	108,975	108,975	108,975	0
£150,000 to £200,000	0	0	0	0	0
more than £200,000	0	0	0	0	0
Total	0	313,061	313,061	313,061	7,500

Total Exit Costs Paid in Year	Total paid in year		Total paid in year
	2025-26		2024-25
	£		£
Exit costs paid in year	204,086		7,500
Total	204,086		7,500

This disclosure reports the number and value of exit packages agreed in the year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period.

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Voluntary Early Release Scheme (VERS).

Where the LHB has agreed early retirements, the additional costs are met by the LHB and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

The figures above are consolidated amounts.

The Health Board has approved four VERS in 2025-26.

Additional requirement as per FreM

£0 exit costs were paid in 2025-26, relating to 2024-25 (the year of departure).

Senedd Cymru / Welsh Parliamentary Accountability and Audit Report 2025/26

Regularity of Expenditure
Regularity of Expenditure Regularity is the requirement for all items of expenditure and receipts to be dealt with in accordance with the legislation authorising them, any applicable delegated authority and the rules of Government Accounting.

Aneurin Bevan University Health Board ensures that the funding provided by Welsh Ministers has been expended for the purposes intended by Welsh Ministers and that the resources authorised by Welsh Ministers to be used have been used for the purposes for which the use was authorised.

The Health Board's Chief Executive is the Accountable Officer and ensures that the financial statements are prepared in accordance with legislative requirements and the Treasury's Financial Reporting Manual. In preparing the financial statements, the Chief Executive is required to:

- observe the accounts directions issued by Welsh Ministers, including the relevant accounting and disclosure requirements and apply appropriate accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards have been followed and disclosed and explain any material departures from them; and
- prepare them on a going concern basis on the presumption that the services of the Health Board will continue in operation.

Fees and charges
Where the Health Board undertakes activities that are not funded directly by the Welsh Government the Health Board receives income to cover its costs which will offset expenditure reported under programme areas. Miscellaneous Income can be seen in Note 4 (page XX) of the Annual Accounts 2025/26. When charging for this activity the Health Board has complied with the cost allocation and charging requirements set out in HM Treasury guidance.

The Health Board incurred costs amounting to £0.470m for the provision of the statutory audit by Audit Wales for the period 2025/26.

Managing public money
This is the required Statement for Public Sector Information Holders as referenced in the Directors' Report. In line with other Welsh NHS bodies, the Health Board has adopted standing financial instructions which enforce the principles outlined in HM Treasury guidance 'Managing Public Money' which sets out the main principles for dealing with resources in the UK public sector. As a result, the Health Board should have complied with the cost allocation and charging requirements of this guidance. The

Health Board has not been made aware of any instances where this has not been done.

Remote Contingent Liabilities

This disclosure was introduced for the first time in 2015-16. It shows those contingent liabilities that are deemed to be extremely remote and have not been previously disclosed within the normal contingent liability note within the accounts.

The 2025/26 remote contingent liabilities consist of 1 medical negligence case and 1 GP Indemnity case (3 medical negligence cases and 1 personal injury case in 2024/25). Should these cases progress the majority of the costs incurred, in excess of £25k per case attributable to the Health Board, will be recovered from the Welsh Risk Pool.

Nicola Prygodzicz
Chief Executive **Date: XX July 2026**

THE CERTIFICATE AND INDEPENDENT AUDITOR'S REPORT OF THE AUDITOR GENERAL FOR WALES TO THE SENEDD

TO BE ADDED ONCE AVAILABLE

Report of the Auditor General to the Senedd

TO BE ADDED WHEN AVAILABLE

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	19 May 2026
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Draft Annual Accounts 2025/26
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Rob Holcombe, Director of Finance, Procurement and Value Based Health Care
SWYDDOG ADRODD: **REPORTING OFFICER:**	Robert Jones, Assistant Finance Director – Financial Systems and Services

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report gives an overview of the accounts for the full year to 31 March 2025 for Aneurin Bevan University Health Board. The accounts are prepared under International Financial Reporting Standards (IFRS).

The report supports the accounts (attached) and describes the reasons for key movements in the figures between 2024/25 and 2025/26.

The accounts are draft at this stage and subject to audit.

The Audit, Risk & Assurance Committee is asked to note this report.

Cefndir / Background

The production of annual accounts is a statutory requirement for the Health Board. Timescales for production are set by Welsh Government (WG). The draft accounts

were submitted on time to WG on 1st May. The final audited and signed accounts are to be submitted by 30th June.

The Audit, Risk & Assurance Committee have received updates on the planning process for producing this year's accounts. The accounts were delivered in line with the plan and the external audit is now well underway.

Asesiad / Assessment

1. Financial Performance and Financial Results

KPI	2023/24 £000	2024/25 £000	2025/26 £000	Commentary
Deliver Against Revenue Resource Limit	(49,754)	(7,185)	(18,282)	Not achieved
Breakeven over a rolling three-year period	(86,359)	(93,793)	(75,233)	Not achieved
Deliver Against Capital Resource Limit	41	66	47	Achieved
Pay 95% non-NHS trade creditors within 30 days	97.4%	97.7%	97.1%	Achieved
Hold a year end cash balance not exceeding £6m	£4.145m	£4.823m	£5.551m	Achieved

The Health Board has two statutory financial duties:

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

Under the rolling 3-year duty, introduced with the NHS (Wales) Act 2014, the first assessment of the first statutory financial duty took place at the end of 2016/17 when it was achieved. The Health Board has **not met** its financial duty to breakeven against its Revenue Resource Limit over 3 years 2023/24 to 2025/26.

In relation to the second duty, the Health Board submitted a balanced Integrated Medium-Term Plan for the period 2025-2028 in accordance with NHS Wales Planning Framework, however the Board was unable to deliver the ambitious financial plan and a deficit was incurred. The note in the accounts shows that this duty was **not achieved**. (Note 2.3.)

Revenue Resource Performance (Note 2.1, *Page 28*)

The Health Board deficit position increased to £18.282m in 2025/26 from £7.185m, and consequently did not meet its Revenue Resource Limit for the year.

In December 2025, the Welsh Government placed the Health Board under intensified intervention, moving it from level three to level four on the government's five-point scale. The intervention covers finance, strategy, and planning, along with performance and outcomes related to urgent and emergency care.

Against the breakeven duty over a rolling three-year period, the Annual Accounts 2025/26 reported an overspend of £75.233m as shown in the table below:

3-year revenue breakeven duty	2023/24 £000	2024/25 £000	2025/26 £000	Total £000
Underspend/(overspend) against allocation	(49,754)	(7,185)	(18,282)	(75,233)

The Health Board submitted an Annual Plan for 2026/27 with a 3-year intent to get back to a sustainable, breakeven position in the 3-year period.

Capital Resource Performance (Note 2.2, *Page 28*)

In addition to a revenue resource limit the Health Board has a capital resource limit (CRL) that sets the target for capital expenditure. The target of £45.305m was **achieved** in 2025/26 with a small underspend of £0.047m. The target is measured over a 3-year period as shown in the table below:

3-year capital breakeven duty	2023/24 £000	2024/25 £000	2025/26 £000	Total £000
Underspend against allocation	41	66	47	154

Public Sector Payment Policy (Note 2.4, *Page 29*)

The Health Board is required to pay at least 95% of its non-NHS trade creditors within 30 days. The target was **achieved** with full year figure of 97.1%, reflecting the best performing Health Board in Wales for 2025/26.

Cash Balance (Statement of Cash Flows, *Page 7*)

WG sets a notional target for Health Boards to have end of period cash balances not exceeding £6m. The actual cash balance was £5.551m and therefore the target was **achieved**.

2. Commentary Supporting Significant Movements to Previous Year's Annual Accounts

This year has been challenging for the NHS and our wider communities. Several significant factors have impacted our accounts, contributing to the reported overspend of £18.3m. The following section outlines significant movements that have contributed to this position:

2.1. Expenditure on Primary Healthcare Services (Note 3.1, *Page 30*)

Line	Note	2025/26 £'m	2024/25 £'m	Change £'m	Change %
Expenditure on Primary Healthcare Services	3.1 Pg 30	366.8	351.9	+14.9	+42.4

Overall expenditure on Primary Healthcare services has increased by £14.9m.

This is broken down as:

Note 3.1	Total 2025/26	Total 2024/25	Movement
	£M	£M	£M
General Medical Services	140.0	132.7	7.4
Pharmaceutical Services	29.4	29.2	0.2
General Dental Services	45.8	44.4	1.3
General Ophthalmic Services	17.3	15.1	2.2
Other Primary Health Care expenditure	3.7	4.7	-1.0
Prescribed drugs and appliances	130.7	125.8	4.9
Total	**366.8**	**351.9**	**14.9**

General Medical Services: £7.4m - The main increase is due to increases in staffing costs in relation to Managed Practices, totalling £7.6m. This has been supported by corresponding Global SUM income, of £6.4m, recognised in Note 4 – Other Income.

Managed practices can often incur higher costs compared to independent contractor partner led models due to the absence of traditional partnership risk sharing and efficiencies. In a managed practices the Health Board typically assumes full responsibility for staffing, estates, and operational oversight, which can lead to increased expenditure through reliance on salaried GP models, locum cover, agenda for change pay scales, terms and conditions. There may also be reduced financial flexibility and fewer opportunities for efficiencies or income generation that would normally sit with independent contractor partners. Additionally, challenges in recruitment and retention can further increase costs, particularly where premium or agency staff are required to maintain service continuity and or assume leadership roles and responsibilities.

This increase from managed practices has been offset by fluctuations in other areas, in particular Dispensing which has seen a reduction of £2m as a result of the decision by Welsh Government to centrally manage the procurement of Flu Vaccines. Other movements relate to an increase in other Staff costs of £1.2m as a result of the pay award.

General Dental Services: £1.3m – Increases to the Main Dental Contract of £0.9m aligned with the increase to the allocation received. There were also increases to Staffing Costs because of the Pay Award.

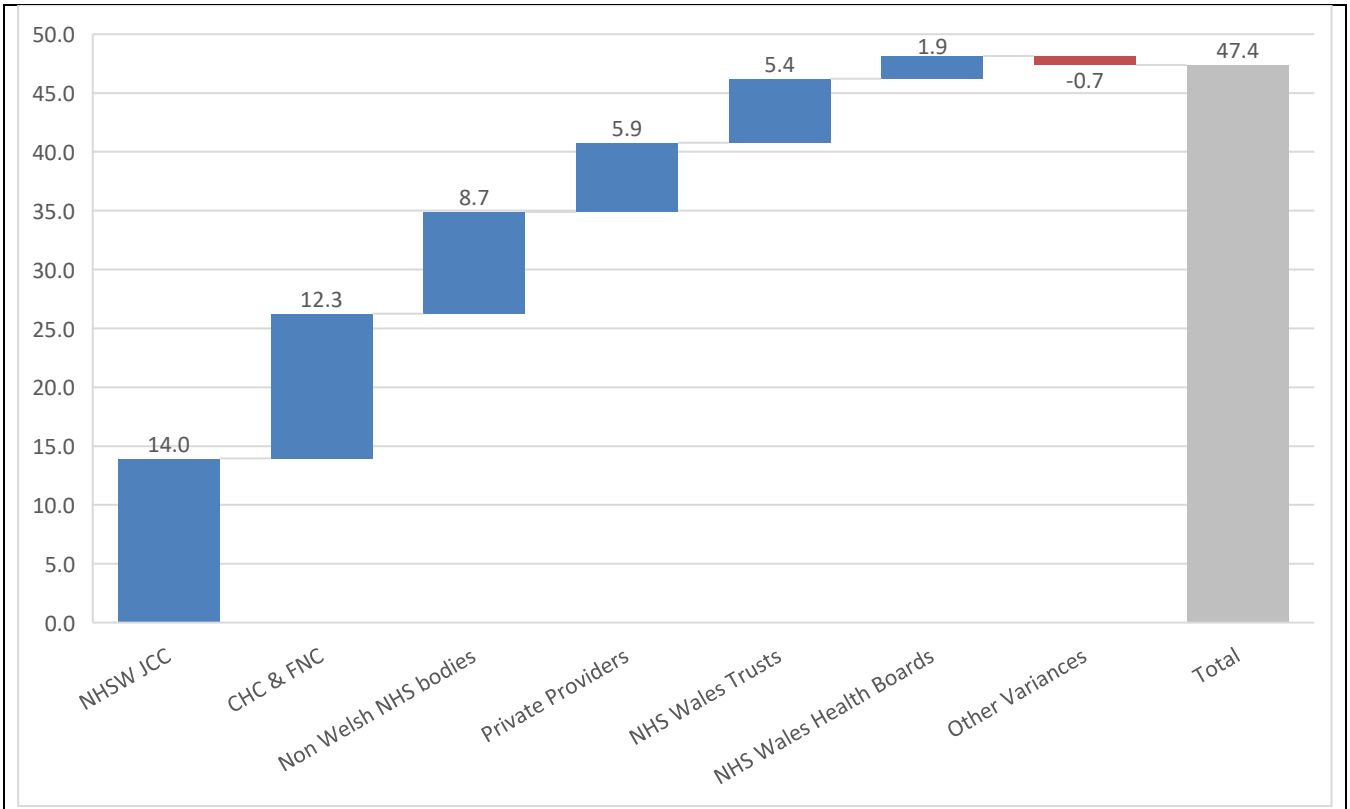
General Ophthalmic Services: £2.2m increase. This reflects the implementation of the new Optometry contract in 2024/25, which has driven a £1.0m rise in optician sight test fees in 2025/26, due to higher fee rates and the introduction of new services, alongside a further £1.2m increase relating to the Eye Health Examination Wales programme.

Prescribed Drugs £4.9m – This is due to a general increase in value of prescriptions, in particular the cost of Mounjaro, a Type 2 diabetes drug. The cost for this drug in 2024/25 for the Health Board was £0.6m, however due to increases in prescription volumes and a price increase by the supplier, the cost rose to £3.4m, a £2.8m growth.

2.2. Expenditure on Healthcare from other providers (Note 3.2, *Page 30*)

Line	Note	2025/26 £'m	2024/25 £'m	Change £'m	Change %
Expenditure on Healthcare from other providers	3.2 Pg 30	574.6	527.2	+47.4m	+8.9

Overall, expenditure on healthcare from other providers has increased by £47.4m from 2024/25 to 2025/26, comprising:



- £14.0m increase in goods and services received from NWJCC (incl. EASC)
- £12.3M increase in CHC and Funded Nursing Care
- £8.7m increase in goods and services from other Non-Welsh NHS bodies
- £5.9m increase in Private Providers
- £5.4m increase in goods and services from NHS Wales Trusts
- £1.9m increase in goods and services from NHS Wales Health Boards

The main reasons for the increase in spend are as follows:

<u>NWJCC (incl EASC) (£14.0m increase)</u>
The increase in NWJCC spend reflects the Commissioning Plans agreed by Chief Executives, including a significant 4.5% investment in Specialised Services totalling £9m.

The additional increase is driven by increased demand by the Health Board on services as part of other JCC agreements, including significant growth in specialised cardiology services (£1m) and individual patient packages of care (£1.6m).

<u>CHC & FNC (£12.3m)</u>

The growth in Continuing Healthcare (CHC) and Funded Nursing Care (FNC) expenditure reflects a combination of increasing demand, rising complexity of patient need, and sustained cost pressures from independent sector providers. The overall movement is summarised as follows:

- £2.9m increase in Learning Disabilities
- £2.1m increase in Young Adults and Children's Services
- £1.9m increase in Adult Mental Health

- £1.7m increase in Elderly Mentally Infirm (EMI) Nursing costs
- £1.3m increase in Funded Nursing Care
- £1.2m increase in Palliative Care

These increases are primarily attributable to uplifts in fee rates from CHC providers across the region, reflecting inflationary pressures (including workforce costs) and market sustainability challenges. In addition, there is evidence of underlying activity growth and increasing acuity, particularly within Learning Disabilities, complex mental health cohorts, and transitions from Children's to Adult services.

Other Non-Welsh NHS Bodies (£8.7m increase)

Description	£m	Explanation
Reported increase (pre-adjustment)	**+8.7**	Reported position showed a significant increase in expenditure with Other Non-Welsh NHS bodies.
Reclassification adjustment identified post-submission	**(9.5)**	Subsequent review identified mis-categorisation of a small number of suppliers. Expenditure of £9.5m should correctly be classified under **Private Providers** rather than Other Non-Welsh NHS Bodies.
Underlying variance (restated position)	**(0.8)**	After correcting for classification, the true movement is a **£0.8m decrease** in expenditure. The decrease is attributed to a reduction in Long-Term Agreements (LTAs) with a range of English providers, due to a decrease in both elective and emergency activity volumes during the year has driven the reduction in spend.

The Health Board has notified the adjustment to our Auditors and included on our schedule of required adjusted differences.

Private Providers

Reported expenditure on Private Providers increased by £5.9m in the year. The mis-categorisation of expenditure under Other Non-Welsh NHS Bodies of £9.5m results in an actual increase in expenditure of £15.4m.

The main reasons for this increase is due to the following:

£m	Description of Spend/Investment	Key Outcomes / Impact
10.6	**External Commissioning (Ophthalmology – Cataracts)** Welsh Government funded increase to support outsourcing of regional ophthalmology activity, primarily cataract treatment.	• Increased cataract surgery capacity across the region • Reduction in long waiting times for ophthalmology patients, particularly those breaching 52 weeks • Improved patient outcomes (e.g. vision restoration and quality of life)
3.8	**Insourcing (26-week Planned Care Programme)**	• Targeted reduction in 26-week waiting list backlogs

	Insourcing solution delivered by Healthcare Business Solutions to increase elective activity within existing Health Board facilities. Directed by Welsh Government.	• Faster patient access to treatment delivered by an external provider • Supports delivery against national RTT performance targets for patients at the stage 1 outpatient stage.
0.6	**Radiology Outsourcing (Everlight Radiology)** Contract for outsourced radiology reporting to support diagnostic capacity and turnaround times.	• Improved turnaround times for diagnostic imaging reports • Reduction in reporting backlog and diagnostic delays • Acceleration of patient pathways (diagnostics as a key bottleneck in planned care) • Supports more timely clinical decision-making

NHS Wales Trusts (£5.4m)
An increase of £5.4m mainly due to an increase of £5.1m in the LTA with Velindre NHS Trust. The £5.1m reflects higher levels of Systemic Anti-Cancer Therapy (SACT) activity and the associated high cost drugs delivered by Velindre as a result of a roll-out of immunotherapies which are significantly more expensive than historic treatments.

NHS Wales Health Boards
There was an overall increase of £1.9m with the other NHS Wales Health Boards.

The main cause of this increase was due to an increase in the LTA with other Welsh Health Boards to reflect the nationally directed pass through of the 1.77% annual uplift agreed by WG. There was also an increase in High-Cost drug costs, due to inflationary uplifts, and increases in activity.

2.3. Expenditure on Hospital and Community Health Services (Note 3.3, *Page 31*)

Line	Note	2025/26 £'m	2024/25 £'m	2023/24 £'m	Change £'m
Expenditure on Hospital and Community Health Services	3.3 Pg 31	1,253.0	1,177.2	75.8	+6.4

The increase in expenditure can be broken down by:

Expenditure on Hospital & Community Services	2025/26 £m	2024/25 £m	Movement £m
Staffing & Pay Expenditure	958.5	888.9	69.6
Non-Pay Expenditure	239.6	235.3	4.3
Non-Cash Expenditure	54.9	53.0	1.9
Total Expenditure on Hospital & Community Services	**1,253.0**	**1,177.2**	**75.8**

- Staffing & Pay Expenditure (See section 2.3.1 below)
- Non-Pay Expenditure (See section 2.3.2 below)
- Non-Cash Expenditure (See section 2.3.3 below)

2.3.1. Staffing & Pay Expenditure (Note 3.1, *Page 30* and Note 3.3, *Page 31*)

Staffing costs are included in both Note 3.1 and Note 3.3 of the Accounts, and the totals are brought through into Note 9.1. The most significant movements relate to the funded pay award, the increase in the permanent staff and the previously mentioned Managed Practice Staff.

The following Table shows an analysis of underlying staff costs for the year followed by some key points:

Staff Costs	2025/26 £m	2024/25 £m	Movement £m	Prior Year Movement £m
Directors Costs	2.8	2.7	0.1	0.5
Staff Costs 3.3	910.4	843.1	67.3	56.6
Single Lead Employer	45.2	43.0	2.2	10.5
Total Pay as per Note 3.3	**958.5**	**888.9**	**69.6**	**67.7**
Staff Costs Note 3.1	21.5	14.3	7.2	-8.9
Total Pay as per Note 9.1	**979.9**	**903.2**	**76.7**	**58.7**
Reasons for Increase				
Agency Costs			-4.1	-13.4
Increase in No. Permanent Staff			17.6	12.7
Increase in No. SLE Staff			1.7	2.6
Pay Award costs as per modelling			42.5	46.9
Employers Contribution to Pension Scheme - 9.4% increase			4.2	19.7
Increase in Primary Care Staffing (Managed Practices)			7.2	-9.0
Study Leave Accrual			0.3	-0.0
Increase in Secondments/ Other Staff			1.0	-1.1
Band 2/3 Pay Uplift			2.5	0.0
NI Increase above allocation			3.7	0.0
Other			0.1	0.3
Total			**76.7**	**58.7**

Of the significant increases the following should be noted:

Agency Staff (£4m decrease)

The HB have undertaken a number of initiatives during the year resulting in decrease in agency expenditure, including: -

- Overall Health Board strategy to reduce the requirement of agency staff.
- Reduction in HCSW agency as part of the variable pay reduction plans.
- Reduced nursing agency by improved recruitment and increased substantive posts.
- Medical agency decreases linked to improved recruitment of substantive posts.

The net effect being a reduction in FTE from 263 to 235 (11%) and a decrease in costs of £4.09m from £28.97m to £24.88m (14%).

Agency Staffing Group	2025/26 Expenditure £000	2024/25 Expenditure £000		2025/26 Average WTE	2024/25 Average WTE
Administrative, Clerical and Board Members	436	93		11	2
Medical and Dental	10,528	11,618		39	49
Nursing, Midwifery Registered	8,242	12,789		111	146
Professional, Scientific, and Technical Staff	1,159	532		10	5
Additional Clinical Services	1,440	882		23	17
Allied Health Professions	1,495	2,017		14	23
Healthcare Scientists	250	392		2	4
Estates and Ancillary	1,333	649		25	17
Total	**24,883**	**28,973**		**235**	**263**

Agency costs in the table above are included in notes 3.1 (page 30) and 3.3 (page 31).

Staff Costs (£18m increase)

The reduction from agency is offset by an increase in staff, with an additional 454 WTE and an average total cost of employment of £39k:

Average Number of Employees	2025/26	2024/25	Variance
Administrative, Clerical and Board Members	2,819	2,722	97
Medical & Dental	1,394	1,339	55
Nursing, Midwifery registered	4,291	4,121	170
Professional, Scientific, and Technical staff	465	433	32
Additional Clinical Services	2,933	2,903	30
Allied Health Professions	1,000	982	18
Healthcare Scientists	260	257	3
Estates and Ancilliary	1,106	1,054	52
Students	3	6	-3
Total	**14,271**	**13,817**	**454**

Pay award costs (£42m)

Reflecting A4C & medical and dental increases approved nationally during the year.

Employer Contribution to pension scheme (£4m)
In 2024/25 the employers' pensions contribution increased from 20.68% to 23.78%. The Health Board continue to pay the first 14.38% of employers' contribution, with Welsh Government paying the additional sum of 9.4%. To ensure that this cost was reflected in the Health Boards accounts a notional adjustment was actioned in month twelve to account for this with funding allocated. The value of the 9.4% pension increases in 2025/26 was £56.0m (2024/25 - £51.8m, a change of £4.2m). The other side of this transaction is shown in note 28 under other cash flow adjustments.

2.3.2. Non-Pay Expenditure (Note 3.3, *Page 31*)

Line	Note	2025/26 £'m	2024/25 £'m	Change £'m	Change %
Non-Pay Costs	3.3 Pg 31	239.6	235.4	4.2	1.8%

Overall, non-pay costs (within Note 3.3) have increased by 1.8%. Whilst this is actually below the average rate of inflation for the UK of 3.4% (CPIH), within the expenditure headings there have been some significant fluctuations. The points below, and supporting narrative highlight the significant pressures incurred:

Within the movement of £4.2m there are three main drivers:
- Supplies and Services – Clinical: an increase of £10.5m.
- Premises: a decrease of £4.9m.
- Supplies and Services – General: a decrease of £2.7m.

These are discussed in more detail below.

Supplies & Services – Clinical (£10.5m increase)

Clinical Supplies and Services have increased by £10.5m (2025/26: £154.1m vs 2024/25 £143.6m), an increase of 7.3%. The cost of consumables remains high for the Health Board, in particular pharmaceuticals, which are a significant cost pressure and are above the inflationary rate.

The main increases relate to the following:

- £3.4m in Medical & Surgical Equipment – General & Disposable, mainly due to consumables in relation the 26 week planned care programme (£1.1m) and an increase in spend on Beds and Mattresses (£0.6m) as a result of a significant volume being identified as obsolete due to age and condition.
- £2.4m in drugs costs due to an increase in the general costs of drugs above the average rate of inflation.

- £1.6m in FP10s drugs, due to an increase in prescription volumes and individual drug costs.
- £1.1m in Laboratory Equipment and Reagants, mainly due to the increase in the Biochemistry Managed Service contract.
- £0.8m in Medical & Surgical Equipment – Maintenance and Maintenance Contracts particularly in Endoscopy services.
- £0.8m in Orthopaedic Implants, in particular Knee and Hip implants
- £0.4m Other increases and decreases in spend

Premises (£4.9m decrease)

The premises category includes expenditure on areas such as Utilities and Business Rates and also the Rent charges for the Health Board's various sites, in addition to other equipment and materials purchases and licenses costs.

There was a decrease from £46.3m in 2024/25 to £41.4m. This is a decrease in the year of £4.9m, which was due to:

- £2.1m decrease in Electricity, because of the new All-Wales tariffs introduced and less consumption costs.
- £1.4m decrease in Gas, also because of the new All-Wales tariff contract.
- £1.4m decrease on Computer Software/License Fees, due to the purchase of software in previous years.
- £0.7m decrease on External Data Contracts
- Offset by:
    - £0.6m increase in Minor Works expenditure
    - £0.5m increase in Water costs.

Supplies and Services – General (£2.7m decrease)

The main reason for the reduction in General Supplies and Services is due to the termination of the PFI agreement at Chepstow Community Hospital which came to an end in March 2025. Expenditure on the PFI managed service contract in 2024/25 was £2.4m.

The Health Board assumed full operational responsibility of the Hospital in late March 2025, including the TUPE of staff. The additional staff costs are included in the increase in number of permanent staff within section 2.3.1, above and are £1m.

Other
There were minor fluctuations in the other expenditure categories from 2024/25 to 2025/26 as follows:

- £0.75m increase in Establishment costs
- £0.75m in Other Expenditure

2.3.3. Non-Cash Expenditure (Note 3.3, *Page 31*)

Depreciation

Depreciation and Amortisation has increased overall by £3.6m compared to 2024/25. This is the net result of a combination of factors, including an increase of £3.8m related to buildings indexation uplifts applied as at 1st April 2025, and a decrease of £0.3m related to non-property assets.

Fixed Asset Impairments

A detailed analysis of impairment charges is shown in the table below.

Fixed Asset Impairments and Reversals	£m	Reason for Impairment
Nevill Hall Satellite Radiotherapy Unit	13.325	Assets Valued on Coming Into Use
ED Extension, GUH	8.685	Assets Valued on Coming Into Use
Decontamination Unit, RGH	2.788	Assets Valued on Coming Into Use
St Woolos Hospital	2.780	Building Closures
Targeted Estates Fund Non-Enhancing Works, HB Wide	1.009	Valuer Desktop Review of TEF complete schemes
2nd MRI Suite, GUH	0.975	Assets Valued on Coming Into Use
Pharmacy Robot, RGH	0.392	Assets Valued on Coming Into Use
Boiler Replacement Works, SCH	0.378	Assets Valued on Coming Into Use
REFIT Non-Enhancing Works, HB Wide	0.327	Valuer Desktop Review of REFIT complete schemes
D7E Ward Refurb, RGH	0.284	Assets Valued on Coming Into Use
NHH Cancer Centre AUC	0.382	Abandonment in the course of construction
Grange University Hospital	-19.067	Indexation - reversal of impairment in previous years
Royal Gwent Hospital	-5.725	
Ysbytty Aneurin Bevan	-3.712	
Nevill Hall Hospital	-2.795	
19 Hills HWBC	-1.794	
St Cadocs Hospital	-1.270	
Bevan HWBC	-1.072	
Other Reversals of Impairment	-1.577	
Total Impairment	-5.687	

2.4. Losses, special payments, and irrecoverable debts: charges to operating expenses (Note 3.4, *Page 31*)

Line	Note	2025/26 £'m	2024/25 £'m	Change £'m	Change %
Losses, Special Payments and Irrecoverable Debts: Charges to Operating Expenses	3.4 Pg 31	8.7	3.1	5.6	184.6%

The £8.7m can be reconciled to the following movements:

	£112.4m	Cases arising (£66.8m) and revised in year (£45.6m) as set out in Note 20
	(£18.8m)	Reduced provisions based on latest legal assessment on existing cases and cases closed in year without loss, the largest being a single case with provision of £20m reduced to £15m on the latest Welsh Risk Assessment.
	(£28.9m)	a further reduction due to two structured settlement cases (£18.4m and £10.5m respectively) as set out in note 20
Total Clinical Negligence movement	£64.6m	Net movements charged to expense due to Clinical Negligence cases
Less income received	(£64.6m)	Income received/ due from the Welsh Risk Pool for Clinical Negligence
Plus		
	£0.6m	Personal injury has increased by £0.5m in 2024/25 based on the quantum reports provided at the end of March 2025. Again, this is largely offset by movement in income received/receivable from WRP.
	£5.3m	All other losses and special payments increased in year by £5.3m mainly due to the Recognition Payment element of the Band 2-3 Pay Uplift Payment of £4.6m.
	£2.3m	Defence costs to support the above claims

As identified above, the Health Board has recognised the Recognition Payment element of the Band 2-3 Pay Uplift payment as a Loss. A losses approval form was submitted to and funding approved by Welsh Government in March.

2.5. Miscellaneous Income (Note 4, *Page 32*)

Line	Note	2025/26 £'m	2024/25 £'m	Change £'m	Change %
Miscellaneous Income	4 Pg 32	151.7	136.6	15.1	11%

The overall movement in income is £15.1m, and the main reasons for this variance is explained by:

Local Health Boards
an increase of £1.1m in 2025/26 due to:

- £0.7m increase in income from Powys Teaching Health Board, due to an increase in the Long Term service agreement.
- £0.5m increase in Cwm Taf Morgannwg Health Board income, mainly due to recharges in relation to Regional Ophthalmology funding.
- £0.2m increase in Cardiff & Vale income due to recharges in relation to Regional Ophthalmology funding.

Welsh NHS Trusts
An increase of £2.2m in 2025/26 mainly due to:

- £2.7m increase of income with Velindre NHS Trust, mainly due to a £2.1m increase in Pharmacy Rebate income from NWSSP relating to WP10s resulting in higher rebate claims in 2025/26. There was further income of £0.3m received in relation to the Satellite Radiotherapy Unit.
- £0.6m reduction in income with Public Health Wales NHS Trust, mainly due to £0.2m in relation to a reduction to reimbursements for the 111 Hub staffing costs, and a further £0.5m as a result of a one-off recharge in 2024/25 in relation to TEC Cymru video conferencing services procured prior to transfer.

Welsh Government Income
An increase of £1.8m in 2024/25 mainly due to:

- £0.6m increase in income in relation to Regional Partnership Board.
- £0.5m increase in Research & Development income

Education, Training & Research
An increase of £2.7m mainly due to:

- £2.3m in relation to Junior Doctors, from HEIW.
- £0.3m increase in Postgraduate Education funding from HEIW.

Other Income
An overall increase of £5.2m, mainly due to Managed Practice Income of £5.3m.

In 2024/25, the Manual for Accounts were revised and Income in relation to Primary Healthcare was moved from Note 3.1 – Expenditure on Primary Healthcare Services to Note 4 – Miscellaneous Income.

As part of this, income in relation to Managed Practices, as mentioned above is now recognised in Note 4.

It should be noted that the reported Other Income analysis at the bottom of Note 4, currently includes a figure of £2.0m in relation to Salary Sacrifice Scheme income. On review of the analysis of Other Income, it was identified that a further £7.5m should have been classified as Salary Sacrifice Income. The updated Other Income Analysis will now be as follows:

	2025-26	2024-25
Other income Includes;	**£000**	£000
Salary Sacrifice Schemes & Fleet Vehicles	**9,603**	7,772
VAT recoveries re Business Activities and Contracted Out Services	**946**	986
Managed Practices	**5,633**	0
Other	**3,120**	5,341
Total	**19,303**	14,099

We have informed Wales Audit of the need for this narrative adjustment.

2.6. Fair Pay disclosure Remuneration Relationship (Note 9.6.1, *Page 38*)

Line	Note	2025/26 £	2024/25 £	Change £	Change %
Chief Executive Pay	9.6.1 Pg 38	247,500	242,500	5,000	2.1%
Median Employee Average Salary	9.6.1 Pg 38	38,364	37,030	1,334	3.6%
Highest Paid Employee	9.6.1 Pg 38	370,626	458,632	-88,006	-19.2%
Ratio of Chief Executive to Average Employee	9.6.1 Pg 38	6.5	6.5	-	0%
Average Salary Percentage Change	9.6.2 Pg 38	1%	5%	-	(4%)

The highest paid director was the Chief Executive Officer, based on Full Time Equivalent values, the highest paid Health Board employee was a consultant earning £371K in 2025/26.

2.7. Percentage Changes (Note 9.6.2, *Page 38*)

The 2% increase related to the increase of the median point of the chief executive pay from £242,500 to £247,500. The 1% increase related to the ***average*** salary increasing from £44,968 in 2024/25 to £45,408 mainly due to the annual pay award.

2.8. Prompt payment policy – measure of compliance (Note 10.1, *Page 41*)

The Health Board achieved the target to pay 95% on non-NHS Creditors within 30 days of delivery, with a cumulative total of 97.1% in 2025/26. This was a slight decrease of the 97.7% achieved in 2024/25.

The total number of Non-NHS invoices processed has increased by 1,024 from 2024/25 to 2025/26.

2.9. Property, Plant and Equipment (Note 11.1, *Pages 4 and 42*)

Line	Note	2025/26 £'m	2024/25 £'m	Change £'m	Change %
Property, Plant and Equipment	11.1 Pgs 4 and 42	987.7	927.5	60.2	6.5%

The main changes in the year can be summarised as follows:

Property, Plant & Equipment	**£m**
Balance as at 1 April 2025	**927.5**
Indexation	56.7
Additions	43.7
Reclassification	0.0
Revaluations	0.0
Impairments	-31.3
Reversals of Impairments	37.0
Depreciation	-45.8
Disposals	-0.2
Transfers	0.0
Balance at 31 March 2026	**987.7**

The key movements in the year relate to:

- The additions of £43.7m relate to general capital expenditure and specific Capital Programme investments including:
  - All-Wales funded backlog maintenance and decarbonisation schemes (£15.2m)
  - RGH Centralised Decontamination unit (£3.6m)
  - NHH Satellite Radiotherapy Unit (£0.9m)
  - Grange Emergency Department extension (£2.7m)
  - 2nd MRI at the Grange Hospital (£2.2m)
  - All-Wales funded Digital (£5.6m) and equipment replacement schemes (£4.2m).

- There has been an increase of £93.7m to land and buildings values from the application of indexation based on indices received from the Valuation Office Agency, applied at 1st April 2025. The increase is shown either against indexation (£56.7m) or, for those assets that have been impaired previously, reversals of impairment (£37.0m).

- The impairment of £31.3m made up of:
  - the impairment of seven assets under construction schemes (£26.8m) including Nevill Hall Satellite Radiotherapy Unit, the Ward D7E upgrade, Pharmacy Robot installation and new Decontamination Unit at Royal Gwent Hospital, the Emergency Department extension and 2nd MRI schemes at Grange University Hospital and boiler replacement upgrade at St Cadoc's Hospital.
  - a further desktop revaluation exercise undertaken by the Valuation Office Agency to assess the Targeted Estates Fund and REFIT backlog maintenance and decarbonisation programmes (£1.3m)

- the permanent closure of buildings at St Woolos Hospital (£2.8m)
- the write off of fees in relation to the Nevill Hall Cancer centre scheme which has now been superseded by the Nevill Hall redevelopment business case (£0.4m).

- Depreciation charges of £45.8m.

- There were no assets held for sale as at 31st March 2026.

Asset lives are applied in line with the policy in the accounts and are reviewed annually. Where there is evidence that standard lives have changed (e.g., due to legislation), the lives are adjusted. Fully depreciated assets are carried at nil net book value.

2.10. Right of Use Assets (Note 11.3, *Page 46*)

Line	Note	2025/26 £'m	2024/25 £'m	Change £'m	Change %
Right of Use Assets	11.3 Pg 45	15.9	18.1	-2.2	-12.3%

Right of Use assets are leases / contracts that convey the right to use an asset for a period of time in exchange for consideration. The Health Board applies an exemption, and therefore does not capitalise, leases that are less than 12 months in duration or where the underlying asset is of a value less than £5,000. Leases that are not excluded by the exemption rules are recorded in the balance sheet as a "Right of Use" asset with a corresponding liability for outstanding payments. The assets are depreciated over the term of the lease.

The main changes in the year can be summarised as follows:

ROU Assets	**£m**
Balance as at 1 April 2025	**18.1**
Additions	2.1
Transfers	0.0
Disposals other than by sale	-0.1
De-recognition	-0.1
Depreciation in year	-4.1
Net Book Value at 31 March 2026	**15.9**

The key movements in year relate to:

- New leases, lease extensions and renewals were approved in year totalling £2.1m including property leases (£0.7m), Vehicle leases (£0.3m), Pathology managed service contracts (£1.0m) and other equipment leases (£0.1m).
- Disposals and de-recognised leases in year totalling £0.2m in relation to the early termination of a Pathology managed service contract and the subletting of the Aberbeeg Medical Centre lease.
- Depreciation charges in year of £4.1m

The Right of Use Liabilities as at 31st March 2026 are detailed below:

Lease Liabilities (net of irrecoverable VAT)	£m
Current	2.9
Non-Current	12.3
Total	**15.2**

Note – the asset and liability will not match exactly due to the differences in lease and asset accounting, largely related to the application of interest on the liability.

2.11. Trade and Other Receivables (Note 15, *Pages 4 and 54*)

Line	Note	2025/26 £'m	2024/25 £'m	Change £'m	Change %
Trade and other receivables	15 Pgs 4 and 55	317.3	273.0	44.1	16.1%

Trade and Other Receivables increased by £44.1m to £317.3m (2024/25: £273.0m), driven primarily by a £40.1m rise in Welsh Risk Pool (WRP) receivables, with a net £4.0m increase across other balances.

The growth in the WRP debtor reflects a higher Clinical Negligence and Personal Injury provision, following updated legal assessments of settlement values and timing. This has resulted in a £3.8m increase in current receivables and a £36.3m increase in non-current receivables, aligned to the expected settlement profile of claims.

There were some other variances in Trade and Other Receivables attributable to:

Welsh NHS Trusts
An increase of £2.3m in year, as a result of an increase in Drug Rebate accruals with Velindre NHS Trust.

Local Authorities
A decrease of £1.1m, mainly due to the value of invoices outstanding at the end of March with Caerphilly County Borough Council reducing from £1.1m at the end of 2024/25 to £0.3m at the end of 2025/26 due to invoices being paid earlier in March 2026. Further decreases of £0.3m in anticipated income with Caerphilly County Borough Council in relation to Families First and Flying Start programmes.

Other Receivables
An increase of £1.2m between 2024/25 and 2025/26, mainly due to the following:
- £0.3m in relation to income due on behalf of the Managed Practices
- £0.3m in relation to VAT receivables from HMRC
- £0.2m in relation to outstanding invoices with Overseas patients

2.12. Trade and Other Payables (Note 18, *Pages 4 and 57*)

Line	Note	2025/26 £'m	2024/25 £'m	Change £'m	Change %
Trade and other payables	18 Pgs 4 and 58	232.4	221.0	+11.4	5.1%

Trade and other payables have increased by £11.4m from £221.0m in 2024/25 to £232.4 in 2025/26. This is mainly due to the following:

NHS Wales Joint Commissioning Committee (NWJCC)
An increase of £2.5m due to the value of the year-end settlement agreement in 2025/26 compared to 2024/25. This is a result of the increase to the overall LTA with JCC due to investment in Specialised Services.

Taxation and Social Security payables
An in-year increase of £2.2m, due to the increase in National Insurance contributions in 2025/26, mainly reflecting the changed Employers NI rates.

Non-NHS Payables – Revenue
An overall increase of £8.7m.

The main movement relates the Band 2-3 Pay Uplift Payment, which has been agreed on an All-Wales basis. The Value of the total payment remaining to be paid is £6.9m and is split by the Corrective payment (£2.3m) and Recognition Payment (£4.6m). As outlined above, the Recognition Payment has also been recognised as a Loss in Note 3.4.

Other movements are mainly attributable to the value of creditor invoices held on the Accounts Payable system (£3.0m) and a decrease in the Primary Care services creditors at year end as below:

- £0.2m decrease on Dental Contractor Services from £3.1m to £2.9m
- £0.3m decrease on GMS Drugs from £0.8m to £0.5m
- £0.8m decrease on Pharmacy Contractor from £13.9m to £13.1m

Pensions: Staff
An in-year increase of £1.7m, due to the increase in Pensions contributions in 2025/26, in line with the general increase in Pay and Staffing.

Non-NHS Accruals
An overall decrease of £2.7m, mainly due to a decrease in value of Continuing Healthcare accruals split as:

- £1.3m decrease in Mental Health
- £0.6m decrease in Community
- £0.6m decrease in Children and Young Adult services.

The decrease in the value of Accruals at year-end for CHC are in direct response to an increase in the actual payments made in year. Actual creditor payments made in the year grew from £98m in 2024/25 to £108m in 2025/26.

Capital Payables - Tangible

An increase of £1.4m in year due to the value of creditor invoices outstanding at year end, which were not paid due to the timing of the receipt of the invoices at the end of March.

Current and Non-Current ROU Lease Liability
The net decrease of the Right of Use Lease Liability in 2025/26 was £1.9m. This was split as:

- Current Liability - £0.8m decrease
- Non-Current Liability - £1.1m decrease.

See table under the ROU section above.

2.13. Provisions (Note 20, *Page 60*)

Line	Note	2025/26 £'m	2024/25 £'m	Change £'m	Change %
Provisions	20 Pg 59	245.7	207.7	38.0	18.3%

Provisions for clinical negligence and personal injury have increased by £37.9m from £198.7m in 2024/25 to £236.6m in 2024/25 reflecting up to date legal assessment of pending litigation claims against the Health Board. Most of this decrease is offset by an equal level of decreased assumed income from the Welsh Risk Pool.

Current Clinical Negligence Provisions – increase of £1.8m
There has been a significant transfer between Non-Current and Current provisions of £32.2m, in addition to arising and revised cases totalling £40.6m, as indicated above in note 3.4 relating to net risk pool adjustments.

This is offset by significant balances in relation to cases which have crystallised (£28.5m) and revised provisions for other cases (£14.7m). With a further £28.9m transferred to WRP for two additional settlements, as outlined above in Note 3.4.

This is then offset by a reduction in provision by £1.2m for amounts agreed and transferred to creditors not yet paid.

Non-Current Clinical Negligence Provisions – increase of £36.1m
The increase in Non-Current Provisions relates in the main to a significant increase in Clinical Negligence cases totalling £75.3m which have been assessed and a provision provided based on the latest information as at 31.03.2025. This is offset by the amount transferred from Non-Current and Current provisions of £32.2m.

From 2023/24 to 2024/25 the number of clinical negligence cases increased from 269 to 298, with personal injury cases increasing from 84 to 97 and redress cases decreasing from 19 to 8. The increase in the number of actual cases for clinical negligence and personal injury reflects the increase to the total provision required based on the current legal assessment.

Other Provisions – increase of £0.2m
Whilst other provisions have increased slightly from £9.0m in 2024/25 to £9.2m in 2025/26 there are fluctuations within this:

- £0.5m increase in CHC provisions due to an increase of £0.7m in arising cases

- £0.5m increase on GP & Dental contractors' provisions
- £0.3m decrease in Capital provisions, including a new arising provision of £0.7m in relation to the GUH Emergency Department, and utilisation of prior year Kier Construction provisions.
- £0.3m decrease in Early Retirement Pensions provisions
- £0.2m decrease in Other provisions which have been released.

2.14. Pensions tax annual allowance – Scheme Pays arrangements 2025/26 (*Page 62*)

WG confirmed that the costs associated with Scheme pays were to be included in the Health Boards accounts from 2021/22. In 2025/26 the amount included within provisions is £690K which is included in Note 20 Provisions with the funding from WG reflected in Note 15 – Trade and Other receivables.

WG also made £35K of payments during the year in relation to scheme pays which has been included in the Health Board accounts with the notional funding received from WG to offset this which is included within the 'other' amount in note 28.

In 2022/23, Audit Wales confirmed in the draft audit plan that whilst any transactions included in the Health Board's financial statements strictly remain irregular, they did not classify them as material by their nature. They have also confirmed that a further qualification of regularity opinion would have a diminishing value, particularly against the backdrop of the Chancellor of the Exchequer abolishing the Lifetime Allowance in his March 2023 budget statement.

The above still applies for 2025/26 and as such no regularity opinion will be placed on this year's accounts in line with last year.

2.15. Remote Contingent Liabilities (Note 21.2, *Page 63*)

Line	Note	2025/26 £'m	2024/25 £'m	Change £'m	Change %
Remote Contingent Liabilities	21.2 Pg 64	0.15	0.43	-0.30	-70%

Remote Contingent Liabilities have decreased from £0.43m in 2024/25 to £0.15m in 2025/26. There is one Medical Negligence case and 1 GP Indemnity case which have all been assessed as having less than a 5% probability of being settled.

The liability is based on what legal services assess the costs/ settlements would be if these cases were to progress to settlement.

3. Other Information

Study Leave Accrual

The remaining balance which related to junior doctors' study leave has been reviewed and based on the revised information received re outstanding days payrates was increased slightly from £3.224m to £3.527m. This study leave accrual

has not been released because Health Education and Improvement Wales, who determine the arrangements for junior doctors' study leave, have chosen to retain the pre-Covid arrangements. It is worth noting that a new Resident Doctor contract will come into force during 2026/27 and will require review of this accrual under the new framework and any behavioural differences that may result in how study is taken, especially with a corresponding increase in external budget allocated to each Resident doctor.
Argymhelliad / Recommendation The Audit, Risk & Assurance Committee is asked to note this report

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

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	IFRS – International Financial Reporting Standards WG – Welsh Government CHC – Continuing Health Care

	FNC – Funded Nursing Care LAC – Looked After Children LTA – Long Term Agreement SLA – Service Level Agreement WTE – Whole Time Equivalent EPU – Education Purchasing Unit FP10 – Drugs prescribed in our hospitals, but prescription is dispensed in community pharmacies. IMTP – Integrated Medium-Term Plan CRL – Capital Resource Limit ROU – Right of Use GAD – Government Actuary's Department NWSSP – NHS Wales Shared Services Partnership WRP – Welsh Risk Pool NWJCC – NHS Wales Joint Commissioning Committee GMS – General Medical Services HCSW – HealthCare Support Worker
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
Resource Assessment: • **Workforce** • **Service Activity & Performance** • **Financial**	**Is EIA Required and included with this paper?** A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following: Yes, outlined within the paper Yes, outlined within the paper Yes, outlined within the paper
Asesiad Effaith Cydraddoldeb **Equality Impact Assessment** (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk

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

ANEURIN BEVAN UNIVERSITY LOCAL HEALTH BOARD

FOREWORD

These accounts have been prepared by the Local Health Board under schedule 9 section 178 Para 3(1) of the National Health Service (Wales) Act 2006 (c.42) in the form in which the Welsh Ministers have, with the approval of the Treasury, directed.

Statutory background

Performance Management and Financial Results

Welsh Health Circular WHC/2016/054 replaces WHC/2015/014 'Statutory and Administrative Financial Duties of NHS Trusts and Local Health Boards' and further clarifies the statutory financial duties of NHS Wales bodies and is effective for 2025-26. The annual financial duty has been revoked and the statutory breakeven duty has reverted to a three year duty, with the first assessment of this duty in 2016-17.

Local Health Boards in Wales must comply fully with the Treasury's Financial Reporting Manual to the extent that it is applicable to them. As a result, the primary statement of in-year income and expenditure is the Statement of Comprehensive Net Expenditure, which shows the net operating cost incurred by the Local Health Board which is funded by the Welsh Government. This funding is allocated on receipt directly to the General Fund in the Statement of Financial Position.

Under the National Health Services Finance (Wales) Act 2014, the annual requirement to achieve balance against Resource Limits has been replaced with a duty to ensure, in a rolling 3 year period, that its aggregate expenditure does not exceed its aggregate approved limits.

The Act came into effect from 1st April 2014 and under the Act the first assessment of the 3 year rolling financial duty took place at the end of 2016-17.

Statement of Comprehensive Net Expenditure for the year ended 31 March 2026

	Note	2025-26 £000	2024-25 £000
Expenditure on Primary Healthcare Services	3.1	**366,848**	351,914
Expenditure on healthcare from other providers	3.2	**574,590**	527,203
Expenditure on Hospital and Community Health Services	3.3	**1,253,030**	1,177,190
		2,194,468	2,056,307
Less: Miscellaneous Income	4	**(151,708)**	(136,606)
LHB net operating costs before interest and other gains and losses		**2,042,760**	1,919,701
Investment Revenue	5	**(16)**	(16)
Other (Gains) / Losses	6	**44**	(41)
Finance costs	7	**816**	777
Net operating costs for the financial year		**2,043,604**	**1,920,421**

Details of the Health Board's performance against its revenue and capital allocations over the last three financial periods are provided in Note 2 on page 28.

The notes on pages 8 to 79 form part of these accounts.

Other Comprehensive Net Expenditure

	2025-26 £000	2024-25 £000
Net (gain) / loss on revaluation of property, plant and equipment	**(56,727)**	(15,174)
Net (gain)/loss on revaluation of right of use assets	**0**	0
Net (gain) / loss on revaluation of intangible assets	**0**	(42)
Net (gain) loss on revaluation of financial assets	**0**	0
Net (gain)/ loss on revaluation of PPE & Intangible assets held for sale	**0**	0
Net (gain)/loss on revaluation of financial assets held for sale	**0**	0
Impairment and reversals	**0**	0
(Gain)/Loss on other reserve movements	**0**	0
Transfers between reserves	**0**	0
Release of reserves to SoCNE	**0**	0
Transfers (to) / from other NHS Wales bodies	**(36)**	0
Reclassification adjustment on disposal of available for sale financial assets	**0**	0
Other comprehensive net expenditure for the year	**(56,763)**	(15,216)
Total comprehensive net expenditure for the year	**1,986,841**	1,905,205

The notes on pages 8 to 79 form part of these accounts.

Statement of Financial Position as at 31 March 2026

	Notes	31 March 2026 £000	31 March 2025 £000
Non-current assets			
Property, plant and equipment	11	**987,707**	927,547
Right of Use Assets	11.3	**15,890**	18,121
Intangible assets	12	**3,095**	4,999
Trade and other receivables	15	**142,398**	105,883
Other financial assets	16	**605**	607
Total non-current assets		**1,149,695**	1,057,157
Current assets			
Inventories	14	**9,794**	10,433
Trade and other receivables	15	**174,870**	167,160
Other financial assets	16	**116**	60
Cash and cash equivalents	17	**5,551**	4,823
		190,331	182,476
Non-current assets classified as "Held for Sale"	11	**0**	0
Total current assets		**190,331**	182,476
Total assets		**1,340,026**	1,239,633
Current liabilities			
Trade and other payables	18	**(217,347)**	(204,826)
Other financial liabilities	19	**0**	0
Provisions	20	**(100,292)**	(98,570)
Total current liabilities		**(317,639)**	(303,396)
Net current assets/ (liabilities)		**(127,308)**	(120,920)
Non-current liabilities			
Trade and other payables	18	**(15,050)**	(16,314)
Other financial liabilities	19	**0**	0
Provisions	20	**(145,467)**	(109,154)
Total non-current liabilities		**(160,517)**	(125,468)
Total assets employed		**861,870**	810,769
Financed by :			
Taxpayers' equity			
General Fund		**612,644**	610,494
Revaluation reserve		**249,226**	200,275
Total taxpayers' equity		**861,870**	810,769

The financial statements on pages 2 to 7 were approved by the Board on XX June 2026 and signed on its behalf by:

Chief Executive and Accountable Officer ..... Date: XX June 2026

The notes on pages 8 to 79 form part of these accounts.

Statement of Changes in Taxpayers' Equity
For the year ended 31 March 2026

	General Fund £000	Revaluation Reserve £000	Total Reserves £000
Changes in taxpayers' equity for 2025-26			
Balance as at 31 March 2025	610,494	200,275	**810,769**
NHS Wales Transfer	0	0	**0**
RoU Asset Transitioning Adjustment	0	0	**0**
Impact of IFRS 16 on PPP/PFI Liability	0	0	**0**
Balance at 1 April 2025	610,494	200,275	**810,769**
Net operating cost for the year	(2,043,604)		**(2,043,604)**
Net gain/(loss) on revaluation of property, plant and equipment	0	56,727	**56,727**
Net gain/(loss) on revaluation of right of use assets	0	0	**0**
Net gain/(loss) on revaluation of intangible assets	0	0	**0**
Net gain/(loss) on revaluation of financial assets	0	0	**0**
Net gain/(loss) on revaluation of PPE and Intangible assets held for sale	0	0	**0**
Net gain/(loss) on revaluation of financial assets held for sale	0	0	**0**
Impairments and reversals	0	0	**0**
Net gain/(loss) on other reserve movements	0	0	**0**
Transfers between reserves	7,776	(7,776)	**0**
Release of reserves to SoCNE		0	**0**
Transfers (to) / from other NHS Wales bodies	36	0	**36**
Reclassification adjustment on disposal of available for sale financial assets	0	0	**0**
Total recognised income and expense for 2025-26	(2,035,792)	48,951	**(1,986,841)**
Net Welsh Government funding	1,981,900		**1,981,900**
Notional Welsh Government Funding	56,042		**56,042**
Balance at 31 March 2026	612,644	249,226	**861,870**

Notional Welsh Government funding line includes 9.4% staff employer pension and Pensions Annual Allowance Charge Compensation Scheme (PAACCS) costs paid centrally by Welsh Government.
The Department of Health and Social Care (DHSC) 2023-24 consultation on the NHS Pension Scheme confirmed that the transitional approach that has operated since 2019-20 for employer contributions will continue in 2025-26. From 1 April 2024 an employer rate of 23.7% (23.78% inclusive of the administration charge) has applied. However, the NHS Business Services Authority continue to only collect 14.38% from NHS Wales employers under their normal monthly payment process to the NHS Pension Scheme. This has resulted in an increase in the central payments made by Welsh Government from 6.3% to 9.4%.

Notional Welsh Government funding split:

Notional 9.4% staff employer pension £56,007K
Pensions Annual Allowance Charge Compensation Scheme (PAACCS) £35K

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The notes on pages 8 to 79 form part of these accounts.

Statement of Changes in Taxpayers' Equity
For the year ended 31 March 2025

	General Fund £000	Revaluation Reserve £000	Total Reserves £000
Changes in taxpayers' equity for 2024-25			
Balance at 31 March 2024	581,378	189,324	**770,702**
NHS Wales Transfer	0	0	**0**
RoU Asset Transitioning Adjustment	422	0	**422**
Impact of IFRS 16 on PPP/PFI Liability	0	0	**0**
Balance at 1 April 2024	581,800	189,324	**771,124**
Net operating cost for the year	(1,920,421)		**(1,920,421)**
Net gain/(loss) on revaluation of property, plant and equipment	0	15,174	**15,174**
Net gain/(loss) on revaluation of right of use assets	0	0	**0**
Net gain/(loss) on revaluation of intangible assets	0	42	**42**
Net gain/(loss) on revaluation of financial assets	0	0	**0**
Net gain/(loss) on revaluation of PPE and Intangible assets held for sale	0	0	**0**
Net gain/(loss) on revaluation of financial assets held for sale	0	0	**0**
Impairments and reversals	0	0	**0**
Net gain/(loss) on other reserve movements	0	0	**0**
Transfers between reserves	4,265	(4,265)	**0**
Release of reserves to SoCNE	0	0	**0**
Transfers (to) / from other NHS Wales bodies	0	0	**0**
Reclassification adjustment on disposal of available for sale financial assets	0	0	**0**
Total recognised income and expense for 2024-25	(1,916,156)	10,951	**(1,905,205)**
Net Welsh Government funding	1,893,053		**1,893,053**
Notional Welsh Government Funding	51,797		**51,797**
Balance at 31 March 2025	610,494	200,275	**810,769**

Notional Welsh Government funding line includes 9.4% staff employer pension and Pensions Annual Allowance Charge Compensation Scheme (PAACCS) costs paid centrally by Welsh Government.
The Department of Health and Social Care (DHSC) 2023-24 consultation on the NHS Pension Scheme confirmed that the transitional approach that has operated since 2019-20 for employer contributions will continue in 2024-25. From 1 April 2024 an employer rate of 23.7% (23.78% inclusive of the administration charge) will apply. However, the NHS Business Services Authority will continue to only collect 14.38% from NHS Wales employers under their normal monthly payment process to the NHS Pension Scheme. This has resulted in an increase in the central payments made by Welsh Government from 6.3% to 9.4%.

Notional Welsh Government funding split:

Notional 9.4% staff employer pension £51,784K
Pensions Annual Allowance Charge Compensation Scheme (PAACCS) £13K

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The notes on pages 8 to 79 form part of these accounts.

Statement of Cash Flows for year ended 31 March 2026

	Notes	2025-26 £000	2024-25 £000
Cash Flows from operating activities			
Net operating cost for the financial year		**(2,043,604)**	(1,920,421)
Movements in Working Capital	27	**(31,754)**	8,153
Other cash flow adjustments	28	**175,515**	110,857
Provisions utilised	20	**(35,123)**	(22,996)
Net cash outflow from operating activities		**(1,934,966)**	(1,824,407)
Cash Flows from investing activities			
Purchase of property, plant and equipment		**(42,183)**	(61,328)
Proceeds from disposal of property, plant and equipment		**193**	116
Purchase of intangible assets		**(135)**	(2,271)
Proceeds from disposal of intangible assets		**0**	0
Payment for other financial assets		**0**	0
Proceeds from disposal of other financial assets		**0**	0
Payment for other assets		**0**	0
Proceeds from disposal of other assets		**0**	0
Net cash inflow/(outflow) from investing activities		**(42,125)**	(63,483)
Net cash inflow/(outflow) before financing		**(1,977,091)**	(1,887,890)
Cash Flows from financing activities			
Welsh Government funding (including capital)		**1,981,900**	1,893,053
Capital receipts surrendered		**0**	0
Capital grants received		**0**	0
Capital element of payments in respect of finance leases and on-SoFP PFI Schemes		**0**	0
Capital element of payments in respect of on-SoFP PFI		**(125)**	(639)
Capital element of payments in respect of Right of Use Assets		**(3,956)**	(3,846)
Cash transferred (to)/ from other NHS bodies		**0**	0
Net financing		**1,977,819**	1,888,568
Net increase/(decrease) in cash and cash equivalents		**728**	678
Cash and cash equivalents (and bank overdrafts) at 1 April 2025		**4,823**	4,145
Cash and cash equivalents (and bank overdrafts) at 31 March 2026		**5,551**	4,823

The notes on pages 8 to 79 form part of these accounts.

Notes to the Accounts

1. Accounting policies

The Minister for Health and Social Services has directed that the financial statements of Local Health Boards (LHBs) in Wales shall meet the accounting requirements of the NHS Wales Manual for Accounts. Consequently, the following financial statements have been prepared in accordance with the 2025-26 Manual for Accounts. The accounting policies contained in that manual follow the 2025-26 Financial Reporting Manual (FReM) in accordance with international accounting standards in conformity with the requirements of the Companies Act 2006, to the extent that they are meaningful and appropriate to the NHS in Wales.

Where the LHB Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the LHB for the purpose of giving a true and fair view has been selected. The particular policies adopted by the LHB are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1. Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets and inventories.

1.2. Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.3. Income and funding

The main source of funding for the LHBs are allocations (Welsh Government funding) from the Welsh Government within an approved cash limit, which is credited to the General Fund of the LHB. Welsh Government funding is recognised in the financial period in which the cash is received.

Non-discretionary funding outside the Revenue Resource Limit is allocated to match actual expenditure incurred for the provision of specific pharmaceutical, or ophthalmic services identified by the Welsh Government. Non-discretionary expenditure is disclosed in the accounts and deducted from operating costs charged against the Revenue Resource Limit.

Funding for the acquisition of fixed assets received from the Welsh Government is credited to the General Fund.

Miscellaneous income is income which relates directly to the operating activities of the LHB and is not funded directly by the Welsh Government. This includes payment for services uniquely provided by the LHB for the Welsh Government such as funding provided to agencies and non-activity costs incurred by the LHB in its provider role. Income received from LHBs transacting with other LHBs is always treated as miscellaneous income.

From 2018-19, IFRS 15 Revenue from Contracts with Customers has been applied, as interpreted and adapted for the public sector, in the FREM. It replaces the previous standards IAS 11 Construction Contracts and IAS 18 Revenue and related IFRIC and SIC interpretations. The potential amendments identified as a result of the adoption of IFRS 15 are significantly below materiality levels.

Income is accounted for applying the accruals convention. Income is recognised in the period in which services are provided. Where income had been received from third parties for a specific activity to be delivered in the following financial year, that income will be deferred. Only non-NHS income may be deferred.

1.4. Employee benefits

1.4.1. Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.4.2. Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

The Department of Health and Social Care (DHSC) 2023-24 consultation on the NHS Pension Scheme confirmed that the transitional approach that has operated since 2019-20 for employer contributions will continue in 2025-26. From 1st April 2024 an employer rate of 23.7% (23.78% inclusive of the administration charge) will apply. However, the NHS Business Services Authority will continue to only collect 14.38% from NHS Wales employers under their normal monthly payment process to the NHS Pension Scheme. This has a resulted in an increase in the central payments made by Welsh Government directly to the Pension Scheme administrator, the NHS Business Services Authority (BSA the NHS Pensions Agency) from 6.3% to 9.4%.

However, NHS Wales' organisations are required to account for their staff employer contributions of 23.78% in full and on a gross basis, in their annual accounts. Payments made on their behalf by Welsh Government are accounted for on a notional basis. For detailed information see the Other Note within these accounts.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the NHS Wales organisation commits itself to the retirement, regardless of the method of payment.

Where employees are members of the Local Government Superannuation Scheme, which is a defined benefit pension scheme this is disclosed. The scheme assets and liabilities attributable to those employees can be identified and are recognised in the NHS Wales organisation’s accounts. The assets are measured at fair value and the liabilities at the present value of the future obligations. The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The expected gain during the year from scheme assets is recognised within finance income. The interest cost during the year arising from the unwinding of the discount on the scheme liabilities is recognised within finance costs.

1.4.3. NEST Pension Scheme

An alternative pensions scheme for employees not eligible to join the NHS Pensions scheme has to be offered. The NEST (National Employment Savings Trust) Pension scheme is a defined contribution scheme and therefore the cost to the NHS body of participating in the scheme is equal to the contributions payable to the scheme for the accounting period.

1.5. Other expenses

Other operating expenses for goods or services are recognised when, and to the extent that, they have been received. They are measured at the fair value of the consideration payable.

1.6. Property, plant and equipment

1.6.1. Recognition

Property, plant and equipment is capitalised if:

● it is held for use in delivering services or for administrative purposes;

● it is probable that future economic benefits will flow to, or service potential will be supplied to, the NHS Wales organisation;

● it is expected to be used for more than one financial year;

● the cost of the item can be measured reliably; and

● the item has cost of at least £5,000; or

● Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or

● Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.6.2. Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Land and buildings used for services or for administrative purposes are stated in the Statement of Financial Position (SoFP) at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

● Land and non-specialised buildings – market value for existing use

● Specialised buildings – depreciated replacement cost

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. NHS Wales' organisations have applied these new valuation requirements from 1st April 2009.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

In 2022-23 a formal revaluation exercise was applied to land and properties. The carrying value of existing assets at that date will be written off over their remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure.

References in IAS 36 to the recognition of an impairment loss of a revalued asset being treated as a revaluation decrease to the extent that the impairment does not exceed the amount in the revaluation surplus for the same asset, are adapted such that only those impairment losses that do not result from a clear consumption of economic benefit or reduction of service potential (including as a result of loss or damage resulting from normal business operations) should be taken to the revaluation reserve. Impairment losses that arise from a clear consumption of economic benefit should be taken to the Statement of Comprehensive Net Expenditure (SoCNE).

From 2015-16, IFRS 13 Fair Value Measurement must be complied with in full. However, IAS 16 and IAS 38 have been adapted for the public sector context which limits the circumstances under which a valuation is prepared under IFRS 13. Assets which are held for their service potential and are in use should be measured at their current value in existing use. For specialised assets current value in existing use should be interpreted as the present value of the assets remaining service potential, which can be assumed to be at least equal to the cost of replacing that service potential. Where there is no single class of asset that falls within IFRS 13, disclosures should be for material items only.

In accordance with the adaptation of IAS 16 in table 6.2 of the FReM, for non-specialised assets in operational use, current value in existing use is interpreted as market value for existing use which is defined in the RICS Red Book as Existing Use Value (EUV).

Assets which were most recently held for their service potential but are surplus should be valued at current value in existing use, if there are restrictions on the NHS organisation or the asset which would prevent access to the market at the reporting date. If the NHS organisation could access the market then the surplus asset should be used at fair value using IFRS 13. In determining whether such an asset which is not in use is surplus, an assessment should be made on whether there is a clear plan to bring the asset back into use as an operational asset. Where there is a clear plan, the asset is not surplus and the current value in existing use should be maintained. Otherwise the asset should be assessed as being surplus and valued under IFRS13.

Assets which are not held for their service potential should be valued in accordance with IFRS 5 or IAS 40 depending on whether the asset is actively held for sale. Where an asset is not being used to deliver services and there is no plan to bring it back into use, with no restrictions on sale, and it does not meet the IAS 40 and IFRS 5 criteria, these assets are surplus and are valued at fair value using IFRS 13.

1.6.3. Subsequent expenditure

Subsequent expenditure that enhances an asset beyond its original specification is capitalised as directly attributable cost. Expenditure that restores an asset to its original specification is also capitalised; where identifiable, the carrying value of the component replaced is written out and charged to the Statement of Comprehensive Net Expenditure (SoCNE).

In line with national protocol set out in the capital accounting chapter of the Manual for Accounts (agreed with Audit Wales and the Welsh Government), and to mitigate limitations in identifying replaced components, NHS Wales organisations obtain valuation evidence to ensure asset carrying values are not materially overstated. This includes in-year good housekeeping revaluations (prior to being brought into use) for All Wales Capital Schemes and for Discretionary Building Schemes with spend greater than £0.5m. Any write-downs arising are charged to operating expenses.

In 2025-26, the valuation approach was updated to include a District Valuer (DV) desktop review for material schemes that include replacement or backlog maintenance but do not meet the criteria for a good housekeeping valuation (generally schemes costing over £500k and linked to a specific block or blocks). The DV desktop review classifies schemes as enhancing or non-enhancing. Non-enhancing schemes are impaired on transfer from assets under construction (AUC) to the relevant property, plant and equipment category.

1.7. Intangible assets

1.7.1. Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the NHS Wales organisation; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use.
- the intention to complete the intangible asset and use it.
- the ability to use the intangible asset.
- how the intangible asset will generate probable future economic benefits.
- the availability of adequate technical, financial and other resources to complete the intangible asset and use it.
- the ability to measure reliably the expenditure attributable to the intangible asset during its

1.7.2 Measurement

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.8. Depreciation, amortisation and impairments

Freehold land, assets under construction and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the NHS Wales Organisation expects to obtain economic benefits or service potential from the asset. This is specific to the NHS Wales organisation and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and estimated useful lives.

At each reporting period end, the NHS Wales organisation checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

Impairment losses that do not result from a loss of economic value or service potential are taken to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to the SoCNE. Impairment losses that arise from a clear consumption of economic benefit are taken to the SoCNE. The balance on any revaluation reserve (up to the level of the impairment) to which the impairment would have been charged under IAS 36 are transferred to retained earnings. Right of use (ROU) asset impairments are reflected in ROU liability.

1.9. Research and Development

Research and development expenditure is charged to operating costs in the year in which it is incurred, except insofar as it relates to a clearly defined project, which can be separated from patient care activity and the benefits from which can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the SoCNE on a systematic basis over the period expected to benefit from the project.

1.10 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the

within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the SoCNE. On disposal, the balance for the asset on the revaluation reserve, is transferred to the General Fund.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead it is retained as an operational asset and its economic life adjusted. The asset is derecognised when it is scrapped or demolished.

1.11 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration.

IFRS 16 leases is effective across public sector from 1st April 2022. The transition to IFRS 16 has been completed in accordance with paragraph C5 (b) of the Standard, applying IFRS 16 requirements retrospectively recognising the cumulative effects at the date of initial application.

In the transition to IFRS 16 a number of elections and practical expedients offered in the standard have been employed. These are as follows: The entity has applied the practical expedient offered in the standard per paragraph C3 to apply IFRS 16 to contracts or arrangements previously identified as containing a lease under the previous leasing standards IAS 17 leases and IFRIC 4 determining whether an arrangement contains a lease and not to those that were identified as not containing a lease under previous leasing standards.

On initial application the LHB has measured the right of use assets for leases previously classified as operating leases per IFRS 16 C8 (b)(ii), at an amount equal to the lease liability adjusted for accrued or prepaid lease payments.

No adjustments have been made for operating leases in which the underlying asset is of low value per paragraph C9 (a) of the standard.

The transitional provisions have not been applied to operating leases whose terms end within 12 months of the date of initial application per paragraph C10 (c) of IFRS 16.

Hindsight is used to determine the lease term when contracts or arrangements contain options to extend or terminate the lease in accordance with C10 (e) of IFRS 16.

Due to transitional provisions employed the requirements for identifying a lease within paragraphs 9 to 11 of IFRS 16 are not employed for leases in existence at the initial date of application. Leases entered into on or after the 1st April 2022 will be assessed under the requirements of IFRS 16.

There are further expedients or election that have been employed by the LHB in applying IFRS 16.

These include:

- the measurement requirements under IFRS 16 are not applied to leases with a term of 12 months or less under paragraph 5 (a) of IFRS 16
- the measurement requirements under IFRS 16 are not applied to leases where the underlying asset is of a low value which are identified as those assets of a value of less than £5,000, excluding any irrecoverable VAT, under paragraph 5 (b) of IFRS 16

The LHB will not apply IFRS 16 to any new leases of intangible assets, applying the treatment described in

List any other expedients employed by the entity (such as low value 5(b) or 15 on componentisation HM Treasury have adapted the public sector approach to IFRS 16 which impacts on the identification and measurement of leasing arrangements that will be accounted for under IFRS 16.

The LHB is required to apply IFRS 16 to lease like arrangements entered into with other public sector entities that are in substance akin to an enforceable contract, that in their formal legal form may not be enforceable. Prior to accounting for such arrangements under IFRS 16 the LHB has assessed that in all other respects these arrangements meet the definition of a lease under the standard.

The LHB is required to apply IFRS 16 to lease like arrangements entered into in which consideration exchanged is nil or nominal, therefore significantly below market value. These arrangements are described as peppercorn leases. Such arrangements are again required to meet the definition of a lease in every other respect prior to inclusion in the scope of IFRS 16. The accounting for peppercorn arrangements aligns to that identified for donated assets. Peppercorn leases are different in substance to arrangements in which consideration is below market value but not significantly below market value.

The nature of the accounting policy change for the lessee is more significant than for the lessor under IFRS 16. IFRS 16 introduces a singular lessee approach to measurement and classification in which lessees recognise a right of use asset.

For the lessor leases remain classified as finance leases when substantially all the risks and rewards incidental to ownership of an underlying asset are transferred to the lessee. When this transfer does not occur, leases are classified as operating leases.

1.11.1 Aneurin Bevan University LHB as lessee

At the commencement date for the leasing arrangement a lessee shall recognise a right of use asset and corresponding lease liability. The LHB employs a revaluation model for the subsequent measurement of its right of use assets unless cost is considered to be an appropriate proxy for current value in existing use or fair value in line with the accounting policy for owned assets. Where consideration exchanged is identified as below market value, cost is not considered to be an appropriate proxy to value the right of use asset.

Irrecoverable VAT is expensed in the period to which it relates and therefore not included in the measurement of the lease liability and consequently the value of the right of use asset.

The incremental borrowing rate of 0.95% has been applied to the lease liabilities recognised at the date of initial application of IFRS 16.

Where changes in future lease payments result from a change in an index or rate or rent review, the lease liabilities are remeasured using an unchanged discount rate.

Where there is a change in a lease term or an option to purchase the underlying asset the LHB applies a revised rate to the remaining lease liability.

Where existing leases are modified the LHB must determine whether the arrangement constitutes a separate lease and apply the standard accordingly.

Lease payments are recognised as an expense on a straight-line or another systematic basis over the lease term, where the lease term is in substance 12 months or less, or is elected as a lease containing low value underlying asset by the LHB.

1.11.2 Aneurin Bevan University LHB as lessor

A lessor shall classify each of its leases as an operating or finance lease. A lease is classified as finance lease when the lease substantially transfers all the risks and rewards incidental to ownership of an underlying asset. Where substantially all the risks and rewards are not transferred, a lease is classified as an operating lease.

Amounts due from lessees under finance leases are recorded as receivables at the amount of the LHB's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the LHB's net investment outstanding in respect of the leases.

Income from operating leases is recognised on a straight-line or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Where the LHB is an intermediate lessor, being a lessor and a lessee regarding the same underlying asset, classification of the sublease is required to be made by the intermediate lessor considering the term of the arrangement and the nature of the right of use asset arising from the head lease.

On transition the LHB has reassessed the classification of all of its continuing subleasing arrangements to include peppercorn leases.

1.12. Inventories

Whilst it is accounting convention for inventories to be valued at the lower of cost and net realisable value using the weighted average or "first-in first-out" cost formula, it should be recognised that the NHS is a special case in that inventories are not generally held for the intention of resale and indeed there is no market readily available where such items could be sold. Inventories are valued at cost and this is considered to be a reasonable approximation to fair value due to the high turnover of stocks. Work-in-progress comprises goods in intermediate stages of production. Partially completed contracts for patient services are not accounted for as work-in-progress.

1.13. Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in three months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value. In the Statement of Cash flows (SoCF), cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the cash management.

1.14. Provisions

Provisions are recognised when the LHB has a present legal or constructive obligation as a result of a past event, it is probable that the LHB will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using the discount rate supplied by HM Treasury.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the LHB has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the LHB has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.14.1. Clinical negligence and personal injury costs

The Welsh Risk Pool Services (WRPS) operates a risk pooling scheme which is co-funded by the Welsh Government with the option to access a risk sharing agreement funded by the participative NHS Wales bodies. The risk sharing option was implemented in both 2024-25 and 2025-26. The WRPS is hosted by

1.14.2. Future Liability Scheme (FLS) - General Medical Practice Indemnity (GMPI)

The FLS is a state backed scheme to provide clinical negligence General Medical Practice Indemnity (GMPI) for providers of GMP services in Wales.

In March 2019, the Minister issued a Direction to Velindre University NHS Trust to enable Legal and Risk Services to operate the Scheme. The GMPI is underpinned by new secondary legislation, The NHS (Clinical Negligence Scheme) (Wales) Regulations 2019 which came into force on 1st April 2019.

GMP Service Providers are not direct members of the GMPI FLS, their qualifying liabilities are the subject of an arrangement between them and their relevant LHB, which is a member of the scheme. The qualifying reimbursements to the LHB are not subject to the £25,000 excess.

1.15. Financial Instruments

From 2018-19 IFRS 9 Financial Instruments has applied, as interpreted and adapted for the public sector, in the FReM. The principal impact of IFRS 9 adoption by NHS Wales' organisations, was to change the calculation basis for bad debt provisions, changing from an incurred loss basis to a lifetime expected credit loss (ECL) basis.

All entities applying the FReM recognised the difference between previous carrying amount and the carrying amount at the beginning of the annual reporting period that included the date of initial application in the opening general fund within Taxpayer's equity.

1.16. Financial assets

Financial assets are recognised on the SoFP when the LHB becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

The accounting policy choice allowed under IFRS 9 for long term trade receivables, contract assets which do contain a significant financing component (in accordance with IFRS 15), and lease receivables within the scope of IAS 17 has been withdrawn and entities should always recognise a loss allowance at an amount equal to lifetime Expected Credit Losses. All entities applying the FReM should utilise IFRS 9's simplified approach to impairment for relevant assets.

IFRS 9 requirements required a revised approach for the calculation of the bad debt provision, applying the principles of expected credit loss, using the practical expedients within IFRS 9 to construct a provision matrix.

1.16.1. Financial assets are initially recognised at fair value

Financial assets are classified into the following categories: financial assets 'at fair value through SoCNE'; 'held to maturity investments'; 'available for sale' financial assets, and 'loans and receivables'. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

1.16.2. Financial assets at fair value through SoCNE

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through SoCNE. They are held at fair value, with any resultant gain or loss recognised in the SoCNE. The net gain or loss incorporates any interest earned on the financial asset.

1.16.3 Held to maturity investments

Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

1.16.4. Available for sale financial assets

Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to the SoCNE on de-recognition.

1.16.5. Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the net carrying amount of the financial asset.

At the SOFP date, the LHB assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the SoCNE and the carrying amount of the asset is reduced directly, or through a provision of impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through the SoCNE to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.17. Financial liabilities

Financial liabilities are recognised on the SOFP when the LHB becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.17.1. Financial liabilities are initially recognised at fair value

Financial liabilities are classified as either financial liabilities at fair value through the SoCNE or other financial liabilities.

1.17.2. Financial liabilities at fair value through the SoCNE

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the SoCNE. The net gain or loss incorporates any interest earned on the financial asset.

1.17.3. Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.18. Value Added Tax (VAT)

Most of the activities of the NHS Wales organisation are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.19. Foreign currencies

Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. Resulting exchange gains and losses are taken to the SoCNE. At the SoFP date, monetary items denominated in foreign currencies are retranslated at the rates prevailing at the reporting date.

1.20. Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS Wales organisation has no beneficial interest in them. Details of third party assets are given in the Notes to the accounts.

1.21. Losses and Special Payments

Losses and special payments are items that the Welsh Government would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and special payments are charged to the relevant functional headings in the SoCNE on an accruals basis, including losses which would have been made good through insurance cover had the LHB not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, the note on losses and special payments is compiled directly from the losses register which is prepared on a cash basis.

The LHB accounts for all losses and special payments gross (including assistance from the WRP).

The LHB accrues or provides for the best estimate of future pay-outs for certain liabilities and discloses all other potential payments as contingent liabilities, unless the probability of the liabilities becoming payable is remote.

All claims for losses and special payments are provided for where the probability of settlement of an individual claim is over 50%. Where reliable estimates can be made, incidents of clinical negligence against which a claim has not, as yet, been received are provided in the same way. Expected reimbursements from the WRP are included in debtors. For those claims where the probability of settlement is between 5- 50%, the liability is disclosed as a contingent liability.

1.22. Pooled budgets

The NHS Wales organisation has entered into pooled budgets with Local Authorities. Under the arrangements funds are pooled in accordance with section 33 of the NHS (Wales) Act 2006 for specific activities defined in the Pooled budget Note 32.

The pool budget is hosted by one NHS Wales's organisation. Payments for services provided are accounted for as miscellaneous income. The NHS Wales organisation accounts for its share of the assets, liabilities, income and expenditure from the activities of the pooled budget, in accordance with the pooled budget arrangement.

Monmouthshire County Council - Monnow Vale Health and Social Care Unit
Funds are pooled for the provision of health and social care inpatient, outpatient, clinic and day care facilities to individuals who have medical, social, community or rehabilitation needs. The pool is hosted by Aneurin Bevan University Local Health Board. The financial operation of the pool is governed by a pooled budget agreement between the Local Health Board and Monmouthshire County Council. The income from Monmouthshire County Council is recorded as Local Authority Income in these accounts.

Expenditure for services provided under the arrangement is recorded under the appropriate expense headings in these accounts.

The property in which the unit is housed has been provided by a Private Finance Partner; the contract with the PFI partner is for 30 years and is categorised as an on balance sheet PFI scheme with the HB recognising 72% of the property - see Note 32 of these accounts for further details.

The five Local Authorities in Gwent and ABUHB- Gwent Wide Integrated Community Equipment Service
Funds are pooled for the provision of an efficient and effective GWICES (Gwent Wide Integrated Community Equipment Service) to service users who are resident in the partner localities. The pool is hosted by Torfaen County Borough Council. The Health Board makes a financial contribution to the scheme but does not account for the schemes expenditure or assets/liabilities generated by this expenditure.
The financial operation of the pool is governed by a pooled budget agreement between the bodies listed above and the Health Board. Payments for services provided by the host body, Torfaen County Borough Council, are accounted for as expenditure within these accounts.

Monmouthshire County Council - Mardy Park Rehabilitation Centre
Funds are pooled for the provision of care to individuals who have rehabilitation needs. The LHB has entered into a pooled budget with Monmouthshire County Council. The pool is hosted by Monmouthshire County Council.

The five Local Authorities in Gwent and ABUHB - Gwent Frailty Programme
Funds are pooled for the purpose of establishing a consistent service across Gwent. The pool is hosted by Caerphilly County Borough Council, as lead commissioner. The financial operation of the pool is governed by a pooled budget agreement between the bodies listed above and the Health Board. Payments for services provided by the host body, Caerphilly County Borough Council, are accounted for as expenditure within these accounts. Additional information is provided in Note 32.

The five Local Authorities in Gwent and ABUHB – A pooled Fund for Care Home Accommodation functions for Older People
Statutory Directions issued under section 169 of the Social Services and Wellbeing (Wales) Act 2014 required Partnership Bodies to enter into partnership arrangements and for the establishment and maintenance of pooled funds from April 2018, for the exercise of their Care Home Accommodation Functions.

The overarching strategic aim of this Agreement is: -

• To ensure coordinated arrangements for ensuring an integrated approach across the Partnership to the commissioning and arranging for Care Home Accommodation for Older People.

• To ensure provision of high quality, cost effective Care Home Accommodation which meets local health and social care needs, through the establishment of a pooled fund.

• To develop a managed market approach to the supply of quality provision to meets the needs of Older People Care Home Accommodation.

Funds are pooled for the provision and commissioning of specified services for older people (>65 years of age) in a care home setting in Gwent. The pool has been hosted by Torfaen County Borough Council since August 2018.

The Health Board makes a financial contribution to the scheme equivalent to actual expenditure incurred in commissioning related placements in homes during the year, but in addition does incur minimal costs associated with a share of the services provided by the host organisation and these are accounted for as expenditure within these accounts.

1.23. Critical Accounting Judgements and key sources of estimation uncertainty

In the application of the accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources.

The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates. The estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or the period of the revision and future periods if the revision affects both current and future periods.

1.24. Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the SoFP date, that have a significant risk of causing material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Significant estimations are made in relation to on-going clinical negligence and personal injury claims. Assumptions as to the likely outcome, the potential liabilities and the timings of these litigation claims are provided by independent legal advisors. Any material changes in liabilities associated with these claims would be recoverable through the Welsh Risk Pool.

Significant estimations are also made for continuing care costs resulting from claims post 1st April 2003. An assessment of likely outcomes, potential liabilities and timings of these claims are made on a case by case basis. Material changes associated with these claims would be adjusted in the period in which they are revised.

Estimates are also made for contracted primary care services. These estimates are based on the latest payment levels.

1.24.1. Provisions

The LHB provides for legal or constructive obligations for clinical negligence, personal injury and defence costs that are of uncertain timing or amount at the balance sheet date on the basis of the best estimate of the expenditure required to settle the obligation.

Claims are funded via the Welsh Risk Pool Services (WRPS) which receives an annual allocation from Welsh Government to cover the cost of reimbursement requests submitted to the bi-monthly WRPS Committee. Following settlement to individual claimants by the NHS Wales organisation, the full cost is recognised in year and matched to income (less a £25K excess) via a WRPS debtor, until reimbursement has been received from the WRPS Committee.

1.24.2. Probable & Certain Cases – Accounting Treatment

A provision for these cases is calculated in accordance with IAS 37. Cases are assessed and divided into four categories according to their probability of settlement;

Remote	Probability of Settlement	0 – 5%
	Accounting Treatment	Remote Contingent Liability.
Possible	Probability of Settlement	6% - 49%
	Accounting Treatment	Defence Fee - Provision *
		Contingent Liability for all other estimated expenditure
Probable	Probability of Settlement	50% - 94%
	Accounting Treatment	Full Provision
Certain	Probability of Settlement	95% - 100%
	Accounting Treatment	Full Provision

** Personal injury cases - Defence fee costs are provided for at 100%.*

The provision for probable and certain cases is based on case estimates of individual reported claims received by Legal & Risk Services within NHS Wales Shared Services Partnership.

The solicitor will estimate the case value including defence fees, using professional judgement and from obtaining counsel advice. Valuations are then discounted for the future loss elements using individual life expectancies and the Government Actuary's Department actuarial tables (Ogden tables) and Personal Injury Discount Rate of 0.5%.

Future liabilities for certain & probable cases with a probability of 95%-100% and 50%- 94% respectively are held as a provision on the balance sheet. Cases typically take a number of years to settle, particularly for high value cases where a period of development is necessary to establish the full extent of the injury caused.

The Health Board has provided for some £237m (£199m 2024/25) within note 20 in respect of potential clinical negligence and personal injury claims and associated defence fees. These provisions have been arrived at on the advice of NHS Wales Shared Services Partnership - Legal & Risk Services. Given the nature of such claims this figure could be subject to significant change in future periods. However, the potential financial effect of such uncertainty is mitigated by the fact that the LHB's ultimate liability in respect of individual cases is capped at £0.025m, with amounts above this excess level being reimbursed by the Welsh Risk Pool.

The Health Board has estimated a liability of £0.869m (£0.379m 2024/25) in respect of retrospective claims for Continuing Health Care funding. The estimated provision is based upon an assessment of the likelihood of claims meeting criteria for continuing health care and the actual costs incurred by individuals in care homes. The provision is based on information made available to the Health Board at the time of these accounts and could be subject to significant change as outcomes are determined.

Aneurin Bevan University Local Health Board has reviewed its portfolio of outstanding claims for continuing healthcare and made an assessment of likely financial liability based on an estimated success factor, eligibility factor and expected weekly average costs of claims. The assumptions have been derived by reviewing a sample of claims.

Primary care expenditure includes estimates for areas which are paid in arrears and not finalised at the time of producing the accounts. These estimates relate to GMS Quality Assurance and Improvement Framework, GMS Enhanced Services, and pharmacy estimates, which are based on an assessment of likely final performance.

1.25 Discount Rates

Where discount is applied, a disclosure detailing the impact of the discounting on liabilities to be included for the relevant notes. The disclosure should include where possible undiscounted values to demonstrate the impact. An explanation of the source of the discount rate or how the discount rate has been determined to be included.

Within the Provisions Note (note 20) the amount relating to Early Retirements and Permanent Injury benefits has been discounted using the PES (2024) Post Employment Benefits Liabilities Real Rate in Excess of CPI of 2.95%.

1.26 Private Finance Initiative (PFI) transactions

HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The LHB therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

a) Payment for the fair value of services received;

b) Payment for the PFI asset, including finance costs; and

c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

1.26.1. Services received

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

1.26.2. PFI asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the LHB's approach for each relevant class of asset in accordance with the principles of IAS 16.

1.26.3. PFI liability

A PFI liability is recognised at the same time as the PFI assets are recognised.

Prior year treatment

It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the SoCNE.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the SoCNE.

1.26.4 Impact of IFRS 16 on on-balance sheet PFI/PPP Schemes as from 1st April 2023.

On-balance sheet PPP arrangements should be based on IFRS 16 accounting principles from 2023-24.

When measuring the liability for on-balance sheet PPP contracts containing capital payments linked to a price index IFRS 16 requires that a lessee shall remeasure the lease liability where there is a change in future lease payments resulting from a change in an index or a rate used to determine those payments. The lessee shall remeasure the lease liability to reflect those revised lease payments only when there is a change in the cash flows.

Initial remeasurement - the future PPP liability will need to be remeasured at 1st April 2023 to include the actual indexation-linked changes to payments for the capital/infrastructure element which have taken effect in the cash flows since the PPP agreement commenced. This should use a cumulative catch-up approach, where the cumulative effect is recognised as an adjustment to the opening balance of retained earnings.

Subsequent measurement - The PPP liability will continue to require remeasurements whenever cash payments change in response to indexation movements as set out in the individual PPP contract. The double entry for the subsequent liability remeasurement should be Debit Finance Cost, Credit PPP liability.

The liability does not include estimated future indexation linked increases.

1.26.5. Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the LHB's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

1.26.6. Assets contributed by the LHB to the operator for use in the scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the LHB's SoFP.

1.26.7. Other assets contributed by the LHB to the operator

Assets contributed (e.g. cash payments, surplus property) by the LHB to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the LHB, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured at the present value of the minimum lease payments, discounted using the implicit interest rate. It is subsequently measured as a finance lease liability in accordance with IAS 17.

On initial recognition of the asset, the difference between the fair value of the asset and the initial liability is recognised as deferred income, representing the future service potential to be received by the NHS Wales organisation through the asset being made available to third party users.

Other PFI arrangements off Statement of Financial Position

The LHB has one PFI Scheme that was previously classified as off-statement of financial position. The scheme related to the provision of replacement heating and lighting systems within Nevill Hall hospital. The scheme commenced in 2000 for a period of 25 years. Since the introduction of IFRS 16 in 2022/23, the off-statement of Financial Position PFI has been recognised as a Right of use Asset.

Joint PFI contract

The LHB has entered into an agreement to share a facility, provided by a Private Finance Partner, with Monmouthshire County Council to match the agreement with the Private Finance Partner. The arrangement is treated as a PFI arrangement and the total obligation is included as a liability of the LHB. The contribution towards the unitary charge committed by Monmouthshire County Council is treated as a financial asset. The future contribution was measured initially at the same amount as the fair value of the share of the PFI asset and is subsequently measured as a finance lease.

1.27. Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the LHB, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the LHB. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

Remote contingent liabilities are those that are disclosed under Parliamentary reporting requirements and not under IAS 37 and, where practical, an estimate of their financial effect is required.

1.28. Absorption accounting

Transfers of function are accounted for as either by merger or by absorption accounting dependent upon the treatment prescribed in the FReM. Absorption accounting requires that entities account for their transactions in the period in which they took place with no restatement of performance required.

Where transfer of function is between LHBs the gain or loss resulting from the assets and liabilities transferring is recognised in the SoCNE and is disclosed separately from the operating costs.

1.29. Accounting standards that have been issued but not yet been adopted

The following accounting standards have been issued and or amended by the IASB and IFRIC but have not been adopted because they are not yet required to be adopted by the FReM.

IFRS14 Regulatory Deferral Accounts - Not UK endorsed. Applies to first time adopters of IFRS after 1st January 2016. Therefore not applicable.

IFRS 18 Presentation and Disclosure in Financial Statements - Application required for accounting periods beginning on or after 1st January 2027. Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted.

IFRS 19 Subsidiaries without Public Accountability: Disclosures - Application required for accounting periods beginning on or after 1st January 2027. Standard is not yet UK endorsed and not yet adopted by

1.30. Accounting standards issued that have been adopted early

During 2025-26 there have been no accounting standards that have been adopted early. All early adoption of accounting standards will be led by HM Treasury.

1.31. Charities

Following Treasury's agreement to apply IAS 27 to NHS Charities from 1 April 2013, the LHB has established that as it is the corporate trustee of the Aneurin Bevan University LHB NHS Charitable Fund, it is considered for accounting standards compliance to have control of the Aneurin Bevan University LHB NHS Charitable Fund as a subsidiary.

The determination of control is an accounting standard test of control and there has been no change to the operation of the Aneurin Bevan University LHB NHS Charitable Fund or its independence in its management of charitable funds.

Whilst there is a requirement to consolidate the results of the Aneurin Bevan University LHB NHS Charitable Fund within the statutory accounts of the LHB. The LHB has with the agreement of the Welsh Government adopted the IAS 27 (10) exemption to consolidate.

Welsh Government as the ultimate parent of the Local Health Boards will disclose the Charitable Accounts of Local Health Boards in the Welsh Government Consolidated Accounts.

Details of the transactions with the charity are included in the related parties' notes.

2. Financial Duties Performance

The National Health Service Finance (Wales) Act 2014 came into effect from 1st April 2014. The Act amended the financial duties of Local Health Boards under section 175 of the National Health Service (Wales) Act 2006. From 1st April 2014 section 175 of the National Health Service (Wales) Act places two financial duties on Local Health Boards:

- A duty under section 175 (1) to secure that its expenditure does not exceed the aggregate of the funding allotted to it over a period of 3 financial years;
- A duty under section 175 (2A) to prepare a plan in accordance with planning directions issued by the Welsh Ministers, to secure compliance with the duty under section 175 (1) while improving the health of the people for whom it is responsible, and the provision of health care to such people, and for that plan to be submitted to and approved by the Welsh Ministers.

The first assessment of performance against the 3 year statutory duty under section 175 (1) was at the end of 2016-17, being the first 3 year period of assessment.

Welsh Health Circular WHC/2016/054 "Statutory and Financial Duties of Local Health Boards and NHS Trusts" clarifies the statutory financial duties of NHS Wales bodies effective from 2016-17.

2.1 Revenue Resource Performance

	Annual financial performance			
	2023-24	**2024-25**	**2025-26**	**Total**
	£000	**£000**	**£000**	**£000**
Net operating costs for the year	1,818,468	1,920,421	2,043,604	**5,782,493**
Less general ophthalmic services expenditure and other non-cash limited expenditure	599	(1,693)	(2,349)	**(3,443)**
Less unfunded revenue consequences of bringing PFI schemes onto SoFP	29	(29)	23	**23**
Less any non funded revenue consequences of IFRS 16	0	0	0	**0**
Total operating expenses	1,819,096	1,918,699	2,041,278	**5,779,073**
Revenue Resource Allocation	1,769,330	1,911,514	2,022,996	**5,703,840**
Under /(over) spend against Allocation	**(49,766)**	**(7,185)**	**(18,282)**	**(75,233)**

Aneurin Bevan University LHB has not met its financial duty to break-even against its Revenue Resource Limit over the 3 years 2023-24 to 2025-26.

The Health Board received £18.3m cash-only support from Welsh Government during 2025-26 with the accumulated cash-only support for 2023-24 to 2025-26 as at 31 March 2026 being £75.6m. This support has been provided by Welsh Government to assist the Health Board with making payments to staff and suppliers; there is no requirement for this funding to be repaid.

2.2 Capital Resource Performance

	2023-24	**2024-25**	**2025-26**	**Total**
	£000	**£000**	**£000**	**£000**
Gross capital expenditure	62,681	72,066	45,821	**180,568**
Add: Losses on disposal of donated assets	1	0	6	**7**
Less NBV on disposal of property, plant and equipment, right of use and intangible assets	(5,845)	(1,534)	(366)	**(7,745)**
Adjustment for transfers (to)/from NHS Trusts	0	(45)	0	**(45)**
Less capital grants received	0	0	0	**0**
Less donations received	(136)	(78)	(203)	**(417)**
Less IFRS16 Peppercorn income	0	0	0	**0**
Less **initial recognition** of RoU Asset Dilapidations	0	0	0	**0**
Charge against Capital Resource Allocation	56,701	70,409	45,258	**172,368**
Capital Resource Allocation	56,742	70,475	45,305	**172,522**
(Over) / Underspend against Capital Resource Allocation	**41**	**66**	**47**	**154**

Aneurin Bevan Univesrity LHB has met its financial duty to break-even against its Capital Resource Limit over the 3 years 2023-24 to 2025-26.

2.3 Duty to prepare a 3 year integrated plan

The NHS Wales Planning Framework for the period 2025-2028 issued to LHBs placed a requirement upon them to prepare and submit balanced Integrated Medium-Term Plans to the Welsh Government.

The LHB was unable to submit a balanced Integrated Medium-Term Plan for the period 2025-2028 in accordance with NHS Wales Planning Framework. The Health Board submitted an Annual Plan for 2025-26 with an intention to reach a balanced in-year position in 2027-28.

The Minister for Health and Social Services extant approval

Status

Date

Aneurin Bevan University LHB has therefore not met its statutory duty to have an approved financial plan.

2.4 Creditor payment

The LHB is required to pay 95% of the number of non-NHS bills within 30 days of receipt of goods or a valid invoice (whichever is the later). The LHB has achieved the following results:

	2025-26	2024-25
Total number of non-NHS bills paid	**302,142**	301,118
Total number of non-NHS bills paid within target	**293,413**	294,215
Percentage of non-NHS bills paid within target	97.1%	97.7%

The LHB has met the target.

3. Analysis of gross operating costs

3.1 Expenditure on Primary Healthcare Services

	Cash limited £000	Non-cash limited £000	2025-26 Total £000	2024-25 Total £000
General Medical Services	140,047		140,047	132,671
Pharmaceutical Services	37,718	(8,322)	29,396	29,224
General Dental Services	45,761		45,761	44,444
General Ophthalmic Services	6,580	10,671	17,251	15,075
Other Primary Health Care expenditure	3,715		3,715	4,729
Prescribed drugs and appliances	130,678		130,678	125,771
Total	**364,499**	**2,349**	**366,848**	351,914

Return of excess funds from primary care contractors are included in the figures above

Included within other notes to the accounts			
Additional Primary Care Expenditure	Positive	0	0
Additional Primary Care Income	Negative	(13,172)	(5,843)
Overall total		**353,676**	346,071

The General Medical Services expenditure includes £18,194k (2024/25 £11,699k) in relation to staff salaries, the General Dental Services expenditure includes £2,757k (2024/25 £2,155k) in relation to staff salaries, the Prescribed Drugs & Appliances expenditure includes £309k (2024/25 £352k) in relation to staff salaries, and the General Ophthalmic Services includes £156k (2024/25 £88k) in relation to staff salaries.

3.2 Expenditure on healthcare from other providers

	2025-26 £000	2024-25 £000
Goods and services from other NHS Wales Health Boards	**66,288**	64,362
Goods and services from other NHS Wales Trusts	**60,101**	54,658
Goods and services from Welsh Special Health Authorities	**0**	0
Goods and services from other non Welsh NHS bodies	**23,059**	14,400
Goods and services from NHSW JCC	**232,273**	218,320
Local Authorities	**39,911**	41,544
Voluntary organisations	**11,777**	10,849
NHS Funded Nursing Care	**13,053**	11,817
Continuing Care	**110,957**	99,904
Private providers	**16,799**	10,942
Specific projects funded by the Welsh Government	**0**	0
Other	**372**	407
Total	**574,590**	527,203

Local Authorities expenditure relates to the following bodies:	2025-26 £'000	2024-25 £'000
Blaenau Gwenty County Borough Council	3,381	3,644
Caerphilly County Borough Council	17,379	17,632
Monmouthshire County Council	4,753	4,947
Newport City Council	7,138	8,548
Torfaen County Borough Council	7,168	6,876
Gloucestershire County Council	92	(103)
	39911	41,544

3.3 Expenditure on Hospital and Community Health Services

	2025-26	2024-25
	£000	£000
Directors' costs	2,802	2,741
Operational Staff costs	910,435	843,137
Single lead employer Staff Trainee Cost	45,228	43,004
Collaborative Bank Staff Cost	0	0
Supplies and services - clinical	154,058	143,559
Supplies and services - general	18,199	20,917
Consultancy Services	649	481
Establishment	7,196	6,438
Transport	1,467	1,542
Premises	41,322	46,305
External Contractors	0	0
Depreciation	45,804	42,231
Depreciation Right of Use assets (RoU)	4,116	3,896
Amortisation	1,960	1,964
Fixed asset impairments and reversals (Property, plant & equipment)	(5,687)	1,817
Fixed asset impairments and reversals (RoU Assets)	0	0
Fixed asset impairments and reversals (Intangible assets)	0	0
Impairments & reversals of financial assets	0	0
Impairments & reversals of non-current assets held for sale	0	0
Audit fees	470	443
Other auditors' remuneration	0	0
Losses, special payments and irrecoverable debts	8,725	3,065
Research and Development	0	0
Expense related to short-term leases	168	367
Expense related to low-value asset leases (excluding short-term leases)	980	973
Other operating expenses	15,138	14,310
Total	**1,253,030**	1,177,190

The Health Board Spent £3.3m (£2.8m 2024-25) on Research and Development. The majority of this spend relates to staff £2.7m (£2.2m 2024-25) which along with the non-staff spend is reflected under the various headings within note 3.3. During 2025-26 Research and Development income received was £3.1m (£2.6m 2024-25).

3.4 Losses, special payments and irrecoverable debts: charges to operating expenses

	2025-26	2024-25
Increase/(decrease) in provision for future payments:	**£000**	£000
Clinical negligence;		
Secondary care	**63,373**	2,814
Primary care	**1,199**	49
Redress Secondary Care	**32**	180
Redress Primary Care	**0**	0
Personal injury	**639**	547
All other losses and special payments	**5,271**	1,062
Defence legal fees and other administrative costs	**2,284**	1,414
Gross increase/(decrease) in provision for future payments	**72,798**	**6,066**
Contribution to Welsh Risk Pool	**0**	0
Premium for other insurance arrangements	**0**	0
Irrecoverable debts	**594**	73
Less: income received/due from Welsh Risk Pool	**(64,667)**	(3,074)
Total	**8,725**	3,065

	2025-26	2024-25
	£	£
Permanent injury included within personal injury £:	**(221,402)**	(472,029)

4. Miscellaneous Income

	2025-26 £000	2024-25 £000
Local Health Boards	25,547	24,380
NHSW Joint Commissioning Committee	15,082	14,774
NHS Wales trusts	19,921	17,702
Welsh Special Health Authorities	2,245	1,404
Foundation Trusts	45	97
Other NHS England bodies	3,520	2,975
Other NHS Bodies	49	21
Local authorities	21,263	21,289
Welsh Government	5,510	3,729
Welsh Government Hosted bodies	0	0
Non NHS:		
Prescription charge income	3	3
Dental fee income	5,742	6,130
Private patient income	0	0
Overseas patients (non-reciprocal)	316	365
Injury Costs Recovery (ICR) Scheme	1,401	1,323
Other income from activities	2,777	2,528
Patient transport services	0	0
Education, training and research	21,848	19,086
Charitable and other contributions to expenditure	1,596	1,394
Receipt of NWSSP Covid centrally purchased assets	0	0
Receipt of Covid centrally purchased assets from other organisations	0	0
Receipt of donated assets	203	78
Receipt of Government granted assets	0	0
Right of Use Grant (Peppercorn Lease)	0	0
Non-patient care income generation schemes	144	155
NHS Wales Shared Services Partnership (NWSSP)	0	0
Deferred income released to revenue	0	0
Right of Use Asset Sub-leasing rental income	0	0
Contingent rental income from finance leases	0	0
Rental income from operating leases	477	467
Other income:		
Provision of laundry, pathology, payroll services	96	82
Accommodation and catering charges	3,532	3,349
Mortuary fees	410	422
Staff payments for use of cars	674	673
Business Unit	0	0
Scheme Pays Reimbursement Notional	4	81
Other	19,303	14,099
Total	**151,708**	136,606

Other income Includes;		
Salary Sacrifice Schemes & Fleet Vehicles	2,083	7,772
VAT recoveries re Business Activities and Contracted Out Services	946	986
Income from Managed Practices	5,633	0
Other	10,641	5,341
Total	**19,303**	14,099

Injury Cost Recovery (ICR) Scheme income

	2025-26 %	2024-25 %
To reflect expected rates of collection ICR income is subject to a provision for impairment of:	24.62	24.45

5. Investment Revenue

	2025-26 £000	2024-25 £000
Rental revenue :		
PFI Finance lease income		
planned	0	0
contingent	0	0
Other finance lease revenue	0	0
Interest revenue :		
Bank accounts	0	0
Other loans and receivables	0	0
Impaired financial assets	0	0
Other financial assets	16	16
Total	**16**	16

6. Other gains and losses

	2025-26 £000	2024-25 £000
Gain/(loss) on disposal of property, plant and equipment	(45)	41
Gain/(loss) on disposal other than by sale of right of use assets	1	0
Gain/(loss) on disposal of intangible assets	0	0
Gain/(loss) on disposal of assets held for sale	0	0
Gain/(loss) on disposal of financial assets	0	0
Change on foreign exchange	0	0
Change in fair value of financial assets at fair value through SoCNE	0	0
Change in fair value of financial liabilities at fair value through SoCNE	0	0
Recycling of gain/(loss) from equity on disposal of financial assets held for sale	0	0
Total	(44)	41

7. Finance costs

	2025-26 £000	2024-25 £000
Interest on loans and overdrafts	0	0
Interest on obligations under finance leases	0	0
Interest on obligations under Right of Use Leases	442	353
Interest on obligations under PFI contracts;		
main finance cost	89	132
contingent finance cost	0	0
Impact of IFRS 16 on PPP/PFI contracts	107	147
Interest on late payment of commercial debt	0	0
Other interest expense	0	0
Total interest expense	**638**	632
Provisions unwinding of discount	178	145
Other finance costs	0	0
Total	**816**	777

8. Future charges to Statement of Comprehensive Net Expenditure (SoCNE)

LHB as lessee

As at 31st March 2026 the Health Board had 0 leases agreements in place for the leases of premises; 488 arrangements in respect of equipment and 265 in respect of vehicles, with 0 property, 100 equipment and 55 vehicle leases having expired in year.

	2025-26 Low Value & Short Term	2025-26 Other	2025-26 Total	2024-25 Total
Payments recognised as an expense				
	£000	**£000**	**£000**	£000
Minimum lease payments	**1,186**	**0**	**1,186**	1,363
Contingent rents	**0**	**0**	**0**	0
Sub-lease payments	**0**	**0**	**0**	0
Total	**1,186**	**0**	**1,186**	1,363

Total future minimum lease payments				
Payable	**£000**	**£000**	**£000**	£000
Not later than one year	**1,391**	**0**	**1,391**	820
Between one and five years	**963**	**0**	**963**	803
After 5 years	**0**	**0**	**0**	0
Total	**2,354**	**0**	**2,354**	1,623

LHB as lessor

	2025-26	2024-25
Rental revenue	**£000**	£000
Rent	**477**	467
Contingent rents	**0**	0
Total revenue rental	**477**	467

Total future minimum lease payments		
Receivable	**£000**	£000
Not later than one year	**306**	290
Between one and five years	**1,157**	1,085
After 5 years	**942**	789
Total	**2,405**	2,164

9. Employee benefits and staff numbers

9.1 Employee costs

	Permanent Staff	Staff on Inward Secondment	Agency Staff	Specialist Trainee (SLE)	Collaborative Bank Staff	Other	Total	2024-25
	£000	£000	£000	£000	£000	£000	£000	£000
Salaries and wages	684,814	1,358	22,042	34,909	0	2,841	**745,964**	702,130
Social security costs	88,244	0	0	4,873	0	0	**93,117**	70,709
Employer contributions to NHS Pension Scheme	136,161	0	0	5,446	0	0	**141,607**	130,925
Other pension costs	17	0	0	0	0	0	**17**	229
Other employment benefits	0	0	0	0	0	0	**0**	0
Termination benefits	0	0	0	0	0	0	**0**	0
Total	**909,236**	**1,358**	**22,042**	**45,228**	**0**	**2,841**	**980,705**	903,993

Charged to capital	**767**	802
Charged to revenue	**979,938**	903,191
	980,705	903,993
Net movement in accrued employee benefits (untaken staff leave)	**80**	(38)

The staff under the 'Other' heading relate to Agency Medical Staff who are paid via a direct engagement scheme which commenced in January 2020.

9.2 Average number of employees

	Permanent Staff	Staff on Inward Secondment	Agency Staff	Specialist Trainee (SLE)	Collaborative Bank Staff	Other	Total	2024-25
	Number	Number	Number	Number	Number	Number	Number	Number
Administrative, clerical and board members	2,800	8	11	0	0	0	**2,819**	2,722
Medical and dental	890	5	39	447	0	13	**1,394**	1,339
Nursing, midwifery registered	4,180	0	111	0	0	0	**4,291**	4,121
Professional, Scientific, and technical staff	455	0	10	0	0	0	**465**	433
Additional Clinical Services	2,910	0	23	0	0	0	**2,933**	2,903
Allied Health Professions	981	5	14	0	0	0	**1,000**	982
Healthcare Scientists	258	0	2	0	0	0	**260**	257
Estates and Ancilliary	1,081	0	25	0	0	0	**1,106**	1,054
Students	3	0	0	0	0	0	**3**	6
Total	**13,558**	**18**	**235**	**447**	**0**	**13**	**14,271**	13,817

9.3. Retirements due to ill-health

	2025-26	2024-25
Number	**15**	16
Estimated additional pension costs £	**962,243**	1,456,012

This note discloses the number and additional pension costs for individuals who retired early on ill-health grounds during the year. These additional pension costs have been calculated on an average basis and will be borne by the NHS Pension Scheme.

9.4 Employee benefits

The Health Board does not have an employee benefit scheme.

9.5 Reporting of other compensation schemes - exit packages

9.5.1 Exit Packages Costs and Numbers

Exit packages cost band (including any special payment element)	2025-26 Number of compulsory redundancies	2025-26 Number of other departures	2025-26 Total number of exit packages	2025-26 Number of departures where special payments have been made	2024-25 Total number of exit packages
	Whole numbers only	Whole numbers only	Whole numbers only	Whole numbers only	Whole numbers only
less than £10,000	0	0	0	0	1
£10,000 to £25,000	0	0	0	0	0
£25,000 to £50,000	0	0	0	0	0
£50,000 to £100,000	0	3	3	0	0
£100,000 to £150,000	0	1	1	0	0
£150,000 to £200,000	0	0	0	0	0
more than £200,000	0	0	0	0	0
Total	0	4	4	0	1

Exit packages cost band (including any special payment element)	2025-26 Cost of compulsory redundancies	2025-26 Cost of other departures	2025-26 Total cost of exit packages	2025-26 Cost of special element included in exit packages	2024-25 Total cost of exit packages
	£	£	£	£	£
less than £10,000	0	0	0	0	7,500
£10,000 to £25,000	0	0	0	0	0
£25,000 to £50,000	0	0	0	0	0
£50,000 to £100,000	0	204,086	204,086	204,086	0
£100,000 to £150,000	0	108,975	108,975	108,975	0
£150,000 to £200,000	0	0	0	0	0
more than £200,000	0	0	0	0	0
Total	0	313,061	313,061	313,061	7,500

Total Exit Costs Paid in Year	Total paid in year 2025-26	Total paid in year 2024-25
	£	£
Exit costs paid in year	204,086	7,500
Total	204,086	7,500

This disclosure reports the number and value of exit packages agreed in the year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period.

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Voluntary Early Release Scheme (VERS).

Where the LHB has agreed early retirements, the additional costs are met by the LHB and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

The figures above are consolidated amounts.

The Health Board has approved 4 VERS in 2025-26.

Additional requirement as per FReM
£0 exit costs were paid in 2025-26, relating to 2024-25 (the year of departure).

9.5 Reporting of other compensation schemes - exit packages continued

9.5.2 Analysis of other departures	2025-26 Agreements Number	2025-26 Total value of agreements £
Type of other departures		
Voluntary redundancies including early retirement contractual costs	4	313,061
Contractual payments in lieu of notice*	0	0
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring Welsh Government Approval**	0	0
Other please specify	0	0
Total	**4**	**313,061**

This disclosure provides detail for the number and value of exit packages agreed in the year.

The figures above are consolidated amounts.

9.6 Fair Pay disclosures

9.6.1 Remuneration Relationship

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director/employee in their organisation and the 25th percentile, median and 75th percentile remuneration of the organisation's workforce.

Total Pay and benefits			**£'000**			**£'000**
Chief Executive Total pay and benefits range			**245-250**			**240-245**
Highest paid Director Total pay and benefits range			**245-250**			**240-245**

	2025-26	**2025-26**	**2025-26**	2024-25	2024-25	2024-25
	£'000	**£'000**		£'000	£'000	
Total pay and benefits mid-point	**Chief Executive**	**Employee**	**Ratio**	Chief Executive	Employee	Ratio
25th percentile pay ratio	**245 - 250**	**30**	**8.3:1**	240 - 245	29	8.2:1
Median pay	**245 - 250**	**38**	**6.5:1**	240 - 245	37	6.5:1
75th percentile pay ratio	**245 - 250**	**49**	**5.0:1**	240 - 245	49	5.0:1
Salary component of total pay and benefits						
25th percentile pay ratio	**245 - 250**	**30**		240 - 245	29	
Median pay	**245 - 250**	**38**		240 - 245	37	
75th percentile pay ratio	**245 - 250**	**49**		240 - 245	49	

	Highest Paid			Highest Paid		
Total pay and benefits mid-point	**Director**	**Employee**	**Ratio**	Director	Employee	Ratio
25th percentile pay ratio	**245 - 250**	**30**	**8.3:1**	240 - 245	29	8.2:1
Median pay	**245 - 250**	**38**	**6.5:1**	240 - 245	37	6.5:1
75th percentile pay ratio	**245 - 250**	**49**	**5.0:1**	240 - 245	49	5.0:1
Salary component of total pay and benefits						
25th percentile pay ratio	**245 - 250**	**30**		240 - 245	29	
Median pay	**245 - 250**	**38**		240 - 245	37	
75th percentile pay ratio	**245 - 250**	**49**		240 - 245	49	

In 2025-26 14 (2024-25, 15) employees received remuneration in excess of the highest-paid director.

Remuneration for all staff ranged from £17k to £371k (2024-25, £17k to £459k).

The all staff range includes directors with the exception of the highest paid CEO Director as appropriate and excludes the non-executive directors and excludes pension benefits of all employees

Financial Year Summary

The 2025-26 pay ratio is comparable with 2024-25 with minimal variation.

The median pay ratio for the relevant financial year is consistent with the pay, reward and progression policies for the entity's employees taken as a whole.

9.6.2 Percentage Changes	**2024-25 to 2025-26**	2023-24 to 2024-25
% Change from previous financial year in respect of Chief Executive	**%**	**%**
Salary and allowances	**2**	7
Performance pay and bonuses	**0**	0
% Change from previous financial year in respect of highest paid director		
Salary and allowances	**2**	7
Performance pay and bonuses	**0**	0
Average % Change from previous financial year in respect of employees takes as a whole		
Salary and allowances	**1**	5
Performance pay and bonuses	**0**	0

9.7 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years".

An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts.

These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new

c) National Employment Savings Trust (NEST)

NEST is a workplace pension scheme, which was set up by legislation and is treated as a trust-based scheme. The Trustee responsible for running the scheme is NEST Corporation. It's a non-departmental public body (NDPB) that operates at arm's length from government and is accountable to Parliament through the Department for Work and Pensions (DWP).

NEST Corporation has agreed a loan with the Department for Work and Pensions (DWP). This has paid for the scheme to be set up and will cover expected shortfalls in scheme costs during the earlier years while membership is growing.

NEST Corporation aims for the scheme to become self-financing while providing consistently low charges to members.

Using qualifying earnings to calculate contributions, currently the legal minimum level of contributions is 8% of a jobholder's qualifying earnings, for employers whose legal duties have started. The employer must pay at least 3% of this.

The earnings band used to calculate minimum contributions under existing legislation is called qualifying earnings. Qualifying earnings are currently those between £6,240 and £50,270 for the 2025-26 tax year (2024-25 £6,240 and £50,270).

Restrictions on the annual contribution limits were removed on 1st April 2017.

10. Public Sector Payment Policy - Measure of Compliance

10.1 Prompt payment code - measure of compliance

The Welsh Government requires that Health Boards pay all their trade creditors in accordance with the CBI prompt payment code and Government Accounting rules. The Welsh Government has set as part of the Health Board financial targets a requirement to pay 95% of the number of non-NHS creditors within 30 days of delivery.

	2025-26	**2025-26**	2024-25	2024-25
NHS	**Number**	**£000**	Number	£000
Total bills paid	5,354	456,451	5,193	433,942
Total bills paid within target	4,994	450,167	4,770	425,567
Percentage of bills paid within target	**93.3%**	**98.6%**	91.9%	98.1%
Non-NHS				
Total bills paid	302,142	738,419	301,118	700,384
Total bills paid within target	293,413	715,779	294,215	676,799
Percentage of bills paid within target	**97.1%**	**96.9%**	97.7%	96.6%
Total				
Total bills paid	**307,496**	**1,194,870**	306,311	1,134,326
Total bills paid within target	**298,407**	**1,165,946**	298,985	1,102,366
Percentage of bills paid within target	**97.0%**	**97.6%**	97.6%	97.2%

10.2 The Late Payment of Commercial Debts (Interest) Act 1998

	2025-26	2024-25
	£	£
Amounts included within finance costs (note 7) from claims made under this legislation	**0**	0
Compensation paid to cover debt recovery costs under this legislation	**207**	114,172
Total	**207**	**114,172**

11.1 Property, plant and equipment

2025-26

	Land £000	Buildings, excluding dwellings £000	Dwellings £000	Assets under construction & payments on account £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2025	79,198	797,467	2,582	49,689	118,390	380	38,655	4,588	1,090,949
Indexation	2,105	59,514	168	0	0	0	0	0	61,787
Additions									
- purchased	0	9,484	56	16,981	10,363	0	6,514	67	43,465
- donated	0	13	0	0	190	0	0	0	203
- government granted	0	0	0	0	0	0	0	0	0
Transfer from/into other NHS bodies	0	0	0	0	52	0	0	0	52
Reclassifications	0	54,142	0	(54,142)	0	0	0	0	0
Revaluations	0	0	0	0	0	0	0	0	0
Reversal of impairments	396	39,287	152	0	0	0	0	0	39,835
Impairments	0	(35,282)	0	(382)	0	0	0	0	(35,664)
Reclassified as held for sale	0	0	0	0	0	0	0	0	0
Disposals	0	(65)	0	0	(4,705)	(21)	(800)	(264)	(5,855)
At 31 March 2026	81,699	924,560	2,958	12,146	124,290	359	44,369	4,391	1,194,772
Depreciation at 1 April 2025	0	63,141	488	0	73,408	374	24,087	1,904	163,402
Indexation	0	5,011	49	0	0	0	0	0	5,060
Transfer from/into other NHS bodies	0	0	0	0	16	0	0	0	16
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluations	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	2,812	11	0	0	0	0	0	2,823
Impairments	0	(4,339)	0	0	0	0	0	0	(4,339)
Reclassified as held for sale	0	0	0	0	0	0	0	0	0
Disposals	0	(65)	0	0	(4,551)	(21)	(800)	(264)	(5,701)
Provided during the year	0	27,266	102	0	12,636	6	5,337	457	45,804
At 31 March 2026	0	93,826	650	0	81,509	359	28,624	2,097	207,065
Net book value at 1 April 2025	79,198	734,326	2,094	49,689	44,982	6	14,568	2,684	927,547
Net book value at 31 March 2026	81,699	830,734	2,308	12,146	42,781	0	15,745	2,294	987,707
Net book value at 31 March 2026 comprises :									
Purchased	78,511	828,705	2,308	12,146	42,198	0	15,700	2,267	981,835
Donated	3,188	1,813	0	0	501	0	45	27	5,574
Government Granted	0	216	0	0	82	0	0	0	298
At 31 March 2026	81,699	830,734	2,308	12,146	42,781	0	15,745	2,294	987,707
Asset financing :									
Owned	81,699	826,498	2,308	12,146	42,781	0	15,745	2,294	983,471
On-SoFP PPP/PFI contracts	0	4,236	0	0	0	0	0	0	4,236
PFI residual interests	0	0	0	0	0	0	0	0	0
At 31 March 2026	81,699	830,734	2,308	12,146	42,781	0	15,745	2,294	987,707

The net book value of land, buildings and dwellings at 31 March 2026 comprises :

	£000
Freehold	909,975
Long Leasehold	4,762
Short Leasehold	4
	914,741

Valuers 'material uncertainty', in valuation. The disclosure relates to the materiality in the valuation report not that of the underlying account. 0

The land and buildings were revalued by the Valuation Office Agency with an effective date of 1st April 2022. The valuation has been prepared in accordance with the terms of the latest version of the Royal Institute of Chartered Surveyors' Valuation Standards. LHBs are required to apply the revaluation model set out in IAS 16 and value its capital assets to fair value. Fair value is defined by IAS 16 as the amount for which an asset could be exchanged between knowledgeable, willing parties in an arms length transaction. This has been undertaken on the assumption that the property is sold as part of the continuing enterprise in occupation.

11.1 Property, plant and equipment

2024-25	Land £000	Buildings, excluding dwellings £000	Dwellings £000	Assets under construction & payments on account £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2024	75,111	750,899	2,390	40,777	117,063	281	39,458	3,953	1,029,932
Indexation	666	5,342	15	0	0	0	0	0	6,023
Additions									
- purchased	0	3,509	149	46,201	7,691	0	5,427	624	63,601
- donated	0	17	0	0	42	0	19	0	78
- government granted	0	0	0	0	0	0	0	0	0
Transfer from/into other NHS bodies	0	0	0	0	0	0	(45)	0	(45)
Reclassifications	0	37,289	0	(37,289)	(60)	0	16	44	0
Revaluations	3,288	6,243	0	0	0	0	0	0	9,531
Reversal of impairments	133	14,644	28	0	0	0	0	0	14,805
Impairments	0	(17,994)	0	0	0	0	0	0	(17,994)
Reclassified as held for sale	0	0	0	0	0	0	0	0	0
Disposals	0	(2,482)	0	0	(6,346)	99	(6,220)	(33)	(14,982)
At 31 March 2025	**79,198**	**797,467**	**2,582**	**49,689**	**118,390**	**380**	**38,655**	**4,588**	**1,090,949**
Depreciation at 1 April 2024	0	43,143	395	0	67,276	269	24,508	1,524	**137,115**
Indexation	0	374	6	0	0	0	0	0	**380**
Transfer from/into other NHS bodies	0	0	0	0	0	0	(11)	0	**(11)**
Reclassifications	0	0	0	0	(16)	0	16	0	**0**
Revaluations	0	0	0	0	0	0	0	0	**0**
Reversal of impairments	0	403	1	0	0	0	0	0	**404**
Impairments	0	(1,776)	0	0	0	0	0	0	**(1,776)**
Reclassified as held for sale	0	0	0	0	0	0	0	0	**0**
Disposals	0	(2,482)	0	0	(6,306)	99	(6,219)	(33)	**(14,941)**
Provided during the year	0	23,479	86	0	12,454	6	5,793	413	**42,231**
At 31 March 2025	**0**	**63,141**	**488**	**0**	**73,408**	**374**	**24,087**	**1,904**	**163,402**
Net book value at 1 April 2024	**75,111**	**707,756**	**1,995**	**40,777**	**49,787**	**12**	**14,950**	**2,429**	**892,817**
Net book value at 31 March 2025	**79,198**	**734,326**	**2,094**	**49,689**	**44,982**	**6**	**14,568**	**2,684**	**927,547**
Net book value at 31 March 2025 comprises :									
Purchased	**76,108**	**732,430**	**2,094**	**49,689**	**44,378**	**6**	**14,503**	**2,652**	**921,860**
Donated	**3,090**	**1,697**	**0**	**0**	**463**	**0**	**65**	**32**	**5,347**
Government Granted	**0**	**199**	**0**	**0**	**141**	**0**	**0**	**0**	**340**
At 31 March 2025	**79,198**	**734,326**	**2,094**	**49,689**	**44,982**	**6**	**14,568**	**2,684**	**927,547**
Asset financing :									
Owned	**79,198**	**730,440**	**2,094**	**49,689**	**44,982**	**6**	**14,568**	**2,684**	**923,661**
On-SoFP PPP/PFI contracts	**0**	**3,886**	**0**	**0**	**0**	**0**	**0**	**0**	**3,886**
PFI residual interests	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
At 31 March 2025	**79,198**	**734,326**	**2,094**	**49,689**	**44,982**	**6**	**14,568**	**2,684**	**927,547**

The net book value of land, buildings and dwellings at 31 March 2025 comprises :

	£000
Freehold	811,217
Long Leasehold	4,390
Short Leasehold	11
	815,618

Valuers 'material uncertainty', in valuation. The disclosure relates to the materiality in the valuation report not that of the underlying account. 0

The land and buildings were revalued by the Valuation Office Agency with an effective date of 1st April 2022. The valuation has been prepared in accordance with the terms of the latest version of the Royal Institute of Chartered Surveyors' Valuation Standards. LHBs are required to apply the revaluation model set out in IAS 16 and value its capital assets to fair value. Fair value is defined by IAS 16 as the amount for which an asset could be exchanged between knowledgeable, willing parties in an arms length transaction. This has been undertaken on the assumption that the property is sold as part of the continuing enterprise in occupation.

11. Property, plant and equipment (continued)

Disclosures:

(i) Donated Assets

Assets totalling £203k were purchased via Charitable Funds donations during the year.

(ii) Valuations

The LHBs land and Buildings were revalued by the Valuation Office Agency with an effective date of 1st April 2022. The valuation has been prepared in accordance with the terms of the latest version of the Royal Institute of Chartered Surveyors' Valuation Standards.

The LHB is required to apply the revaluation model set out in IAS 16 and value its capital assets to fair value. Fair value is defined by IAS 16 as the amount for which an asset could be exchanged between knowledgeable, willing parties in an arms length transaction. This has been undertaken on the assumption that the property is sold as part of the continuing enterprise in operation.

In 2025-26, indexation has been applied to land and buildings based on indices received from the Valuation Office Agency and as agreed in the Technical Update Note 01 issued by Welsh Government on 24th September 2025. No indexation has been applied to equipment.

In addition, in 2025-26 there have been separate revaluations for seven assets under construction coming into use. These include Nevill Hall Satellite Radiotherapy Unit, the ward D7E upgrade, pharmacy robot installation and new decontamination unit at Royal Gwent Hospital, and boiler replacement upgrade at St Cadoc's Hospital.

Further to these revaluations, an exercise was undertaken by the Valuation Office Agency to assess the TEF and REFIT estates programmes for enhancing and non-enhancing expenditure in 2025-26. Any non-enhancing expenditure has been impaired from the asset values as at 31st March 2026. This assessment covers work to take place in 2026-27 when a similar impairment impact will be expected.

(iii) Asset Lives

Property, plant and equipment is depreciated using the following asset lives:

- Land is not depreciated.
- Buildings as determined by the Valuation Office Agency.
- Equipment between 5-15 years.

(iv) Compensation

There has been no compensation received from third parties for assets impaired, lost or given up, that is included in the income statement.

(v) Write Downs

There have not been any write downs in the period.

(vi) Open Market Value

The Health Board does not hold any property where the value is materially different from its open market value.

(vii) Assets Held for Sale or sold in the period

There are no assets held for sale or sold in the period.

(viii) IFRS 13 Fair value measurement

There are no assets requiring Fair Value measurement under IFRS 13.

11. Property, plant and equipment

11.2 Non-current assets held for sale

	Land	Buildings, including dwelling	Other property, plant and equipment	Intangible assets	Other assets	Total
	£000	£000	£000	£000	£000	£000
Balance brought forward 1 April 2025	0	0	0	0	0	**0**
Plus assets classified as held for sale in the year	0	0	0	0	0	**0**
Revaluation	0	0	0	0	0	**0**
Less assets sold in the year	0	0	0	0	0	**0**
Add reversal of impairment of assets held for sale	0	0	0	0	0	**0**
Less impairment of assets held for sale	0	0	0	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	**0**
Balance carried forward 31 March 2026	0	0	0	0	0	**0**
Balance brought forward 1 April 2024	0	0	0	0	0	**0**
Plus assets classified as held for sale in the year	0	0	0	0	0	**0**
Revaluation	0	0	0	0	0	**0**
Less assets sold in the year	0	0	0	0	0	**0**
Add reversal of impairment of assets held for sale	0	0	0	0	0	**0**
Less impairment of assets held for sale	0	0	0	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	**0**
Balance carried forward 31 March 2025	0	0	0	0	0	**0**

11.3 Right of Use Assets

The organisation's right of use asset leases are disclosed across the relevant headings within the note. Most leases are individually insignificant, however, four are significant in their own right (>£1m):

- Blaenavon Primary Care Resource Centre (LHB lease) held under Land & Buildings NBV at 31 March 2026: £1,086k
- Brynmawr Primary Care Resource Centre (LHB lease) held under Land & Buildings NBV at 31 March 2026: £1,956k
- Rhymney Integrated H&SC Resource Centre (LHB lease) held under Land & Buildings NBV at 31 March 2026: £1,840k
- Biochemistry Managed Service Contract held under Plant & Machinery NBV at 31 March 2026: £1,903k

2025-26	Land £000	Land & buildings £000	Buildings £000	Dwellings £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2025	**658**	**15,466**	**0**	**0**	**9,029**	**944**	**1,822**	**0**	**27,919**
Additions	0	700	0	0	1,058	338	0	0	**2,096**
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	**0**
Disposals other than by sale	0	(345)	0	0	(453)	(134)	0	0	**(932)**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Revaluations	0	0	0	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	0	0	0	**0**
De-recognition	0	(128)	0	0	0	0	0	0	**(128)**
At 31 March 2026	**658**	**15,693**	**0**	**0**	**9,634**	**1,148**	**1,822**	**0**	**28,955**
Depreciation at 1 April 2025	**132**	**3,885**	**0**	**0**	**4,181**	**532**	**1,068**	**0**	**9,798**
Recognition	0	0	0	0	0	0	0	0	**0**
Transfers from/into other NHS bodies	0	0	0	0	0	0	0	0	**0**
Disposals other than by sale	0	(345)	0	0	(370)	(134)	0	0	**(849)**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Revaluations	0	0	0	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	0	0	0	**0**
De-recognition	0	0	0	0	0	0	0	0	**0**
Provided during the year	44	1,881	0	0	1,535	318	338	0	**4,116**
At 31 March 2026	**176**	**5,421**	**0**	**0**	**5,346**	**716**	**1,406**	**0**	**13,065**
Net book value at 1 April 2025	**526**	**11,581**	**0**	**0**	**4,848**	**412**	**754**	**0**	**18,121**
Net book value at 31 March 2026	**482**	**10,272**	**0**	**0**	**4,288**	**432**	**416**	**0**	**15,890**

RoU Asset Total Value Split by Lessor	Land £000	Land & buildings £000	Buildings £000	Dwellings £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
NHS Wales Peppercorn Leases	0	0	0	0	0	0	0	0	**0**
NHS Wales Market Value Leases	0	0	0	0	0	0	0	0	**0**
Other Public Sector Peppercorn Leases	472	258	0	0	0	0	0	0	**730**
Other Public Sector Market Value Leases	10	1,155	0	0	0	0	0	0	**1,165**
Private Sector Peppercorn Leases	0	0	0	0	0	0	0	0	**0**
Private Sector Market Value Leases	0	8,859	0	0	4,288	432	416	0	**13,995**
Total	**482**	**10,272**	**0**	**0**	**4,288**	**432**	**416**	**0**	**15,890**

11.3 Right of Use Assets

The organisation's right of use asset leases are disclosed across the relevant headings below. Most leases are individually insignificant, however, six are significant in their own right (>£1m):

- Blaenavon Primary Care Resource Centre (LHB lease) held under Land & Buildings NBV at 31 March 2025: £1,213k
- Brynmawr Primary Care Resource Centre (LHB lease) held under Land & Buildings NBV at 31 March 2025: £2,117k
- Rhymney Integrated H&SC Resource Centre (LHB lease) held under Land & Buildings NBV at 31 March 2025: £2,078k
- Ty Gwent held under Land & Buildings NBV at 31 March 2025: £1,092k
- Biochemistry Managed Service Contract held under Plant & Machinery NBV at 31 March 2025: £2,172k
- NHH Energy scheme (previously classified as an off balance sheet PFI scheme) held under Plant & Machinery NBV at 31 March 2025: £1,411k

2024-25	Land £000	Land & buildings £000	Buildings £000	Dwellings £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2024	**813**	**12,180**	**0**	**0**	**9,058**	**860**	**2,045**	**0**	**24,956**
Additions	0	4,151	0	0	1,818	184	0	0	**6,153**
Transfer from/into other NHS bodies	0	(57)	0	0	0	0	0	0	**(57)**
Disposals other than by sale	(155)	(808)	0	0	(1,847)	(100)	(223)	0	**(3,133)**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Revaluations	0	0	0	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	0	0	0	**0**
De-recognition	0	0	0	0	0	0	0	0	**0**
At 31 March 2025	**658**	**15,466**	**0**	**0**	**9,029**	**944**	**1,822**	**0**	**27,919**
Depreciation at 1 April 2024	**196**	**2,968**	**0**	**0**	**3,138**	**339**	**945**	**0**	**7,586**
Recognition	0	0	0	0	0	0	0	0	**0**
Transfers from/into other NHS bodies	0	(12)	0	0	0	0	0	0	**(12)**
Disposals other than by sale	(155)	(513)	0	0	(681)	(100)	(223)	0	**(1,672)**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Revaluations	0	0	0	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	0	0	0	**0**
De-recognition	0	0	0	0	0	0	0	0	**0**
Provided during the year	91	1,442	0	0	1,724	293	346	0	**3,896**
At 31 March 2025	**132**	**3,885**	**0**	**0**	**4,181**	**532**	**1,068**	**0**	**9,798**
Net book value at 1 April 2024	**617**	**9,212**	**0**	**0**	**5,920**	**521**	**1,100**	**0**	**17,370**
Net book value at 31 March 2025	**526**	**11,581**	**0**	**0**	**4,848**	**412**	**754**	**0**	**18,121**

RoU Asset Total Value Split by Lessor	Land £000	Land & buildings £000	Buildings £000	Dwellings £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
NHS Wales Peppercorn Leases	0	0	0	0	0	0	0	0	**0**
NHS Wales Market Value Leases	0	0	0	0	0	0	0	0	**0**
Other Public Sector Peppercorn Leases	516	277	0	0	0	0	0	0	**793**
Other Public Sector Market Value Leases	10	1,046	0	0	0	0	0	0	**1,056**
Private Sector Peppercorn Leases	0	0	0	0	0	0	0	0	**0**
Private Sector Market Value Leases	0	10,258	0	0	4,848	412	754	0	**16,272**
Total	**526**	**11,581**	**0**	**0**	**4,848**	**412**	**754**	**0**	**18,121**

11.3 Right of Use Assets continued

Quantitative disclosures

Maturity analysis Contractual undiscounted cash flows relating to lease liabilities	2025-26 Land £000	2025-26 Buildings £000	2025-26 Other £000	2025-26 Total £000	2024-25 Total £000
Less than 1 year	0	1,831	1,398	3,229	4,091
2-5 years	1	4,957	2,551	7,509	7,633
> 5 years	11	4,999	1,225	6,235	7,291
Less finance charges allocated to future periods	(2)	(1,390)	(387)	(1,779)	(1,878)
Total	**10**	**10,397**	**4,787**	**15,194**	**17,137**

Lease Liabilities (net of irrecoverable VAT)	2025-26	2024-25
Current	2,865	3,708
Non-Current	12,329	13,429
Total	**15,194**	**17,137**

Amounts Recognised in Statement of Comprehensive Net Expenditure	2025-26	2024-25
Depreciation	4,116	3,896
Impairment	0	0
Variable lease payments not included in lease liabilities - Interest expense	442	353
Sub-leasing income	(3)	(2)
Expense related to short-term leases	168	367
Expense related to low-value asset leases (excluding short-term leases)	980	973

Amounts Recognised in Statement of Cashflows (net of irrecoverable VAT)		
Interest expense	(442)	(353)
Repayments of principal on leases	(3,956)	(3,846)
Total	**(4,398)**	**(4,199)**

12. Intangible non-current assets

2025-26

	Software (purchased)	Software (internally generated)	Licences and trademarks	Patents	Development expenditure- internally generated	Assets under Construction	Total
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2025	3,118	0	5,086	0	0	1,041	9,245
Revaluation	0	0	0	0	0	0	0
Reclassifications	318	0	901	0	0	(1,219)	0
Reversal of impairments	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0
Additions- purchased	159	0	(281)	0	0	178	56
Additions- internally generated	0	0	0	0	0	0	0
Additions- donated	0	0	0	0	0	0	0
Additions- government granted	0	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0	0
Transfer from/into other NHS bodies	0	0	0	0	0	0	0
Disposals	(45)	0	(1,390)	0	0	0	(1,435)
Gross cost at 31 March 2026	3,550	0	4,316	0	0	0	7,866
Amortisation at 1 April 2025	2,052	0	2,194	0	0	0	4,246
Revaluation	0	0	0	0	0	0	0
Reclassifications	(142)	0	142	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0
Impairment	0	0	0	0	0	0	0
Provided during the year	540	0	1,420	0	0	0	1,960
Reclassified as held for sale	0	0	0	0	0	0	0
Transfer from/into other NHS bodies	0	0	0	0	0	0	0
Disposals	(45)	0	(1,390)	0	0	0	(1,435)
Amortisation at 31 March 2026	2,405	0	2,366	0	0	0	4,771
Net book value at 1 April 2025	1,066	0	2,892	0	0	1,041	4,999
Net book value at 31 March 2026	1,145	0	1,950	0	0	0	3,095
NBV at 31 March 2026							
Purchased	1,145	0	1,950	0	0	0	3,095
Donated	0	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0	0
Internally generated	0	0	0	0	0	0	0
Total at 31 March 2026	1,145	0	1,950	0	0	0	3,095

12. Intangible non-current assets
2024-25

	Software (purchased)	Software (internally generated)	Licences and trademarks	Patents	Development expenditure- internally generated	Assets under Construction	Total
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2024	**3,531**	**0**	**2,924**	**0**	**0**	**1,063**	**7,518**
Revaluation	0	0	27	0	0	0	**27**
Reclassifications	21	0	158	0	0	(179)	**0**
Reversal of impairments	0	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	0	**0**
Additions- purchased	15	0	2,064	0	0	157	**2,236**
Additions- internally generated	0	0	0	0	0	0	**0**
Additions- donated	0	0	0	0	0	0	**0**
Additions- government granted	0	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	0	**0**
Transfer from/into other NHS bodies	0	0	0	0	0	0	**0**
Disposals	(449)	0	(87)	0	0	0	**(536)**
Gross cost at 31 March 2025	**3,118**	**0**	**5,086**	**0**	**0**	**1,041**	**9,245**
Amortisation at 1 April 2024	**1,800**	**0**	**1,033**	**0**	**0**	**0**	**2,833**
Revaluation	0	0	(15)	0	0	0	**(15)**
Reclassifications	0	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	0	**0**
Impairment	0	0	0	0	0	0	**0**
Provided during the year	701	0	1,263	0	0	0	**1,964**
Reclassified as held for sale	0	0	0	0	0	0	**0**
Transfer from/into other NHS bodies	0	0	0	0	0	0	**0**
Disposals	(449)	0	(87)	0	0	0	**(536)**
Amortisation at 31 March 2025	**2,052**	**0**	**2,194**	**0**	**0**	**0**	**4,246**
Net book value at 1 April 2024	**1,731**	**0**	**1,891**	**0**	**0**	**1,063**	**4,685**
Net book value at 31 March 2025	**1,066**	**0**	**2,892**	**0**	**0**	**1,041**	**4,999**
NBV at 31 March 2025							
Purchased	1,066	0	2,892	0	0	1,041	**4,999**
Donated	0	0	0	0	0	0	**0**
Government Granted	0	0	0	0	0	0	**0**
Internally generated	0	0	0	0	0	0	**0**
Total at 31 March 2025	**1,066**	**0**	**2,892**	**0**	**0**	**1,041**	**4,999**

Additional Disclosures re Intangible Assets

Disclosures:

(i) Donated Assets
Aneurin Bevan University LHB has not received any donated intangible assets during the year.

(ii) Recognition
Intangible assets acquired separately are initially recognised at fair value. The amount recognised for internally-generated intangible assets is the sum of the expenditure incurred to date when the criteria for recognising internally generated assets has been met (see accounting policy 1.7 for criteria).

(iii) Asset Lives
The Useful Economic Lives (UEL) of intangible non-current assets are assigned on an individual asset basis. Software is generally assigned a 5 year UELunless known to differ, with the UEL of any internally generated software being based on the professional judgement of Health Board professionals and finance staff.

(iv) Additions during the period
Intangible assets acquired during the period amounted to £0.056m; this primarily related to software renewals offset by the release of a VAT provision in relation to software licences purchased in 2024/25.

(v) Disposals during the period
Fully amortised software and licences with a GBV of £1.435m were disposed of as no longer in use, during the year.

vi) Transfers into other NHS Bodies
Aneurin Bevan University LHB has not received any intangible assets transferred from another NHS body.

13 . Impairments

	2025-26 Property, plant & equipment £000	2025-26 Right of Use Assets £000	2025-26 Intangible assets £000	2025-26 Held for sale assets £000	2025-26 Financial Assets £000	2025-26 Total Asset Impairment £000
Impairments arising from :						
Loss or damage from normal operations	0	0	0	0	0	0
Abandonment in the course of construction	382	0	0	0	0	382
Over specification of assets (Gold Plating)	0	0	0	0	0	0
Loss as a result of a catastrophe	0	0	0	0	0	0
Unforeseen obsolescence	0	0	0	0	0	0
Changes in market price	0	0	0	0	0	0
Others (specify)	30,943	0	0	0	0	30,943
Reversal of Impairments	(37,012)	0	0	0	0	(37,012)
Total of all impairments	(5,687)	0	0	0	0	(5,687)
Analysis of impairments charged to reserves in year :						
Impairments charged to the Statement of Comprehensive Net Expenditure	(5,687)	0	0	0	0	(5,687)
Impairments as a result of revaluation/indexation charged to Revaluation Reserve	0	0	0	0	0	0
Impairments as a result of a loss of economic value or service potential Charged to Revaluation Reserve	0	0	0	0	0	0
Right of Use (RoU) asset impairments reflected in RoU Liability	0	0	0	0	0	0
Total	(5,687)	0	0	0	0	(5,687)

	2024-25 Property, plant & equipment £000	2024-25 Right of Use Assets £000	2024-25 Intangible assets £000	2024-25 Held for sale assets £000	2024-25 Financial Assets £000	2024-25 Total Asset Impairment £000
Impairments arising from :						
Loss or damage from normal operations	236	0	0	0	0	236
Abandonment in the course of construction	0	0	0	0	0	0
Over specification of assets (Gold Plating)	0	0	0	0	0	0
Loss as a result of a catastrophe	0	0	0	0	0	0
Unforeseen obsolescence	0	0	0	0	0	0
Changes in market price	0	0	0	0	0	0
Others (specify)	15,982	0	0	0	0	15,982
Reversal of Impairments	(14,401)	0	0	0	0	(14,401)
Total of all impairments	1,817	0	0	0	0	1,817
Analysis of impairments charged to reserves in year :						
Impairments charged to the Statement of Comprehensive Net Expenditure	1,817	0	0	0	0	1,817
Impairments as a result of revaluation/indexation charged to Revaluation Reserve	0	0	0	0	0	0
Impairments as a result of a loss of economic value or service potential Charged to Revaluation Reserve	0	0	0	0	0	0
Right of Use (RoU) asset impairments reflected in RoU Liability	0	0	0	0	0	0
Total	1,817	0	0	0	0	1,817

2025-26	Impairment amount	Reason for impairment	Nature of Asset	Valuation basis	Charge to SoCNE	Charge to reserve
	£000	£000	£000	£000	£000	£000
Nevill Hall Satellite Radiotherapy Unit	13,325	Assets Valued on Coming Into Use	Operational	Fair Value	13,325	0
ED Extension, GUH	8,685	Assets Valued on Coming Into Use	Operational	Fair Value	8,685	0
Decontamination Unit, RGH	2,788	Assets Valued on Coming Into Use	Operational	Fair Value	2,788	0
St Woolos Hospital	2,780	Building Closures	Non Operational	Fair Value	2,780	0
Targeted Estates Fund Non-Enhancing	1,009	Valuer Desktop Review of TEF complete schemes	Operational	Fair Value	1,009	0
2nd MRI Suite, GUH	975	Assets Valued on Coming Into Use	Operational	Fair Value	975	0
Pharmacy Robot, RGH	392	Assets Valued on Coming Into Use	Operational	Fair Value	392	0
Boiler Replacement Works, SCH	378	Assets Valued on Coming Into Use	Operational	Fair Value	378	0
REFIT Non-Enhancing Works, HB Wid	327	Valuer Desktop Review of REFIT complete schemes	Operational	Fair Value	327	0
D7E Ward Refurb, RGH	284	Assets Valued on Coming Into Use	Operational	Fair Value	284	0
NHH Cancer Centre AUC	382	Abandonment in the course of construction	Under Constructio n	Fair Value	382	0
Total Impairment	31,325				31,325	0
Reversal of Impairments						
Grange University Hospital	(19,067)		Operational	Indexation	(19,067)	0
Royal Gwent Hospital	(5,725)		Operational	Indexation	(5,725)	0
Ysbytty Aneurin Bevan	(3,712)		Operational	Indexation	(3,712)	0
Nevill Hall Hospital	(2,795)		Operational	Indexation	(2,795)	0
19 Hills HWBC	(1,794)	Indexation - reversal of impairment in previous years	Operational	Indexation	(1,794)	0
St Cadocs Hospital	(1,270)		Operational	Indexation	(1,270)	0
Bevan HWBC	(1,072)		Operational	Indexation	(1,072)	0
Ysbyty Ystrad Fawr	(671)		Operational	Indexation	(671)	0
Llanfrechfa Grange	(432)		Operational	Indexation	(432)	0
Various Community	(78)		Operational	Indexation	(78)	0
Indexation - Land	(396)		Operational	Indexation	(396)	0
Total Reversal of Impairments	(37,012)				(37,012)	0
Net credit to SoCNE	(5,687)				(5,687)	0

14.1 Inventories

	31 March 2026	31 March 2025
	£000	£000
Drugs	3,203	3,753
Consumables	6,332	6,430
Energy	259	250
Work in progress	0	0
Other	0	0
Total	**9,794**	10,433
Of which held at realisable value	**0**	0

14.2 Inventories recognised in expenses

	31 March 2026	31 March 2025
	£000	£000
Inventories recognised as an expense in the period	0	0
Write-down of inventories (including losses)	0	0
Reversal of write-downs that reduced the expense	0	0
Total	**0**	**0**

The Health Board does not purchase any stock or assets with the intention to sell, and as such the above is a nil return.

15. Trade and other Receivables

Current	31 March 2026 £000	31 March 2025 £000
Welsh Government	2,654	2,406
NHSW JCC Joint Commissioning Committee	458	478
Welsh Health Boards	3,501	3,753
Welsh NHS Trusts	9,407	7,109
Welsh Special Health Authorities	913	1,037
Non - Welsh Trusts	0	0
Other NHS	577	1,426
2019-20 Scheme Pays - Welsh Government Reimbursement	690	686
Welsh Risk Pool Claim reimbursement		
NHS Wales Secondary Health Sector	128,261	125,057
NHS Wales Primary Sector FLS Reimbursement	1,785	883
NHS Wales Redress	268	422
Other	269	412
Local Authorities	4,426	5,617
Other receivables	12,149	10,929
Provision for irrecoverable debts	(2,448)	(2,015)
Pension Prepayments NHS Pensions	0	0
Pension Prepayments NEST	0	0
Other prepayments	11,821	8,960
Other accrued income	0	0
Right of Use capital receivables	0	0
Capital Receivables		
Tangibles capital receivables	0	0
Intangibles capital receivables	0	0
Other capital prepayments	139	0
Sub total	**174,870**	167,160
Non-current		
Welsh Government	0	0
NHSW JCC Joint Commissioning Committee	0	0
Welsh Health Boards	0	0
Welsh NHS Trusts	0	0
Welsh Special Health Authorities	0	0
Non - Welsh Trusts	0	0
Other NHS	0	0
2019-20 Scheme Pays - Welsh Government Reimbursement	0	0
Welsh Risk Pool Claim reimbursement;		
NHS Wales Secondary Health Sector	140,823	104,507
NHS Wales Primary Sector FLS Reimbursement	0	10
NHS Wales Redress	0	0
Other	0	0
Local Authorities	0	0
Other receivables	1,575	1,366
Provision for irrecoverable debts	0	0
Pension Prepayments NHS Pensions	0	0
Pension Prepayments NEST	0	0
Other prepayments	0	0
Other accrued income	0	0
Right of Use capital receivables	0	0
Capital Receivables		
Tangibles capital receivables	0	0
Intangibles capital receivables	0	0
Other capital prepayments	0	0
Sub total	**142,398**	105,883
Total	**317,268**	273,043

The great majority of trade undertaken by the Health Board is with other NHS bodies. As NHS bodies are funded by Welsh Government, no credit scoring of them is considered necessary.

The value of trade receivables that are past their payment date but not impaired is £3.420m (£3.286m in 2024-25).

15. Trade and other Receivables (continued)

Receivables past their due date but not impaired

	31 March 2026 £000	31 March 2025 £000
By up to three months	1,109	1,420
By three to six months	561	142
By more than six months	1,750	1,724
	3,420	3,286

Expected Credit Losses (ECL) / Provision for impairment of receivables

Balance at 1 April	(2,015)	(1,942)
Transfer to other NHS Wales body	0	0
Amount written off during the year	(68)	0
Amount recovered during the year	0	0
(Increase) / decrease in receivables impaired	(318)	(58)
Bad debts recovered during year	(47)	(15)
Balance at 31 March	(2,448)	(2,015)

In determining whether a debt should be impaired, consideration is given to the age of the debt, historic collectability rates and the results of actions already taken including referral to the Health Board's credit agencies.

Receivables VAT

Trade receivables	1,558	1,295
Other	120	137
Total	1,678	1,432

16. Other Financial Assets

	Current		Non-current	
	31 March 2026	31 March 2025	**31 March 2026**	31 March 2025
	£000	£000	**£000**	£000
Financial assets				
Shares and equity type investments				
Held to maturity investments at amortised costs	**0**	0	**0**	0
At fair value through SOCNE	**0**	0	**0**	0
Available for sale at FV	**0**	0	**0**	0
Deposits	**0**	0	**0**	0
Loans at amortised cost	**0**	0	**0**	0
Derivatives	**0**	0	**0**	0
Other (Specify)				
Held to maturity investments at amortised costs	**0**	0	**0**	0
At fair value through SOCNE	**0**	0	**0**	0
Available for sale at FV	**0**	0	**0**	0
Capital Financial Assets				
Loans at amortised cost	**37**	36	**380**	417
Right of Use Asset Finance Sublease	**79**	24	**225**	190
Total	**116**	**60**	**605**	**607**

RoU Sub-leasing income Recognised in Statement of Comprehensive Net Expenditure	**2025-26**	**2024-25**
RoU Sub-leasing income	**(3)**	(2)

17. Cash and cash equivalents

	2025-26	2024-25
	£000	£000
Balance at 1 April	**4,823**	4,145
Net change in cash and cash equivalent balances	**728**	678
Balance at 31 March	**5,551**	4,823
Made up of:		
Cash held at GBS	**5,530**	4,801
Commercial banks	**0**	0
Cash in hand	**21**	22
Cash and cash equivalents as in Statement of Financial Position	**5,551**	4,823
Bank overdraft - GBS	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in Statement of Cash Flows	**5,551**	4,823

In response to the IAS 7 requirement for additional disclosure, the changes in liabilities arising for financing activities are;

Lease Liabilities (ROUA) -£1.943m
Lease Liabilities (short-term and low value leases) £0.731m
PFI liabilities: -£0.148m

The movement relates to cash, no comparative information is required by IAS 7 in 2025-26.

18. Trade and other payables

Current	**31 March 2026**	31 March 2025
	£000	£000
Welsh Government	**0**	12
NHSW Joint Commissioning Committee	**6,253**	3,785
Welsh Health Boards	**5,952**	5,590
Welsh NHS Trusts	**3,446**	3,954
Welsh Special Health Authorities	**28**	61
Other NHS	**7,092**	7,336
Taxation and social security payable / refunds	**19,585**	17,338
Refunds of taxation by HMRC	**0**	0
VAT payable to HMRC	**0**	0
Other taxes payable to HMRC	**0**	0
NI contributions payable to HMRC	**0**	0
Non-NHS payables - Revenue	**67,697**	59,008
Local Authorities	**16,472**	16,397
Overdraft	**0**	0
Rentals due under operating leases	**0**	0
Pensions: staff	**13,243**	11,571
Non NHS Accruals	**74,918**	77,652
Deferred Income:		
Deferred Income brought forward	**0**	0
Deferred Income Additions	**18**	0
Transfer to / from current/non current deferred income	**0**	0
Released to SoCNE	**0**	0
Other creditors	**0**	0
Payments on account	**(10,705)**	(10,711)
Impact of IFRS 16 on SoFP PFI contracts	**134**	122
Right of Use asset payables	**2,865**	3,708
Capital asset payables		
Tangibles - Payables	**10,187**	8,766
Intangibles - Payables	**33**	112
Obligations under finance leases, HP contracts	**0**	0
Imputed finance lease element of on SoFP PFI contracts	**129**	125
PFI assets – deferred credits	**0**	0
Capital Payments on account	**0**	0
Sub Total	**217,347**	204,826
Non-current		
Welsh Government	**0**	0
NHSW Joint Commissioning Committee	**0**	0
Welsh Health Boards	**0**	0
Welsh NHS Trusts	**0**	0
Welsh Special Health Authorities	**0**	0
Other NHS	**0**	0
Taxation and social security payable / refunds	**0**	0
Refunds of taxation by HMRC	**0**	0
VAT payable to HMRC	**0**	0
Other taxes payable to HMRC	**0**	0
NI contributions payable to HMRC	**0**	0
Non-NHS payables - Revenue	**0**	0
Local Authorities	**0**	0
Overdraft	**0**	0
Rentals due under operating leases	**0**	0
Pensions: staff	**0**	0
Non NHS Accruals	**0**	0
Deferred Income :		
Deferred Income brought forward	**0**	0
Deferred Income Additions	**0**	0
Transfer to / from current/non current deferred income	**0**	0
Released to SoCNE	**0**	0
Other creditors	**0**	0
PFI assets –deferred credits	**0**	0
Payments on account	**0**	0
Impact of IFRS 16 on SoFP PFI contracts	**1,386**	1,421
Right of Use asset payables	**12,329**	13,429
Capital asset payables		
Capital Creditors - Tangibles	**0**	0
Capital Creditors - Intangibles	**0**	0
Obligations under finance leases, HP contracts	**0**	0
Imputed finance lease element of on SoFP PFI contracts	**1,335**	1,464
PFI assets – deferred credits	**0**	0
Capital Payments on account	**0**	0
Sub Total	**15,050**	16,314
Total	**232,397**	221,140

It is intended to pay all invoices within the 30 day period directed by the Welsh Government.

The LHB aims to pay all invoices within the 30 day period directed by the Welsh Government.

The Capital Payables - Tangibles figure includes balances that have been agreed with Welsh NHS Trusts, as part of the Agreement of Balances process, totalling £25k (2024-25, £52K).

18. Trade and other payables (continued).

Amounts falling due more than one year are expected to be settled as follows:	31 March 2026 £000	31 March 2025 £000
Between one and two years	2,091	2,601
Between two and five years	5,576	5,136
In five years or more	7,383	8,577
Sub-total	15,050	16,314

19. Other financial liabilities

	Current		Non-current	
Financial liabilities	31 March 2026 £000	31 March 2025 £000	31 March 2026 £000	31 March 2025 £000
Financial Guarantees:				
At amortised cost	0	0	0	0
At fair value through SoCNE	0	0	0	0
Derivatives at fair value through SoCNE	0	0	0	0
Other:				
At amortised cost	0	0	0	0
At fair value through SoCNE	0	0	0	0
Total	0	0	0	0

20. Provisions

	At 1 April 2025	Structured settlement cases transferred to Risk Pool	Transfer of provisions to creditors	Transfer between current and non-current	Arising during the year	Utilised during the year	Reversed unused	Unwinding of discount	At 31 March 2026
Current	£000	£000	£000	£000	£000	£000	£000	£000	£000
Clinical negligence:-									
Secondary care	90,650	(28,931)	1,170	31,556	37,291	(26,555)	(13,942)	0	91,239
Primary care	746	0	(40)	0	892	(54)	(63)	0	1,481
Redress Secondary care	159	0	78	0	123	(198)	(91)	0	71
Redress Primary care	0	0	0	0	0	0	0	0	0
Personal injury	49	0	0	0	523	(287)	(12)	0	273
All other losses and special payments	915	0	0	0	5,271	(5,271)	0	0	915
Defence legal fees and other administration	1,445	0	0	426	1,842	(1,356)	(552)		1,805
Pensions relating to former directors	0			0	0	0	0	0	0
Pensions relating to other staff	400			261	205	(381)	(188)	85	382
2019-20 Scheme Pays - Reimbursement	33			0	24	(36)	0	0	21
Restructuring	0			0	0	0	0	0	0
Other	3,102		0	0	580	(3)	(319)	0	3,360
Capital provisions									
RoU Asset Dilapidations CAME	0		0	0	0	0	0	0	0
Other Capital Provisions	1,071		0	0	745	(778)	(293)	0	745
Total	98,570	(28,931)	1,208	32,243	47,496	(34,919)	(15,460)	85	100,292
Non Current									
Clinical negligence:-									
Secondary care	100,721	0	(1,620)	(31,556)	73,729	(233)	(4,774)	0	136,267
Primary care	0	0	0	0	370	0	0	0	370
Redress Secondary care	0	0	0	0	0	0	0	0	0
Redress Primary care	0	0	0	0	0	0	0	0	0
Personal injury	3,169	0	0	0	128	(316)	0	93	3,074
All other losses and special payments	0	0	0	0	0	0	0	0	0
Defence legal fees and other administration	1,754	0	0	(426)	1,121	(321)	(127)		2,001
Pensions relating to former directors	0			0	0	0	0	0	0
Pensions relating to other staff	2,479			(261)	0	0	0	0	2,218
2019-20 Scheme Pays - Reimbursement	652			0	16	0	0	0	668
Restructuring	0			0	0	0	0	0	0
Other	379		0	0	775	(112)	(173)	0	869
Capital provisions									
RoU Asset Dilapidations CAME	0		0	0	0	0	0	0	0
Other Capital Provisions	0		0	0	0	0	0	0	0
Total	109,154	0	(1,620)	(32,243)	76,139	(982)	(5,074)	93	145,467
TOTAL									
Clinical negligence:-									
Secondary care	191,371	(28,931)	(450)	0	111,020	(26,788)	(18,716)	0	227,506
Primary care	746	0	(40)	0	1,262	(54)	(63)	0	1,851
Redress Secondary care	159	0	78	0	123	(198)	(91)	0	71
Redress Primary care	0	0	0	0	0	0	0	0	0
Personal injury	3,218	0	0	0	651	(603)	(12)	93	3,347
All other losses and special payments	915	0	0	0	5,271	(5,271)	0	0	915
Defence legal fees and other administration	3,199	0	0	0	2,963	(1,677)	(679)		3,806
Pensions relating to former directors	0			0	0	0	0	0	0
Pensions relating to other staff	2,879			0	205	(381)	(188)	85	2,600
2019-20 Scheme Pays - Reimbursement	685			0	40	(36)	0	0	689
Restructuring	0			0	0	0	0	0	0
Other	3,481		0	0	1,355	(115)	(492)	0	4,229
Capital provisions									
RoU Asset Dilapidations CAME	0		0	0	0	0	0	0	0
Other Capital Provisions	1,071		0	0	745	(778)	(293)	0	745
Total	207,724	(28,931)	(412)	0	123,635	(35,901)	(20,534)	178	245,759

Expected timing of cash flows:

	In year to 31 March 2027	Between 1 April 2027 31 March 2031	Thereafter	Total
				£000
Clinical negligence:-				
Secondary care	91,239	136,267	0	227,506
Primary care	1,481	370	0	1,851
Redress Secondary care	71	0	0	71
Redress Primary care	0	0	0	0
Personal injury	273	3,074	0	3,347
All other losses and special payments	915	0	0	915
Defence legal fees and other administration	1,805	2,001	0	3,806
Pensions relating to former directors	0	0	0	0
Pensions relating to other staff	382	2,218	0	2,600
2019-20 Scheme Pays - Reimbursement	21	668	0	689
Restructuring	0	0	0	0
Other	3,360	869	0	4,229
Capital provisions				
RoU Asset Dilapidations CAME	0	0	0	0
Other Capital Provisions	745	0	0	745
Total	100,292	145,467	0	245,759

The expected timing of cash flows are based on best available information; but they could change on the basis of individual case changes. The claims outstanding with the Welsh Risk Pool are based on best estimates of settlement of claims provided by the Health Board's legal advisors. The Health Board estimates that in 2026/27 it will receive £92,619k and in 2027/28 and beyond £137,742k from the Welsh Risk Pool in respect of clinical negligence and personal injury payments.

Other provisions include: Continuing Healthcare Independent Review Panel (IRP) & Ombudsman claims £869K. The estimation method used to calculate the provision for 2025/26 is consistent with the methodology used in 2024/25. In the continuing absence of detailed assessment information the Health Board has used a mixture of actual assessments and the application of an expected success factor and average weekly costs to determine whether an individual claimant provision would be established.

Other provisions have also been made for Ancillary Staff Banked Annual Leave Payments, GP Annual Leave, Dental Contractors Overachievement, PACS Onerous Contract and Scheme Pays.

20. Provisions (continued)

	At 1 April 2024	Structured settlement cases transferred to Risk Pool	Transfer of provisions to creditors	Transfer between current and non-current	Arising during the year	Utilised during the year	Reversed unused	Unwinding of discount	At 31 March 2025
Current	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Clinical negligence:-									
Secondary care	64,140	(3,887)	1,586	34,629	28,319	(18,490)	(15,647)	0	**90,650**
Primary care	791	0	0	0	91	(94)	(42)	0	**746**
Redress Secondary care	263	0	3	0	326	(287)	(146)	0	**159**
Redress Primary care	0	0	0	0	0	0	0	0	**0**
Personal injury	37	0	0	0	162	(136)	(14)	0	**49**
All other losses and special payments	0	0	0	0	1,062	(147)	0	0	**915**
Defence legal fees and other administration	1,954	0	0	(419)	1,244	(939)	(395)		**1,445**
Pensions relating to former directors	0			0	0	0	0	0	**0**
Pensions relating to other staff	397			107	418	(405)	(189)	72	**400**
2019-20 Scheme Pays - Reimbursement	7			0	26	0	0	0	**33**
Restructuring	0			0	0	0	0	0	**0**
Other	2,511		0	0	1,699	0	(1,108)	0	**3,102**
Capital provisions									
RoU Asset Dilapidations CAME	0		0	0	0	0	0	0	**0**
Other Capital Provisions	1,727		0	0	524	(1,115)	(65)	0	**1,071**
Total	**71,827**	**(3,887)**	**1,589**	**34,317**	**33,871**	**(21,613)**	**(17,606)**	**72**	**98,570**
Non Current									
Clinical negligence:-									
Secondary care	142,027	0	0	(34,629)	20,546	(706)	(26,517)	0	**100,721**
Primary care	0	0	0	0	0	0	0	0	**0**
Redress Secondary care	0	0	0	0	0	0	0	0	**0**
Redress Primary care	0	0	0	0	0	0	0	0	**0**
Personal injury	3,027	0	0	0	466	(330)	(67)	73	**3,169**
All other losses and special payments	0	0	0	0	0	0	0	0	**0**
Defence legal fees and other administration	1,017	0	0	419	732	(247)	(167)		**1,754**
Pensions relating to former directors	0			0	0	0	0	0	**0**
Pensions relating to other staff	2,586			(107)	0	0	0	0	**2,479**
2019-20 Scheme Pays - Reimbursement	597			0	55	0	0	0	**652**
Restructuring	0			0	0	0	0	0	**0**
Other	393		0	0	249	(100)	(163)	0	**379**
Capital provisions									
RoU Asset Dilapidations CAME	0		0	0	0	0	0	0	**0**
Other Capital Provisions	0		0	0	0	0	0	0	**0**
Total	**149,647**	**0**	**0**	**(34,317)**	**22,048**	**(1,383)**	**(26,914)**	**73**	**109,154**
TOTAL									
Clinical negligence:-									
Secondary care	206,167	(3,887)	1,586	0	48,865	(19,196)	(42,164)	0	**191,371**
Primary care	791	0	0	0	91	(94)	(42)	0	**746**
Redress Secondary care	263	0	3	0	326	(287)	(146)	0	**159**
Redress Primary care	0	0	0	0	0	0	0	0	**0**
Personal injury	3,064	0	0	0	628	(466)	(81)	73	**3,218**
All other losses and special payments	0	0	0	0	1,062	(147)	0	0	**915**
Defence legal fees and other administration	2,971	0	0	0	1,976	(1,186)	(562)		**3,199**
Pensions relating to former directors	0			0	0	0	0	0	**0**
Pensions relating to other staff	2,983			0	418	(405)	(189)	72	**2,879**
2019-20 Scheme Pays - Reimbursement	604			0	81	0	0	0	**685**
Restructuring	0			0	0	0	0	0	**0**
Other	2,904		0	0	1,948	(100)	(1,271)	0	**3,481**
Capital provisions									
RoU Asset Dilapidations CAME	0		0	0	0	0	0	0	**0**
Other Capital Provisions	1,727		0	0	524	(1,115)	(65)	0	**1,071**
Total	**221,474**	**(3,887)**	**1,589**	**0**	**55,919**	**(22,996)**	**(44,520)**	**145**	**207,724**

The expected timing of cash flows are based on best available information; but they could change on the basis of individual case changes. The claims outstanding with the Welsh Risk Pool are based on best estimates of settlement of claims provided by the Health Board's legal advisors. The Health Board estimates that in 2025/26 it will receive £91,146k and in 2026/27 and beyond £101,877k from the Welsh Risk Pool in respect of clinical negligence and personal injury payments.

Other provisions include: Continuing Healthcare Independent Review Panel (IRP) & Ombudsman claims £379K. The estimation method used to calculate the provision for 2024/25 is consistent with the methodology used in 2023/24. In the continuing absence of detailed assessment information the Health Board has used a mixture of actual assessments and the application of an expected success factor and average weekly costs to determine whether an individual claimant provision would be established.

Other provisions include an amount for Ancillary Staff Banked Annual Leave Payments, potential VAT payment to HMRC and Capital provision.
The total Health Board provision also includes an amount of £164K which relates to 22 Redress cases where offers have been made to the families but not yet accepted or breach and causation have been proven.

Provision (Continued)

Pensions tax annual allowance – Scheme Pays arrangements 2019/20

In accordance with a Ministerial Direction issued on 18 December 2019, the Welsh Government have taken action to support circumstances where pensions tax rules are impacting upon clinical staff who want to work additional hours, and have determined that:

Clinical staff who are members of the NHS Pension Scheme and who, as a result of work undertaken in the 2019-20 tax year, face a tax charge on the growth of their NHS pension benefits, may opt to have this charge paid by the NHS Pension Scheme, with their pension reduced on retirement.

Welsh Government, on behalf of the Aneurin Bevan University Health Board, will pay the members who opt for reimbursement of their pension, a corresponding amount on retirement, ensuring that they are fully compensated for the effect of the deduction.

This scheme will be funded directly by the Welsh Government to the NHS Business Services Authority Pension Division, the administrators on behalf of the Welsh claimants.

Clinical staff had until 31 March 2022 to opt for this scheme and the ability to make changes up to 31 July 2026.

The Health Board have included a Scheme Pay provsion of £689,932 (£685,920, 2024-25) as notified by Welsh Government within these accounts.

21. Contingencies

21.1 Contingent liabilities

Provisions have not been made in these accounts for the following amounts :	**2025-26 £'000**	2024-25 £'000
Legal claims for alleged medical or employer negligence:-		
Secondary care	**294,957**	305,930
Primary care	**3,371**	1,470
Redress Secondary care	**0**	63
Redress Primary care	**0**	0
Doubtful debts		0
Equal Pay costs	**0**	0
Defence costs	**3,744**	4,364
Continuing Health Care costs	**1,368**	1,388
Other	**0**	0
Total value of disputed claims	**303,440**	313,215
Less amounts recoverable in the event of claims being successful	**(298,507)**	(307,921)
Net contingent liability	**4,933**	5,294

Other litigation claims could arise in the future due to known incidents. The expenditure which may arise from such claims cannot be determined and no provision has been made for them. The value of legal claims has decreased by £9.8m from the value of legal claims in 2024-25, while the number of claims has also decreased from 252 in 2024-25 to 248 in 2025-26.

Liability for Permanent Injury Benefit under the NHS Injury Benefit Scheme lies with the employer. Individual claims to the NHS Pensions Agency could arise due to known incidents.

Continuing Healthcare Cost uncertainties
The Health Board continues to review claims for reimbursement of retrospective care payments (IRPs). As a consequence, there has been a movement in the level of provision and uncertainty including in these Accounts.

Note 20 sets out the £0.869m provision made for probable continuing care costs relating to 80 outstanding phase 9, 10 and 11 claims received by 31st March 2026. This compares with the 2024/25 provision of £0.379m and 69 outstanding phase 9 and 10 claims.

Note 21.1 also sets out the £1.368m contingent liability for possible additional continuing care costs relating to those claims if they are all settled and in full, a slight reduction to the £1.388m reported for 2024/25.

There are 13 new claims (4 - Phase 10, 9 - Phase 11), which have been received whereby the assessment process remains incomplete, as we are still awaiting full details to support the claims. The assessment process is highly complex and involves a multi-disciplinary teams and for those reasons can take many months. At this stage, the Health Board does not have enough information to make a judgement on the likely success or otherwise of these claims, however, they may result in additional costs to

21.2 Remote Contingent liabilities

	2025-26 £000	2024-25 £000
Guarantees	0	0
Indemnities	148	428
Letters of Comfort	0	0
Total	**148**	**428**

The 2025-26 remote contingent liabilities consist of 1 medical negligence case and 1 GP Indemnity case (3 medical negligence cases and 1 personal injury case in 2024-25). Should these cases progress the majority of the costs incurred, in excess of £25k per case attributable to the Health Board, will be recovered from the Welsh Risk Pool.

21.3 Contingent assets

	2025-26 £000	2024-25 £000
	0	0
Total	**0**	0

22. Capital commitments

Contracted capital commitments at 31 March

The disclosure of future capital commitments not already disclosed as liabilities in the accounts.

	2025-26 £000	2024-25 £000
Property, plant and equipment	12,498	12,365
Right of Use Assets	0	0
Intangible assets	0	14
Total	**12,498**	12,379

23. Losses and special payments

Losses and special payments are charged to the Statement of Comprehensive Net Expenditure in accordance with IFRS but are recorded in the losses and special payments register when payment is made. Therefore, the payments in this note for settlement and claimant costs are prepared on a cash basis.

Gross loss to the Exchequer

23.1 Number of cases and associated amounts paid out during the financial year

	Amounts paid out during period to 31 March 2026	
	Number of cases	£
Clinical negligence:-		
Secondary Care	109	26,787,957
Primary Care	4	53,848
Redress Secondary Care	16	197,628
Redress Primary Care	0	0
Personal injury	37	602,422
All other losses and special payments	53	5,271,499
Total	219	32,913,354

23.2 Analysis of number of cases and associated amounts paid out during the financial year

Case Type	In year cases in excess of £300,000		Cumulative amount
	L&R Case reference number	£	£
Cases in excess of £300,000:			
Medical Negligence	SSPLR141196	537,000	647,000
Medical Negligence	SSPLR132790	391,844	1,276,844
Medical Negligence	SSPLR144801	4,000,000	4,300,000
Medical Negligence	SSPLR144158	7,368,254	7,664,500
Medical Negligence	SSPLR120834	700,000	1,150,000
Medical Negligence	SSPLR142702	454,296	454,296
Medical Negligence	SSPLR145803	332,301	332,301
Medical Negligence	SSPLR149401	325,000	325,000
Medical Negligence	SSPLR144378	5,203,000	5,538,000
Medical Negligence	SSPLR136706	865,585	925,585
Medical Negligence	SSPLR147877	360,000	360,000
	Number of cases	**£**	**£**
Sub-total	**11**	**20,537,280**	**22,973,526**
All other cases paid in year	208	12,376,074	23,360,488
Total cases paid in year	**219**	**32,913,354**	**46,334,014**

23.3 Analysis of number of cases and associated amounts where no payments were made in financial year

	Number of cases	£
Cumulative amount up to £300k	101	4,769,316
Cumulative amount greater than £300k	13	19,146,807
Total	**114**	**23,916,123**

24. Right of Use lease obligations

24.1 Obligations (as lessee)

Amounts payable under right of use asset leases:

2025-26

	LAND	BUILDINGS	OTHER	TOTAL
	31 March 2026	31 March 2026	31 March 2026	31 March 2026
Minimum lease payments	£000	£000	£000	£000
Within one year	0	1,831	1,398	**3,229**
Between one and five years	1	4,957	2,551	**7,509**
After five years	11	4,999	1,225	**6,235**
Less finance charges allocated to future periods	(2)	(1,390)	(387)	**(1,779)**
Minimum lease payments	**10**	**10,397**	**4,787**	**15,194**
Included in:				
Current borrowings	0	1,566	1,299	**2,865**
Non-current borrowings	10	8,831	3,488	**12,329**
	10	**10,397**	**4,787**	**15,194**
Present value of minimum lease payments				
Within one year	0	1,566	1,299	**2,865**
Between one and five years	1	4,212	2,328	**6,541**
After five years	9	4,619	1,160	**5,788**
Present value of minimum lease payments	**10**	**10,397**	**4,787**	**15,194**
Included in:				
Current borrowings	0	1,566	1,299	**2,865**
Non-current borrowings	10	8,831	3,488	**12,329**
	10	**10,397**	**4,787**	**15,194**

2024-25

	LAND	BUILDINGS	OTHER	TOTAL
	31 March 2025	31 March 2025	31 March 2025	31 March 2025
Minimum lease payments	£000	£000	£000	£000
Within one year	0	1,853	2,238	4,091
Between one and five years	1	5,078	2,554	7,633
After five years	11	6,147	1,133	7,291
Less finance charges allocated to future periods	(2)	(1,645)	(231)	(1,878)
Minimum lease payments	**10**	**11,433**	**5,694**	**17,137**
Included in:				
Current borrowings	0	1,567	2,141	**3,708**
Non-current borrowings	10	9,866	3,553	**13,429**
	10	**11,433**	**5,694**	**17,137**
Present value of minimum lease payments				
Within one year	0	1,567	2,141	3,708
Between one and five years	1	4,241	2,436	6,678
After five years	9	5,625	1,117	6,751
Present value of minimum lease payments	**10**	**11,433**	**5,694**	**17,137**
Included in:				
Current borrowings	0	1,567	2,141	**3,708**
Non-current borrowings	10	9,866	3,553	**13,429**
	10	**11,433**	**5,694**	**17,137**

24.2 Right of Use Assets receivables (as lessor)

The Health Board has two Right of Use Assets lease receivables, as a lessor, at the balance sheet date.

Amounts receivable under right of use assets :

	31 March 2026	31 March 2025
Gross Investment in leases	**£000**	£000
Within one year	**87**	26
Between one and five years	**166**	106
After five years	**65**	92
Less finance charges allocated to future periods	**(12)**	(9)
Minimum lease payments	**306**	215
Included in:		
Current financial assets	**81**	25
Non-current financial assets	**225**	190
	306	215
Present value of minimum lease payments		
Within one year	**81**	25
Between one and five years	**161**	100
After five years	**64**	90
Less finance charges allocated to future periods	**0**	0
Present value of minimum lease payments	**306**	215
Included in:		
Current financial assets	**81**	25
Non-current financial assets	**225**	190
	306	215

25. Private Finance Initiative contracts

25.1 PFI schemes off-Statement of Financial Position

The LHB has one PFI Scheme that was previously classified as off-statement of financial position. The scheme related to the provision of replacement heating and lighting systems within Neville Hall hospital. The scheme commenced in 2000 for a period of 25 years. Since the introduction of IFRS 16 in 2022/23, the off-statement of Financial Position PFI has been recognised as a Right of use Asset.

Commitments under off-SoFP PFI contracts	**Off-SoFP PFI contracts**	Off-SoFP PFI contracts
	31 March 2026	31 March 2025
	£000	£000
Total payments due within one year	**0**	0
Total payments due between 1 and 5 years	**0**	0
Total payments due thereafter	**0**	0
Total future payments in relation to PFI contracts	**0**	0
Total estimated capital value of off-SoFP PFI contracts	**0**	0

25.2 PFI schemes on-Statement of Financial Position

Capital value of scheme included in Fixed Assets Note 11	**£000**
	4,236
Contract start date:	**Mar-04**
Contract end date:	**Mar-36**

Monnow Vale Health and Social Care Facility - a new health and social care facility. This scheme commenced in 2006 with unitary charge payments being made for a period of 30 years from 2006. The obligation for the scheme is £2,984k. In 2025/26, the liability for the scheme was increased by £107k due to the IFRS16 requirement to reflect the impact of RPI increases within the scheme obligation.

Total obligations for on-Statement of Financial Position PFI contracts due:

2025-26	**On SoFP PFI Capital element**	**On SoFP PFI IFRS 16 impact Finance Charge**	**On SoFP PFI Imputed interest**	**On SoFP PFI Service charges**
	31 March 2026	**31 March 2026**	**31 March 2026**	**31 March 2026**
	£000	**£000**	**£000**	**£000**
Total payments due within one year	**129**	**134**	**82**	**761**
Total payments due between 1 and 5 years	**553**	**573**	**253**	**3,042**
Total payments due thereafter	**782**	**813**	**128**	**3,803**
Total future payments in relation to PFI contracts	**1,464**	**1,520**	**463**	**7,606**

2024-25	On SoFP PFI Capital element	On SoFP PFI IFRS 16 impact Finance Charge	On SoFP PFI Imputed interest	On SoFP PFI Service charges
	31 March 2025	31 March 2025	31 March 2025	31 March 2025
	£000	£000	£000	£000
Total payments due within one year	125	122	86	735
Total payments due between 1 and 5 years	538	521	274	2,938
Total payments due thereafter	926	900	174	4,407
Total future payments in relation to PFI contracts	1,589	1,543	534	8,080

	31/03/2026
	£000
Total present value of obligations for on-SoFP PFI contracts	11,053

25.3 Charges to expenditure	2025-26	2024-25
	£000	£000
Service charges for On Statement of Financial Position PFI contracts (excl interest costs)	722	2,764
Total expense for Off Statement of Financial Position PFI contracts	0	0
The total charged in the year to expenditure in respect of PFI contracts	722	2,764

The LHB is committed to the following annual charges

PFI scheme expiry date:	£000	£000
Not later than one year	0	0
Later than one year, not later than five years	0	0
Later than five years	761	735
Total	761	735

The estimated annual payments in future years will vary from those which the Health Board is committed to make during the next year by the impact of movement in the Retail Prices Index.

25.4 Number of PFI contracts

	Number of on SoFP PFI contracts	Number of off SoFP PFI contracts
Number of PFI contracts	1	0
Number of PFI contracts which individually have a total commitment > £500m	0	0

The LHB has one on-going PFI contract as at 31.03.26

25.5 Public Private Partnerships

The Health Board did not have any Public Private Partnerships during the year

26. Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking it's activities. The Health Board is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which these standards mainly apply. The Health Board has limited powers to invest and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Health Board in undertaking its activities.

Currency risk

The Health Board is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the United Kingdom and Sterling based. The Health Board does not have any overseas operations. The Health Board therefore has low exposure to currency rate fluctuations.

Interest rate risk

Health Boards are not permitted to borrow and the Health Board therefore has low exposure to interest rate fluctuations.

Credit risk

As the majority of the Health Board's funding derives from funds voted by the Welsh Government the Health Board has low exposure to credit risk.

Liquidity risk

The Health Board is required to operate within cash limits set by the Welsh Government for the financial year and draws down funds from the Welsh Government as the requirement arises. The Health Board is not, therefore, exposed to significant liquidity risks.

27. Movements in working capital

	2025-26 £000	2024-25 £000
(Increase)/decrease in inventories	639	(589)
(Increase)/decrease in trade and other receivables - non-current	(36,513)	38,243
(Increase)/decrease in trade and other receivables - current	(7,766)	(30,588)
Increase/(decrease) in trade and other payables - non-current	(1,264)	426
Increase/(decrease) in trade and other payables - current	12,521	2,664
Total	(32,383)	10,156
Adjustment for accrual movements in fixed assets - creditors	(1,217)	(1,599)
Adjustment for accrual movements in fixed assets - debtors	103	(34)
Adjustment for accrual movements in right of use assets - creditors	1,943	(800)
Adjustment for accrual movements in right of use assets - debtors	90	(25)
Other adjustments	(290)	455
	(31,754)	8,153

Other Adjustments include:
-£778K - Arising Capital Provisions Not Included Elsewhere
£452K - Utilised Capital Provisions Not Included Elsewhere
£36k - Movement in Fixed Asset Debtors

28. Other cash flow adjustments

	2025-26 £000	2024-25 £000
Depreciation	49,920	46,127
Amortisation	1,960	1,964
(Gains)/Loss on Disposal	44	(41)
Impairments and reversals	(5,687)	1,817
Release of PFI deferred credits	0	0
NWSSP Covid assets issued debited to expenditure but non-cash	0	0
Covid assets received credited to revenue but non-cash	0	0
Donated assets received credited to revenue but non-cash	(203)	(78)
Government Grant assets received credited to revenue but non-cash	0	0
Right of Use Grant (Peppercorn Lease) credited to revenue but non cash	0	0
Non-cash movements in right of use assets	(45)	25
Non-cash movements in provisions	73,484	9,246
Other movements	56,042	51,797
Total	175,515	110,857

Other movements of £56,042K (2024-25 £51,797K) is made up of notional funding received for:

- LHB notional 9.4% Staff Employer Pension Contribution: £56,007K
- the 2019-20 Pensions Annual Allowance Charge Compensation Scheme (PAACCS): £35K

which are both funded directly to the NHSBA Pensions Division by Welsh Government.

29. Events after the Reporting Period

These financial statements were authorised for issue by the Chief Executive and Accountable Officer on 24 June 2026; post the date the financial statements were certified by the Auditor General for Wales.

30. Related Party Transactions

The Welsh Government is regarded as a related party of the Health Board. During the year the Health Board had a significant number of material revenue and capital transactions with either the Welsh Government or with other entities for which the Welsh Government is regarded as the parent body, namely:

Related Parties	2025-26 Expenditure to related party	2025-26 Income from related party	As at 31st March 2026 Amounts owed to related party	As at 31st March 2026 Amounts due from related party
	£000	£000	£000	£000
Welsh Government	7	7,434	0	2,654
Betsi Cadwaladr University Health Board	110	25	17	2
Cardiff & Vale University Health Board	46,700	3,639	3,654	1,167
Cwm Taf University Health Board	19,304	4,188	1,836	907
Hywel Dda University Health Board	549	425	8	32
Powys Teaching Health Board	231	16,015	0	1,189
Swansea Bay University Health Board	2,508	1,254	438	204
Public Health Wales NHS Trust	883	6,231	149	929
Velindre NHS Trust	121,499	14,684	3,036	8,312
Welsh Ambulance Services NHS Trust	691	387	287	166
NHS Wales Joint Commissioning Committee (WHSSC)	232,406	15,082	5,868	458
Digital Health and Care Wales (DHCW)	8,485	2,085	1	261
Health Education and Improvement Wales (HEIW)	142	19,022	27	651
	433,515	**90,471**	**15,321**	**16,932**

In addition the LHB has had significant number of material transactions with other Government Departments and other central and local Government bodies. The most significant of these transactions are with the following:-

Government Body	2025-26 Expenditure to related party	2025-26 Income from related party	As at 31st March 2026 Amounts owed to related party	As at 31st March 2026 Amounts due from related party
	£000	£000	£000	£000
Blaenau Gwent County Borough Council	5,335	1,116	2,326	66
Caerphilly County Borough Council	21,279	14,673	5,063	3,461
Monmouthshire County Council	8,471	1,866	2,157	384
Newport City Council	8,054	2,335	3,106	161
Torfaen County Borough Council	9,085	1,447	3,269	154
	52,224	**21,437**	**15,921**	**4,226**

The LHB has also had significant material transactions with the following:

	2025-26 Expenditure to related party	2025-26 Income from related party	As at 31st March 2026 Amounts owed to related party	As at 31st March 2026 Amounts due from related party
	£000	£000	£000	£000
Aneurin Bevan Local Health Board Charitable Fund	16	1,596	16	209

A number of the LHB's Board members have interests in related parties as follows:

Member	Related Organisation	Relationship with Related Party	2025-26 Expenditure to related party	2025-26 Income from related party	As at 31st March 2026 Amounts owed to related party	As at 31st March 2026 Amounts due from related party
			£000	£000	£000	£000
Helen Cunningham	Blaenau Gwent County Borough Council	Elected Member	5,335	1,116	2,326	66
Penny Jones	Monmouthshire County Council	Councillor	8,471	1,866	2,157	384
	Welsh Government	Daughter is a Member of the Senedd	7	7,434	0	2,654
Peter Carr	Digital Health & Care Wales	Chair of National LIMS 2.0 Programme Board	8,485	2,085	1	261
Richard Clark	Torfaen County Borough Council	Elected Member, Deputy Leader and Executive Member for Children, Families and Education	9,085	1,447	3,269	154

31. Third Party assets

The LHB held £41,184 cash at bank and in hand at 31 March 2026 (31st March 2025, £33,690) which relates to monies held by the LHB on behalf of patients. Cash held in patient Investment Accounts amounted to £0 at 31st March 2026 (31st March 2025, £0). This has been excluded from the Cash and Cash equivalents figure reported in the accounts.

In addition the LHB had located on its premises a significant quantity of consignment stock. This stock remains the property of the supplier until it is used. The value of consignment stock at 31 March 2026 amounted to £3.7m (£3.5m as at 31st March 2025).

32. Pooled budgets

The Health Board has five pooled budgets. The specific accounting treatment of each pooled budget is covered within Accounting Policies note 1.22.

Monnow Vale Health and Social Care Unit

The Health Board has entered into a pooled budget with Monmouthshire County Council. Under the arrangement funds are pooled under section 33 of the NHS (Wales) Act 2006 to provide health and social care inpatient, outpatient, clinic and day care facilities to individuals who have medical, social, community or rehabilitation needs and a memorandum note to the accounts provides details of the joint income and expenditure. The asset value of property, plant & equipment is **£5,883K** which is split 72% Aneurin Bevan Health Board and 28% Monmouthshire County Council. The costs incurred under the pooled budget is declared in the memorandum trading account.

	Cash	Own Contribution	Grants	2025/26	2024/25
Pooled Budget contributions				**£000**	£000
Aneurin Bevan University Health Board	-	3,127	-	**3,127**	2,965
Monmouthshire County Council	454	981	-	**1,435**	1,382
Total Pooled Budget contributions for the year	**454**	**4,108**	**-**	**4,562**	**4,347**
Expenditure					
Aneurin Bevan Health Board	-	3,401		**3,401**	3,271
Monmouthshire County Council	644	898		**1,542**	1,501
Total Expenditure for the year	**644**	**4,299**	**0**	**4,943**	**4,772**
Net Surplus/(Deficit) on the Pooled Budget for the Year	**(190)**	**(191)**	**0**	**(381)**	(425)

Gwent Wide Integrated Community Equipment Service

The Health Board has entered into a pooled budget with the 5 Local Authorities in the Gwent area, namely Blaenau Gwent, Caerphilly, Monmouth, Newport and Torfaen County Borough Councils, for the provision of an effective integrated GWICES (Gwent Wide Integrated Community Equipment Service) to service users who are resident in the partners' localities. Under the arrangement funds are pooled under section 33 of the NHS (Wales) Act 2006 for the joint equipment store in the Gwent area. The Health Board accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement. The LHB's contribution is **£1,323K** for 2025/26 (£1,289K in 2024/25).

The Health Board is waiting for the lead Local Authority partner to publish the Memorandum Account for 2025/26, at

	2025/26	2024/25
Pooled Budget contributions	**£000**	**£000**
Blaenau Gwent County Borough Council		379
Caerphilly County Borough Council		635
Monmouthshire County Borough Council		518
Newport City Council		537
Torfaen County Borough Council		989
Aneurin Bevan University Health Board		1,264
CRT		161
Contribution to Lead Commisioner - LAs		98
Contribution to Lead Commisioner - UHB		25
Reserve		180
Total Pooled Budget contributions for the year	**-**	**4,787**
Expenditure		
Staff Costs		149
Non Staff Expenditure		4,638
Total Expenditure for the year	**-**	**4,787**
Net Surplus/(Deficit) on the Pooled Budget for the Year	**0**	**0**

Mardy Park Rehabilitation Centre

The Health Board has entered into a pooled budget arrangement with Monmouthshire County Council. Under the arrangement funds are pooled under Section 33 of the NHS (Wales) Act 2006 to provide care to individuals who have rehabilitation needs. The pool is hosted by Monmouthshire County Council and the LHBs contribution is **£283K** for 2025/26 (£278K in 2024/25).

	2025/26	2024/25
Pooled Budget contributions	**£000**	**£000**
Monmouthshire County Borough Council	375	368
Aneurin Bevan University Health Board	283	278
Total Pooled Budget contributions for the year	**658**	**646**
Expenditure		
Staff Costs	453	421
Premises	112	92
Transport	-	6
Supplies & Services	26	32
Other Expenditure	35	45
Total Expenditure for the year	**626**	**596**
Net Surplus/(Deficit) on the Pooled Budget for the Year	**32**	**50**

32. Pooled budgets (continued)

Gwent Frailty Programme

The Health Board has entered into a pooled budget with 5 Local Authorities in the Gwent area, namely Blaenau Gwent , Caerphilly, Monmouthshire, Newport and Torfaen County councils, for the provision of a Gwent wide integrated health and social care Frailty service, for service users who are resident in the partners' localities. Under the arrangement funds are pooled under section 33 of the NHS (Wales) Act 2006 for the purpose of establishing a consistent service for the Gwent area. The Health Board accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement. The LHB's contribution is **£10,677K** for 2025/26 (£10,320K in 2024/25).

	2025/26	2024/25
Pooled Budget contributions	**£000**	**£000**
Blaenau Gwent County Borough Council	756	689
Caerphilly County Borough Council	2,372	2,349
Monmouthshire County Borough Council	1,794	1,628
Newport City Council	2,080	2,148
Torfaen County Borough Council	881	833
Aneurin Bevan University Health Board	10,677	10,320
Total Pooled Budget contributions for the year	**18,560**	**17,967**
Expenditure		
Reimbursements to Local Authorities from Pooled Fund:		
Blaenau Gwent County Borough Council	180	159
Caerphilly County Borough Council	1,886	1,940
Monmouthshire County Borough Council	1,492	1,442
Newport City Council	2,091	2,131
Torfaen County Borough Council	759	680
Reimbursements to ABUHB from Pooled Fund	11,414	11,006
Central Costs	812	777
Total Expenditure for the year	**18,634**	**18,135**
Net Surplus/(Deficit) on the Pooled Budget for the Year	**(74)**	**(168)**

Continuing Healthcare - Older People in Care Homes

The Health Board has entered into a pooled budget with the 5 Local Authorities in the Gwent area, namely Blaenau Gwent, Caerphilly, Monmouthshire, Newport and Torfaen County Councils, for the provision and commissioning of certain specialised services for older people (>65 years of age) in a care home setting in Gwent. Statutory Directions issued under section 169 of the Social Services and Wellbeing (Wales) Act 2014 required Partnership Bodies to enter into partnership arrangements and for the establishment and maintenance of pooled funds from April 2018, for the exercise of their Care Home Accommodation Functions.

The pool was established in August 2018 and is hosted by Torfaen County Borough Council. Under the arrangement, the Health Board makes a financial contribution equivalent to related expenditure in commissioning related placements in homes during the year. The LHB's contribution is **£46,803K** for 2025/26 (£43,955K in 2024/25).
The Health Board is waiting for the lead Local Authority partner to publish the Memorandum Account for 2025/26, at which point the below disclosure will be completed.

	2025/26	2024/25
Pooled Budget contributions	**£000**	**£000**
Blaenau Gwent County Borough Council		11,303
Caerphilly County Borough Council		34,641
Monmouthshire County Borough Council		15,255
Newport City Council		29,117
Torfaen County Borough Council		15,983
Aneurin Bevan University Health Board		43,955
Total Pooled Budget contributions for the year	**-**	**150,254**
Expenditure		
Gwent Local Auhtority Residential Homes		20,193
Other Elderly Frail Residential Care		14,817
Other EMI Residential Care		29,968
Elderly Frail Funded Nursing Care		32,863
EMI Funded Nursing Care		21,264
Elderly frail Continuing Health Care		8,908
EMI Conituining Health Care		21,942
Step Up/ Step Down		237
Lead Commissioner Costs		62
Total Expenditure for the year	**-**	**150,254**
Net Surplus/(Deficit) on the Pooled Budget for the Year	**0**	**0**

33. Operating segments

Accounting standard IFRS 8 defines an operating segment as a component of an entity:

IFRS 8 requires bodies to report information about each of its operating segments.

Whilst the organisation is structured into divisions, the performance management and the allocation of resources flow from the Board of Aneurin Bevan University Health Board.

There are no hosted services within the health board. Divisions do not manage capital programmes, have any autonomy in relation to balance sheets or produce discrete accounts.

For the purposes of IFRS 8 it is therefore deemed that there is no requirement to report any operating segments

34. Other Information

34.1. 9.4% Staff Employer Pension Contributions - Notional Element

The value of notional transactions is based on estimated costs for the twelve month period 1st April 2025 to 31st March 2026. This has been calculated from actual Welsh Government expenditure for the 9.4% staff employer pension contributions between April 2025 and February 2026 alongside Health Board data for March 2026.

Transactions include notional expenditure in relation to the 9.4% paid to NHSBSA by Welsh Government and notional funding to cover that expenditure as follows:

	2025-26	2024-25
Statement of Comprehensive Net Expenditure for the year ended 31 March 2026	**£000**	**£000**
Expenditure on Primary Healthcare Services	**1,220**	780
Expenditure on healthcare from other providers	**0**	0
Expenditure on Hospital and Community Health Services	**54,787**	51,004
Statement of Changes in Taxpayers' Equity for the year ended 31 March 2026		
Net operating cost for the year	**56,007**	51,784
Notional Welsh Government Funding	**56,007**	51,784
Statement of Cash Flows for year ended 31 March 2026		
Net operating cost for the financial year	**56,007**	51,784
Other cash flow adjustments	**56,007**	51,784
2.1 Revenue Resource Performance		
Revenue Resource Allocation	**56,007**	51,784
3. Analysis of gross operating costs		
3.1 Expenditure on Primary Healthcare Services		
General Medical Services	**1,111**	684
Pharmaceutical Services	**0**	0
General Dental Services	**99**	85
Other Primary Health Care expenditure	**10**	11
3.2 Expenditure on healthcare from other providers		
	0	0
	0	0
3.3 Expenditure on Hospital and Community Health Services		
Directors' costs	**190**	166
Staff costs	**52,444**	50,838
Single Lead Employer staff trainee costs	**2,153**	0
9.1 Employee costs		
Permanent Staff		
Employer contributions to NHS Pension Scheme	**56,007**	51,784
Charged to capital	**0**	0
Charged to revenue	**56,007**	51,784
18. Trade and other payables		
Current		
Pensions: staff	**0**	0
28. Other cash flow adjustments		
Other movements	**56,007**	51,784

The Department of Health and Social Care (DHSC) 2023-24 consultation on the NHS Pension Scheme confirmed that the transitional approach that has operated since 2019-20 for employer contributions will continue in 2024-25. From 1 April 2024 an employer rate of 23.7% (23.78% inclusive of the administration charge) will apply. However, the NHS Business Services Authority will continue to only collect 14.38% from NHS Wales employers under their normal monthly payment process to the NHS Pension Scheme. This has a resulted in an increase in the central payments made by Welsh Government from 6.3% to 9.4%.

Other

34.2 IFRS 17 - Insurance Contract Disclosures

The outcome of the contract review for a range of income contract types applicable to the organisation, did not identify any insurance contracts that fall within the scope of IFRS 17.

STATEMENT OF FINANCIAL POSITION

(Signage as per provision note disclosure)	£000
Liability for incurred claims @ 1 April 2025	0
Liability for remaining payments @ 31 March 2026	0
	0
Arising during year	0
Utilised	0
Reversed unused	0
Movement in Discount Rates	0
	0

STATEMENT OF COMPREHENSIVE NET EXPENDITURE

(Signage as per income and expenditure note disclosure)	£000
Insurance Income	0
Insurance expenditure	0

THE NATIONAL HEALTH SERVICE IN WALES ACCOUNTS DIRECTION GIVEN BY WELSH MINISTERS IN ACCORDANCE WITH SCHEDULE 9 SECTION 178 PARA 3(1) OF THE NATIONAL HEALTH SERVICE (WALES) ACT 2006 (C.42) AND WITH THE APPROVAL OF TREASURY

LOCAL HEALTH BOARDS

1. Welsh Ministers direct that an account shall be prepared for the financial year ended 31 March 2011 and subsequent financial years in respect of the Local Health Boards (LHB)[1], in the form specified in paragraphs [2] to [7] below.

BASIS OF PREPARATION

2. The account of the LHB shall comply with:

(a) the accounting guidance of the Government Financial Reporting Manual (FReM), which is in force for the financial year in which the accounts are being prepared, and has been applied by the Welsh Government and detailed in the NHS Wales LHB Manual for Accounts;

(b) any other specific guidance or disclosures required by the Welsh Government.

FORM AND CONTENT

3. The account of the LHB for the year ended 31 March 2011 and subsequent years shall comprise a statement of comprehensive net expenditure, a statement of financial position, a statement of cash flows and a statement of changes in taxpayers' equity as long as these statements are required by the FReM and applied by the Welsh Assembly Government, including such notes as are necessary to ensure a proper understanding of the accounts.

4. For the financial year ended 31 March 2011 and subsequent years, the account of the LHB shall give a true and fair view of the state of affairs as at the end of the financial year and the operating costs, changes in taxpayers' equity and cash flows during the year.

5. The account shall be signed and dated by the Chief Executive of the LHB.

MISCELLANEOUS

6. The direction shall be reproduced as an appendix to the published accounts.

7. The notes to the accounts shall, inter alia, include details of the accounting policies adopted.

Signed by the authority of Welsh Ministers

Signed : Chris Hurst Dated :

[1.] Please see regulation 3 of the 2009 No.1559 (W.154); NATIONAL HEALTH SERVICE, WALES; The Local Health Boards (Transfer of Staff, Property, Rights and Liabilities) (Wales) Order 2009.

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	19 May 2026
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Audit Enquiries Response to Audit Wales
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Robert Holcombe, Director of Finance, Procurement and Value Based HealthCare
SWYDDOG ADRODD: **REPORTING OFFICER:**	Robert Jones, Assistant Finance Director

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

Er Gwybodaeth/For Information

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

As part of their annual audit process, Audit Wales have request documented consideration and understanding on a number of governance areas that impact on the audit of the financial statements. These considerations are relevant to both the management of Health Board and those charged with governance (the Board and Audit Committee). The information provided will inform the auditors' understanding of the Health Board and its business processes and support their work in providing an audit opinion on the 2025/26 financial statements.

Cefndir / Background

See above

Asesiad / Assessment
The completed document is included in the attachment. The responses have required input from a number of individuals from the Health Board, in particular, the Director of Corporate Governance, Head of Counter Fraud and Head of Financial Accounts.
Argymhelliad / Recommendation
The Committee is asked to note the report for Information

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

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	FCP – Financial Control Procedure PSPP – Public Sector Payment Policy NWSSP – NHS Wales Shared Services Partnership KPI – Key Performance Indicators SFI – Standing Financial Instructions

Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

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

Audit enquiries to those charges with governance and management. Please contact us in Welsh or English / cysylltwch â ni'n Gymraeg neu'n Saesneg.

Appendix 1: Enquiries of management

Enquiries of management – in relation to fraud

Question	2025-26 Response
1. What is management's assessment of the risk that the financial statements may be materially misstated due to fraud? What is the nature, extent and frequency of management's assessment?	The risk of misstatement remains low. The basis being an effective system of internal controls and sound control environment mitigate against the risk.
2. Do you have knowledge of any actual, suspected or alleged fraud affecting the audited body?	Yes. All instances of fraud and suspected fraud have been recorded, investigated and reported to the Director of Finance and the Audit Risk and Assurance Committee. Over the course of the financial year: • **19 active cases** were carried forward from the previous year • **54 new referrals** were received and recorded • **59 cases** were concluded during the year • **14 cases** remain open and under active review at year end and will be carried forward • **1 case** was transferred to the NHS Counter Fraud Service (CFS) Wales Team following creation; no further action was taken in this instance • **5 Interviews Under Caution (IUCs)** were conducted

Question	2025-26 Response
3. What is management's process for identifying and responding to the risks of fraud in the audited body, including any specific risks of fraud that management has identified or that have been brought to its attention?	Management has established a structured and risk-led process for identifying and responding to fraud risks across the organisation. Fraud risks are identified through a combination of formal Fraud Risk Assessments aligned to Cabinet Office methodology, analysis of referrals and investigations, data matching exercises such as the National Fraud Initiative, and intelligence from national bodies including the NHS Counter Fraud Authority. These risks are formally recorded, assessed, and managed through the organisation's risk management framework and Datix system, with oversight provided by the Audit, Risk and Assurance Committee and Executive Board. Identified risks have included areas such as workforce-related fraud (e.g. sickness abuse, dual employment, timesheet irregularities), payroll and overpayments, and emerging risks such as agency staff impersonation and fuel card usage. In response, management implements targeted mitigating actions including local proactive exercises, control improvements, policy updates, staff awareness and training programmes, and, where appropriate, formal investigation and disciplinary action. This integrated approach ensures that fraud risks are proactively identified, continuously monitored, and effectively managed in line with national standards and legislative requirements.

Question	2025-26 Response
4. What classes of transactions, account balances and disclosures have you identified as most at risk of fraud?	The following thematic areas have been formally assessed for the Risk of Fraud during the financial year as part of our continued assessments: - Agile Working - Special Leave - Staff Expenses - Salary Overpayments - Agency Staff – Impersonation - Staff Leavers - Pre-Employment Checks – Agencies - Petty Cash - Virtual Credit Cards - Payment Terminals Wider than these thematic areas, there is inherent risk, typical for any organisation including: • **Procurement and purchasing transactions** – including single tender actions, supplier setup/amendment, and purchase-to-pay processes • **Invoice processing and payments** – particularly risks such as invoice redirection, duplicate payments, and false invoicing

Question	2025-26 Response
	• **Mandate and bank detail changes** – where there is risk of diversion of payments (mandate fraud) • **Payroll transactions** – including starter/leaver processes, overtime, and allowances • **Expenses and reimbursement claims** – including travel and subsistence claims
5. Are you aware of any whistleblowing or complaints by potential whistle blowers? If so, what has been the audited body's response?	All complaints made in relation to fraud are directed to the Local Counter Fraud team via the reporting routes available. These can be anonymous or named. There have been a number of complaints/referrals this year involving whistle blowers and the response is always consistent. Whistle blowers are treated in accordance with policy and identity is protected where appropriate. ABUHB has a clear Whistle Blowing Policy that would be adhered to in any instances of whistle blowing by staff or contractors etc. If staff wish to report matters concerning suspected fraud, there are a number of ways of doing this, including utilising the NHS Fraud and Corruption

Question	2025-26 Response
	Reporting line and remaining anonymous in doing so. These referrals are then processed by the NHS CFA and passed to ABUHB Head of Counter Fraud via the CLUE system.
6. What is management's communication, if any, to those charged with governance regarding their processes for identifying and responding to risks of fraud?	ABHUB's Head of Counter Fraud reports regularly (as a standing agenda item) to the Public and Private session of the Health Board's Audit, Risk and Assurance Committee. Reports from the Audit, Risk and Assurance Committee are submitted to the Board. Should a fraud matter require urgent escalation then this is carried out via the Director of Finance and reported to the Audit Committee Chair. The Head of Counter Fraud also has ongoing independent access to the Audit Committee Chair outside of the Executive Board. If there is a clear conflict of interest for ABUHB or if it involved a very senior staff member the likelihood would be the matter would be referred to NHS CFS Wales.

Question	2025-26 Response
7. What is management's communication, if any, to employees regarding their views on business practices and ethical behaviour?	ABUHB has an agreed Values and Behaviours Framework and Business Conduct Policy. The staff values and behaviour are reinforced via the appraisal process which is linked now to pay progression. Declarations of Interests are sought annually with the expectation that as staff are aware of their duty to disclose this will be done as and when this need arises. All Board members are provided with a direct request regarding completing a Declaration of Interest and are made aware of their continuing duty to declare as and when required to do so.
8. For service organisations, have you reported any fraud to the user entity?	N/A we are a Health Board and therefore a Primary Audited Body.

Enquiries of management – in relation to laws and regulations

Question	2025-26 Response
9. Is the audited body in compliance with relevant laws and regulations? How have you gained assurance that all relevant laws and regulations have been complied with? Are there any policies or procedures in place?	Compliance with legislation and regulations form part of the scopes of external and internal scrutiny bodies reviews. Compliance with major new or revised legislation and regulation are reported as separate

Question	2025-26 Response
	items to various Executive Groups and Board Committees. During the year a series of Welsh Health Circulars and Ministerial Directions were issued to the health board. Compliance with these is monitored by the corporate governance team and a nominated Director is required to oversee implementation. Assurance on compliance is reported to the Audit, Risk & Assurance Committee and disclosed in the Annual Governance Statement.
10. Have there been any instances of non-compliance or suspected non-compliance with relevant laws and regulations in the financial year, or earlier with an ongoing impact on this year's audited financial statements?	In line with last year, and with no further updates: The Health Board currently have an open case with the Health and Safety Executive (HSE). The case relates to a fatal patient fall that occurred in 2019. The HSE have completed their investigation into the matter and have identified possible breaches of legislation by the Health Board. Although the HSE have yet to make an enforcement decision, this now looks likely and a provision is therefore possible in the accounts.
11. Are there any potential litigations or claims that would affect the financial statements?	Yes. The Health Board is involved in a number of claims and potential litigations, primarily relating to

Question	2025-26 Response
	clinical negligence and personal injury. These are managed in accordance with the Board's litigation policies and are supported by valuations provided by NHS Wales Shared Services Partnership Legal Services.
12. Have there been any reports from other regulatory bodies, such as HM Revenues and Customs which indicate non-compliance?	There have been no such reports.
13. Are you aware of any non-compliance with laws and regulations within NWSPP since 1 April of the financial year?	No issues to report.
14. Have there been any changes to laws and regulations that directly impact the entity this year?	During the year there have been no material changes to laws and regulations that fundamentally alter the Health Board's operational framework; however, there have been important developments in the legislative environment relating to fraud and economic crime. In particular, the Economic Crime and Corporate Transparency Act 2023 introduced a new 'failure to prevent fraud' corporate offence from 1 September 2025, requiring large organisations to demonstrate that reasonable procedures are in place to prevent fraud.

Question	2025-26 Response
	Management has assessed the implications of this change and has confirmed that existing counter fraud arrangements—including risk assessment, preventative controls, governance structures, and the Counter Fraud work plan—are aligned to the principles set out in the legislation. These changes have therefore reinforced, rather than fundamentally changed, existing processes, with ongoing work to ensure continued compliance and demonstrable adherence to the updated legislative expectations.
15. Has there been any significant communications with regulators?	The Health Board continues to maintain positive relationships with its regulators, including Healthcare Inspectorate Wales and the Health and Safety Executive as well as professional regulators such as GMC and NMC. There are no significant communications to report. Reports issued by the regulators are presented to the Board's Patient Quality, Safety & Outcomes Committee alongside management actions plans for improvements. These reports are disclosed into the public domain
16. For service organisations, have you reported any non-compliance with laws and regulations?	N/A we are a Health Board and therefore a Primary Audited Body.

Enquiries of management – in relation to related parties

Question	2025-26 Response
17. Have there been any changes to related parties from the prior year? If so, what is the identity of the related parties and the nature of those relationships? Confirm these have been disclosed to the auditor.	There have been no new related parties. Where related parties exist by virtue of declaration of interest disclosures from individuals these are managed and reported through the Declaration of Interest process.
18. What transactions have been entered into with related parties during the period? What is the purpose of these transactions? Confirm these have been disclosed to the auditor.	These will be provided as part of the annual accounts and associated statements.
19. What controls are in place to identify, account for and disclose related party transactions and relationships?	These will be provided as part of the annual accounts and associated statements.
20. What controls are in place to authorise and approve significant transactions and arrangements: • with related parties, and • outside the normal course of business?	There is an Annual Declarations of Interest process that is completed for all Board Members, standard agenda item on all meetings for disclosure of any Declarations of Interest. Business Conduct Policy in operation

Enquiries of management – in relation to regularity

Question	2025-26 Response
21. What is your assessment of the risk of material irregularity?	There are no known issues in respect of non-compliance with laws or regulations for reporting, as previously stated. The Health Board also has confidence in its preparation of the financial statements and the data used to inform this. The level of risk of irregularity is therefore deemed very low.
22. What is the process for responding to the risk of irregularity?	A robust process is in place through a comprehensive Internal Audit Plan and annual fraud workplan, both of which are approved and monitored/responded to through the Audit Committee.
23. What is your knowledge of actual, suspected or alleged irregularity?	We are not aware of any
24. Where service organisations are used by the entity, have any irregularities been reported to the user entity?	We are not aware of any

Enquiries of management – in relation to the control environment & IT systems

Question	2025-26 Response
25. If internal control deficiencies were reported in the prior year, please comment on the status of these.	As reported at the April Audit Committee, the 2025/26 Internal Audit Opinion is Reasonable Assurance: **1.2 Head of Internal Audit Opinion 2025/26** The purpose of the annual Head of Internal Audit opinion is to contribute to the assurances available to the Chief Executive as Accountable Officer and the Board which underpin the Board's own assessment of the effectiveness of the system of internal control. The approved Internal Audit plan is focused on risk and therefore the Board will need to integrate these results with other sources of assurance when making a rounded assessment of control for the purposes of the Annual Governance Statement. The overall opinion for 2025/26 is:  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. **Low to moderate impact** on residual risk exposure until resolved. This includes the review of "Follow-up of Internal Audit Regulations" where the following was reported with no issues noted: • **Follow-up of Internal Audit Recommendations** – For this review, we considered whether a sample of 2024/25 internal audit recommendations were implemented in a timely manner, with supporting evidence. We also assessed the accuracy of the Audit Recommendation Tracker, to ensure audit actions had been correctly recorded, including any implementation timeframe extension. No matters were identified for reporting.

Question	2025-26 Response
26. Have there been any changes to significant IT systems or applications in the period?	None, we expect the next Oracle Patch version to be implemented during 2026/27

Enquiries of management – in relation to financial reporting

Question	2025-26 Response
27. Are you aware of significant transactions that are outside the normal trading activities of the business?	None
28. Are you aware of any transactions, events or changes in circumstances that would cause impairments of non-current assets?	Impairments are shown in full the financial statements.
29. Are you aware of any transactions, events and conditions (or changes in these) that may give rise to recognition or disclosure of significant accounting estimates that require significant judgement?	The HSE enforcement order issue is being assessed with current information available regarding the requirement for a provision in the final accounts.

Question	2025-26 Response
	This has been discussed in audit planning meetings and full details will be provided during the audit.
30. Have there been any changes in accounting policies in relation to significant estimates?	As above
31. Have you used any experts in the preparation of the accounts?	No experts are used in the preparation of the accounts themselves – that is done by the in-house financial accounts team. However, as usual, a range of experts are used to provide information for the accounts in the normal way e.g. District Valuer, the solicitors in NWSSP Legal Services who provide a quantum report which includes estimated settlements/costs used to calculate a provision.
32. Have there been any issues that may impact the preparation of the accounts identified so far?	None

Question	2025-26 Response
33. Do you have knowledge of events or conditions beyond the period of the going concern assessment that may cast significant doubt on the entity's ability to continue as a going concern?	No issues in this regard

Appendix 2: Enquiries of those charged with governance

Enquiries of those charged with governance – in relation to fraud

Question	2025-26 Response
1. Do you have any knowledge of actual, suspected or alleged fraud affecting the audited body?	Yes. All instances of fraud and suspected fraud have been recorded, investigated and reported to the Director of Finance and the Audit Risk and Assurance Committee. Over the course of the financial year: • **19 active cases** were carried forward from the previous year • **54 new referrals** were received and recorded • **59 cases** were concluded during the year • **14 cases** remain open and under active review at year end and will be carried forward • **1 case** was transferred to the NHS Counter Fraud Service (CFS) Wales Team following creation; no further action was taken in this instance • 5 Interviews Under Caution (IUCs) were conducted
2. What is your assessment of the risk of fraud within the audited body, including those risks that are specific to the audited body's business sector?	The level of fraud risk is identified in the Fraud Risk Profile that is maintained by the Head of Counter Fraud. This profile lists those Fraud Risks that are,

Question	2025-26 Response
	inherent to all NHS Organisations as identified by the NHS Counter Fraud Authority; and, those that are emerging and specific to ABUHB identified as a result of proactive work, intelligence sharing or as the result of investigation work carried out. The Fraud Risk work carried out is prioritised against the accepted methodology of Impact/likelihood. It is aligned with the Government Functional Standards and forms part of the Counter Fraud Annual Workplan. All risk work undertaken is reported to the Director of Finance and the Audit Risk and Assurance Committee. The ABUHB Risk Management Policy is strictly followed in relation to assessments made and all risks are recorded accordingly on the Datix system that the organisation uses for this purpose. Should a risk score highly then the matter is escalated to the relevant level i.e. Corporate/Divisional/Directorate/Local. All risk identified that are subject to assessment work remain live and are reviewed at intervals appropriate to their risk level.
3. How do you exercise oversight of: • management's processes for identifying and responding to the risk of fraud in the audited body, and • the controls that management has established to mitigate these risks?	Those charged with governance exercise oversight of management's processes and controls relating to fraud through a combination of structured assurance, reporting, and independent scrutiny. The Health Board benefits from an established NHS Wales counter fraud framework, supported by the NHS

Question	2025-26 Response
	Counter Fraud Authority, which enables the timely sharing of emerging fraud risks across organisations. This intelligence is considered by management and informs the ongoing development and strengthening of internal controls and processes to mitigate identified risks. Specific assurance is also provided through national services such as the **Post Payment Verification (PPV) function**, delivered by NHS Wales Shared Services Partnership. This service reviews payments to primary care contractors (including GPs and opticians), identifies anomalies, and undertakes investigation and recovery where appropriate. The existence of this function acts as both a **preventative and detective control**, and it works closely with Local Counter Fraud Specialists (LCFS) to monitor emerging risks and trends. The **Audit, Risk and Assurance Committee (ARAC)** provides formal oversight on behalf of the Board. The Committee: • Receives regular reports from **Counter Fraud, Internal Audit, and External Audit**, providing independent assurance over fraud risks and the effectiveness of controls • Reviews identified fraud risks, the work undertaken to assess them, and the

Question	2025-26 Response
	effectiveness of management's mitigating actions • Is updated on emerging risks and national trends, including those identified through NHS Counter Fraud intelligence and PPV activity In addition, there are **private and "in confidence" sessions** between Counter Fraud and the independent members of ARAC (including the Director of Corporate Governance), enabling open discussion of sensitive matters and strengthening independent challenge. Through these arrangements, those charged with governance maintain oversight of: • The robustness of management's fraud risk assessment processes • The design and operational effectiveness of key controls • The adequacy of actions taken to address identified weaknesses This ensures that fraud risks are appropriately identified, monitored, and mitigated, and that there is effective independent scrutiny and challenge across the organisation.

Enquiries of those charged with governance – in relation to laws and regulations

Question	2025-26 Response
4. Are you aware of any non-compliance with laws and regulations that may be expected to have a fundamental effect on the operations of the entity?	There are no issues to report
5. How does the Audit Committee in your role as those charged with governance, obtain assurance that all relevant laws and regulations have been complied with?	Those charged with governance obtain assurance through a combination of integrated reporting, independent scrutiny, and structured compliance monitoring across the Health Board. The Audit, Risk and Assurance Committee receives regular assurance from Internal Audit, External Audit, and management, including reports on compliance with key legislation, Welsh Health Circulars, and Ministerial Directions. Compliance with new or revised requirements is formally monitored through the Corporate Governance function and overseen by nominated Executive Directors, with assurance reported to the Committee and reflected in the Annual Governance Statement. The Committee maintains oversight of the effectiveness of the overall risk and assurance framework, ensuring that compliance risks are identified, assessed, and appropriately managed across all areas of the organisation. Through these arrangements, the Committee is assured that appropriate systems and controls are in

Question	2025-26 Response
	place to ensure compliance with relevant laws and regulations, and that any issues are identified and addressed in a timely manner.

Enquiries of those charged with governance – in relation to related parties

Question	2025-26 Response
6. How does the Audit Committee, in its role as those charged with governance, exercise oversight of management's processes to identify, authorise, approve, account for and disclose related party transactions and relationships?	There is an Annual Declarations of Interest process and Business Conduct Policy in operation. The Financial statements include a dedicated section in regard to related party relationships where disclosures are made for related party transactions/relationships. Arrangements for declarations of interest are also disclosed in the Annual Governance, reviewed by the Committee.

Enquiries of those charged with governance – supplementary queries

Question	2025-26 Response
7. Are you aware of any actual, suspected or alleged irregularity affecting the entity?	There are none known for reporting.
8. Are there any matters which those charged with governance consider require particular attention during the audit?	All issues regarding the financial statements have been raised throughout the year and fully disclosed to the auditors. These are described in earlier answers.
9. Are those charged with governance aware of any significant communications with regulators?	Yes. Reports issued by regulators are presented to the Board's Patient Quality, Safety & Outcomes Committee alongside management actions plans for improvements. These reports are disclosed into the public domain. A report from each meeting of the Patient Quality, Safety & Outcomes Committee is reported to the Board.

Appendix 3: Background information

Matters in relation to fraud

International Standard for Auditing (UK) 240 covers auditors' responsibilities relating to fraud in an audit of financial statements. This standard has been revised for 2022-23 audits.

The primary responsibility to prevent and detect fraud rests with both management and 'those charged with governance', which for the Health Board is the Board. Management, with the oversight of those charged with governance, should ensure there is a strong emphasis on fraud prevention and deterrence and create a culture of honest and ethical behaviour, reinforced by active oversight by those charged with governance.

As external auditors, we are responsible for obtaining reasonable assurance that the financial statements are free from material misstatement due to fraud or error. We are required to maintain professional scepticism throughout the audit, considering the potential for management override of controls.

What are we required to do?

As part of our risk assessment procedures we are required to consider the risks of material misstatement due to fraud. This includes understanding the arrangements management has put in place in respect of fraud risks. The ISA views fraud as either:

- The intentional misappropriation of assets (cash, property, etc); or
- The intentional manipulation or misstatement of the financial statements.

We also need to understand how those charged with governance exercises oversight of management's processes. We are also required to make enquiries of both management and those charged with governance as to their knowledge of any actual, suspected or alleged fraud, management's process for identifying and responding to the risks and the internal controls established to mitigate them.

Matters in relation to laws and regulations

International Standard for Auditing (UK and Ireland) 250 covers auditors' responsibilities to consider the impact of laws and regulations in an audit of financial statements.

Management, with the oversight of those charged with governance, is responsible for ensuring that the Health Board ‘s operations are conducted in accordance with laws and regulations, including compliance with those that determine the reported amounts and disclosures in the financial statements.

As external auditors, we are responsible for obtaining reasonable assurance that the financial statements are free from material misstatement due to fraud or error, taking into account the appropriate legal and regulatory framework. The ISA distinguishes two different categories of laws and regulations:

- laws and regulations that have a direct effect on determining material amounts and disclosures in the financial statements;
- other laws and regulations where compliance may be fundamental to the continuance of operations, or to avoid material penalties.

What are we required to do?

As part of our risk assessment procedures we are required to make enquiries of management and those charged with governance as to whether the Health Board is in compliance with relevant laws and regulations. Where we become aware of information of non-compliance or suspected non-compliance we need to gain an understanding of the non-compliance and the possible effect on the financial statements

Matters in relation to related parties

International Standard for Auditing (UK) 550 covers auditors’ responsibilities relating to related party relationships and transactions.

The nature of related party relationships and transactions may, in some circumstances, give rise to higher risks of material misstatement of the financial statements than transactions with unrelated parties.

Because related parties are not independent of each other, many financial reporting frameworks establish specific accounting and disclosure requirements for related party relationships, transactions and balances to enable users of the financial statements to understand their nature and actual or potential effects on the financial statements. An understanding of the entity's related party relationships and transactions is relevant to the auditor's evaluation of whether one or more fraud risk factors are present as required by ISA (UK and Ireland) 240, because fraud may be more easily committed through related parties.

What are we required to do?

As part of our risk assessment procedures, we are required to perform audit procedures to identify, assess and respond to the risks of material misstatement arising from the entity's failure to appropriately account for or disclose related party relationships, transactions or balances in accordance with the requirements of the framework.

Matters in relation to regularity

International Standard for Auditing (UK and Ireland) 250 covers auditors' responsibilities to consider the regularity of the organisation's transactions.

Regularity is the concept that transactions that are reflected in the financial statements of an audited entity must be in accordance with the relevant framework of authorities.

Frameworks of authorities are external frameworks, specific to an audited entity, with which the audited entity's transactions must conform. These frameworks are set up by bodies able to issue and/or enforce the authorities for that entity and might include, for example:

- authorising legislation;
- regulations issued under governing legislation;
- parliamentary authorities; and
- government or related authorities (for example Managing Welsh Public Money, issued by the Welsh Government).

Further information is available in Practice Note 10.

What are we required to do?

The Practice Note includes an overview, from page 56 of the Practice Note, of what we are required to do.

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	19 May 2026
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	**Update on Losses and Special payments – 1st April 2025 – 31st March 2026**
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	**Director of Finance, Procurement and Value Based HealthCare**
SWYDDOG ADRODD: REPORTING OFFICER:	**Robert Jones, Assistant Director of Finance (Financial Systems & Services)**

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report provides the Audit, Risk & Assurance Committee with information in relation to financial losses and special payments made by the Health Board between 1st April 2025 and 31st March 2026.

Cefndir / Background

Losses and special payments are reported to ARAC because they are *exceptions* to normal expenditure—i.e., items that Welsh Government would not have contemplated when it agreed the Health Board's funding, and which "ideally should not arise". As a result, they are subject to **additional scrutiny, delegated approval limits, and formal reporting** (including disclosure in the Annual Accounts), so ARAC can gain assurance that:

(1) the underlying control failures/causes are understood,
(2) appropriate actions and "lessons learnt" are implemented, and
(3) any recoveries (e.g., Welsh Risk Pool) are correctly pursued and accounted for.

Asesiad / Assessment

The Welsh Government Manual for Accounts (Chapter 6) outlines the types of expenditure which are considered as a loss or special payment (one where they ideally should not arise, or would not have been contemplated when Welsh Government agreed funds for ABUHB. The total cost year to date for ABUHB is £8.2m:

Loss Type	No. of Cases	Total £000	Met by the Welsh Risk Pool £000	Net cost to ABUHB £000
Losses per Annex 1				
Losses of cash	8	0.5	-	0.5
Fruitless payments, including abandoned capital schemes and constructive losses	1	382	-	382
Bad Debts and claims abandoned	147	93	-	93
Damage to buildings and loss of equipment or property	-	-	-	-
Theft of IT Equipment	-	-	-	-
TOTAL LOSSES	**156**	**475**	**-**	**475**
Special Payments per Annex 2				
Compensation payments made under legal obligation	-	-	-	-
Extra contractual payments to contractors	-	-	-	-
Ex gratia payments	-	-	-	-
Loss of personal effects	18	9	-	9
Personal Injury Settlements	114	746	159	587
Clinical Negligence Settlements	273	28,375	26,578	1,797
Other cases	39	5,148	181	4,966
Maladministration	-	-	-	-
Patient referrals outside the United Kingdom, the European Economic Area (EEA) and Switzerland	-	-	-	-
Extra statutory or extra regulatory payments	-	-	-	-
Voluntary Early Release Scheme	4	313	-	313
TOTAL SPECIAL PAYMENTS	**448**	**34,590**	**26,918**	**7,672**
Other - Penalties	63	158	-	158
TOTAL LOSSES AND SPECIAL PAYMENTS	**670**	**35,154**	**26,918**	**8,236**

The losses & special payments for which the Health Board are accountable for, including movements in provision, are recorded as expenditure and are reflected in the reported and forecasted expenditure position.

In addition to the cost recorded above, a provision for clinical negligence and personal injury cases is recorded on the balance sheet and is based on the estimated potential liability, as advised by Welsh Health Legal Services, of the maximum possible future cost for all known cases.

This provision has increased by £37.9m since 31st March 2025 to an overall provision of £236.6m. Of this, it is expected that £230.4m is recoverable from WRP leaving potential future losses to the Health Board of £6.2m.

The remainder of the report gives context to each loss or special payments that has arisen.

Losses

Loss Type	No. of Cases	Total £000	Met by the Welsh Risk Pool £000	Net cost to ABUHB £000
Losses of cash	8	0.5	0	0.5

A small value of cash, £460, has been recognised as a loss during the year, as a consequence of the Health Board's standard practice of reviewing petty cash balances at the end of each Financial Year. The main reason is due to reconciling issues where cash in tills has been receipted as income, instead of being banked correctly through the Health Board's nominated cash carrier.

Whilst not a true loss to the Health Board, the value held in the petty cash floats have reduced, and therefore it is processed through the ledger as a reduction/ loss to the ledger. The Corporate Finance team have re-iterated the correct process with the individual departments and have instigated quarterly reviews with each petty cash holder to ensure processes are maintained correctly.

Loss Type	No. of Cases	Total £000	Met by the Welsh Risk Pool £000	Net cost to ABUHB £000
Bad Debts and claims abandoned	147	93	0	93

147 bad debts have been written-off in the period, following a comprehensive review by the Corporate Finance team on aged debts held on the ledger as uneconomical to pursue.

The authorisation of the individual bad debt write-offs was determined by the value of the debt outstanding, and followed the delegated authorised limit, as below:

DELEGATED AUTHORITY LEVEL	From £	To £	No. Cases	Total £
Assistant Head of Financial Services	-	10	15	8
Head of Financial Services & Accounting	10	50	11	398
Assistant Director of Finance (Financial Systems & Services)	50	2,500	120	67,806
Director of Finance & Performance	2,500	25,000	0	0
Audit Committee	25,000	50,000	1	24,786
Welsh Government	50,000+		0	0
Total			**147**	**92,742**

As part of the Corporate Finance review, it was identified that a significant volume of debts (109) were over 6 years old and therefore exceeded the statute-barred timeframe for chasing debts.

The majority of write-offs processed relate to Salary Overpayments (96), with other debts written-off relating to Private Patients (21) and Overseas Patients (13).

The one significant value debt, was presented to the Audit, Risk and Assurance Committee in June 2025, relating to a salary overpayment, and the write-off was approved.

Fruitless payments, including abandoned capital schemes and constructive losses

Loss Type	No. of Cases	Total £000	Met by the Welsh Risk Pool £000	Net cost to ABUHB £000
Fruitless payments, including abandoned capital schemes and constructive losses	1	382	0	382

As reported through to the Executive Committee, the North Gwent Cancer Centre Project is no longer being progressed due to the extent, condition and associated risk of RAAC within the affected estate, which materially impacts the deliverability and viability of the scheme.

Capital expenditure in relation to early project development activities only of £382k has been incurred and will require impairment, as the project will not proceed and does not deliver future economic benefit. The project did not progress beyond feasibility and early design stages, and no construction activity commenced.

In line with accounting standards, where a Capital Scheme is discontinued, development costs incurred to date must be accounted as an impairment and reported as a loss. Approval from Welsh Government for this treatment has been provided, and impairment funding issued.

N

Special Payments

Loss of personal effects

Loss Type	No. of Cases	Total £000	Met by the Welsh Risk Pool £000	Net cost to ABUHB £000
Loss of personal effects	18	9	0	9

The Health Board has processed a number of Special Payments in the period in relation to the Loss of Personal Effects, whilst in the Health Board's care.

There have been 18 total payments made, totalling £9k. The largest value payment made in this category was £1.5k in relation to the loss of Dentures.

Losses forms are completed for each loss, which are subsequently authorised by the relevant Division and reviewed and approved by the Putting Things Right team.

Clinical negligence with advice

Loss Type	No. of Cases	Total £000	Met by the Welsh Risk Pool £000	Net cost to ABUHB £000
Clinical negligence with advice	273	28,375	26,578	1,797

273 claims have been processed in the period which relate to Clinical Negligence cases which have a total value over £25k. The Health Board is liable for the first £25k of each claim, with the remaining amount recoverable from the WRP.

Each payment will have been verified and received appropriate authorisation before processing. Before reimbursement is recoverable from the WRP, a lessons learnt report is required, which is reviewed by the Litigation Committee. Feedback on the lessons learnt is also provided by the Quality and Patient Safety Committee.

Within the case figures above, there have been 12 cases in the period where the total amounts paid by the Health Board are above £300k.

The single largest payment made in the period in relation to a Clinical Negligence case was for £7.42m.

Personal injury with advice

Loss Type	No. of Cases	Total £000	Met by the Welsh Risk Pool £000	Net cost to ABUHB £000
Personal injury with advice	114	746	159	587

Similarly, a large volume of claims have been processed in the period which relate to Personal Injury cases, which have a total value over £25k. These also include Personal Injury Benefit payment which the Health Board has processed.

The single largest payment made in the period in relation to a Personal Injury case was for £140k.

Other Clinical Negligence and Personal Injury

Loss Type	No. of Cases	Total £000	Met by the Welsh Risk Pool £000	Net cost to ABUHB £000
Other Clinical Negligence and Personal Injury	16	198	181	17

This relates to the amounts for cases classified as Redress (or Putting Things Right) which are Clinical Negligence and Personal Injury cases, where the total value of the claim is expected to not exceed £25k in totality. The vast majority of the costs for these cases are recoverable from the WRP, except for the "Excess" amounts, which are the Defence/ Claimant costs borne by each case.

Members are reminded that from April 2026, Welsh Government are re-naming these cases as "Listening to People" cases. As part of this strategy, the limit on the value of cases which are covered by this process will now be increased to £50k, rather than the previous £25k.

Other

Loss Type	No. of Cases	Total £000	Met by the Welsh Risk Pool £000	Net cost to ABUHB £000
Other	23	4,949	0	4,949

These are losses payments which relate to a variety of cases which the Health Board has been required to make payments towards during the period 1st April 2025 to 31st March 2026.

Included within the above amounts are:
- Band 2-3 Recognition Payment, totalling £4,895k
- 3 Employment Tribunal payments, totalling £27.3k
- 3 Settlement payments in relation to Mortuary incidents, totalling £25.2k
- 6 Ombudsman Investigation Cases, totalling £0.7k

Voluntary Early Release Scheme (VERS)

Loss Type	No. of Cases	Total £000	Met by the Welsh Risk Pool £000	Net cost to ABUHB £000
Voluntary Early Release Scheme (VERS)	4	313	-	313

The Health Board may agree a Voluntary Early Retirement/Early Release Scheme where it supports service re-design and delivers sustainable, recurrent workforce savings. Each case is considered on its individual merits, ensuring that the cost of release is recovered within an appropriate payback period (less than one year) and that patient care and business continuity are not adversely impacted.

During the period 1st April 2025 and 31st March, the Health Board has agreed four VERS with staff members.

Each case has been reviewed and formally approved by the Remuneration and Terms of Service (RATS) Committee.

Penalties

Loss Type	No. of Cases	Total £000	Met by the Welsh Risk Pool £000	Net cost to ABUHB £000
Penalties	61	153	0	153

As detailed above, following initial payment by the Health Board, the amounts for Clinical Negligence and Personal Cases which exceed £25k are recoverable from WRP.

However to ensure reimbursement for the amounts recoverable, the Health Board must submit Lessons Learnt report to the WRP Committee which identify the key learnings taken from each case.

Only when the WRP Committee have received a satisfactory Lessons Learnt report which is clearly documented and implemented will they approved reimbursement to the Health Board.

To ensure compliance with this process, the Health Board must submit Lessons Learnt report within an adequate timeframe following the conclusion or final settlement of a case. If the deadline for submitting cases to the WRP Committee is not achieved, the Health Board will receive a £2,500 "penalty" for late submission. The WRP Committee meet every other month, and any failure to submit will face additional penalties at each committee where the report is either not submitted, or not approved as appropriately documented or implemented.

During the financial year, the Health Board has missed the deadline for submission of Lessons Learnt reports to the WRP Committee 61 times, including the following 3+ penalties on single cases:

- 1 case received 5 penalties totalling £12.5k,
- 2 cases received 4 penalties each, totalling £10k per case,
- 2 cases received 3 penalties each, totalling £7.5k per case.

Further to the direct costs of fines, there is a consequential impact on the risk sharing mechanism. The performance of each organisation is considered and forms part of the overall allocation of the risk share pool. IN the most recent allocations ABUHB fell by 0.75% points to 1.91% which resulted in an additional allocation of £270k. 1.91% reflects the third worst performance of all bodies.

	2024/25 RSA %	2025/26 RSA%	Increase/ Decrease %	HCHS Allocation	Claims History	PTR	Cashflow < 1 year	PPO	Audits / Lessons Learned
Aneurin Bevan	16.78%	18.22%	1.43%	5.72%	3.31%	2.54%	2.40%	2.34%	1.91%
Swansea Bay	15.25%	13.97%	-1.28%	3.79%	2.70%	1.77%	2.03%	2.38%	1.30%
Betsi Cadwaladr	19.22%	21.00%	1.79%	6.75%	3.94%	1.93%	3.09%	1.89%	3.40%
Cardiff & Vale	15.86%	16.76%	0.90%	4.08%	4.56%	1.66%	3.67%	1.56%	1.23%
Cwm Taf Morgannwg	14.76%	14.60%	-0.16%	4.49%	2.64%	1.05%	2.34%	1.04%	3.04%
Hywel Dda	9.70%	10.03%	0.34%	3.86%	2.47%	0.77%	1.19%	0.53%	1.21%
Powys	4.13%	2.12%	-2.01%	1.31%	0.02%	0.00%	0.02%	0.17%	0.60%
Public Health Wales	1.14%	0.64%	-0.50%	0.00%	0.08%	0.06%	0.13%	0.00%	0.38%
Velindre	1.15%	0.79%	-0.36%	0.00%	0.05%	0.00%	0.05%	0.00%	0.69%
Welsh Ambulance	2.01%	1.87%	-0.14%	0.00%	0.22%	0.22%	0.07%	0.09%	1.27%
	100.00%	**100.00%**	**0.00%**	**30%**	**20%**	**10%**	**15%**	**10%**	**15%**

Clinical Negligence and Personal Injury Provisions

The table below shows the analysis of the estimated liability for losses as at 28th February 2026 compared to the position reported at 31st March 2025. It reflects the estimated liability in relation to cases advised by Welsh Health Legal Services for both clinical negligence, personal injury and redress with the provision updated to reflect new or changed cases.

After the expected recoveries from the Welsh Risk Pool are taken in to account the estimated liability to the Health Board at 28th February 2026 is £6.2m.

Losses & Special Payments Provisions	31-Mar-25		31-Mar-26	
	No. of Cases	£'000	No. of Cases	£'000
Clinical Negligence	286	195,202	330	232,900
Personal Injury	63	158	76	527
Permanent Injury Benefit	21	3,169	21	3,075
Redress	19	164	8	80
Sub Total	**389**	**198,693**	**435**	**236,582**
Less WRP Recoverable: Clinical Negligence	-175	-192,868	-212	-230,188
Less WRP Recoverable: Personal Injury	0	0	-4	-100
Less WRP Recoverable: Redress	-19	-155	-7	-73
Net Liability	**195**	**5,670**	**213**	**6,222**

The percentage of recovery for Personal Injury cases is much lower than Medical Negligence cases as most Personal Injury cases are under £25K. Up to the end of March 2026, only 4 of the Personal Injury cases out of the 70 cases are over £25K whereas 209 of the 212 Medical Negligence cases are over £25K.

Argymhelliad / Recommendation

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

Amcanion: (rhaid cwblhau)

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

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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	**Is EIA Required and included with this paper** A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:

• **Workforce** • **Service Activity & Performance** • **Financial**	Not Applicable Yes, outlined within the paper Yes, outlined within the paper
Asesiad Effaith Cydraddoldeb **Equality Impact Assessment** (EIA) completed	Choose an item. An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. Choose an item.

Agenda Item:3.6

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	19 May 2025
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	1. The Annual Counter Fraud Report 2025/26.
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Robert Holcombe, Director of Finance, Procurement and Value Based Healthcare
SWYDDOG ADRODD: **REPORTING OFFICER:**	Gareth Lavington, Head of Counter Fraud

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

Er Sicrwydd/For Assurance

To provide an overview to the Audit, Risk and Assurance Committee of the work carried out by the Counter Fraud Department in 2025/26 and assurance that it meets necessary requirements.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

It is a requirement of the NHS Counter Fraud Authority that an Annual report of Counter Fraud Activity is completed and is submitted to the ARAC.

Cefndir / Background

The Annual Counter Fraud Report is prepared to provide assurance to the organisation ARAC that the ABUHB Counter Fraud Department have met its obligations under the Welsh Government Directions and the Government Counter Fraud Functional Standards SO(13). It accurately reflects the work carried out during the course of the 2025-26 financial year.

Asesiad / Assessment

This report reflects the work undertaken by the Counter Fraud team during 2025-2026 financial year. It accurately describes what work has been undertaken and provides a self-assessment of compliance and overview of the Counter Fraud Functional Standard Return submitted to the NHS Counter Fraud Authority, and

the reasonable measures that the organisation is required to have in place under the Economic Crime and Corporate transparency Act 2023. ABUHB Counter Fraud remains Green in all areas required and therefore successfully meets it obligations as described above.
Argymhelliad / Recommendation That the report is accepted as assurance by the ARAC, that ABUHB continues to meet its obligations in Countering Fraud.

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

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

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

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

COUNTER FRAUD ANNUAL REPORT 2025/26

CONTENTS

1. INTRODUCTION

NHS bodies in Wales are required to maintain effective arrangements to prevent, detect, and respond to fraud, bribery, and corruption in accordance with the Welsh Government Directions on Counter Fraud Measures, the service agreement under section 83 of the Government of Wales Act 2006, and the principles set out in the NHS Counter Fraud Authority standards aligned to the Government Functional Standard 013 (Counter Fraud).

In addition, the new, Economic Crime and Corporate Transparency Act 2023 (ECCTA) requires that ‘large organisations’ have in place reasonable measures to prevent fraud. This annual report provides assurance to the Board on the effectiveness of the organisation’s counter fraud arrangements, including governance, risk assessment, awareness, reporting, investigation, and recovery activity, and demonstrates compliance with the required standards and legislation through the work delivered by the Counter Fraud team during the year.

2. LEGISLATIVE REQUIREMENTS

Welsh Government Directions

The table at **Appendix 1** shows the key requirements under Welsh Government (WG) Directions July 2006 and illustrates how ABUHB Counter Fraud are performing in line with these. ABUHB Counter Fraud Provision is fully compliant.

Economic Crime and Corporate Transparency Act 2023

The Economic Crime and Corporate Transparency Act 2023 (ECCTA 2023) was created to strengthen the UK's ability to tackle fraud, money laundering and other forms of economic crime. ECCTA 2023 represents a major overhaul of the UK Government's framework for tackling financial crime and has brought into force several significant changes and bolstered existing legislation by introducing stricter regulation and increased transparency around corporate activities.

One of the most significant changes introduced by ECCTA 2023 is the new corporate offence of the failure to prevent fraud which came into force on 1st September 2025.

Under the offence *an organisation may be criminally liable where an employee, agent, subsidiary, or other 'associated person', commits a fraud intending to benefit the organisation and the organisation did not have reasonable fraud prevention procedures in place*.

ABUHB meets the criteria that defines a large organisation for the purposes of this act.

As a result of this new legislation ABUHB must be able to show that it has in place reasonable fraud prevention measures.

Government guidance suggests that for an organisation to demonstrate that they have **reasonable procedures** in place they need to implement a fraud prevention framework which should be informed by **six** principles. These are detailed below together with a description of whether ABUHB have these in place and how they align to the NHS CFA Standard requirements.

ECCTA Reasonable Measure	Summary	CFFSR Rating
Top Level Commitment	Links with Counter Fraud Standard **requirement 1**; to have an accountable individual at board level who is responsible for fraud, bribery and corruption. The Director of Finance holds responsibility for counter fraud matters and a nominated Fraud Champion is in place.	
Risk Assessment	Links with Counter Fraud Standard **requirement 3**; to have a fraud, bribery and corruption risk assessment that feeds into the organisational workplan and is managed in line with the organisation's local risk management policies. ABUHB has a maturing Fraud Risk process which aligns with established risk management processes.	
Proportionate Risk-Based Prevention Procedures	Links with Counter Fraud Standard **requirement 5**; to have an annual action plan that is informed by fraud risk, identifying activities to improve capability and resilience. ABUHB has an annual Counter Fraud Work Plan agreed with the Director of Finance and approved by the Audit Committee.	
Due Diligence	Links to a number of components including Counter Fraud Standard **requirement 2;** the organisation should align their counter fraud, bribery and corruption work to the NHSCFA's central strategy. ABUHB has its strategy set out in the Counter Fraud Work Plan which fully aligns with NHS CFA and NHS Wales strategy. In addition, policies such as the Counter Fraud Policy and Response Plan are in place and current.	
Communication (Including Training)	Links with Counter Fraud Standard **requirement 7**; to have well established and documented reporting routes for staff, contractors and members of the public where necessary to report fraud suspicions. ABUHB has multi-modal reporting routes for staff which are well established and documented. This also links with Counter Fraud Standard **requirement 11**; ensuring that all staff have access to and undertake fraud awareness, bribery and corruption training as appropriate to their role. All CF are Accredited and qualified and attend all available CPD. All staff are required to undertake mandatory e-Learning every 3 years.	
Monitoring and Review	Links with Counter Fraud Standard **requirement 6**; to identify and report upon annual outcome-based metrics to support improvement in performance. ABUHB reports KPIs on a quarterly basis to Welsh Government, and ARAC. In addition, the CF team carry out various data research in order to ensure continuous improvement.	

CFFSR – Counter Fraud Functional Standard Return

A high level of assurance can be provided that the Health Board currently has effective measures in place via compliance with the NHS Counter Fraud Standards which map directly to the six principles set out for defence against the new corporate offence.

NHS CFA Requirement Gov Standard 13

The NHS Counter Fraud Authority (NHS CFA) Requirements set out the mandatory standards that NHS organisations must meet to prevent, detect, and respond to fraud, bribery, and corruption. They require organisations to have effective governance, trained counter-fraud staff, risk assessments, awareness activity, and arrangements for reporting, investigating, and recovering losses. Compliance is assessed against NHS CFA Standard (aligned to the Government Functional Standard for Counter Fraud) and is a condition of good governance and accountability within the NHS. There are 12 requirements that the Health Board must achieve compliance with. Compliance is measured as

Green – Fully achieved
Amber – Partially achieved
Red – Not achieved

ABUHB has achieved an overall compliance rating of **Green** for the year 2025-2026. A more detailed overview each requirement and how ABUHB comply is provided at **Appendix 3**.

3. RESOURCE

At the close of the financial year the Counter Fraud Department is resourced by four staff members. One Head of Service and three Local Counter Fraud Specialists (LCFS). All are fully accredited Counter Fraud Specialists (ACFS). This resource is equal to 3.4 WTE equivalent.

* Figures for 2024-2025 are provided in brackets.

AREA OF ACTIVITY	Resource Planned (days)	Resource Used (days)
STRATEGIC GOVERNANCE	110	100 *(90)*
INFORM AND INVOLVE	163	160 *(94)*
PREVENT AND DETER	163	156 *(60)*
HOLD TO ACCOUNT	265	250 *(300)*
TOTAL	**701**	**666 *(544)***

Days provided in total are less than planned due to sickness.

Cost	£
Proactive costs (Strategic Governance, Inform and Involve, Prevent and Deter)	£140,782.78
Reactive costs (Hold to Account)	£86,286.22
Total costs for counter fraud, bribery, and corruption work	**£227,069.00**

4. KEY OUTCOMES

OUTCOME	2025-2026	2024-2025
PROVEN FRAUD LOSS (£)	9,560.94	13,793.00
RECOVERY (£)	9,258.47	13,793.00
PREVENTION (£)	86,520.69	31,476.00
REFERRALS	54	57
OVERPAYMENT REFERRALS	19	38
OVERPAYMENT TOTALS (£)	219,885.42	447,798.24
LPE COMMENCED	16	17
PRESENTATIONS	35	19
MEDIA REPORTS	70	15
CRIMINAL SANCTION	2	1
INTERNAL DISCIPLINARY SANCTION	6	6
EXTERNAL DISCIPLINARY SANCTION	1	0
LPE OUTCOMES	26	1

5. WORKSTREAM OVERVIEW

Education And Fraud Awareness

A local Counter Fraud Education Strategy has been implemented within the department to ensure a consistent, effective, and high-quality approach to fraud awareness across the organisation. The strategy is designed to maintain and strengthen fraud awareness at all levels, supporting the delivery of a proactive and prevention-focused counter fraud service. The overarching aim of the strategy is to deliver a comprehensive, engaging, and accessible fraud education programme that:

- Raises awareness of fraud risks within the NHS
- Promotes the role, visibility, and accessibility of the Counter Fraud Team
- Encourages proactive reporting and ongoing vigilance
- Equips staff with the knowledge and confidence to identify and prevent fraud
- Embeds a culture of integrity, transparency, and accountability

Education is delivered through a blended approach, incorporating both digital and face-to-face engagement, including internal and external newsletters, Fraud Clinics, bespoke presentations, e-learning modules, corporate induction sessions, site visits, and targeted social media communications.

Significant progress has been made during the year, with demonstrable impact across the organisation and primary care partners. Key outcomes are demonstrated below.

E-Learning:

A total of **3,310** members of staff completed counter fraud e-learning during the year, supporting widespread baseline awareness.

Corporate Induction:

Counter Fraud continues to feature as a core component of Corporate Induction, ensuring early engagement with new starters.

Bespoke Presentations:

The Counter Fraud Department delivered **35** tailored presentations to a range of teams. Each session was bespoke to the audience, focusing on relevant risks and issues relevant to them. This represents a significant increase compared to the previous year.

International Fraud Awareness Week (IFAW):

IFAW was again delivered through an in-person programme, with visits undertaken at all major hospital sites. This was supported by daily intranet communications, reaching both staff and the wider public.

Primary Care Engagement:

Targeted and impactful newsletters issued to primary care partners addressing identified fraud risks.

Attendance at the Primary Care Forums, enabling the articulation of thematic risks and emerging trends.

ABUHB Counter Fraud Hub (Viva Engage):

The creation of the ABUHB Counter Fraud Hub community has significantly enhanced engagement.

- 60 posts published
- 197 members
- Reach of 790 individuals
- Over 75,000 views

Feedback to date has been overwhelmingly positive, demonstrating the platform's effectiveness in promoting awareness and engagement.

Evaluation and Continuous Improvement:

Participant evaluations have been routinely conducted, with positive feedback received regarding the relevance and value of sessions. Constructive feedback has also been actively welcomed and used to inform continuous improvement of education delivery.

Investigation Activity

The Local Counter Fraud Specialist (LCFS) receives information and intelligence from a range of internal and external sources. Robust processes are in place to ensure that all referrals are appropriately assessed, prioritised, and investigated in line with agreed procedures.

In accordance with national reporting requirements, all notified concerns are recorded on the NHS Counter Fraud Authority (NHSCFA) crime reporting system, CLUE, which is used to log, monitor, and manage all current cases.

Case Volumes and Outcomes

Over the course of the financial year:

- **19 active cases** were carried forward from the previous year
- **54 new referrals** were received and recorded
- **59 cases** were concluded during the year
- **14 cases** remain open and under active review at year end and will be carried forward
- **1 case** was transferred to the NHS Counter Fraud Service (CFS) Wales Team following creation; no further action was taken in this instance
- **5 Interviews Under Caution (IUCs)** were conducted

Workforce and Professional Engagement

In conjunction with the Health Board's Workforce & Organisational Development (WOD) Directorate, all investigations relating to current employees were formally referred to the relevant Workforce contacts to ensure appropriate management action could be considered alongside the counter fraud investigation.

Where investigations involved individuals who are members of professional regulatory bodies, referrals were made to the relevant bodies in line with routine practice. This enables those organisations to consider whether separate professional conduct investigations are required.

The Counter Fraud Team is currently supporting **one ongoing professional body investigation.**

Sanctions and Regulatory Outcomes

Of the investigations finalised and closed during the year, outcomes included:

- 2 Criminal Sanction by way of Restorative Justice

- 6 internal disciplinary sanctions
- 1 external disciplinary sanction
- 2 onward referrals to professional bodies

These outcomes demonstrate effective collaboration between Counter Fraud and Workforce and OD.

Salary Overpayments

Automatically referred salary overpayment cases have **reduced by 50% year-on-year**, decreasing from **38 cases** in 2024/25 **to 19** cases in the current year. There were **two** salary overpayment cases formally investigated by the Counter Fraud team. These did not result in prosecution as no evidence of theft was identified. Financial recovery has been made in both cases.

Thematic Areas of Referral

The main themes identified across referrals during the year were:

- Working elsewhere whilst on sick leave
- False sickness
- Timesheet and overtime irregularities
- Prescription fraud
- Dual working / working elsewhere during contracted hours

These themes continue to inform targeted preventative work, education sessions, and engagement activity across the organisation.

The National Fraud Initiative (NFI)

The National Fraud Initiative (NFI) is a UK-wide data matching exercise coordinated by central government to support the prevention and detection of fraud across the public sector. Participating organisations are required to submit specified datasets on a biennial basis. These datasets are cross-matched to identify potential financial irregularities across a range of areas, including employment, pensions, benefits, payroll, trade creditors, and company directorships.

As part of the 2025 NFI cycle, Aneurin Bevan University Health Board (ABUHB) received its data matches in January 2025.

2025 NFI Data Matches

Report	Description	Matches Received
66	Payroll to Payroll – secondary employment with other NHS bodies / local authorities	157
78	Re-employed pensioners where earnings may affect pension abatement	123
81	Payroll to Creditors – shared bank details or address	42
750	Payroll to Companies House – staff listed as directors of trade creditors	16
752	Staff address linked to company directors or companies	44

Each data match was individually assessed by the Counter Fraud Team to determine:

- The staff member's role and responsibilities
- The nature and legitimacy of the data match
- Whether any indicators of fraud, error, or policy non-compliance were present

Outcomes and Impact

The 2025 NFI exercise has resulted in the following outcomes:

- Three formal investigations were initiated.
- Two investigations identified fraud.
- One investigation concluded with no issues found.
- Outcomes included one dismissal and one associated disciplinary sanction.
- Significant levels of undeclared secondary employment and business interests were. identified across the workforce, highlighting key compliance risks.
- Targeted remedial action was undertaken, including direct engagement with staff and clear instructions to update Declarations of Interest (DOI) records.
- Over 70 members of staff were directly contacted by Counter Fraud staff.

- Substantial improvement in DOI compliance, supported by wider fraud awareness activity and education delivered throughout the year.

Findings from the exercise have been used to inform ongoing preventative work, workforce engagement, and targeted awareness activity.

Proactive And Risk-Led Counter Fraud Activity

During the year, the Counter Fraud Team has prioritised the expansion of its proactive, risk-led work. As the table below highlights, more resource and time than ever before has been dedicated to this area, reflecting a strategic shift towards early identification, prevention, and system strengthening.

Year	Proactive Days
2023/24	283
2024/25	244
2025/26	416

As part of this approach, a formal Fraud Risk Assessment (FRA) process has been introduced. This process is aligned with Cabinet Office Fraud Risk Assessment methodology and has received formal approval from Executive Board, providing a consistent and robust framework for identifying and managing fraud risk across the organisation.

Risk Reviews and Fraud Risk Assessments

Using this new framework:

- **10** formal Fraud Risk Assessments into the following areas have been completed:
    - Agile Working
    - Special Leave
    - Staff Expenses
    - Salary Overpayments
    - Agency Staff – Impersonation
    - Staff Leavers
    - Pre-Employment Checks – Agencies

- Petty Cash
- Virtual Credit Cards
- Payment Terminals

Each assessment considered fraud risk exposure, existing controls, vulnerabilities, and recommended mitigating actions.

Local Proactive Exercises (LPEs)

In addition to formal risk assessments, the team commenced over **20 Local Proactive Exercises (LPEs)** during the year. These were informed by:

- National intelligence, including NHS Counter Fraud Authority Fraud Prevention Notices, and
- Locally identified emerging risks and thematic issues

These exercises have resulted in impactful outcomes, including:

- Identification of control weaknesses
- Policy and process change
- Strengthened financial controls
- **Financial prevention outcomes totalling £86,520.69**

Significant Proactive Projects

Two large-scale proactive projects were undertaken during the year and remain ongoing:

1. **Agency Staff Impersonation – Nursing Division**
2. **Medical Staff Extra Duties – Medical Division**

Both projects were subject to formal fraud risk assessment and system testing, resulting in the identification of several control weaknesses.

- Findings from the **Agency Staff Impersonation project** have been reported to the **Executive Director of Nursing**, with mitigating actions being pursued through the formal risk management process.

- The **Medical Staff Extra Duties project** is now complete. Reporting has been drafted and is awaiting approval prior to submission. The **Executive Medical Director** is aware of the work.

Emerging Risk Areas

Two further proactive projects have commenced and are currently at an early scoping and assessment stage:

1. Overseas Visitors
2. Fuel Card Usage

These areas have been identified as emerging risk themes and will be progressed in line with the established proactive and risk-led framework.

Collaboration, Governance and Training

The Counter Fraud Team continue to work collaboratively across a wide range of internal and external stakeholders to ensure effective governance, compliance, and continuous professional development.

Collaboration

The LCFS maintains close and ongoing liaison with the NHS Counter Fraud Service (CFS) Wales Regional Team, ensuring appropriate information sharing and coordination on referrals. Particular use is made of the Regional Team's financial investigation provision, including the application of Proceeds of Crime Act (POCA) powers where appropriate.

Casework activity is formally reported on a quarterly basis to NHS CFS Wales, enabling oversight, monitoring of performance, and onward reporting of Counter Fraud statistics to Welsh Government.

The Head of Counter Fraud has also attended the Counter Fraud Liaison Group, a newly established forum designed to promote the sharing of best practice, emerging trends, and proactive initiatives across NHS Wales.

Effective governance arrangements have been maintained through ongoing liaison with both Internal and External Audit services.

The Head of Counter Fraud has attended all Policy Review Group meetings during the year, providing expert fraud-proofing advice to support the development and revision of organisational policies.

A representative of the Counter Fraud Team attended all Controlled Drugs Local Intelligence Network (LIN) meetings

The Head of Counter Fraud attended all Post Payment Verification (PPV) meetings

These forums support intelligence sharing, system assurance, and timely identification of emerging risks.

Training and Professional Development

Staff within the Counter Fraud Team have continued to undertake relevant training to ensure competence, resilience, and compliance with national standards. Training during the year included:

- Digital system training, including L2P, Health Roster and Patchwork
- Attendance by all staff at both Wales Counter Fraud Conferences, providing updates and development opportunities in line with NHS Counter Fraud Authority (NHSCFA) requirements
- Additional training in Datix Web, Risk Management, Microsoft Purview, and various Microsoft 365 / O365 applications

All staff have maintained mandatory training compliance in excess of 90% throughout the year.

Internal Engagement and Joint Working

Targeted engagement has taken place with the **Capital and Estates Division** and the **Nursing Division**, resulting in stronger collaborative working relationships. This engagement has been driven by, and has supported, a number of investigations within these areas.

In addition, the Counter Fraud Team has strengthened its relationship with the **Cyber Security Team**, leading to the initiation of several joint projects aimed at addressing shared and emerging risk areas, particularly where fraud and cyber risk intersect.

6. CONCLUSION

The Counter Fraud Team has delivered a robust, risk-led and fully compliant programme during 2025–2026. Effective governance, proactive risk assessment, strong investigative outcomes, and extensive awareness activity provide a high level of assurance that Aneurin Bevan University Health Board meets its statutory obligations under Welsh Government Directions, the NHS Counter Fraud Authority Standards, and the Economic Crime and Corporate Transparency Act 2023. The Board can be assured that appropriate and effective arrangements are in place to prevent, detect, and respond to fraud, bribery, and corruption.

Gareth Lavington
Head of Counter Fraud, Aneurin Bevan University Health Board
24/04/2026

APPENDIX 1

Welsh Government Directions

Para.	Instruction	Action taken by health body
2 (1)	Each NHS body must take all necessary steps to counter fraud in the NHS in accordance with these Directions and in accordance with. (a) the NHS Counter Fraud and Corruption Manual; and (b) the policy statement "Applying appropriate sanctions consistently" published by the CFS, (c) and having regard to guidance or advice issued by the CFS.	**Achieved**
2 (2)	Each NHS body must require its Chief Executive and Director of Finance to monitor and ensure compliance with these Directions.	**Achieved**
3 (1)	Each NHS body must co-operate with the CFS to enable the CFS efficiently and effectively to carry out its counter fraud functions and in particular each NHS body must, subject to the following paragraphs of this direction. (a) enable the CFS to have access to its premises. (b) put in place arrangements which will enable the CFS to have access, as appropriate, to the NHS body's staff; and (c) supply such information including files and other data (whether in electronic or manual form) as the CFS may require for the purposes of the CFS counter fraud functions.	**Achieved**
3 (2)	In the case of information required under paragraph (1)(c) in connection with the CFS responsibility for quality inspection, fraud measurement, National Proactive Exercises (NPEs) and fraud prevention reviews, inspections and instructions, an NHS body must respond to any request from the CFS as soon as reasonably practicable.	**Achieved**
3 (3)	In the case of information required under paragraph (1)(c) for the purposes of investigations relating to the CFS' counter fraud functions, an NHS body must respond to a request as soon as reasonably practicable and in any event within seven days from the date the request was made.	**Achieved**

Para.	Instruction	Action taken by health body
3 (4)	Nothing in paragraph 1(b) contravenes any right a member of staff may otherwise have to refuse to be interviewed.	**N/A**
3 (5)	Nothing in paragraph 1(c) or direction 7(f) obliges or permits an NHS body to supply information which is prohibited from disclosure by or under any enactment, rule of law or ruling of a court of competent jurisdiction or is protected by the common law.	**N/A**
3 (6)	Without prejudice to the generality of direction 2(1)(a), each NHS body must comply with the requirements specified in the NHS Counter Fraud and Corruption Manual concerning. (a) the arrangements for reporting fraud cases to the LCFS and to the NHS body's audit committee and auditors. (b) the arrangements for agreeing to undertake a criminal prosecution and to refer a matter to the police. (c) the confidentiality of information relevant to the investigation of suspected fraud. (d) the arrangements for the LCFS to report weaknesses in fraud related systems to the CFS and the NHS body's audit committee and auditors; and (e) the arrangements for gathering information to enable the Director of Finance to seek recovery of money lost through fraud.	**Achieved**
5 (1)	Each NHS body must nominate at least one person that it proposes to appoint as the body's LCFS within six weeks of the date on which these Directions come into force.	**Achieved**
5 (2)	A person nominated under paragraph 5(1) may be either employed by the NHS body or a person whose services are supplied to it by an outside organisation.	**Achieved**
5 (3)	The name of the nominee must be notified to the CFSMS together with the information specified in the NHS Counter Fraud and Corruption Manual within 7 days of the nomination.	**Achieved**
5 (4)	Without prejudice to the generality of direction 2(1), before making a nomination each NHS body must consider any guidance issued by the CFSMS on the suitability criteria for an LCFS.	**Achieved**

Para.	Instruction	Action taken by health body
5 (5)	After a nominee has. (a) been approved by the CFS as a person suitable for appointment. (b) successfully completed any training required by the CFS; and (c) been accredited by the Counter Fraud Professionals Accreditation Board, the NHS body may appoint the person as its LCFS.	**Achieved**
5 (6)	Where an NHS body nominates a person, whose services are provided to it by an outside organisation, it must: (a) comply with the requirements of the CFS as to the suitability of the organisation in question. (b) satisfy itself and the CFS that the terms on which those services are provided are such as to enable the LCFS to carry out his functions effectively and efficiently and in particular that he will be able to devote sufficient time to that NHS body; and (c) give to the CFS a copy of the contract under which the services of the LCFS are supplied to it.	**N/A**
5 (7)	A further nomination must be made within 3 months of the date on which an NHS body learns that there is to be a vacancy for an LCFS.	**Achieved**
5 (8)	The procedures in paragraphs (3) to (6) also apply to a person nominated under paragraph (7).	**Achieved**
6 (1)	Each NHS body must specify a job description for its LCFS which includes the operational and liaison responsibilities specified by the CFS.	**Achieved**
6 (2)	The job description under paragraph (1) must include a requirement that the LCFS must adhere to the CFPAB Principles of Professional Conduct as set out in the NHS Counter Fraud and Corruption Manual.	**N/A**
6 (3)	An LCFS must report directly to the NHS body's Director of Finance.	**Achieved**

Para.	Instruction	Action taken by health body
6 (4)	An LCFS must not undertake responsibility for or be in any way engaged in the management of security for any NHS body.	**Achieved**
7	Each NHS body must. (a) require that in addition to the job description mentioned in direction 6(1), the LCFS and the Director of Finance agree, at the beginning of the financial year, a written work plan which outlines the LCFS's projected work for that financial year by reference to the seven generic areas of counter fraud activity set out in the NHS Counter Fraud and Corruption Manual.	**Achieved**
	(b) enable its LCFS to attend the NHS body's audit committee meetings.	**Achieved**
	(c) require its LCFS to keep full and accurate records of any instances of fraud or suspected fraud.	**Achieved**
	(d) require its LCFS to report to the CFS any weaknesses in fraud related systems of the NHS body and any other matters which may have fraud related implications for the NHS.	**Achieved**
	(e) ensure that its LCFS has all necessary support including access to the CFS secure intranet site to enable him efficiently and effectively to carry out his responsibilities.	**Achieved**
	(f) subject to any contractual or legal constraint, require all of its staff to co-operate with the LCFS and in particular that those responsible for human resources disclose information which arises in connection with any matters (including disciplinary matters) which may have implications in relation to the investigation, prevention, or detection of fraud.	**Achieved**
	(g) enable its LCFS to receive training recommended by the CFS.	**Achieved**

Para.	Instruction	Action taken by health body
	(h) require its LCFS, its other employees and any persons whose services are provided to the NHS body in connection with counter fraud work to have regard to guidance and advice on media handling of counter fraud matters which may be issued by the CFS.	**Achieved**
	(i) enable its LCFS to participate in activities in which the CFS is engaged, including national anti-fraud measures, where he is requested to do so by the CFS.	**Achieved**
	(j) enable its LCFS to work in conditions of sufficient security and privacy to protect the confidentiality of his work.	**Achieved**
	(k) enable its LCFS generally to perform his functions effectively, efficiently, and promptly.	**Achieved**

APPENDIX 2

Compliance with the 12 components of the NHS Counter Fraud Authority Requirements.

1: Accountable individual

NHS Requirement 1A:

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

Your Rating is: **GREEN**

Comments:

At ABUHB the Director of Finance has executive responsibility for counter fraud work. In addition, the DoF receives a quarterly report in relation to investigations carried out by NHS CFSW that impact ABUHB. Local CF work is communicated externally via quarterly reports to Welsh Government. These reports are also shared with ARAC. DOF and the Head of Counter Fraud met on an agreed schedule. The work undertaken by the HB LCFS is presented internally, via quarterly reports to ARAC. This committee is made up of lay nonexecutive members and executives. ARAC and DOF review the annual CF work plan. The Assistant Director of Corporate Finance acts as the fraud champion and is the line manager to the Head of Counter Fraud. Meetings are undertaken on an agreed cycle between ADOF and Head of CF. In addition, Head of CF meets monthly with other Heads of Financial Service and ADOF to update on CF matters. DoF, ACC, Fraud Champion, and all LCFS' are nominated correctly with the NHSCFA.

NHS Requirement 1B:

The organisation's non-executive directors, counter fraud champion or lay members and board/governing body level senior management are accountable for gaining assurance that sufficient control and management mechanisms in relation to counter fraud, bribery and

corruption are present within the organisation. The counter fraud champion understands the threat posed and promotes awareness of fraud, bribery and corruption within the organisation. Board level evaluation of the effectiveness of counter fraud, bribery and corruption work undertaken is documented. Where recommendations have been made by NHSCFA following an engagement, it is the responsibility of the accountable board member to provide assurance to the board surrounding the progress of their implementation. The organisation reports annually on how it has met the standards set by NHSCFA in relation to counter fraud, bribery and corruption work, and details corrective action where standards have not been met.

Your Rating is: **GREEN**

Comments:

The governance route for CF is via ARAC. ARAC receives reports from Head of CF. These reports are also reviewed by DoF and Fraud Champion. CF is a standing agenda item at ARAC. Actions raised by ARAC that impact CF are added to the ARAC action tracker to ensure remedial action is taken. The Head of Counter Fraud meets in private with the ARAC Chair and other ARAC lay members every 6 months, and can approach the Chair independently of the executive body at anytime to raise any concerns. The end of year report aims to provide assurance to the ARAC that the counter fraud provision for the past year has been effective and has met the current standards set by NHS CFA. This report is reviewed by the DOF and the ARAC. Any issues requiring remedy are dealt with as above via Action tracker. CFFSR is completed yearly within time limits and is shared with ARAC. Audit Chair maintains an NHS Wales email account. All ARAC meetings are minuted and reports are publicly available via ABUHB internet.

2: Counter fraud bribery and corruption strategy

NHS Requirement 2:

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

Your Rating is: **GREEN**

Comments:

Key national and legislative documents, including the NHSCFA Strategy 2023–2026, the Economic Crime and Corporate Transparency Act 2023, and the NHS Wales Counter Fraud Strategy, have informed the design of Counter Fraud services within ABUHB. The ABUHB Counter Fraud Strategy, as set out in the Counter Fraud Annual Plan, is closely aligned to these requirements and adopts an intelligence led, preventative approach focused on risk mitigation. Evidence within the ABUHB Annual Report confirms that counter fraud activity delivered during the year was aligned with these strategic and legislative expectations. In addition, ABUHB has established a Counter Fraud, Bribery and Corruption Policy and Procedure, which underpins the operational approach to counter fraud and provides clarity for staff on reporting concerns.

This policy is accessible to all employees via the ABUHB intranet.

3: Fraud bribery and corruption risk assessment

NHS Requirement 3:

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

Your Rating is: **GREEN**

Comments:

Counter fraud risk activity is prioritised with all inherent and emerging local risks subject to review and, where appropriate, formal risk assessment. Risk work is undertaken in accordance with Cabinet Office risk methodology and the ABUHB Local Risk Management Policy, with all risks consistently scored using the approved risk assessment matrix. A Counter Fraud Risk Profile is maintained to support oversight and active management of

identified risks. All counter fraud risks are formally recorded on the Datix risk management system. A structured counter fraud risk process has been implemented and formally agreed by both the Executive Board and the Audit, Risk and
Assurance Committee (ARAC). ARAC is the established governance route for reported counter fraud risks, with Executive Directors retaining overall accountability for risks within their respective areas. Where appropriate local proactive counter fraud exercises are initiated to mitigate risk and strengthen controls.

4: Policy and response plan

NHS Requirement 4:

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

Your Rating is: **GREEN**

Comments:

ABUHB has a Counter Fraud Policy and Response Plan in place, compliant with NHSCFA requirements and the Economic Crime and Corporate Transparency Act. The Counter Fraud Team operates formal joint working protocols with Workforce & Organisational Development and Internal Audit, supporting effective governance and assurance. Counter fraud related policies are accessible to staff via the Health Board intranet, including the Standards of Behaviour Framework Policy, which explicitly addresses fraud, bribery and corruption. Policies are subject to formal review every three years, with oversight and approval through the Audit, Risk and Assurance Committee (ARAC). Standing Financial Instructions are maintained by Corporate Finance, with effective liaison in place between Corporate Finance and Counter Fraud to support preventative controls. Staff awareness of counter fraud arrangements is tested annually through surveys and education activity, with results indicating a high level of awareness

5: Annual action plan

NHS Requirement 5:

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

Your Rating is: **GREEN**

Comments:

The Counter Fraud, Bribery and Corruption Workplan has been agreed by the Director of Finance, and is scheduled for scrutiny and approval by the Audit, Risk and Assurance Committee (ARAC). The workplan has been designed in accordance with Government Functional Standard GovS 013; the Economic Crime and Corporate Transparency Act (ECCTA); and aligns with Welsh Government Directions; NHSCFA Strategy; and NHS Wales Counter Fraud Strategy. It demonstrates the establishment of reasonable, proportionate, risk based procedures to prevent, detect and respond to fraud and economic crime. The workplan sets out a structured programme of risk assessment, prevention, intelligence led activity, investigation and reporting, with clearly defined governance. The plan is adaptive enabling timely response to emerging risks and unplanned allegations of fraud that cannot be anticipated. Counter Fraud is a standing agenda item at ARAC, with progress reports provided to support senior oversight and assurance.

6: Outcome-based metrics

NHS Requirement 6:

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

Your Rating is: **GREEN**

Comments:

Locally managed data systems are in place to provide accurate, reliable and timely performance information on counter fraud activity and outcomes. These systems supplement established datasets, including ESR, CLUE, the National Fraud Initiative, and All Wales statistical reporting. Performance data is routinely collected, monitored and reviewed across the core GovS 013 delivery areas, including prevention and awareness, referrals and investigations, risk management, joint working, strategic planning, sanction outcomes, and financial loss identification and recovery. This supports evidence based decision making and demonstrates effective performance monitoring, as required by the standard. The use of structured performance data enables accurate analysis of outcomes, and allows adjustment to priorities during the year. Ongoing analysis also supports the identification of emerging fraud risks, enabling timely action and reinforcing a consistent proactive, risk based approach.

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

NHS Requirement 7:

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

Your Rating is: **GREEN**

Comments:

ABUHB receives fraud referrals externally through the NHSCFA Fraud and Corruption Reporting Line. All reports are initially triaged by the NHSCFA Central Intelligence Team and disseminated to the ABUHB Counter Fraud Team for action. In addition, the Counter Fraud Team maintains a dedicated intranet webpage with a bespoke digital reporting form, clearly setting out all available reporting routes. These arrangements are formalised within the Counter Fraud Policy and reinforced through the Counter Fraud education and awareness programme, supporting consistent reporting mechanisms in line with GovS 013 expectations. Staff awareness of reporting routes is assessed annually through a dedicated survey, with results demonstrating a consistently high level of

knowledge. The All Wales Raising Concerns Policy is also in place, providing assurance that staff can safely report suspected fraud, while the All Wales Disciplinary Policy outlines the actions to be taken where fraud is suspected.

8: Report identified loss

NHS Requirement 8:

The organisation uses the approved NHS fraud case management system to record all incidents of reported suspect fraud, bribery and corruption, to inform national intelligence and NHS counter fraud functional standard return submission by the NHSCFA. The case management system is used to record all fraud, bribery and corruption investigative activity, including all outcomes,

recoveries and system weaknesses identified during the course of investigations and/or proactive prevention and detection exercises

Your Rating is: **GREEN**

Comments:

All incidents of suspected fraud and financial crime are recorded and managed by the Counter Fraud Team using the CLUE case management system, which is used to document investigations, sanctions, financial losses, recoveries and preventions, as well as identified system weaknesses and Local Proactive Exercise activity. The system supports the effective recording and reporting of non- financial outcomes as a result of proactive activity. ABUHB Counter Fraud uses CLUE consistently and in accordance with national requirements, with system oversight provided by NHSCFA. Information recorded within CLUE is used to inform progress and assurance reporting to ARAC. Identified fraud losses are formally reported through the Counter Fraud Annual Report and the Functional Return submitted to NHSCFA. In Wales, quarterly counter fraud statistics are overseen by the Head of NHS Counter Fraud Services Wales and subsequently reported to Welsh Government, providing national oversight and assurance.

9: Access to trained investigators

NHS Requirement 9:

The organisation employs or contracts in an accredited, person (or persons) nominated to the NHSCFA to undertake the full range of counter fraud, bribery and corruption work, including proactive work to prevent and deter fraud, bribery and corruption and reactive work

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

Your Rating is: **GREEN**

Comments:

The Counter Fraud Team is adequately resourced when benchmarked against similar organisations. The service comprises the Head of Counter Fraud, acting as Senior Investigating Officer, and three Local Counter Fraud Specialists (LCFSs). All staff are experienced criminal investigators and all hold Accredited Counter Fraud Specialist (ACFS) status. During the year, all LCFSs have undertaken a number of investigations and Interviews Under Caution (IUCs), which have been subject to review for quality and compliance. All mandatory NHS Counter Fraud Authority training has been completed by team members, ensuring capability remains current and in line with national requirements. Governance arrangements remain consistent, with the Director of Finance, fraud champion, and Audit Committee Chair unchanged during the period. All required nominations with the NHSCFA are current and up to date.

10: Undertake detection activity

NHS Requirement 10:

The organisation undertakes proactive work to detect fraud using relevant information, intelligence and fraud risk assessments to identify anomalies that may be indicative of fraud, bribery and corruption. Proactive detection activity includes local proactive exercises (LPE) in high fraud risk areas, based on the organisation's fraud risk assessment and participation in national exercises coordinated by the NHSCFA. Other proactive activity that are not LPEs include taking action in response to Fraud Prevention Notices (FPN) or IBURNS. Findings of this proactive work are evaluated and where appropriate used to develop improvements to prevent and deter fraud, bribery and corruption as well inform the organisation's fraud risk assessment. Instances of suspected fraud, bribery and corruption identified through the proactive work are subject to appropriate investigation. Relevant information and

intelligence may include (but is not limited to) internal and external audit reports, information on outliers, recommendations in investigation reports and NHSCFA intelligence reports and loss measurement exercises.Key findings from proactive work are acted upon promptly.

Your Rating is: **GREEN**

Comments:

The Counter Fraud Team undertakes proactive work to assess potential control, process or system weaknesses and to determine whether remedial action is required. Local Proactive Exercises have been delivered during the year to both detect potential offences and identify weaknesses requiring improvement. The organisation operates a Post Payment verification (PPV) programme, with quarterly meetings attended by the Head of Counter Fraud. PPV reports are shared directly with Counter Fraud, and where appropriate, investigations or further proactive activity are initiated in response to identified outliers. The most recent National Fraud Initiative (NFI) data matching exercise has been successfully completed, with all matches reviewed, investigated, and finalised. The Counter Fraud Team has also responded to all NHSCFA Fraud

Prevention Notices and Intelligence Bulletins, and continues to participate in Local Intelligence Network meetings, supporting intelligence led and preventative activity.

11: Access to and completion of training

NHS Requirement 11:

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

Your Rating is: **GREEN**

Comments:

In line with Government Functional Standard GovS 013, ABUHB has established and maintains appropriate capability, skills and awareness arrangements to prevent, detect and respond to fraud. All Wales fraud
awareness training continues to be designated as mandatory training. Counter Fraud input and signposting is embedded within the Corporate Induction programme, ensuring new starters are aware of fraud risks, and reporting routes from the outset. Bespoke counter fraud presentations have been delivered within directorates where heightened fraud risk has been identified.
Additional awareness activity was delivered across ABUHB sites during International Fraud Awareness Week, further reinforcing preventative messaging. All members of the Counter Fraud Team have completed mandatory and specialist training provided by the NHS Counter Fraud Authority. Supplementary development has also been undertaken in risk management and the use of digital systems.

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

NHS Requirement 12:

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

Your Rating is: **GREEN**

Comments:

ABUHB has established and maintains policies requiring staff and Non Executive Directors to declare conflicts of interest (COI) and gifts and hospitality, consistent with the prevention and governance expectations set out in Government Functional Standard GovS 013 and the Economic Crime and Corporate Transparency Act (ECCTA) 2023. In line with transparency, oversight and control of fraud risk, all COI and gifts and hospitality declarations are captured within a central register maintained by Corporate Governance. This information is shared with the Counter Fraud Team, supporting proactive oversight, and the identification of potential vulnerabilities associated with fraud, bribery or corruption. The requirement to disclose conflicts of interest, gifts and hospitality is reinforced through mandatory counter fraud e learning. These arrangements collectively support the

establishment of “reasonable procedures” under ECCTA. All relevant policies are accessible on the ABUHB staff website.

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	19 May 2026
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	**Deep Dive of Discharge Planning, Digital and Pre 2024/25 Audit Recommendations**
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Head of Corporate Risk and Assurance & Corporate Risk Officer

Pwrpas yr Adroddiad
Purpose of the Report

Ar Gyfer Trafodaeth/For Discussion

The purpose of this report is to provide the Audit, Risk and Assurance Committee (the Committee) with assurance on the Health Board's progress in addressing key areas within the Audit Recommendations Tracker, with a particular focus on Discharge Planning, Digital and outstanding pre-2024/25 recommendations.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

Discharge Planning, Digital, and pre-2024/25 audit recommendations have remained key areas of focus for the Committee. In recognition of this, the Committee requested a comprehensive assurance report to provide an overarching and integrated assessment of progress made in implementing audit recommendations across these areas.

This approach strengthens oversight and assurance by enabling the Committee to assess whether agreed actions have been effectively implemented, identify themes and recurring issues, and determine whether any residual gaps, risks, or barriers to delivery require further management attention or escalation.

Cefndir / Background

The Audit Recommendations Tracker is a key mechanism through which the Health Board monitors, manages, and provides oversight of recommendations arising from Internal Audit and external review activity. Effective implementation of audit

recommendations is essential in strengthening governance, internal control, risk management, and organisational learning, whilst also providing assurance that identified weaknesses are being addressed in a timely and sustainable manner.

Throughout 2025/26, the Committee has maintained a particular focus on recommendations relating to Discharge Planning, Digital, and pre-2024 actions due to the significance, complexity, and duration of a number of these recommendations. In response, the Committee requested a consolidated assurance review to provide greater visibility of progress, identify any barriers to implementation, and confirm whether recommendations remain relevant, appropriately managed, and aligned to current organisational risks and priorities.

This report provides that overarching position and highlights the progress made, recommendations closed, and the remaining actions subject to ongoing monitoring and oversight.

Asesiad / Assessment

Discharge Planning

At the end of the 2025/26 financial year, significant progress had been made in addressing audit recommendations relating to Discharge Planning. Across both the 2022 Internal Audit review and the 2024 Audit Wales review, only **two** recommendations remained outstanding, as set out below.

The **two** outstanding recommendations related to the 2022/23 Internal Audit report (R3.1a and R3.1c). All other recommendations had previously been implemented and formally closed following approval by the Committee at previous meetings. Further detail is provided in **Appendix 1**.

Discharge Planning 2022 Internal Audit Report	
Recommendation	**Status**
1.1a	Completed
1.1b	Completed
1.1c	Completed
2.1	Completed
3.1a	Outstanding
3.1b	Completed
3.1c	Outstanding
4.1	Completed
4.2	Completed
4.3	Completed
5.1	Completed
6.1	Completed
7.1	Completed

2024 Discharge Planning Progress Update Audit Wales	
Recommendation	**Status**
1.1	Completed
2.1	Completed
2.2	Completed
3.1	Completed

Since Quarter 4 2025/26, further progress has been made and the **two** remaining recommendations from the 2022/23 Internal Audit report have now been fully implemented.

The Committee is therefore asked to approve the closure of recommendations R3.1a and R3.1c based on the evidence of completion provided in **Appendix 2.** Subject to Committee approval, all Discharge Planning audit recommendations will be confirmed as complete and embedded within operational practice.

Overall, this demonstrates that the Health Board has effectively implemented the required actions to address the control weaknesses previously identified. This provides assurance that governance, oversight, and operational arrangements relating to Discharge Planning have been strengthened and are operating more effectively.

Digital Recommendations

Throughout 2025/26, the Committee raised concerns regarding the pace of progress in implementing digital audit recommendations. In several instances, delivery has been dependent upon external factors, including national programmes, shared digital infrastructure, or the implementation of related national recommendations that are outside the direct control of the Health Board.

In response, the Committee requested a comprehensive review of all live digital recommendations to provide greater visibility of progress, dependencies, and remaining risks.

There were **32** live digital recommendations, of which **eight** relate to audits carried out pre-2024/25 audit year, shown below in Table 1. Further details can be found in **Appendix 3.**

Table 1

Requested Updates for Digital Recommendations			
Audit Title	**Assurance Rating**	**Number by Priority Rating**	
2020 IM&T Control & Risk Assessment 2020/21	Advisory	R6-R9-R14	
2022 Records Management	Limited	R5-R13	
2023 IT Infrastructure	Reasonable	R2	R4-R6
2024 Cyber Security	Reasonable	R1-R4	R3
2024 EDRMS	Reasonable	R1	R2-R3
2024 Intelligence Led Organisation	Reasonable	R2	R3

2024 Records Management	Limited	R3-R4	R2-R5-R6-R7
2024 Subject Access Requests	Limited	R1-R2-R5	R3-R4-R6
2024 Technical Continuity	Reasonable	R2	R1-R3-R4
TOTAL		**32**	

Following a comprehensive review of the **32** digital recommendations, it has been proposed that **four** be formally closed. Further detail of the four recommendations proposed for closure can be found in **Appendix 4.**

Table 2

COMPLETED Digital Recommendations		
Audit Title	**Assurance Rating**	**Recommendation by Priority Rating**
2020 IM&T Control & Risk Assessment	Not Rated	R9
2022 Records Management	Limited	R5-R13
2023 IT Infrastructure	Reasonable	R6
TOTAL		**4**

Following completion of the **four** recommendations, **28** live digital audit recommendations remain outstanding.

Of the **28** remaining recommendations:

- **14** have not yet reached their implementation dates as set out within the agreed management responses,
- **14** although beyond their original implementation dates, continue to be actively progressed.

Where delays have occurred, these are primarily attributable to factors outside the direct control of the Health Board, including national dependencies, funding limitations, and wider resource and capacity constraints. Despite these challenges, progress continues to be monitored through established governance arrangements to support delivery and oversight. Further details can be found in **Appendix 5**

The position reflects the complexity and scale of digital transformation activity across the Health Board, together with a number of national, financial, and resource dependencies that continue to influence delivery timescales. Despite these challenges, recommendations continue to be actively managed through

established governance arrangements, with ongoing monitoring and scrutiny to support implementation and risk reduction.

The Committee can therefore take assurance that there is a clear understanding of the remaining actions, appropriate oversight of delivery, and continued progress towards strengthening digital governance, controls, and infrastructure across the Health Board.

The Committee is asked to approve the completion of **four** recommendations based on the evidence of completion.

Pre-2024-25 Audit Recommendations

At the request of the Committee, a review has been undertaken of all recommendations that remain on the Tracker that pre-date the 2024/25 audit year. Excluding the **two** Discharge Planning recommendations and **eight** Digital recommendations referenced in this report, a total of **10** recommendations were identified within scope.

A number of these recommendations have remained open for a prolonged period. This review therefore provides the Committee with a consolidated assessment of progress to date, the continued relevance and appropriateness of the recommendations, and the further actions required to support implementation, resolution, or where appropriate, formal closure. Further details can be found in **Appendix 6 & 7.**

Table 3

Requested Updates for Recommendations Pre-2024/25 Audit Year			
Audit Titles	**Lead Director**	**Assurance Rating**	**Recommendation and Priority Rating**
2021 Pathology	COO	Reasonable	R8
2021 IT System Controls (WRIS)	COO	Reasonable	R5-R7-R8-R9-10
2021 Audit of Accounts Report	DoW&OD	Not Rated	R1
2022 Integrated Wellbeing Networks	DPH	Reasonable	R2
2023 Estates Condition	DoSP&P	Limited	R4.2
2023 Waiting List Management	COO	Reasonable	R1.1a
		Total	**10**

Table 4

COMPLETED Recommendations Pre-2024/25 Audit Year			
Audit Titles	**Lead Director**	**Assurance Rating**	**Recommendation and Priority Rating**
2021 Pathology	COO	Reasonable	R8
2021 IT System Controls (WRIS)	COO	Reasonable	R7
2022 Integrated Wellbeing Networks	DPH	Reasonable	R2
2023 Waiting List Management	COO	Reasonable	R1.1a
		Total	**4**

Following completion of the four recommendations, **14** pre-2024 recommendations remain live for tracking (inc. eight Digital recommendations referenced earlier in this report).

In conclusion, the remaining pre-2024 recommendations have been reviewed and continue to be considered relevant, appropriate, and necessary. Retaining these recommendations supports ongoing visibility, oversight, and accountability, and provides assurance that longstanding actions continue to be actively progressed in line with current organisational risks and governance requirements. Further detail is provided in **Appendix 8**.

Conclusion

Overall, this review demonstrates that audit recommendations relating to Discharge Planning, Digital, and pre-2024 areas are being effectively managed and monitored. Significant progress has been achieved during the year, including the full completion of all Discharge Planning recommendations and the closure of a number of Digital and longstanding recommendations.

While some actions remain open, these have been subject to review, continue to be actively progressed, and remain aligned to current risk, operational, and organisational priorities.

This provides assurance that appropriate governance, oversight, and accountability arrangements are in place to support the effective implementation of audit recommendations and continuous organisational improvement.

Argymhelliad / Recommendation

The Audit, Risk and Assurance Committee is asked to:

- **NOTE** the progress made in implementing audit recommendations relating to Discharge Planning, Digital, and pre-2024 recommendations;

- **APPROVE** the completion of the **two** Discharge Planning recommendations, as detailed within Appendix 2;
- **APPROVE** the completion of the **four** Digital recommendations, as detailed within Appendix 4;
- **APPROVE** completion of the **four** pre-2024 recommendations; and
- **TAKE ASSURANCE** that appropriate governance, oversight, and monitoring arrangements are in place to support the continued management and implementation of outstanding audit recommendations.

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

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	COO – Chief Operating Officer DoW&OD – Director of Workforce & Organisational Development DPH – Director of Public Health

	DoSP&P – Director of Strategy, Planning & Partnerships
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

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

Discharge Planning Recommendation Deep Dive:

Discharge Planning 2022/23 Internal Audit Report		
Recommendation	**Management Response**	**Status**
1.1a Where a Health Board policy is to expire that an extension to the document is formally granted, with a revised review by date established. Such policy extensions should be reported to the Board or designated Committee and checks made to ensure that the policy remains as relevant as possible, pending any formal review.	The Health Board's clinical policies have a review date rather than an expiry date, and whilst the review date may have elapsed, the policy remains extant and does not require a formal extension. However, whilst the Policy remains extant, we recognise there may be differences between the Policy and current practice. Therefore, the current process will be reviewed and compared to the existing Policy. Where gaps are identified, these will be risk assessed and mitigation implemented to reduce risk to an acceptable level. We anticipate this will include an interim update to the Policy. Following this process, we will provide assurance to the QPSOG over actions to be implemented, with regular updates provided on implementation status.	**COMPLETED:** All Wales Reluctant Discharge Policy was endorsed for Health Board use at the Clinical Standards and Policy Group meeting in October. The All-Wales Discharge Policy has been delayed, but the local Discharge Policy has been aligned with the discharge to recover and assess pathways and was presented to the Clinical Standards and Policy Group in October and signed off.
1.1b The Discharge Policy is updated, approved and reissued, to be compliant with the All-Wales policy, when issued.	The All-Wales Discharge Policy is expected to be released imminently and will be intrinsic to the development of the new Health Board policy. We acknowledge that since the policy was published current practice has moved on so that the policy does not describe the working arrangements. A Task & Finish group will be established with cross divisional representation to redraft the policy and ensure the content reflects current and emerging practice once the new All Wales Policy has been made available. This work will be completed within three months of the introduction of the All-Wales Policy. In the meantime, and as noted above we will review the current Policy. We will report any ongoing risk and position to the QPSOG. The Health Board will ensure a process is in place for regular update and review of the new policy when reissued, reporting to the Clinical Standards Board.	**COMPLETED:** All Wales Reluctant Discharge Policy was endorsed for Health Board use at the Clinical Standards and Policy Group meeting in October. The All-Wales Discharge Policy has been delayed, but the local Discharge Policy has been aligned with the discharge to recover and assess pathways and was presented to the Clinical Standards and Policy Group in October and signed off. Implementation and training of the policies have started.
1.1c The Discharge Policy is updated, approved and reissued, to reflect current practice and approach to discharge planning adopted by the Health Board (Medical Fit Date for Discharge, simple and complex	In the interim we will identify the gaps between current practice and the current policy and ensure that it is updated. We will then ensure the Policy is approved by the appropriate Committee. Once the All-Wales Policy is published, we will ensure that any requirements are incorporated into the Health Board's Policy. The revised policies will be re-issued with training overseen by the Head of Discharge and Divisional Nurses. We will continue to monitor the implementation of the policy and update training requirements as required.	**COMPLETED:** The Discharge Policy has been updated and is scheduled for sign-off at the Integrated Discharge Board in May 2026. Following approval, the revised policy will be made available to all staff via the intranet, alongside publication on a dedicated discharge Padlet to support accessibility and awareness.
2.1 We recommend that Health Board management ensure that formal discharge planning training is provided to both clinical and administrative staff engaged in the pathway, including updates if the process is amended.	Within the Health Board, training for discharge planning is delivered across existing induction and education programmes: Newly qualified and overseas nurses have an introduction to discharge planning through the Journey of excellence programme. The Health Boards practice educators provide ongoing education & training on discharge planning for nursing staff. October 2023 Assistant Medical Director for Planning Discharge Planning Final Internal Audit Report NWSSP Audit and Assurance Services 13 The Head of Discharge has been working with the Universities to introduce a discharge	**COMPLETED:** This is included on the Journey to Excellence Programme, and the Patient Safety Events focus on learning and improvement.

	planning session into student nurse training, ensuring awareness of the fundamentals before starting in their first post. Training for medical staff is currently ward based. The Assistant Medical Director for Planning will be working with a task and finish group to standardise training. Therapy staff receive discharge training throughout their undergraduate training. Much of their work is dedicated to preparing patients for discharge to their home environment or through referral to the provisions of rehabilitation or other support. Local discharge planning arrangements are disseminated through the site and ward teams.	
	The Health Board has a work programme for discharge to be overseen by the newly created Discharge Improvement Board, chaired by the Executive Director of Nursing. This will strategically co-ordinate the current workstreams and include oversight of the roll out of the 'optimising discharge framework' issued by the NHS delivery unit. All workstreams currently form part of the goals 5 & 6 for improving urgent care and this will now form part of the overarching discharge programme. Embedding the optimising discharge framework will be a key priority of the Discharge Improvement Board, with a launch event hosted by a number of Health Board Executives held in January 2023. Local training has already commenced with sessions delivered across the acute sites and with plans for roll out to the other hospital sites within the next 6 months. This will be supported by the national training programme to be delivered by the NHS delivery unit. The lack of procedural documentation will be addressed through the new discharge policy formation.	**COMPLETED:** Discharge programme of work through the integrated discharge board is embedded through the defined work streams to support the safe and timely discharge in line with the 6 goals programme. The optimising discharge framework is rolled out and embedded cross divisionally and ongoing education is supported by key groups, events, workshops and ward based champions The Health Board continues to take forward a Discharge Improvement Programme, aligned to the WG Six Goals for Urgent and Emergency Care Programme, under Goals 5 & 6 – Return and Stay Well at Home. The focus over the last three months includes, roll out of a new D2RA digital solution alongside an education and training programme, supporting capturing meaningful data including red to green days, medically optimised discharge status and D2RA pathways to support patient flow across sites. The function and performance of the Discharge Lounges at RGH and NHH have been reviewed to support timely patient discharge. The RGH Discharge Lounge has relocated and is now aligned with the RGH Discharge Hub and the NHH Discharge Lounge has introduced a new transport booking system. Further works is ongoing regarding the GUH Discharge Lounge with the potential to expand the capacity and realign WAST resource to facilitate discharges earlier in the day. The learning from the Patient Safety Events has been taken forward, a robust validation process is in place with Local Authority colleagues to identify reasons for delays, weekly POCD meetings are held and education and training programme is in place aligned to the WG Optimising Patient Flow Framework.
3.1a All patient discharges from the care of the Health Board are effectively controlled and evidenced by issuing a timely, completed discharge notification.	The Medical Director is aware that the timeliness of some discharge notifications needs to be improved. A letter was sent to all medical staff outlining their responsibilities in respect of timely discharge notifications in 2021. This is now being followed up by the Assistant Medical Director for Planning who will be leading a task & finish group to develop standardisation of approach. This work will aim to ensure that patients are able to leave hospital with their discharge	**REQUEST TO COMPLETE:** The Assistant Medical Director for Planning delivered teaching sessions to junior doctors on the completion of discharge summaries, aiming to improve quality and consistency. In parallel, a manual process has been implemented to remove

	summary / notification and ensure it will be sent electronically to the GP on the same day.	inappropriate discharges from Emergency Department (ED) to medicine from performance reporting, supporting more accurate data and improving reported outcomes. A business case has been submitted to the Executive Committee to secure funding for automation of this process through robotic (RPA) technology. The proposal is currently awaiting a decision.
3.1b Where an expected, standard processes is assessed as not required, for example discharge meetings held to discuss needs and establishment of care packages, that the assessment and conclusion be evidenced.	The Health Board acknowledges that there is inconsistency in the documentation of MDT meetings. The introduction of the Welsh Nursing Care Record (WNCR) may provide an opportunity to capture the content of discharge meetings as a digital record which clinical and admin staff can access and will formally record the actions agreed. The Health Board's Chief Nurse for Information has been engaged in this process. In the interim, the Head of Discharge will work with ward staff to introduce a consistent approach to documentation and evidence in the notes. It should be acknowledged that discharge arrangements will vary considerably depending on the assessed requirements of the individual.	**COMPLETED:** Welsh Nursing care record (WNCR) is established and embedded in all in patient areas and that include discharge documentation. Discharge documentation is audited to ensure compliance and standardisation. Audit results and areas for improvement will feed in to the safer discharge group, a cross divisional group to ensure that safer discharge principles are adhered to and that learning is evident from any examples of poor discharge. Board rounds and MDT rounds are a daily practice on in patient areas to facilitate a safe and timely discharge and ensures documentation and communication with patient and family
3.1c A consistent discharge approach is adopted for all day care appointments and for inpatient transfers between Health Board sites.	In respect of day care episodes of care, there are many diagnostic / treatment areas and specialities who have different methods of notifying both the GP and patient of the care episode. We acknowledge that this is not a standard approach with some departments combining the clinical details as the discharge summary. As part of the Task and Finish group, the Assistant Medical Director for planning will ensure that discharge notifications form part of the standardised approach. For inter-site transfers an SBAR is completed for every patient that outlines the patient's condition, diagnosis and any actions needed to be taken by the receiving site.	**REQUEST TO COMPLETE:** A new SBAR and step-down process for inter-site transfers was implemented in 2025 to support safer and more effective patient flow. The process is subject to ongoing review through the 'Our Next Patient' programme, with continuous feedback used to identify opportunities for improvement and optimise operational delivery.
4.1 We recommend that the Health Board ensure all patients admitted and recorded on CWS should have either 'simple' or 'complex' discharge status noted.	The complex list is an operational tracking tool to ensure that patients who may require support on discharge are captured and all appropriate assessments completed as required.All potential complex patients are added to the complex list, so that by default the remaining patients are simple discharges. Status can change during admission as patients may deteriorate or circumstances change so that patients are added to the complex list during their admission. The allocation of a 'simple' or 'complex' label may be difficult to assess on admission and would be of little benefit operationally. In December the Health Board recommenced shadow reporting to Welsh Government for Pathways of Care Delays (replaced DTOC reporting) and provides an audit / monitoring process for all patients with a delayed discharge status. This process also includes an action plan overseen by the Discharge Improvement Board, supported by improved operational information in the discharge dashboard.	**COMPLETED:** All patients requiring discharge planning are recorded on the Complex List to ensure clear oversight of actions and designated ownership. The list is maintained by the Hospital Discharge Assistant, who updates patient status and records actions arising from Board Rounds and Huddles. The Complex List is shared with Local Authority partners to support joined-up discharge planning and facilitate a coordinated, multi-agency approach. The Integrated Discharge Board maintains oversight of performance relating to Pathway of Care Delays, providing both challenge and support to drive improvement.
4.2 The recording of transfers between sites as discharges in CWS should be investigated to determine that it is not	There are acknowledged limitations within the Health Boards CWS system, whereby patients need to be discharged from one hospital to be admitted to another hospital on transfer. This has been the case since the inception of CWS, and forms part of the	**COMPLETED:** The Complex List serves as the primary system for capturing and recording discharge planning actions across both Health and

adversely impacting the Complex List by removing patients in error when in fact they remain under the care of the Health Board.	training provided to staff on induction. Mitigation of this risk is provided as all hospital staff are aware of the need to readmit to the receiving hospital on arrival. All acute and community wards have an allocated Hospital Discharge Assistant who ensures that transferred patients who may require support on discharge are captured on the complex list. For community hospitals transfers, patients are always added to the complex list by default as they are by nature complex cases. The mitigation described ensures that patients are not lost to the complex list, and we have evidence to support this. The new discharge dashboard demonstrates that the majority of our patients are included as part of the complex list either pending assessment or provision of discharge arrangements.	Social Care. It provides a single, consistent view of patient progress, actions, and responsible owners. When patients transfer between hospital sites, they are recorded on CWS and formally discharged and re-admitted in line with established processes. However, the Complex List retains continuity, with the patient record remaining live and only the site field being updated. This ensures that patients are not lost from oversight during inter-site transfers. In addition, all patients are recorded on CWS2, a complementary discharge management tool that captures key patient information, including Red to Green status, Discharge to Recover and Assess (D2RA), and reasons for delay. This dataset is updated twice daily by the Ward Manager to ensure timely and accurate reporting.
4.3 A method for identifying delays during the discharges of 'simple' cases should be introduced, monitored and reported.	Discharge delays can affect both simple and complex discharges and therefore emphasis should be improving the process for all patients. Length of stay data is available to explore the feasibility and the benefits of such an approach. The Health Board continually seeks to identify the factors that delayed discharge and this work forms part of the workstream for goal 5 of the Welsh Government '6 Goals for Urgent and Emergency Care' programme. As part of this programme, the Delivery Unit has recently released the 'optimal patient flow framework', and the Health Board will be embedding these principles as 'business as usual'. The framework will also feature in the new All Wales Discharge Policy, to include the introduction of the SAFER principles, D2RA and 'red & green days. These concepts have the potential to reduce LOS and improve discharge planning, so will be embedded within our policy.	**COMPLETED:** Roll out of CWS2 across all wards and sites to support the recording of data which includes D2RA pathway, Red to Green days, reason for delay and clinically optimised status aligned to the 'Optimal Hospital Flow Framework'. Development of ward dashboards to assist operational staff with identifying reasons for delayed discharge and support with timely discharge planning. Ongoing monitoring re compliance, training and education to improve patient flow and deliver timely pathways of care
5.1 Determining whether to make the use of the discharge checklist mandatory (including which aspects to include) or not and if so, the document should be consistently completed. Performance should be monitored until fully embedded.	Discharge checklists are used by most wards; however, we acknowledge there is an inconsistent approach in their use. The Welsh Nursing Care Record is currently being rolled out across the Health Board and may provide the opportunity to make the checklist part of the digital record as part of a standardised approach. In the interim, the use of checklists will be reviewed as part of the Discharge Improvement Board workstreams. The use of checklists will be further defined in the new discharge policy.	**COMPETED:** Discharge Champions appointed - rolling programme of teaching sessions in place. WNCR rolled out across the HB - discharge checlist features within this. Further work being led nationally to refine with a lead in time of circa 1 year.
6.1 We recommend that the Health Board ensure that the monitoring programme is reinstated and lessons learnt from reviewing each service areas are shared throughout.	The Health Board acknowledges that the monitoring as set out in the policy has not taken place. When drafting the new discharge policy, we will consider the most appropriate audit mechanism to ensure that compliance is monitored and reported. The lessons learnt will be reported through the new Discharge Improvement Board and through to the 6 Six Goals Programme Board. Reporting will also be provided to the Executive Committee and PQSOC.	**COMPLETED:** The Integrated discharge board and the 6 goals programme board, alongside the focus group has a learning and improvement focus. Safer discharge group and the discharge group discuss and implement improvement and change as needed through patient experience and learning. Data and Audit support the improvement and learning.
7.1 We recommend that the Health Board continue to analyse the reasons behind re-admissions within a suitable	The analysis of readmission rates is acknowledged as being problematic, as without clinical input at the time of readmission, our current systems are unable to differentiate between a readmission for a reason connected to a prior episode of care, or one that relates to a completely different clinical scenario.	**COMPLETED:** It is recognised that monitoring readmission rates is challenging without appropriate clinical input to provide context and validate findings. As a result, bespoke data analyses are

period of time. Where themes and trends are identified that these are investigated further.	CHKS, which is the national benchmarking solution choice for Wales looks at the number of patients who have been readmitted regardless of specialty, consultant, diagnosis etc. This makes any analysis difficult to interpret or perhaps meaningless. The planning department is currently working with clinical teams to develop a number of meaningful measures to determine and understand readmission trends, and to identify where improvement is required. A number of data viewers have been developed and can provide 'bespoke' data by request. Moving forward, these measures will be included within the outcome measures and QPS insights. The Health Board has dedicated services to address frequent or 'high impact' service users that are working across Divisional Boundaries to provide alternative pathways. There is also a workstream focusing on patients at high risk of readmission supported by Lightfoot data and linked to goals 1 and 2 of the 6 Goals for Urgent & Emergency Care programme.	undertaken on an as-needed basis to support specific areas of work, ensuring that insights are clinically informed and meaningful.

2024 Discharge Planning Progress Update Audit Wales		
Recommendation	**Management Response**	**Status**
1.1 The Health Board should ensure future and updated tools to support discharge pathways are developed with partners (where relevant), communicated to staff and displayed prominently on wards.	1.1a Policy: • The Health Board will review its Discharge Policy in light of the new National Policy published in September 2024. • The Policy will include standard operating procedures (SOP) for Discharge to ensure that there is clarity for staff. • A communication plan for staff, partners and managers will be completed, and posters forward areas will be developed which set out simply the SOPs.	**COMPLETED:** Tools supporting discharge (CWS2, OHFF rollout, 'Ask Annie' app, and digital dashboards) have been co-developed with partners and shared with staff through communication and training sessions. Ward visibility has improved with posters and digital tool access
	1.1b Clinical Workstation 2 (CWS2), which is currently being rolled out across the health board has the functionality to assign the correct pathway to each patient: this will integrate with Qlik to ensure daily live capture of patient pathways.	**COMPLETED:** CWS2 digital application rolled out across all sites, weekly compliance monitoring, monthly submission of data to WG
	1.1c Complex List' to be developed into CWS2 with daily data feedback, local authority and health staff to have access to the digital system.	COMPLETED: Tools supporting discharge (CWS2, OHFF rollout, 'Ask Annie' app, and digital dashboards) have been co-developed with partners and shared with staff through communication and training sessions. Ward visibility has improved with posters and digital tool access
	1.1d Agreement has been reached to develop an app called 'Ask Annie: this app will provide access to information on Integrated Discharge Pathways and Services. This app is in the early stages of development.	**COMPLETED:** Community Directory of Services Options appraisal to Integrated Discharge Board, option to progress with TPX Impact £53k,

		progress interim internal solution aligned to SPoA and discharge planning
	1.1e A series of workshops are planned to develop a single integrated pathway for Discharge – this will aim to reduce complexity and duplication by creating single access points for discharge services and advice and guidance. This follows a successful piece of work on integrating front door pathways.	**COMPLETED:** Community Directory of Services Options appraisal to Integrated Discharge Board, option to progress with TPX Impact £53k, progress interim internal solution aligned to SPoA and discharge planning
	1.1f An optimal ward project 'Perfect Ward' is planned which will right size the processes, capacity and capability within ward environments to optimise patient flow and discharge.	**COMPLETED:** "Tools supporting discharge (CWS2, OHFF rollout, 'Ask Annie' app, and digital dashboards) have been co-developed with partners and shared with staff through communication and training sessions. Ward visibility has improved with posters and digital tool access."
	1.1g Audit and evaluation of the Discharge improvements, plans and pathways will be undertaken post implementation.	**COMPLETED:** Evaluation of Optimal Ward Pilot undertaken
	1.1h A patient discharge leaflet will be developed to reinforce the 'what matters' conversation and discharge planning at point of admission.	**COMPLETED:** Discharge planning leaflet signed off and shared with Divisional nurses and ward staff
	1.1i The Health Board and its partners have secured additional funding to pilot the Balancing Rights and Responsibilities Training – the first cohort took place in November 2024 and following evaluation will be embedded within the discharge programme.	**COMPLETED:** Balancing Rights and Responsibilities Training undertaken across health and social care and evaluation workshop held to discuss next steps
	1.1J Further review of the training for new registrants and additional update training will be scoped in the context of the above training and the development of the app.	**COMPLETED:** Tools supporting discharge (CWS2, OHFF rollout, 'Ask Annie' app, and digital dashboards) have been co-developed with partners and shared with staff through communication and training sessions. Ward visibility has improved with posters and digital tool access."
	1.1k Embedding of the Optimal Hospital Flow Framework across all sites – Red to Green, SAFER, D2RA, Deconditioning	**COMPLETED:** Optimal Ward Model piloted at three wards at RGH • Roll out of optimal ward model across all sites and wards to start 4th August and completed by end of March 2026

2.1 The Health Board should strengthen arrangements for managing patient transport by ensuring staff have easy access to relevant transport policies and information and their use is monitored to ensure they are operating as intended	Review current guidance on transport booking that is on the Intranet and update as required. • Develop communication plan with the Health Board's Communications Team to disseminate information across the Health Board. • Roll out renewed guidance to service users. • Discuss potential for live reporting system the National NEPTS Delivery Action Group and Joint Commissioning Committee.	**COMPLETED:** Ambulance transport arrangements intranet site containing all information updated; guidance sent to Flow Centre & Ops Teams as points of contact for wards
2.2 The Health Board should strengthen arrangements for managing patient transport by putting in place a formal mechanism to monitor waiting times for patient transport to enable any themes to be highlighted and challenges to be addressed.	Utilise current WAST reports available to provide monthly updates on waiting times and themes. Arrange for standing agenda item at Tier 3 Transport Group meeting. • Discharge Lounges to be operational across all sites, to ensure timely patient transport.	**COMPLETED:** Discharge lounges operational at GUH, RGH & NHH. All transport concerns & themes are generally raised by the relevant sites & reported into the GUH System Lead for onward escalation. Monthly reporting from WAST shows performance; discussed at local & national forums. ""Live reporting for discharges & tranfers is in the process of being rolled out operationally by WAST. Names of relevant staff who will require access have been passed to WAST for set up. Transfer Lounge at GUH now undertaking all D&T bookings on behalf of the GUH site; increased visibility & monitoring now enabled."
3.1 The Health Board should work with its local authority partners to identify ways of providing staff with up-todate information on waiting times for needs assessments for community-based services and the lead in time for those services to commence.	3.1a Further work to improve the flow of information will be addressed through the 'Perfect Ward' project which will create the optimal environment for clinical teams working with social care colleagues to optimise discharge.	**COMPLETED:** Optimal Hospital Flow Framework has been rolled out across all site during 2025/2026
	3.1b Agreement has been reached to develop an app called 'Ask Annie': this app will provide access to information on Integrated Discharge Pathways and Services. This app is in the early stages of development.	**COMPLETED:** Community Directory of Services Options appraisal to Integrated Discharge Board, option to progress with TPX Impact £53k, progress interim internal solution aligned to SPoA and discharge planning
	3.1c The Integrated Discharge Board will be formalised as a Tactical subgroup of the RPB. It is intended and has been agreed that greater transparency in reporting will be developed. A dashboard providing access to waiting times for community assessment and service availability will be included.	**COMPLETED:** IDB continue to monitor performance through performance data
	3.1d Weekly review of Pathway of Care Delays, patients over 100 days, working local authority partners.	**COMPLETED:** A weekly review is undertaken of the top 20 longest-staying patients across all sites, in partnership with Local Authority colleagues. Emerging themes and learning are shared through the Integrated Discharge Board to support system improvement.

		Weekly ‘fishbowl’ and length of stay meetings are held across acute and community sites, with attendance from Local Authority partners. These meetings focus on discharge delays and the required lead in times for services, ensuring timely escalation and action.""""

ABUHB Ref Number	Audit Type	Report Title	Assurance Rating	Responsible Executive Director	Recommendation Priority	Recommendation Number	Recommendation	Management Response	Responsible Handler	Original Completion Deadline	Proposed Revised Deadline	Date Revised Deadline accepted by Committee	Original completion date status	Revised Deadline Status	Number of Revised Timescales	Progress of work underway	Barriers to implementation	Evidence to complete or close recommednation	Reporting Date
ABUHB-2425-16	Internal Audit	Records Management	Limited	Director of Digital	High		Paper records From our sample review of records for 90 patients we found evidence of poor records management. We also found issues, such as records not being kept in chronological order, files overflowing and the absence of patient IDs on certain records. We came across two instances where multiple patient records were bundled together in one file.	Agreed Action: Although it is not evidenced that ward clerks were in place in each of these wards, the lack of records management does require to be addressed across the organisation. The service has previously requested for local health records management training to be mandatory. This was not approved and therefore there is limited engagement at Health Records Awareness sessions that are scheduled bi-monthly. We recommend mandated Health records management training for all ward clerks during induction, alongside refresher sessions, to provide a more in-depth understanding of the processes involved. Although there is a national Health records Management Module incorporated in the mandatory Information Governance training,this does not provide in-depth records management training in ABUHB processes. We are implementing a schedule of ward visits and training updates across the Health Board, to promote best practice and provide evidence of where there are gaps that need to be addressed but there is a resource gap to undertake extensive training across all sites. Discussions will be held with the Executive Director of Nursing on including some of these elements in the Ward Accreditation Programme.Expected Evidence of Implementation:Microsoft list with information on all wards and scheduled dates to visit, to commence from 21/02/2025. Microsoft form designed to gather information from the ward clerks across the HealthBoard regarding current records management processes, which we can analyse. A formal report can be generated from these findings.We can proactively support wards with records management training based on the evidence from the ward visits but there is a resource gap to undertake extensive training across all sites.	Head of Health Records - DHR	31/12/2025	30/06/2026		Not Yet Due		2	January 2026 Update - 63 ward visits completed between April & November 2025. Feedback received from ward clerks and action taken in response to this to support and share best practice. The DHR service launched The Health Records Support Network via Microsoft Teams now with almost 100 members. This network provides a space for sharing records management resources, access to policies, standard operating procedures, best practice guides and access to video resources created by the service on the NHS Wales Records Management Code of Practice. From October 2025, Health Records Management is presented in The Journey of Excellence Corporate Induction for newly qualified nurses, The FP1 programme for junior doctors and in presentations to new cohorts of overseas nurses focusing on effective records management and best practice. Bi-monthly health records awareness sessions continue to be scheduled in collaboration with colleagues from clinical coding, Information Services, Cyber security and Information Governance. The Deputy Head of Nursing agreed that records mangement training will be added to the compliance criteria for ward accreditation. The ABUHB Employee Handbook has been updated with details for new staff joining the organisation on how to access health records awareness sessions, where to find record management policies and resources on AB Pulse and how to join the Health Records Support Network.			30/09/2025
ABUHB-2425-16	Internal Audit	Records Management	Limited	Director of Digital	Medium	3.1	System alerts We found some examples where mental capacity limitations are not always accurately reflected on CWS. While there are warning flags available in the system to alert system users about specific conditions of a patient, these flags are required to be switched on manually. We found six patients where the "This is me" document was on file, but no flag was turned on within CWS. We also note that Lasting Power of Attorney (LPA) is listed as a clinical alert in CWS, which links through from WPAS keynotes. This alert is added to WPAS by the Health Records Team when the LPA document is received for scanning, and this should also be recorded at ward level when documents are presented.	Agreed Action: We recommend that this forms part of the basic WPAS training for new starters, and also the refresher WPAS training. We will link in with the WPAS systems team to ensure this is incorporated into the new training packages that are being developed as part of the Planned Care Academy work. Expected Evidence of Implementation: Evident in training and guidance documentation for all staff.	Head of Health Records - DHR	30/06/2025	30/11/2026	28/04/2026	Overdue	Not Yet Due	4	The proposal has been developed but funding not yet identified			30/09/2025
ABUHB-2425-16	Internal Audit	Records Management	Limited	Director of Digital	Medium	4.1	Spot checks Spot checks of patient records are conducted regularly; however, these assessments primarily take place at or near the final stages of the digitalisation process or following its completion. As a result, it is challenging to address any issues identified at this point of the time.	Agreed Action: The Information Governance Team are in the process of gaining approval for an internal audit team who will undertake regular spot checks on wards, with data quality and record keeping being part of the remit. Expected Evidence of Implementation: Audit reports from the newly established IG Audit team.	Head of IG & DPO	31/03/2026	31/01/2027	28/04/2026	Overdue	Not Yet Due	1	March 2026: March 2026: Progress continues across the WPAS training workstream, with core lesson plan development moving forward and wider training materials being refreshed to ensure consistency and alignment with current operational requirements. Userguides are undergoing further revision, and related updates on ABPulse. Phase one of the training programme remains fully operational, supported by the booking app and appropriate training facilities, and additional materials are nearing completion. Planning is progressing for the next phase of refresher and review activity, which is helping to broaden the overall training offer. Work is also underway to strengthen organisational support through RBC's dedicated training resource, to support raising awareness and promote consistent standards across booking processes. A Training Hub has been developed within the RBC ABPulse page, providing a central repository for standard operating procedures. Functionality within WPAS to prompt users to check keynotes is being explored, with ongoing engagement across other Health Boards already using this feature.			30/09/2025
ABUHB-2425-16	Internal Audit	Records Management	Limited	Director of Digital	High	5.1	Security of patient records NHH: The B3 storage block and related courtyard remained shared with Works & Estates. We also found that the gate to the courtyard was left wide open, and recyclable materials, including metals and cardboards were deposited in the area. Additionally, a couple of vehicles were parked in the courtyard. The lift to the Filing library had been out of service for the past two months, with maintenance staff actively working on it. As a result, we were asked to access the library through the back door. While the lift is equipped with a digital lock and is located within the building, the back door, opens from the courtyard, and was operated by a single metal key. Furthermore, we note that on the day of our visit, one of the keys to the backdoor was with OTIS (the lift contractors), and the other key was with Works & Estates. Subsequently to our visit, we were told that the parts to the lift was ordered, and the repair was scheduled to be completed on 14/01/2025. St. Cadocs: Although we did not observe any files stored in the corridors during this visit, we noted that several of the entrance doors remained outdated and did not provide adequate security to patient records.	Agreed Action: The B3 storage block at Nevill Hall has been a communal area, shared with Works & Estates, for 20+ years. The courtyard area is a service area for works & estates with vehicular access required. Access is also required for delivery of records into this facility. The gates are locked out of hours. This area is for archived records, therefore limited access by health records staff. Records are stored in terminal digit order, therefore access to the WPAS system is required to access a specific record. This reduces the risk of unauthorised disclosure. Works & Estates staff are bound by the same rules of confidentiality as all Health board staff. However, the issues found at Nevill Hall Hospitalwill be reviewed and an action plan developed whilst the wider scanning project continues. Following review individual action items will be added to the audit recommendations tracker. The lift to the filing library is now repaired andoperational.The Mental Health Business case has been approved with 3 WTE, and a program of work is due to commence to start andremove records from St Cadocs for scanning. Priority will be given to areas that have inadequate security. Work is ongoing to configure the XDS Intelliscanner software and electronic document management system with the new categories required, and AD groups are required to be configured for some services. When the scanner configuration and groups are tested and assured, we will commence. Standard operating procedures and work packages will be developed. A group has been setup to develop options for the future of online house when lease expires in October 2026. Expected Evidence of Implementation:Reduction of records held at B3 due to the ongoing destruction process and at St Cadocs due to scanning.	Head of Health Records – DHR	31/12/2027			Not Yet Due		0				30/09/2025
ABUHB-2425-16	Internal Audit	Records Management	Limited	Director of Digital	High	6.1	Storage conditions We found that storage conditions at St. Cadocs were inappropriate (e.g. leaks through the ceiling, high humidity levels etc). We also found incorrect storage practices in operation to store patients' records (e.g. collapsing boxes, loose patients' records) creating opportunities for unauthorised access to patients' files). These issues at St. Cadocs were in-line with our previous findings.	Agreed Action: The Mental Health Business case has been approved with 3 WTE, and a program of work is due to commence to remove records from St Cadocs for scanning. Priority will be given to areas that have inadequate security. Work is ongoing to configure the scanners with required categories and when this is complete,work will begin. Alternative locations for St Cadocs records will be investigated whilst the wider scanning project continues. Expected Evidence of Implementation: Reduction of records in St Cadocs will reduce over time when scanning commences.	Head of Health Records - DHR	31/01/2030			Not Yet Due		0				30/09/2025
ABUHB-2425-16	Internal Audit	Records Management	Limited	Director of Digital	High	7.1	Access to paper records We reviewed records for 90 patients from 18 different wards (see ward details listed under objective 2), we found the following issues: Ref Description of the issue Number of patients 1 The alive / deceased patient file was not sent for scanning. - 47 2 The patient was not formally discharged within 24 hours after left the hospital in CWS,and physical records were left behind at the ward. - 4 3 The Patient was transferred without physical patient record within the HB. - 4 4 The Patient was transferred with the physical records within the HB, but the DHR files were not tracked to the new location in WPAS. - 4 5 No patient file was raised in WPAS during the inpatient period or after the discharge at the time of our visit. -10 6 Various supplementary paper records left behind after the patient's DHR file was sent for scanning. - 8 We note that many of the issues outlined above resulted from the pro-longed absence of the local ward clerk (for example: • no ward clerk worked at the Cas Gwent ward at Chepstow Community Hospital in the last 6 months; or • the Health Records Services were provided by temporary staff who had no access to any of the health records systems (e.g. WPAS and CWS).	Agreed Action: The lack of records management does require to be addressed across the organisation. The service has previously requested for local health records management training to be mandatory. This was not approved and therefore there is limited engagement at Health Records Awareness sessions that are scheduled monthly. We recommend mandated Health records training for all ward clerks during induction to provide a more in-depth understanding of the processes involved. We are implementing a schedule of ward visits and training updates across the Health board to promote best practice and provide evidence of where there are gaps that need to be addressed but there is a resource gap to undertake extensive training across all sites. A board development session will also be undertaken on records management to improve support by the executive team and independent members. Expected Evidence of Implementation: A Microsoft list with information on all wards and scheduled dates to visit, to commence from 21/02/2025. Microsoft form to gather information from the ward clerk regarding current processes which we can analyse and support where required. A formal report can be generated from these findings The Information Governance Team are in the process of establishing an internal audit team who will undertake regular spot checks on wards, with data quality and record keeping being part of the remit.	Head of Health Records – DHR	31/12/2025	31/07/2026	28/04/2026	Overdue	Not Yet Due	4	March 2026 Update: Completed ward engagement visits, providing hands on support and advice to ward clerks with issues that were reported in the Audit. Following feedback from ward clerks, who reported uncertainty with role expectations and records management standards, The Health Records Support Network was established. This network enables real time advice, best practice sharing and access to Standard Operating Procedures. The Network has introduced a Monthly "Spotlight on" feature where a topic, issue or prrocess is selected to share tips and best practice. Supplementary health records management training has been integrated into Corporate Induction for newly qualified nurses & ward accreditation. This training directly addresses issues with access to paper records and provides best practice guidance for nurses and ward managers. A proposal presented to the Core Learning Committee in February 2026 to make this training mandatory for specific staff groups is currently awaiting decision. A Health Records Survey was shared with all General Managers (Open November 2025 - April 2026) and the insights will be used to help shape improvement activity, and create a comprehensive Health Records Standards Plan. A contingency plan for ward clerk absences has been shared with Senior Divisional Nurses, outlining responsibilites and the process on how to notify The DHR service of ward clerk long term absences. The DHR service remains committed to continue these actions, improvements and engagement efforts to support continuous improvement and open communication.			30/09/2025

ABUHB-2425-22	Internal Audit	Intelligence Led Organisation	Reasonable	Director of Digital	Medium	2.1	A Data Quality Policy should be developed to underpin the commitments made within the Data, Analytics and Information Strategy and to act as an actionable statement of intent to all staff.	A formal data quality policy will be developed alongside a proposal for an audit team within Digital, Data & Technology to provide assurance over implementation and compliance.	Chief Information Officer	30/09/2026	30/09/2026	28/04/2026	Overdue	Not Yet Due	2	OCP still to be completed. The DQ policy will follow when the OCP is completed.			30/09/2025
ABUHB-2425-22	Internal Audit	Intelligence Led Organisation	Reasonable	Director of Digital	High	3.1	Management should ensure that all information products produced outside of Information Services clearly indicate where definitions differ from the standard.	Through the implementation of the Data & Analytics Information Management Strategy a Centre of Excellence will be established led by the Chief Information Officer to ensure outputs where relevant comply with standards and a ABUHB "kitemark" will be added to reports so this will be clearly visible.	Chief Information Officer	31/07/2025	30/09/2026	28/04/2026	Overdue	Not Yet Due	1	Data strategy launch is scheduled for 13th May. The |CoE will be established followuing this launch.			30/09/2025
ABUHB-2425-23	Internal Audit	Technical Continuity	Reasonable	Director of Digital	Medium	1.1	Old Equipment There are a number of old switches which are at, or coming to end of life and which contain risks and vulnerabilities, although we note ongoing work to update these. Similarly, although there are only a small number of out of support servers, with work ongoing to resolve, there are a large number of 2016 servers, for which support ends in 2027.	Agreed Action: Noted. As stated, there is a continuous programme of works to replace end of life equipment and included within digital priority list to obtain the necessary funding that is required. Similarly on servers there is a continuous programme of works to update/remove servers where the operating systems approaches end of life. Expected Evidence of Implementation: Through the cyber security report	Head of ICT	31/01/2027			Not Yet Due		0				30/09/2025
ABUHB-2425-23	Internal Audit	Technical Continuity	Reasonable	Director of Digital	High	2.1	Switch Patching There is currently no report or process to monitor patching compliance within the switching estate. Our testing noted that not all switches are running the latest approved software, with some running old versions which contain security vulnerabilities, including critical ones.	Agreed Action: Partially Agreed. ABUHB does have a network patching framework process in place which is in line with ABUHB Cyber Security Patch Management Policy. As part of our network support contract, we will be implementing network collector that provides patching compliance. Expected Evidence of Implementation: Through the cyber security report	Head of ICT	30/06/2026	30/06/2026	28/04/2026	Overdue	Not Yet Due	1	March 26 - Resource constrainst with re-prioritising workloads and activities has delayed progression of this. The challenges with enabling Firewall rules which has now been overcome, our partner Block Solutions now need to complete their work to bring this service online			30/09/2025
ABUHB-2425-23	Internal Audit	Technical Continuity	Reasonable	Director of Digital	Medium	3.1	Application Record There is no full record of applications in use within the Health Board and the tier to which they belong, as such, clarity and understanding of RTO/RPO within the services may be lacking, neither is there a clear prioritised order to systems to be restored that is based on a business impact analysis and agreed with the services.	Agreed Action: Agreed. Service Management is documenting the services and CIs that we are aware and appreciate that there is more to uncover. In conjunction with our Business Continuity Lead we will ensure this is captured alongside the agreed tier they belong to in the Service Catalogue. For new services on-boarded this will be included in the service transition process going forward. Expected Evidence of Implementation: Service catalogue	Head of digital service management	30/06/2026			Not Yet Due		0				
ABUHB-2425-23	Internal Audit	Technical Continuity	Reasonable	Director of Digital	Medium	4.1	Application Disaster Recovery There is a lack of clarity over application-level disaster recovery plans. Application-level disaster recovery plans offer the necessary granularity and specific instructions for dealing with application-specific issues and edge cases, and enable communication of agreed recovery targets.	Agreed Action: Agreed. For in-house developed applications/services we will ensure service owners will have the necessary level of instructions in place to meet the agreed recovery targets. There are over 200 services and implement on a risk priority basis. In conjunction with our Business Continuity Lead, we will establish those agreed recovery targets.	Head of Digital Service Management	31/12/2026			Not Yet Due		0				

ABUHB-2425-24	Internal Audit	EDRMS	Reasonable	Director of Digital	Medium	1.1	E forms The lack of eForms functionality means the approach remains focused on paper transformation rather than true paper avoidance.	Agreed Action: Limited development of eForms took place prior to 2019, after which responsibility for development transferred to the informatics budget, and the Health Board's software development team. Since 2018/19, linear eForms have been available within Clinical Workstation, the Health Board's clinical portal, and are in regular use. However, this functionality is outdated and poses a risk to the organisation. To address this, a business case is being developed to procure a replacement eForms and workflow solution. This will enable form and workflow development in both inpatient and outpatient settings supporting clinical safety, productivity and efficiency benefits. This will also release DHR capacity to focus on digitising historical paper records for mental health and learning disabilities services as they transition to the new EPR in 2026. With the roll out to primary & community care services, in the futureFurther reductions in paper usage will also be achieved through the implementation of national applications, such as Welsh Nursing Care Record (WNCR) Badgernet for Maternity services, subject to their respective implementation roadmaps. Expected Evidence of Implementation: • Reduction in use of inpatient and outpatient supplementary scanning in acute care settings. • Reduction in the use of paper forms • Increase in the use of eForms	Head of Digitised Health Records Service	31/05/2026			Not Yet Due		0				
ABUHB-2425-24	Internal Audit	EDRMS	Reasonable	Director of Digital	High	2.1	Current suitability A lack of upgrades has meant that the Health Board is on an old, unsupported version of cCube which is not able to provide modern functionality and interoperability with other clinical systems. Consequently, the system has not evolved with organisational requirements.	Agreed Action: The Health Board acknowledges that remaining on an unsupported version of cCube limits functionality and interoperability with other clinical systems and no longer meets organisational requirements. Progression to the required version, 4.4, is dependent on amendments to an API code by the Health Board's software development team however, internal development required to progress with the upgrade will not be completed prior to September 2025. Further development planning sessions are scheduled for September 2025 to agree a timeline for completion of the upgrade. However, completion is dependent on approval of the CWS Risk Business Case and the reorganisation of the service to establish a core support team to undertake the required API amendment. Subject to these dependencies, completion is estimated for early 2026/27. A risk has been raised relating to cCube on the directorate risk register: • 1829 – cCube out of support (Score 6)Support is provided by the supplier for issues although no development requests can be submitted. Expected Evidence of Implementation: Successful upgrade of the Noveva software group (formerly known as cCube solutions) Electronic Document Management System and corresponding capsure scanning software to the latest version 4.4.	Head of Digitised Health Records Service	31/05/2026			Not Yet Due		0				
ABUHB-2425-24	Internal Audit	EDRMS	Reasonable	Director of Digital	High	3.1	Servers: cCube is hosted on Windows Server 2012 R2, which is now unsupported and exposed to known security vulnerabilities.	Agreed Action: The Health Board acknowledges that cCube is currently hosted on Windows Server 2012 R2, which is unsupported and presents known security vulnerabilities. To mitigate this risk in the short term, Extended Security Update (ESU) support has been applied to the web and importer servers for a 12-month period, as confirmed by the Business Systems Unit. This provides continued security patching and reduces the immediate exposure.For the long term, a business case and upgrade plan are in place to move to cCube version 4.4, which will run on a supported operating system. Progression to the required version, 4.4, is dependent on amendments to an API code by the Health Board's software development team however, internal development required to progress with the upgrade will not be completed prior to September 2025. Subject to this dependency, migration to the supported version and operating platform is expected thereafter. A risk has been raised relating to cCube on the directorate risk register: • 1739 – cCube Cyber Security Vulnerability (Score 12)Standard mitigations have been put in place by our Cyber Security Team to ensure the system is protected from cyber security threats and support is provided by the supplier for issues although no development requests can be submitted. Expected Evidence of Implementation: Successful upgrade of the Noveva software group (formerly known as cCube solutions) Electronic Document Management System and corresponding capsure scanning software to the latest version 4.4.	Head of Digitised Health Records Service	31/05/2026			Not Yet Due		0				
ABUHB-2526-04	Internal Audit	Subject Access Requests	Limited	Director of Digital	Medium	1.1	Policies and Procedures A total of 23 documents were tested, a mixture of Procedures, Standing Operating Procedures (SOPs), guides, factsheets, flowcharts, and a handbook.The main four themes drawing out of the review were: • Documents requiring review – Four documents were due for review and needed to be assessed to ensure they are up to date and in line with GPDR legislation. • Legal timeframes - Documents incorrectly used a fixed28-day deadline instead of the legally required "one calendar month" under UK GDPR Article 12(3). This needs to be used consistently. • ID verification - Several documents lacked explicit protocols for verifying the identity of requesters, especially in cases involving third-party representatives. Inadequate verification increases the risk of unauthorised access or disclosure of personal data. • Third party information - Many SOPs did not clearly define how third-party data was redacted, shared, or exempted. This runs the risk of unlawful disclosures, lack of transparency, and failure to meet GDPR principles. • Terminology – Various documents may use different terms, such as AHR or ATHR, to refer to the Access to Health Records team. Documents should be consistent –to avoid ambiguity. There needs to be a review on all SAR related documents to ensure they align with GDPR legislation and there is consistency.	Agreed Action: • Conduct a full review of all SAR related documents (procedures, SOPs, flowcharts, handbook) to ensure compliance with UK GDPR and internal policy. • Replace all references to '28 days' with 'one calendar month'. • Implement a consistency check across all documents. • Add explicit steps for verifying identity of requestors, including 3rd party representatives. • Include guidance on acceptable forms of ID and escalation procedures for insufficient verification. • Define clear processes for redacting, sharing, or exempting 3rd party information. • Use a single term: Access to health records. • Schedule annual reviews and maintain a version log control. Expected Evidence of Implementation: • Provide a list of revised documents with version numbers, review dates, and sign off. • Maintain a log showing amendments made. • Evidence that staff have been trained on updated procedures.	Assistant Director of Digital Governance & Assurance / DPO	30/09/2026			Not Yet Due		0				
ABUHB-2526-04	Internal Audit	Subject Access Requests	Limited	Director of Digital	Medium	2.1	Subject Access Request Process Walkthroughs were completed with both the IG and AHR teams, there was a process in place within both teams regarding SAR requests. Audit testing found the records held were detailed and complete. Testing of 22 cases (12 IG and 10 AHR) found: • Three IG cases were not acknowledged within two working days – two of which were because of a request for more information and/ or consent was needed to proceed. Once this information/ consent was received, they were then acknowledged within 24 hours.	Agreed Action: • Reinforce the requirement that all SAR requests must be acknowledged within 2 working days, even if consent is pending. • Amend SAR related SOPs to include guidance for interim acknowledgements when requests are incomplete. • Introduce weekly compliance checks to monitor acknowledgement times. Expected Evidence ofImplementation: • Copies of revised SOP's showing interim acknowledgement step. A monitoring log showing acknowledgement times for SAR cases over a defined period. • Evidence that A2HR & IG teams have been briefed on the updated process	Assistant Director of Digital Governance & Assurance / DPO	30/09/2026			Not Yet Due		0				
ABUHB-2526-04	Internal Audit	Subject Access Requests	Limited	Director of Digital	High	3.1	Inaccurate reporting The September 2025 reported figures were reviewed for the AHR Halo and the IG Civica systems. Overall, the testing identified one breach reported over the two data sets with the Putting Things Right (PTR) team involvement. Whilst the overall reported figures were found to be reconcilable to the source data, some discrepancies were identified in respect of the closing dates: • Three discrepancies (incorrect dates entered) were identified at the Halo system – all were subsequently investigated and corrected on the system. • Four discrepancies (case extensions within the records should have been updated) in the Civica system were identified where requests were closed on the system beyond the expected closure date. The above were addressed during the audit. Furthermore, analysis indicated that the report generated by the Civica system documented 621 closed requests, while the system's internal records reflected a total of 637 closed requests. This is currently being investigated in conjunction with the system provider.	Agreed Action: • Implement a mandatory validation step for closing dates and case extensions before finalising SAR records in both Halo and Civica systems. • Introduce a monthly reconciliation process between reported figures and source data to identify discrepancies early. • Work with Civica system provider to investigate the discrepancy between reported closed requests (621) and internal records (637). • Update SOPs to include: o Double-check of closing dates o Clear guidance on recording case extensions o Ensure A2HR & IG teams follow consistent data entry practises. Expected Evidence of Implementation: • Copies of revised SOPs with new validation steps. • Monthly reporting demonstrating reconciliation between system data and reported figures. • Evidence that A2HR & IG teams have been briefed on the updated process.	Assistant Director of Digital Governance & Assurance / DPO	31/12/2026			Not Yet Due		0				

ABUHB-2526-04	Internal Audit	Subject Access Requests	Limited	Director of Digital	High	4.1	Appropriate checks Audit testing verified processes were in place with regards to appropriate checks for identification, clarification, and review of information before release. Of the twelve IG cases tested, there was one case where ID was not requested and not identified – this was attributed to an error during a period of staff training. This was not identified internally and accordingly had not been investigated/ reported. The team should ensure that independent checks are periodically undertaken to confirm that ID verification has been requested - particularly where staff may be training.	Agreed Action: • Implement a quarterly audit of SAR cases to confirm ID verification has been requested and documented. • Amend SAR SOPs to explicitly require ID verification for all requests, with no exceptions. • Add a control step for supervisors to review ID verification during case sign off. • Incident Reporting: establish a process for immediate reporting and investigation of any missed ID verification. Expected Evidence of Implementation: • Produce audit reports quarterly showing compliance rates and any corrective action taken. • Copies of revised SOPs. • Evidence that A2HR & IG teams have been briefed on the updated process. • Create an incident register of any identified non compliance and actions taken to address them.	Assistant Director of Digital Governance & Assurance / DPO	31/12/2026			Not Yet Due		0				
ABUHB-2526-04	Internal Audit	Subject Access Requests	Limited	Director of Digital	Medium	5.1	Staff awareness and training The overall compliance of IG training for September 2025 was 76% which is below the Health Board target of 85%. In September 2025, Facilities had 50% compliance and Planning had 65%, making them the lowest-performing divisions. There should be more focus on training within the Divisions to ensure compliance meets the Health Board target – with particular focus on the Divisions with lowest compliance.	Agreed Action: • Develop and implement an action plan to raise IG training compliance to meet or exceed the target o85%. • Prioritise Divisions with the lowest compliance. • Enhanced monitoring and reporting. • Assign Divisional Managers responsibility for ensuring staff complete training. Expected Evidence of Implementation: • Training Plan. • Monthly Reports. • Committee minutes showing discussion of compliance performance and agreed actions.	Assistant Director of Digital Governance & Assurance / DPO	30/06/2026			Not Yet Due		0				
ABUHB-2526-04	Internal Audit	Subject Access Requests	Limited	Director of Digital	High	6.1	Complaints and appeals Testing of seven complaints found that six of them were initially processed through the Putting Things Right process: • One had their details checked and driver's licence submitted for verification. • For the remaining five, it was assumed that the PTR team had already verified the requestor's identity. However, it was confirmed that the PTR team had not undertaken these checks. Accordingly, ID check procedures for complaints were inconsistent.	Agreed Action: • Update complaints and appeals procedures to require mandatory ID verification for all cases regardless of whether they originate from the PTR process. • Update SOPs. • Communicate the process to both A2HR and IG staff to ensure consistent application. • Implement a monthly audit of complaints and appeals to confirm to confirm ID verification compliance. • Escalate non-compliance to senior management and record corrective actions. Expected Evidence of Implementation: • Copies of revised SOPs. • Audit report summarising checks over a defined period. • Evidence that A2HR & IG teams have been briefed on the updated process.	Assistant Director of Digital Governance & Assurance / DPO	30/06/2026			Not Yet Due		0				
ABUHB-2526-22	Internal Audit	Cyber Security	Reasonable	Director of Digital	High	1.1	Strategic Risk Register The key controls recorded on the Strategic Risk Register against Strategic Risk 006 Part A (SRR 006A) are cyber security focused, however some are outdated or no longer relevant. The current risk and threat recorded for SRR 006A does not explicitly outline cyber security, although all the key controls for this risk and threat are cyber security focused. This could be updated to raise the profile of the cyber security risk to the organisation. The current risk appetite theme for SRR 006A is 'Service Delivery' which indicates an 'Open' risk appetite level. However, the most appropriate risk appetite theme for cyber security may be 'Compliance and Safety' which has a 'Minimal' risk appetite level, and this would mean the current risk score is outside of the risk appetite for the organisation. and, where appropriate, captured and monitored within the CRR.	Agreed Action: At a strategic level, the Strategic Risk Register (SRR) is intended to capture broad organisational risks, rather than focusing on specific areas. Detailed and operationally focused risks, such as those relating specifically to cyber security are more appropriately captured within the Corporate Risk Register (CRR). This approach ensures that sensitive information and specific control measures are managed securely. The SRR will continue to reflect digital risk at a strategic level, with cyber security risks managed and monitored through the CRR where a more granular level of detail and assurance can be maintained. We recognise that some of the key controls currently listed under SRR 006A are outdated or no longer relevant and a comprehensive review will be undertaken to ensure that: • The risk and key controls remain current, relevant, and aligned to the organisation's risk appetite. • References to cyber security within SRR 006A accurately reflect its role within the wider digital risk landscape. Expected Evidence of Implementation: • Updated version of SRR 006A reflecting refreshed risk, controls • Strategic Risk Reports to the Board and Finance and performance Committee with the updated assessment. • Confirmation that specific cyber security risks have been reviewed	ICT Cyber Security Manager/ Head of Corporate Risk and Assurance	31/01/2026	30/06/2026	28/04/2026	Overdue	Not Yet Due	1	Risk Registers continue to reflect Cyber risk at both Strategic(SRR) and Corporate (CRR) risk levels within the organisation. The Strategic Cyber risk may need amending Risk SRR006A to reflect current cyber threats. Specific detailed Cyber Risks continue to be recorded and reported on at Corporate level with review through Service Delivery and quarterly reviews through the Information Governance Group with further reporting to Risk and Finance by the SIRO if deemed necessary.			
ABUHB-2526-22	Internal Audit	Cyber Security	Reasonable	Director of Digital	Medium	3.1	Staff awareness and training Recent phishing simulations indicate a click rate of 12% across the organisation. The absence of targeted training for compromised staff, combined with mandatory Information Governance and Cyber Security training completion rates falling below the Health Board's 85% target, increases the risk of continued vulnerability. It was suggested that staff awareness should be added as a cyber security risk to raise the profile and ensure further monitoring of progress.	Agreed Action: Management accepts the recommendation and will address the findings through the following actions. • Continue the phishing simulation programme, using the established baseline to drive measurable improvement. • Deliver targeted follow-up training modules to individuals who regularly fail simulations, using tailored content linked directly to the exercises. • Report phishing simulation outcomes monthly through relevant governance groups to support monitoring of staff awareness improvements. • Enhance the visibility of cyber security messaging through regular internal communication and security awareness campaigns. • Work collaboratively with Information Governance, Counter Fraud, and other stakeholders to maximise use of available training resources. • Ensure cyber security staff awareness is appropriately reflected within the corporate risk framework for ongoing oversight. Expected Evidence of Implementation: • Monthly phishing simulation results and reports submitted through governance structures. • Governance and Assurance Group minutes demonstrating review of security awareness materials and outcomes. • Copies of cyber security awareness campaigns and communications issued via multiple channels. • Evidence of a corporate risk register entry to monitor staff awareness as part of the cyber security risk profile.	ICT Cyber Security Manager	31/01/2026	30/06/2026	28/04/2026	Overdue	Not Yet Due	1	Cyber has continued with its simulated phishing exercises and staff failing the exercise receive targeted training as part of the campaign. Procurement of the incumbent Phishing Tool has been approved for three years which will help to increase email security awareness . The tool also has a library of security related training that will also be provided over the next three years and can be utilised by teams other than Cyber. Monthly reporting and trending of phishing campaign outcomes will be provided within the monthly Cyber Security Report. Training compliance for staff has now reached 85% and is continually monitored with an aim to improve levels.			
ABUHB-2526-22	Internal Audit	Cyber Security	Reasonable	Director of Digital	High	4.1	Cyber Incident Response Plan • The Cyber Incident Response Plan highlights that the plan should be tested every six months but his has not been done. • The Cyber Security Team do not have the capabilities, expertise or resources to deal with a cyber event internally and they do not have third-party support formally agreed. • The incident response plan highlights that there should be action cards that define the duties of everyone in the Cyber Incident Response Team (CIRT), however these have not been drafted. • Communications have not been drafted for any audience outside of the Health Board.	Agreed Action: A tailored tabletop exercise will be undertaken within the next three months to specifically test the current Cyber Incident Response Plan, as required. The scenario will incorporate the areas identified in the audit findings, including clarity of team responsibilities, escalation pathways and communication requirements. Following completion, the Cyber Security Team will produce a formal post-exercise report that clearly documents lessons learned and required improvements. These improvements may include the creation of action cards, enhanced external communication arrangements and the securing of specialist third-party cyber support. Learning and feedback from the recent national DHCW exercise will also be reviewed and used to strengthen the Health Board's Cyber Incident Response capability in line with the existing plan. Expected Evidence of Implementation: • Copy of the tabletop exercise scenario • Post-exercise report including improvement actions and implementation owners • Updated Cyber Incident Response Plan testing schedule (2026–27) • Documentation confirming the review and options appraisal for external specialist support (e.g., forensic retainer) • Draft or completed action cards supporting the Cyber Incident Response Team roles and responsibilities • Communications templates developed in collaboration with the Communications Team for external use during a cyber incident.	ICT Cyber Security Manager	31/01/2026	30/06/2026	28/04/2026	Overdue	Not Yet Due	1	A table top exercise(TTX) specifically aimed to test the Cyber Incident Response plan was undertaken in Decenber 2025. Cyber have provided a post exercise report of recomended actions to include the development of action cards to support the incident management process. Cyber also met with KPMG and DHCW where agreement was reached around a process to call off external cyber expertise provided through DHCW by KPMG if required to support cyber incident management and forensic investigation for ABUHB. A schedule of quarterly TTXs are planned for 2026-27			

2020	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R6	R6 Consideration should be given to the placement of all informatics provision and support across the Health Board. As part of this the current partially decentralised model should be re-assessed in terms of its suitability for the modern use of technology.	Accepted. Following the exec review of the Target Operating Framework and overarching governance will appraise the hybrid environment of departmental asset ownership, responsibility, risk management. As the report sets out this is a largely historical and organic model which will be complex to resolve in itself. A risk based approach will be adopted andan options paper will be developed forconsideration by the Board.	Director of Digital	31/12/2022	30/06/2026		Overdue	Not Yet Due	4	"May 2025:No update awaiting Internat Audit work. ""January 2025 Internal Audit have been tasked to undertake a specific audit of Shadow ICT as part of their 2025 audit plan. The organisational change process for Service Management structures is underway and due to complete April 2025.""June 2024: Phase 1 of the structural changes are underway to support formalisation of Service Management structures and WPAS product team. Job description development is underway for senior roles across the directorate. January 2024: The target operating model has been reviewed by the new Director of Digital and a proposal on the revised structure will be presented to the Executive Committee in April 2024. This structure will bring forward some options on the current decentralised model in some departments. "			
2020	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R9	R9 A network of champions across the organisation should be established. The Digital Strategy should be re-issued alongside the roadmap. This should form the basis for engaging the network of champions to drive the Strategy forward.	Accepted-The Channel 3 report also identified a need for more emphasis on Clinical Leadership, Design and Business Partnering. This is subject to additional investment although recently the appointment of a full time CNIO/CSO has been a significant step forward. Outwith the Directorate recommendations will be presented to Execs on overarching exec level oversight which is intended to both strengthen accountability but also to ensure Informatics capacity is used to best effect. Benefits realisation training has commenced in Informatics and will form part of reporting. It is in principle agreed that the Health Board adopts a single methodology and framework that should be co produced to manage all priority investments.	Director of Digital / Assistant Director for Strategy, Planning & Design	30/09/2021	30/06/2026	28/04/2026	Overdue	Not Yet Due	7	All engagement has now completed with a board briefing in April before Public Board approval in May			
2020	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R14	R14 The asset and configuration management processes developed within the Informatics Directorate should be adopted as Health Board wide documents and departments with devolved control required to comply with the requirements.	Accepted. The HB governance, policy and processes will be reviewed as part of the SIROs objectives with resultant recommendations to Board. Informatics will need to review internal processes and capacity to ensure it can scale to meet the challenge.	Director of Digital	31/12/2021	31/07/2026	28/04/2026	Overdue	Not Yet Due	5	March 2026: No progress due to insufficient resources to complete, now the OCP within Service Management this will now be taken forward in the summer.			
2022.12	Internal	Records Managment	Limited	Director of Digital	Medium	R5	R5 The need for records management storage places should be regularly reviewed to ensure that sufficient spaces are available for record keeping purposes.	This issue is to be raised with the All Wales Medical Directors Forum as Caldicott Guardians. The Data Protection Officer will raise this at quarterly meetings with the Medical Director and agree an action plan.	DPO & Head of IG	31/12/2023	30/06/2026	20/05/2025	Overdue	Not Yet Due	3	"""April 2025 - Following recent refreshed audit into Records Management a task & finish sub-group is being setup to ensure any physical issues are identified and remeidated where possible. The scanning of Mental Health paper records has commenced."" August 24 - Continuing issue with mould and water ingress, danger of holes in glass roof within storage area in St Cadocs requires immediate attention as will not be permitted to retrieve or track records from this area following visit by health and safety. Urgent remediation work required and inroads into the digitisation of mental health records as they require long term storage and no suitable premises have been identified. June 2024: Will be considered as part of WPAS product team support and changes, discussions are underway with Chief Operating Officer and Executive Director of Nursing so this can be aligned with the ward accreditation process. Mar 24- Closure of another library of records achieved at Llangennech and move of some mental health, children service records to vacated Antenatal Basement Library to relieve pressures. - Unable to provide a revised timescale at this stage."			
2022.12	Internal	Records Managment	Limited	Director of Digital	Medium	R13	R13 All records should be formally tracked to ensure that they are retrievable when they are needed.	"a.) The Business case for DHR phase 3 is in development, this will include the scanning of paper records to be available to view in CWS/cCube Portal negating the need for tracking. b.) Future phases for community, District Nursing, children's services and therapies are being planned and expedited and tracking will be implemented."	DPO & Head of IG	31/12/2023	30/06/2026	18/09/2025	Overdue	Not Yet Due	7	August 2025 - No resources within directorate to move forward with this recommendation, organisational change process within Service Management is underway and this recommendation will be reviewed once this has completed with resource alignment.Jun 24 Business Case for digitisation of remaining services records awaiting agreement so that work can commence as per R5. Further risk identified where existing tracking on former Epex system has not been fully migrated to WCCIS. Mar 24 - Phase 3 Mental Health, Community, District Nursing, Childrens Services Business case with Director of Digital for review.			
2023.17	Internal	IT Infrastructure	Reasonable	Director of Digital	Low	R4.1	Alert thresholds should be configured to identify relevant issues promptly	"ABUHB accepts this recommendation. Event management and alerting is under review with the aim to provide a consolidated platform (single pane of glass) for all alerts. Once the procedure outlined in 4.2 has been implemented this will be applied to any new infrastructure at install with existing assets being addressed over time."	Head of Ict	31/07/2025	31/07/2026	28/04/2026	Overdue	Not Yet Due	1	March 2026: No progress due to insufficient resources to complete, now the OCP within Service Management this will now be taken forward in the summer.			

2023.17	Internal	IT Infrastructure	Reasonable	Director of Digital	Medium	R.2	"A set of formal procedure documentation and guides for managing the infrastructure should be defined."	"ABUHB accepts this recommendation. There is already a large amount of documentation available for infrastructure management – mostly done to coincide with our Service Desk Institute Audit of policies and processes. Gap analysis will be undertaken to ensure that comprehensive documentation is developed and maintained for all infrastructure services"	Chief Technology Officer	31/07/2024	31/07/2026	28/04/2026	Overdue	Not Yet Due	3	March 2026: No progress due to insufficient resources to complete, now the OCP within Service Management this will now be taken forward in the summer.			
2023.17	Internal	IT Infrastructure	Reasonable	Director of Digital	Low	R6	Consideration should be given to enhancing the use of SolarWinds to enable full network monitoring and the use of the CatTool	"ABUHB partially accepts this recommendation in so far as the need for full network monitoring is recognised and will be addressed. The specific tool to do this will be decided once the event management review outlined previously has been completed"	Chief Technology Officer	31/07/2025	30/06/2026		Overdue	Not Yet Due	0	"""October 2025 - We are collaborating with our SolarWinds partner to scope a platform upgrade, which will enable the use of additional licensed modules and features. The professional services engagement is included in a capital funding request. Block Solutions is implementing the Axiom monitoring platform as part of our support contract, providing enhanced oversight of hardware lifecycle, licensing, and network status. We are also assessing the integration of Cisco's Thousand Eyes for further monitoring capabilities, subject to cost considerations.""April 2025 - No further progress"			

ABUHB Ref Number	Audit Type	Report Title	Assurance Rating	Responsible Executive Director	Recommendation Priority	Recommendation Number	Recommendation	Management Response	Responsible Handler	Original Completion Deadline	Proposed Revised Deadline	Date Revised Deadline accepted by Committee	Original completion date status	Revised Deadline Status	Number of Revised Timescales	Progress of work underway	Barriers to implementation	Evidence to complete or close recommednation	Reporting Date
2020	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R9	R9 A network of champions across the organisation should be established. The Digital Strategy should be re-issued alongside the roadmap. This should form the basis for engaging the network of champions to drive the Strategy forward.	Accepted-The Channel 3 report also identified a need for more emphasis on Clinical Leadership, Design and Business Partnering. This is subject to additional investment although recently the appointment of a full time CNIO/CSO has been a significant step forward. Outwith the Directorate recommendations will be presented to Execs on overarching exec level oversight which is intended to both strengthen accountability but also to ensure Informatics capacity is used to best effect. Benefits realisation training has commenced in Informatics and will form part of reporting. It is in principle agreed that the Health Board adopts a single methodology and framework that should be co produced to manage all priority investments.	Director of Digital / Assistant Director for Strategy, Planning & Design	30/09/2021	30/06/2026	28/04/2026	Completed	Completed	7	All engagement has now completed with a board briefing in April before Public Board approval in May		The proposed funding for a Microsoft 365 product team which would support the digital champions network could not be progressed at this time due to the financial challenges in the organisation. This would potentially now be fulfilled through medium term options looking at regional working and sharing resources with Cwm Taf and Cardiff & Vale Health Boards. Given age of this recommendation, advisory rating and plans for regional opportunities suggest this recommendation is closed.	
2022.12	Internal	Records Managment	Limited	Director of Digital	Medium	R5	R5 The need for records management storage places should be regularly reviewed to ensure that sufficient spaces are available for record keeping purposes.	This issue is to be raised with the All Wales Medical Directors Forum as Caldicott Guardians. The Data Protection Officer will raise this at quarterly meetings with the Medical Director and agree an action plan.	DPO & Head of IG	31/12/2023	30/06/2026	20/05/2025	Completed	Completed	3	"""April 2025 - Following recent refreshed audit into Records Management a task & finish sub-group is being setup to ensure any physical issues are identified and remediated where possible. The scanning of Mental Health paper records has commenced."" August 24 - Continuing issue with mould and water ingress, danger of holes in glass roof within storage area in St Cadocs requires immediate attention as will not be permitted to retrieve or track records from this area following visit by health and safety. Urgent remediation work required and inroads into the digitisation of mental health records as they require long term storage and no suitable premises have been identified. June 2024: Will be considered as part of WRAS product team support and changes, discussions are		This audit recommendation can be closed as it has been picked up in the recommendations from the refreshed audit into records management.	
2022.12	Internal	Records Managment	Limited	Director of Digital	Medium	R13	R13 All records should be formally tracked to ensure that they are retrievable when they are needed.	"a.) The Business case for DHR phase 3 is in development, this will include the scanning of paper records to be available to view in CWS/cCube Portal negating the need for tracking. b.) Future phases for community, District Nursing, children's services and therapies are being planned and expedited and tracking will be implemented."	DPO & Head of IG	31/12/2023	30/06/2026	18/09/2025	Completed	Completed	7	August 2025 - No resources within directorate to move forward with this recommendation, organisational change process within Service Management is underway and this recommendation will be reviewed once this has completed with resource alignment.Jun 24 Business Case for digitisation of remaining services records awaiting agreement so that work can commence as per R5. Further risk identified where existing tracking on former Epex system has not been fully migrated to WCCIS. Mar 24 - Phase 3 Mental Health, Community, District Nursing, Childrens Services Business case with Director of Digital for review.		This audit recommendation can be closed as picked up in recent records management audit ad business case now not being developed as scanning progressing with local resources	
2023.17	Internal	IT Infrastructure	Reasonable	Director of Digital	Low	R6	Consideration should be given to enhancing the use of SolarWinds to enable full network monitoring and the use of the CatTool	"ABUHB partially accepts this recommendation in so far as the need for full network monitoring is recognised and will be addressed. The specific tool to do this will be decided once the event management review outlined previously has been completed"	Chief Technology Officer	31/07/2025	30/06/2026		Completed	Completed	0	"""October 2025 - We are collaborating with our SolarWinds partner to scope a platform upgrade, which will enable the use of additional licensed modules and features. The professional services engagement is included in a capital funding request. Block Solutions is implementing the Axiom monitoring platform as part of our support contract, providing enhanced oversight of hardware lifecycle, licensing, and network status. We are also assessing the integration of Cisco's Thousand Eyes for further monitoring capabilities, subject to cost considerations.""April 2025 - No further progress"		Upgrade to Solarwinds network monitoring completed, configuration of monitoring and alterting, training of staff	

ABUHB Ref Number	Audit Type	Report Title	Assurance Rating	Responsible Executive Director	Recommendation Priority	Recommendation Number	Recommendation	Management Response	Responsible Handler	Original Completion Deadline	Proposed Revised Deadline	Date Revised Deadline accepted by Committee	Original completion date status	Revised Deadline Status	Number of Revised Timescales	Progress of work underway	Barriers to implementation	Evidence to complete or close recommednation	Reporting Date
ABUHB-2425-16	Internal Audit	Records Management	Limited	Director of Digital	High	2.1	Paper records From our sample review of records for 90 patients we found evidence of poor records management. We also found issues, such as records not being kept in chronological order, files overflowing and the absence of patient IDs on certain records. We came across two instances where multiple patient records were bundled together in one file.	Agreed Action: Although it is not evidenced that ward clerks were in place in each of these wards, the lack of records management does require to be addressed across the organisation. The service has previously requested for local health records management training to be mandatory. This was not approved and therefore there is limited engagement at Health Records Awareness sessions that are scheduled bi-monthly. We recommend mandated Health records management training for all ward clerks during induction, alongside refresher sessions, to provide a more in-depth understanding of the processes involved. Although there is a national Health records Management Module incorporated in the mandatory Information Governance training,this does not provide in-depth records management training in ABUHB processes. We are implementing a schedule of ward visits and training updates across the Health Board, to promote best practice and provide evidence of where there are gaps that need to be addressed but there is a resource gap to undertake extensive training across all sites. Discussions will be held with the Executive Director of Nursing on including some of these elements in the Ward Accreditation Programme.Expected Evidence of Implementation:Microsoft list with information on all wards and scheduled dates to visit, to commence from 21/02/2025. Microsoft form designed to gather information from the ward clerks across the HealthBoard regarding current records management processes, which we can analyse. A formal report can be generated from these findings.We can proactively support wards with records management training based on the evidence from the ward visits but there is a resource gap to undertake extensive training across all sites.	Head of Health Records - DHR	31/12/2025	30/06/2026		Not Yet Due		2	63 ward visits completed between April & November 2025. Feedback received from ward clerks and action taken in response to this to support and share best practice. The DHR service launched The Health Records Support Network via Microsoft Teams now with almost 100 members. This network provides a space for sharing records management resources, access to policies, standard operating procedures, best practice guides and access to video resources created by the service on the NHS Wales Records Management Code of Practice. From October 2025, Health Records Management is presented in The Journey of Excellence Corporate Induction for newly qualified nurses, The FP1 programme for junior doctors and in presentations to new cohorts of overseas nurses focusing on effective records management and best practice. Bi-monthly health records awareness sessions continue to be scheduled in collaboration with colleagues from clinical coding, Information Services, Cyber security and Information Governance. The Deputy Head of Nursing agreed that records mangement training will be added to the compliance criteria for ward accreditation. The ABUHB Employee Handbook has been updated with details for new staff joining the organisation on how to access health records awareness sessions, where to find record management policies and resources on AB Pulse and how to join the Health Records Support Network.			30/09/2025
ABUHB-2425-16	Internal Audit	Records Management	Limited	Director of Digital	Medium	3.1	System alerts We found some examples where mental capacity limitations are not always accurately reflected on CWS. While there are warning flags available in the system to alert system users about specific conditions of a patient, these flags are required to be switched on manually. We found six patients where the "This is me" document was on file, but no flag was turned on within CWS. We also note that Lasting Power of Attorney (LPA) is listed as a clinical alert in CWS, which links through from WPAS keynotes. This alert is added to WPAS by the Health Records Team when the LPA document is received for scanning, and this should also be recorded at ward level when documents are presented.	Agreed Action: We recommend that this forms part of the basic WPAS training for new starters, and also the refresher WPAS training. We will link in with the WPAS systems team to ensure this is incorporated into the new training packages that are being developed as part of the Planned Care Academy work. Expected Evidence of Implementation: Evident in training and guidance documentation for all staff.	Head of Health Records - DHR	30/06/2025	30/11/2026	28/04/2026	Overdue	Not Yet Due	4	The proposal has been developed but funding not yet identified			30/09/2025
ABUHB-2425-16	Internal Audit	Records Management	Limited	Director of Digital	Medium	4.1	Spot checks Spot checks of patient records are conducted regularly; however, these assessments primarily take place at or near the final stages of the digitalisation process or following its completion. As a result, it is challenging to address any issues identified at this point of the time.	Agreed Action: The Information Governance Team are in the process of gaining approval for an internal audit team who will undertake regular spot checks on wards, with data quality and record keeping being part of the remit. Expected Evidence of Implementation: Audit reports from the newly established IG Audit team.	Head of IG & DPO	31/03/2026	31/01/2027	28/04/2026	Overdue	Not Yet Due	1	March 2026: March 2026: Progress continues across the WPAS training workstream, with core lesson plan development moving forward and wider training materials being refreshed to ensure consistency and alignment with current operational requirements. Userguides are undergoing further revision, and related updates on ABPulse. Phase one of the training programme remains fully operational, supported by the booking app and appropriate training facilities, and additional materials are nearing completion. Planning is progressing for the next phase of refresher and review activity, which is helping to broaden the overall training offer. Work is also underway to strengthen organisational support through RBC's dedicated training resource, to support raising awareness and promote consistent standards across booking processes. A Training Hub has been developed within the RBC ABPulse page, providing a central repository for standard operating procedures. Functionality within WPAS to prompt users to check keynotes is being explored, with ongoing engagement across other Health Boards already using this feature.			30/09/2025
ABUHB-2425-16	Internal Audit	Records Management	Limited	Director of Digital	High	5.1	Security of patient records NHH: The B3 storage block and related courtyard remained shared with Works & Estates. We also found that the gate to the courtyard was left wide open, and recyclable materials, including metals and cardboards were deposited in the area. Additionally, a couple of vehicles were parked in the courtyard. The lift to the Filing library had been out of service for the past two months, with maintenance staff actively working on it. As a result, we were asked to access the library through the back door. While the lift is equipped with a digital lock and is located within the building, the back door, opens from the courtyard, and was operated by a single metal key. Furthermore, we note that on the day of our visit, one of the keys to the backdoor was with OTIS (the lift contractors), and the other key was with Works & Estates. Subsequently to our visit, we were told that the parts to the lift was ordered, and the repair was scheduled to be completed on 14/01/2025. St. Cadocs: Although we did not observe any files stored in the corridors during this visit, we noted that some of the entrance	Agreed Action: The B3 storage block at Nevill Hall has been a communal area, shared with Works & Estates, for 20+ years. The courtyard area is a service area for works & estates with vehicular access required. Access is also required for delivery of records into this facility. The gates are locked out of hours. This area is for archived records, therefore limited access by health records staff. Records are stored in terminal digit order, therefore access to the WPAS system is required to access a specific record. This reduces the risk of unauthorised disclosure. Works & Estates staff are bound by the same rules of confidentiality as all Health board staff. However, the issues found at Nevill Hall Hospitalwill be reviewed and an action plan developed whilst the wider scanning project continues. Following review individual action items will be added to the audit recommendations tracker. The lift to the filing library is now repaired andoperational.The Mental Health Business case has been approved with 3 WTE, and a program of work is due to commence to start andremove records from St Cadocs for scanning. Priority will be given to areas that have inadequate security. Work is ongoing to configure the XDS Intelliscanner software and electronic document management system with the new categories required, and AD groups are required to be configured for some services. When the scanner configuration and groups are tested and assured, we will commence. Standard operating procedures and work packages will be developed. A group has been setup to develop options for the future of online house when lease expires in October 2026. Expected Evidence of Implementation:Reduction of records held at B3 due to the ongoing destruction process and at St Cadocs due to scanning.	Head of Health Records – DHR	31/12/2027			Not Yet Due		0	No progress update as initial completion date has not yet passed			30/09/2025
ABUHB-2425-16	Internal Audit	Records Management	Limited	Director of Digital	High	6.1	Storage conditions We found that storage conditions at St. Cadocs were inappropriate (e.g. leaks through the ceiling, high humidity levels etc). We also found incorrect storage practices in operation to store patients' records (e.g. collapsing boxes, loose patients' records) creating opportunities for unauthorised access to patients' files). These issues at St. Cadocs were in-line with our previous findings.	Agreed Action: The Mental Health Business case has been approved with 3 WTE, and a program of work is due to commence to remove records from St Cadocs for scanning. Priority will be given to areas that have inadequate security. Work is ongoing to configure the scanners with required categories and when this is complete,work will begin. Alternative locations for St Cadocs records will be investigated whilst the wider scanning project continues. Expected Evidence of Implementation: Reduction of records in St Cadocs will reduce over time when scanning commences.	Head of Health Records - DHR	31/01/2030			Not Yet Due		0	No progress update as initial completion date has not yet passed			30/09/2025
ABUHB-2425-16	Internal Audit	Records Management	Limited	Director of Digital	High	7.1	Access to paper records We reviewed records for 90 patients from 18 different wards (see ward details listed under objective 2), we found the following issues: Ref Description of the issue Number of patients 1 The alive / deceased patient file was not sent for scanning. - 47 2 The patient was not formally discharged within 24 hours after left the hospital in CWS,and physical records were left behind at the ward. - 4 3 The Patient was transferred without physical patient record within the HB. - 4 4 The Patient was transferred with the physical records within the HB, but the DHR files were not tracked to the new location in WPAS. - 4 5 No patient file was raised in WPAS during the inpatient period or after the discharge at the time of our visit. -10 6 Various supplementary paper records left behind after the	Agreed Action: The lack of records management does require to be addressed across the organisation. The service has previously requested for local health records management training to be mandatory. This was not approved and therefore there is limited engagement at Health Records Awareness sessions that are scheduled monthly. We recommend mandated Health records training for all ward clerks during induction to provide a more in-depth understanding of the processes involved. We are implementing a schedule of ward visits and training updates across the Health board to promote best practice and provide evidence of where there are gaps that need to be addressed but there is a resource gap to undertake extensive training across all sites. A board development session will also be undertaken on records management to improve support by the executive team and independent members. Expected Evidence of Implementation: A Microsoft list with information on all wards and scheduled dates to visit, to commence from 21/02/2025. Microsoft form to gather information from the ward clerk regarding current processes which we can analyse and support where required. A formal report can be generated from these findings The Information Governance Team are in the process of establishing an internal audit team who will undertake regular spot checks on wards, with data quality and record keeping being part of the remit.	Head of Health Records – DHR	31/12/2025	31/07/2026	28/04/2026	Overdue	Not Yet Due	4	Completed ward engagement visits, providing hands on support and advice to ward clerks with issues that were reported in the Audit. Following feedback from ward clerks, who reported uncertainty with role expectations and records management standards, The Health Records Support Network was established. This network enables real time advice, best practice sharing and access to Standard Operating Procedures. The Network has introduced a Monthly "Spotlight on" feature where a topic, issue or prrocess is selected to share tips and best practice. Supplementary health records management training has been integrated into Corporate Induction for newly qualified nurses & ward accreditation. This training directly addresses issues with access to paper records and provides best practice guidance for nurses and ward managers. A proposal presented to the Core Learning Committee in February 2026 to make this training mandatory for specific staff groups is currently awaiting decision. A Health Records Survey was shared with all General Managers (Open November 2025 - April 2026) and the insights will be used to help shape improvement activity, and create a comprehensive Health Records Standards Plan. A contingency plan for ward clerk absences has been shared with Senior Divsional Nurses, outlining responsibilites and the process on how to notify The DHR service of ward clerk long term absences. The DHR service remains committed to continue these actions, improvements and engagement efforts to support continuous improvement and open communication.			30/09/2025

ABUHB-2425-22	Internal Audit	Intelligence Led Organisation	Reasonable	Director of Digital	Medium	2.1	A Data Quality Policy should be developed to underpin the commitments made within the Data, Analytics and Information Strategy and to act as an actionable statement of intent to all staff.	A formal data quality policy will be developed alongside a proposal for an audit team within Digital, Data & Technology to provide assurance over implementation and compliance.	Chief Information Officer	30/09/2026	30/09/2026	28/04/2026	Overdue	Not Yet Due	2	OCP still to be completed. The DQ policy will follow when the OCP is completed.			30/09/2025
ABUHB-2425-22	Internal Audit	Intelligence Led Organisation	Reasonable	Director of Digital	High	3.1	Management should ensure that all information products produced outside of Information Services clearly indicate where definitions differ from the standard.	Through the implementation of the Data & Analytics Information Management Strategy a Centre of Excellence will be established led by the Chief Information Officer to ensure outputs where relevant comply with standards and a ABUHB "kitemark" will be added to reports so this will be clearly visible.	Chief Information Officer	31/07/2025	30/09/2026	28/04/2026	Overdue	Not Yet Due	1	Data strategy launch is scheduled for 13th May. The |CoE will be established followuing this launch.			30/09/2025
ABUHB-2425-23	Internal Audit	Technical Continuity	Reasonable	Director of Digital	Medium	1.1	Old Equipment There are a number of old switches which are at, or coming to end of life and which contain risks and vulnerabilities, although we note ongoing work to update these. Similarly, although there are only a small number of out of support servers, with work ongoing to resolve, there are a large number of 2016 servers, for which support ends in 2027.	Agreed Action: Noted. As stated, there is a continuous programme of works to replace end of life equipment and included within digital priority list to obtain the necessary funding that is required. Similarly on servers there is a continuous programme of works to update/remove servers where the operating systems approaches end of life. Expected Evidence of Implementation: Through the cyber security report	Head of ICT	31/01/2027			Not Yet Due		0	No progress update as initial completion date has not yet passed			30/09/2025
ABUHB-2425-23	Internal Audit	Technical Continuity	Reasonable	Director of Digital	High	2.1	Switch Patching There is currently no report or process to monitor patching compliance within the switching estate. Our testing noted that not all switches are running the latest approved software, with some running old versions which contain security vulnerabilities, including critical ones.	Agreed Action: Partially Agreed. ABUHB does have a network patching framework process in place which is in line with ABUHB Cyber Security Patch Management Policy. As part of our network support contract, we will be implementing network collector that provides patching compliance. Expected Evidence of Implementation: Through the cyber security report	Head of ICT	30/06/2026	30/06/2026	28/04/2026	Overdue	Not Yet Due	1	Resource constrainst with re-prioritising workloads and activities has delayed progression of this. The challenges with enabling Firewall rules which has now been overcome, our partner Block Solutions now need to complete their work to bring this service online			30/09/2025
ABUHB-2425-23	Internal Audit	Technical Continuity	Reasonable	Director of Digital	Medium	3.1	Application Record There is no full record of applications in use within the Health Board and the tier to which they belong, as such, clarity and understanding of RTO/RPO within the services may be lacking, neither is there a clear prioritised order to systems to be restored that is based on a business impact analysis and agreed with the services.	Agreed Action: Agreed. Service Management is documenting the services and CIs that we are aware and appreciate that there is more to uncover. In conjunction with our Business Continuity Lead we will ensure this is captured alongside the agreed tier they belong to in the Service Catalogue. For new services on-boarded this will be included in the service transition process going forward. Expected Evidence of Implementation: Service catalogue	Head of digital service management	30/06/2026			Not Yet Due		0	No progress update as initial completion date has not yet passed			
ABUHB-2425-23	Internal Audit	Technical Continuity	Reasonable	Director of Digital	Medium	4.1	Application Disaster Recovery There is a lack of clarity over application-level disaster recovery plans. Application-level disaster recovery plans offer the necessary granularity and specific instructions for dealing with application-specific issues and edge cases, and enable communication of agreed recovery targets.	Agreed Action: Agreed. For in-house developed applications/services we will ensure service owners will have the necessary level of instructions in place to meet the agreed recovery targets. There are over 200 services and implement on a risk priority basis. In conjunction with our Business Continuity Lead, we will establish those agreed recovery targets.	Head of Digital Service Management	31/12/2026			Not Yet Due		0	No progress update as initial completion date has not yet passed			

ABUHB-2425-24	Internal Audit	EDRMS	Reasonable	Director of Digital	Medium	1.1	E forms The lack of eForms functionality means the approach remains focused on paper transformation rather than true paper avoidance.	Agreed Action: Limited development of eForms took place prior to 2019, after which responsibility for development transferred to the informatics budget, and the Health Board's software development team. Since 2018/19, linear eForms have been available within Clinical Workstation, the Health Board's clinical portal, and are in regular use. However, this functionality is outdated and poses a risk to the organisation. To address this, a business case is being developed to procure a replacement eForms and workflow solution. This will enable form and workflow development in both inpatient and outpatient settings supporting clinical safety, productivity and efficiency benefits. This will also release DHR capacity to focus on digitising historical paper records for mental health and learning disabilities services as they transition to the new EPR in 2026. With the roll out to primary & community care services, in the futureFurther reductions in paper usage will also be achieved through the implementation of national applications, such as Welsh Nursing Care Record (WNCR) Badgernet for Maternity services, subject to their respective implementation roadmaps. Expected Evidence of Implementation: • Reduction in use of inpatient and outpatient supplementary scanning in acute care settings. • Reduction in the use of paper forms • Increase in the use of eForms	Head of Digitised Health Records Service	31/05/2026			Not Yet Due		0	No progress update as initial completion date has not yet passed			
ABUHB-2425-24	Internal Audit	EDRMS	Reasonable	Director of Digital	High	2.1	Current suitability A lack of upgrades has meant that the Health Board is on an old, unsupported version of cCube which is not able to provide modern functionality and interoperability with other clinical systems. Consequently, the system has not evolved with organisational requirements.	Agreed Action: The Health Board acknowledges that remaining on an unsupported version of cCube limits functionality and interoperability with other clinical systems and no longer meets organisational requirements. Progression to the required version, 4.4, is dependent on amendments to an API code by the Health Board's software development team however, internal development required to progress with the upgrade will not be completed prior to September 2025. Further development planning sessions are scheduled for September 2025 to agree a timeline for completion of the upgrade. However, completion is dependent on approval of the CWS Risk Business Case and the reorganisation of the service to establish a core support team to undertake the required API amendment. Subject to these dependencies, completion is estimated for early 2026/27. A risk has been raised relating to cCube on the directorate risk register: • 1829 – cCube out of support (Score 6)Support is provided by the supplier for issues although no development requests can be submitted. Expected Evidence of Implementation: Successful upgrade of the Noveva software group (formerly known as cCube solutions) Electronic Document Management System and corresponding capsure scanning software to the latest version 4.4.	Head of Digitised Health Records Service	31/05/2026			Not Yet Due		0	No progress update as initial completion date has not yet passed			
ABUHB-2425-24	Internal Audit	EDRMS	Reasonable	Director of Digital	High	3.1	Servers: cCube is hosted on Windows Server 2012 R2, which is now unsupported and exposed to known security vulnerabilities.	Agreed Action: The Health Board acknowledges that cCube is currently hosted on Windows Server 2012 R2, which is unsupported and presents known security vulnerabilities. To mitigate this risk in the short term, Extended Security Update (ESU) support has been applied to the web and importer servers for a 12-month period, as confirmed by the Business Systems Unit. This provides continued security patching and reduces the immediate exposure.For the long term, a business case and upgrade plan are in place to move to cCube version 4.4, which will run on a supported operating system. Progression to the required version, 4.4, is dependent on amendments to an API code by the Health Board's software development team however, internal development required to progress with the upgrade will not be completed prior to September 2025. Subject to this dependency, migration to the supported version and operating platform is expected thereafter. A risk has been raised relating to cCube on the directorate risk register: • 1739 – cCube Cyber Security Vulnerability (Score 12)Standard mitigations have been put in place by our Cyber Security Team to ensure the system is protected from cyber security threats and support is provided by the supplier for issues although no development requests can be submitted. Expected Evidence of Implementation: Successful upgrade of the Noveva software group (formerly known as cCube solutions) Electronic Document Management System and corresponding capsure scanning software to the latest version 4.4.	Head of Digitised Health Records Service	31/05/2026			Not Yet Due		0	No progress update as initial completion date has not yet passed			
ABUHB-2526-04	Internal Audit	Subject Access Requests	Limited	Director of Digital	Medium	1.1	Policies and Procedures A total of 23 documents were tested, a mixture of Procedures, Standing Operating Procedures (SOPs), guides, factsheets, flowcharts, and a handbook.The main four themes drawing out of the review were: • Documents requiring review – Four documents were due for review and needed to be assessed to ensure they are up to date and in line with GPDR legislation. • Legal timeframes - Documents incorrectly used a fixed28-day deadline instead of the legally required "one calendar month" under UK GDPR Article 12(3). This needs to be used consistently. • ID verification - Several documents lacked explicit protocols for verifying the identity of requesters, especially in cases involving third-party representatives. Inadequate verification increases the risk of unauthorised access or disclosure of personal data. • Third party information - Many SOPs did not clearly define how third-party data was redacted, shared, or exempted. This runs the risk of unlawful disclosures, lack of transparency, and	Agreed Action: • Conduct a full review of all SAR related documents (procedures, SOPs, flowcharts, handbook) to ensure compliance with UK GDPR and internal policy. • Replace all references to '28 days' with 'one calendar month'. • Implement a consistency check across all documents. • Add explicit steps for verifying identity of requestors, including 3rd party representatives. • Include guidance on acceptable forms of ID and escalation procedures for insufficient verification. • Define clear processes for redacting, sharing, or exempting 3rd party information. • Use a single term: Access to health records. • Schedule annual reviews and maintain a version log control. Expected Evidence of Implementation: • Provide a list of revised documents with version numbers, review dates, and sign off. • Maintain a log showing amendments made. • Evidence that staff have been trained on updated procedures.	Assistant Director of Digital Governance & Assurance / DPO	30/09/2026			Not Yet Due		0	No progress update as initial completion date has not yet passed			
ABUHB-2526-04	Internal Audit	Subject Access Requests	Limited	Director of Digital	Medium	2.1	Subject Access Request Process Walkthroughs were completed with both the IG and AHR teams, there was a process in place within both teams regarding SAR requests. Audit testing found the records held were detailed and complete. Testing of 22 cases (12 IG and 10 AHR) found: • Three IG cases were not acknowledged within two working days – two of which were because of a request for more information and/ or consent was needed to proceed. Once this information/ consent was received, they were then acknowledged within 24 hours.	Agreed Action: • Reinforce the requirement that all SAR requests must be acknowledged within 2 working days, even if consent is pending. • Amend SAR related SOPs to include guidance for interim acknowledgements when requests are incomplete. • Introduce weekly compliance checks to monitor acknowledgement times. Expected Evidence ofImplementation: • Copies of revised SOP's showing interim acknowledgement step. A monitoring log showing acknowledgement times for SAR cases over a defined period. • Evidence that A2HR & IG teams have been briefed on the updated process	Assistant Director of Digital Governance & Assurance / DPO	30/09/2026			Not Yet Due		0	No progress update as initial completion date has not yet passed			
ABUHB-2526-04	Internal Audit	Subject Access Requests	Limited	Director of Digital	High	3.1	Inaccurate reporting The September 2025 reported figures were reviewed for the AHR Halo and the IG Civica systems. Overall, the testing identified one breach reported over the two data sets with the Putting Things Right (PTR) team involvement. Whilst the overall reported figures were found to be reconcilable to the source data, some discrepancies were identified in respect of the closing dates: • Three discrepancies (incorrect dates entered) were identified at the Halo system – all were subsequently investigated and corrected on the system. • Four discrepancies (case extensions within the records should have been updated) in the Civica system were identified where requests were closed on the system beyond the expected closure date. The above were addressed during the audit. Furthermore, analysis indicated that the report generated by the Civica system documented 621 closed requests, while the system's internal records reflected a total of 637 closed requests. This is currently being investigated in conjunction with the system provider.	Agreed Action: • Implement a mandatory validation step for closing dates and case extensions before finalising SAR records in both Halo and Civica systems. • Introduce a monthly reconciliation process between reported figures and source data to identify discrepancies early. • Work with Civica system provider to investigate the discrepancy between reported closed requests (621) and internal records (637). • Update SOPs to include: o Double-check of closing dates o Clear guidance on recording case extensions o Ensure A2HR & IG teams follow consistent data entry practises. Expected Evidence of Implementation: • Copies of revised SOPs with new validation steps. • Monthly reporting demonstrating reconciliation between system data and reported figures. • Evidence that A2HR & IG teams have been briefed on the updated process.	Assistant Director of Digital Governance & Assurance / DPO	31/12/2026			Not Yet Due		0	No progress update as initial completion date has not yet passed			

ABUHB-2526-04	Internal Audit	Subject Access Requests	Limited	Director of Digital	High	4.1	Appropriate checks Audit testing verified processes were in place with regards to appropriate checks for identification, clarification, and review of information before release. Of the twelve IG cases tested, there was one case where ID was not requested and not identified – this was attributed to an error during a period of staff training. This was not identified internally and accordingly had not been investigated/ reported. The team should ensure that independent checks are periodically undertaken to confirm that ID verification has been requested - particularly where staff may be training.	Agreed Action: • Implement a quarterly audit of SAR cases to confirm ID verification has been requested and documented. • Amend SAR SOPs to explicitly require ID verification for all requests, with no exceptions. • Add a control step for supervisors to review ID verification during case sign off. • Incident Reporting: establish a process for immediate reporting and investigation of any missed ID verification. Expected Evidence of Implementation: • Produce audit reports quarterly showing compliance rates and any corrective action taken. • Copies of revised SOPs. • Evidence that A2HR & IG teams have been briefed on the updated process. • Create an incident register of any identified non compliance and actions taken to address them.	Assistant Director of Digital Governance & Assurance / DPO	31/12/2026			Not Yet Due		0	No progress update as initial completion date has not yet passed			
ABUHB-2526-04	Internal Audit	Subject Access Requests	Limited	Director of Digital	Medium	5.1	Staff awareness and training The overall compliance of IG training for September 2025 was 76% which is below the Health Board target of 85%. In September 2025, Facilities had 50% compliance and Planning had 65%, making them the lowest-performing divisions. There should be more focus on training within the Divisions to ensure compliance meets the Health Board target – with particular focus on the Divisions with lowest compliance.	Agreed Action: • Develop and implement an action plan to raise IG training compliance to meet or exceed the target o85%. • Prioritise Divisions with the lowest compliance. • Enhanced monitoring and reporting. • Assign Divisional Managers responsibility for ensuring staff complete training. Expected Evidence of Implementation: • Training Plan. • Monthly Reports. • Committee minutes showing discussion of compliance performance and agreed actions.	Assistant Director of Digital Governance & Assurance / DPO	30/06/2026			Not Yet Due		0	No progress update as initial completion date has not yet passed			
ABUHB-2526-04	Internal Audit	Subject Access Requests	Limited	Director of Digital	High	6.1	Complaints and appeals Testing of seven complaints found that six of them were initially processed through the Putting Things Right process: • One had their details checked and driver's licence submitted for verification. • For the remaining five, it was assumed that the PTR team had already verified the requestor's identity. However, it was confirmed that the PTR team had not undertaken these checks. Accordingly, ID check procedures for complaints were inconsistent.	Agreed Action: • Update complaints and appeals procedures to require mandatory ID verification for all cases regardless of whether they originate from the PTR process. • Update SOPs. • Communicate the process to both A2HR and IG staff to ensure consistent application. • Implement a monthly audit of complaints and appeals to confirm to confirm ID verification compliance. • Escalate non-compliance to senior management and record corrective actions. Expected Evidence of Implementation: • Copies of revised SOPs. • Audit report summarising checks over a defined period. • Evidence that A2HR & IG teams have been briefed on the updated process.	Assistant Director of Digital Governance & Assurance / DPO	30/06/2026			Not Yet Due		0	No progress update as initial completion date has not yet passed			
ABUHB-2526-22	Internal Audit	Cyber Security	Reasonable	Director of Digital	High	1.1	Strategic Risk Register The key controls recorded on the Strategic Risk Register against Strategic Risk 006 Part A (SRR 006A) are cyber security focused, however some are outdated or no longer relevant. The current risk and threat recorded for SRR 006A does not explicitly outline cyber security, although all the key controls for this risk and threat are cyber security focused. This could be updated to raise the profile of the cyber security risk to the organisation. The current risk appetite theme for SRR 006A is 'Service Delivery' which indicates an 'Open' risk appetite level. However, the most appropriate risk appetite theme for cyber security may be 'Compliance and Safety' which has a 'Minimal' risk appetite level, and this would mean the current risk score is outside of the risk appetite for the organisation. and, where appropriate, captured and monitored within the CRR.	Agreed Action: At a strategic level, the Strategic Risk Register (SRR) is intended to capture broad organisational risks, rather than focusing on specific areas. Detailed and operationally focused risks, such as those relating specifically to cyber security are more appropriately captured within the Corporate Risk Register (CRR). This approach ensures that sensitive information and specific control measures are managed securely. The SRR will continue to reflect digital risk at a strategic level, with cyber security risks managed and monitored through the CRR where a more granular level of detail and assurance can be maintained. We recognise that some of the key controls currently listed under SRR 006A are outdated or no longer relevant and a comprehensive review will be undertaken to ensure that: • The risk and key controls remain current, relevant, and aligned to the organisation's risk appetite. • References to cyber security within SRR 006A accurately reflect its role within the wider digital risk landscape. Expected Evidence of Implementation: • Updated version of SRR 006A reflecting refreshed risk, controls • Strategic Risk Reports to the Board and Finance and performance Committee with the updated assessment. • Confirmation that specific cyber security risks have been reviewed	ICT Cyber Security Manager/ Head of Corporate Risk and Assurance	31/01/2026	30/06/2026	28/04/2026	Overdue	Not Yet Due	1	Risk Registers continue to reflect Cyber risk at both Strategic(SRR) and Corporate (CRR) risk levels within the organisation. The Strategic Cyber risk may need amending Risk SRR006A to reflect current cyber threats. Specific detailed Cyber Risks continue to be recorded and reported on at Corporate level with review through Service Delivery and quarterly reviews through the Information Governance Group with further reporting to Risk and Finance by the SIRO if deemed necessary.			
ABUHB-2526-22	Internal Audit	Cyber Security	Reasonable	Director of Digital	Medium	3.1	Staff awareness and training Recent phishing simulations indicate a click rate of 12% across the organisation. The absence of targeted training for compromised staff, combined with mandatory Information Governance and Cyber Security training completion rates falling below the Health Board's 85% target, increases the risk of continued vulnerability. It was suggested that staff awareness should be added as a cyber security risk to raise the profile and ensure further monitoring of progress.	Agreed Action: Management accepts the recommendation and will address the findings through the following actions. • Continue the phishing simulation programme, using the established baseline to drive measurable improvement. • Deliver targeted follow-up training modules to individuals who regularly fail simulations, using tailored content linked directly to the exercises. • Report phishing simulation outcomes monthly through relevant governance groups to support monitoring of staff awareness improvements. • Enhance the visibility of cyber security messaging through regular internal communication and security awareness campaigns. • Work collaboratively with Information Governance, Counter Fraud, and other stakeholders to maximise use of available training resources. • Ensure cyber security staff awareness is appropriately reflected within the corporate risk framework for ongoing oversight. Expected Evidence of Implementation: • Monthly phishing simulation results and reports submitted through governance structures. • Governance and Assurance Group minutes demonstrating review of security awareness materials and outcomes. • Copies of cyber security awareness campaigns and communications issued via multiple channels. • Evidence of a corporate risk register entry to monitor staff awareness as part of the cyber security risk profile.	ICT Cyber Security Manager	31/01/2026	30/06/2026	28/04/2026	Overdue	Not Yet Due	1	Cyber has continued with its simulated phishing exercises and staff failing the exercise receive targeted training as part of the campaign. Procurement of the incumbent Phishing Tool has been approved for three years which will help to increase email security awareness . The tool also has a library of security related training that will also be provided over the next three years and can be utilised by teams other than Cyber. Monthly reporting and trending of phishing campaign outcomes will be provided within the monthly Cyber Security Report. Training compliance for staff has now reached 85% and is continually monitored with an aim to improve levels.			
ABUHB-2526-22	Internal Audit	Cyber Security	Reasonable	Director of Digital	High	4.1	Cyber Incident Response Plan • The Cyber Incident Response Plan highlights that the plan should be tested every six months but his has not been done. • The Cyber Security Team do not have the capabilities, expertise or resources to deal with a cyber event internally and they do not have third-party support formally agreed. • The incident response plan highlights that there should be action cards that define the duties of everyone in the Cyber Incident Response Team (CIRT), however these have not been drafted. • Communications have not been drafted for any audience outside of the Health Board.	Agreed Action: A tailored tabletop exercise will be undertaken within the next three months to specifically test the current Cyber Incident Response Plan, as required. The scenario will incorporate the areas identified in the audit findings, including clarity of team responsibilities, escalation pathways and communication requirements. Following completion, the Cyber Security Team will produce a formal post-exercise report that clearly documents lessons learned and required improvements. These improvements may include the creation of action cards, enhanced external communication arrangements and the securing of specialist third-party cyber support. Learning and feedback from the recent national DHCW exercise will also be reviewed and used to strengthen the Health Board's Cyber Incident Response capability in line with the existing plan. Expected Evidence of Implementation: • Copy of the tabletop exercise scenario • Post-exercise report including improvement actions and implementation owners • Updated Cyber Incident Response Plan testing schedule (2026–27) • Documentation confirming the review and options appraisal for external specialist support (e.g., forensic retainer) • Draft or completed action cards supporting the Cyber Incident Response Team roles and responsibilities • Communications templates developed in collaboration with the Communications Team for external use during a cyber incident.	ICT Cyber Security Manager	31/01/2026	30/06/2026	28/04/2026	Overdue	Not Yet Due	1	A table top exercise(TTX) specifically aimed to test the Cyber Incident Response plan was undertaken in Decenber 2025. Cyber have provided a post exercise report of recomended actions to include the development of action cards to support the incident management process. Cyber also met with KPMG and DHCW where agreement was reached around a process to call off external cyber expertise provided through DHCW by KPMG if required to support cyber incident management and forensic investigation for ABUHB. A schedule of quarterly TTXs are planned for 2026-27			

2020	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R6	R6 Consideration should be given to the placement of all informatics provision and support across the Health Board. As part of this the current partially decentralised model should be re-assessed in terms of its suitability for the modern use of technology.	Accepted. Following the exec review of the Target Operating Framework and overarching governance will appraise the hybrid environment of departmental asset ownership, responsibility, risk management. As the report sets out this is a largely historical and organic model which will be complex to resolve in itself. A risk based approach will be adopted andan options paper will be developed forconsideration by the Board.	Director of Digital	31/12/2022	30/06/2026		Overdue	Not Yet Due	4	Internal Audit have been tasked to undertake a specific audit of Shadow ICT as part of their 2025 audit plan. The organisational change process for Service Management structures is underway and due to complete April 2025.""June 2024: Phase 1 of the structural changes are underway to support formalisation of Service Management structures and WPAS product team. Job description development is underway for senior roles across the directorate. January 2024: The target operating model has been reviewed by the new Director of Digital and a proposal on the revised structure will be presented to the Executive Committee in April 2024. This structure will bring forward some options on the current decentralised model in some departments. "			
2020	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R14	R14 The asset and configuration management processes developed within the Informatics Directorate should be adopted as Health Board wide documents and departments with devolved control required to comply with the requirements.	Accepted. The HB governance, policy and processes will be reviewed as part of the SIROs objectives with resultant recommendations to Board. Informatics will need to review internal processes and capacity to ensure it can scale to meet the challenge.	Director of Digital	31/12/2021	31/07/2026	28/04/2026	Overdue	Not Yet Due	5	No progress due to insufficient resources to complete, now the OCP within Service Management this will now be taken forward in the summer.			
2023.17	Internal	IT Infrastructure	Reasonable	Director of Digital	Low	R4.1	Alert thresholds should be configured to identify relevant issues promptly	"ABUHB accepts this recommendation. Event management and alerting is under review with the aim to provide a consolidated platform (single pane of glass) for all alerts. Once the procedure outlined in 4.2 has been implemented this will be applied to any new infrastructure at install with existing assets being addressed over time."	Head of Ict	31/07/2025	31/07/2026	28/04/2026	Overdue	Not Yet Due	1	No progress due to insufficient resources to complete, now the OCP within Service Management this will now be taken forward in the summer.			
2023.17	Internal	IT Infrastructure	Reasonable	Director of Digital	Medium	R.2	"A set of formal procedure documentation and guides for managing the infrastructure should be defined."	"ABUHB accepts this recommendation. There is already a large amount of documentation available for infrastructure management – mostly done to coincide with our Service Desk Institute Audit of policies and processes. Gap analysis will be undertaken to ensure that comprehensive documentation is developed and maintained for all infrastructure services"	Chief Technology Officer	31/07/2024	31/07/2026	28/04/2026	Overdue	Not Yet Due	3	No progress due to insufficient resources to complete, now the OCP within Service Management this will now be taken forward in the summer.			

ABUHB Ref Number	Audit Type	Report Title	Assurance Rating	Responsible Executive Director	Recommendation Priority	Recommendation Number	Recommendation	Management Response	Responsible Handler	Original Completion Deadline	Proposed Revised Deadline	Date Revised Deadline accepted by Committee	Original completion date status	Revised Deadline Status	Number of Revised Timescales	Progress of work underway	Barriers to implementation	Evidence to complete or close recommednation	Reporting Date
2021.05	Internal	Pathology	Reasonable	Chief Operating Officer	Low	R8	R8 The Health Board should complete a refresh of the latest workforce planning exercise(including associated laboratory space and equipment), to ensure the service requirements can still be met over the next five years and beyond.Where additional resourcing / facilities arerequired, theseshould be factored into the IMTP process.	To review and updateworkforce plans as appropriate. Workforce is factored into the IMTP	Assistant Directorate Manager	24/02/2022	01/09/2026	08/02/2024	Overdue	Not Yet Due	3	"January 2024: Workforce model to address Demand and Capacity gap for Cellular Pathology laboratory has been developed that will allow annual laboratory demand to repatriated from outsourcing from April 2024. Equipment requirements to support repatriation of outsourcing are identified and included in Divisional Capital request for 24/25. Plan in progress to reconfigure current accommodation in Pathology block in RGH to provide suitable medium term accommodation (ETA for accommodation plan 31/03/24). Wider Cell Path workforce plan to include Digital Cell Path future challenges to be developed (ETA end of 24/25). Microbiology WFP has been developed and continues to be reviewed and updated, with HR input, as the landscape regarding Health Protection Services (HPS [formally COVID]) develops. Current core, HPS and Hot lab WFP being reviewed to define impact to service if current funding streams are not recurrent. All managers were asked to review their workforce plans following the audit. The Cellular Pathology workforce plan is included in sustainability paper, JH has confirmed the paper will need to be re-reviewed if 7 day working is planned. Mortuary workforce plan in progress with follow up meeting 6 weeks from 27/9/22. Microbiology workforce plan in progress to be completed by 5/10/22. Blood Sciences workforce plan in progress to be reviewed 5/10/22 prior to completion. All additional workforce requirements are already factored into annual plan/IMTP."			
2021.12	Internal	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R10	R10 The WRIS backups should be subject to regular testing / restore to ensurevalidity.	A request to ensure that a process for regular testing of the back up to ensure their validity will be made.	PACS & RADIS Manager	30/04/2022	31/05/2026		Overdue	Not Yet Due	5	"June 2025 - Same as previous RadIS is no longer being developmed and the risk will remain until the new RIS is rolled out in ABUHB in line with our current go live date of 24/11/2025 April 2025 - Radis is no longer being developed with the RISP project with all resource being focused on the data migration and rolling up of the RadIS team. We are expected to go live with a new RIS to replace RadIS November 24th 2025 at the moment. The ABUHB RISP Project Board meet monthly and feed into a National Project Board on a monthly basis.January 2024: Please refer to completed assurance report. Nov 2023: WRIS backups with recent upgrade work proved to be reliable. "			
2021.12	Internal	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R5	R5 The Board should investigate an electronic solution to uploading requests into WRIS.	Radiology have requested CWS to work with WCP for fully electronic requesting.	PACS & RADIS Manager	31/03/2022	31/05/2026	09/07/2024	Overdue	Not Yet Due	5	"June 2025- Software Development in ABUHB are developing an electronic request for that will integrate with the new RIS (Soliton) we will have as a part of RISP. The electronic request from CWS will cover all requests made in CWS in Secondary Care. This was planned for our go live date of 24/11/2025 but is no longer achievable and is planned for early stage of 2026. WCP are rolling out their electronic requesting solution through primary care and currently have 6 GP practices in ABUHB requesting electronically. This Risk will remain until we have the new RIS (Soliton) to replace RadIS and the electronic form has been developed by ABUHB in CWS and DHCW have completed the roll out in primary care with the WCP electronic form. June 2024- we are currently live in two GP practice using WCP's electronic requesting solution that integrates with our RIS so we it process the request electronically. We will be looking to roll this out in another two GP practices over the next 6 months. This is the chosen solution of RISP or whatever we currently have. There will be discussions with software development and the CCIO over the summer along with Philips and Soliton our new PACS/RIS providers to discuss true electronic requesting. Integrated electronic requesting was a part of RISP. The solution provided by Soliton the new RIS provider was not selected. There will be meetings between ABUHB and Philips/Soliton do discuss a live fully integration electronic requesting solution for the go live date of November 2025.			
2021.12	Internal	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R7	R7 The success of the use of the leavers list should be monitored to ensure that it works as anticipated and that all leaver accounts are removed on a timely basis.	We monitor this as much possible in Radiology. We have recently started receiving consultant leaver'slists from the Health Board and action these also.The success of the process will be tracked and evaluated to ensure it is working.	PACS & RADIS Manager	30/04/2022	31/05/2026		Overdue	Not Yet Due	5	"June 2025 - we have reviewed active users in RadIS to only create required users in the new RIS (Soliton) and are trying to work through this to replicate and make users inactive when appropriate. This is a manual task so dependant on admin work and us being made aware of recent leavers. Aug 2024: We are still limited to users outside of Radiology but there is communication for those internal to Radiology though it's not automated and dependant on people informing us of this. Outside of Radiology IT should disable their account in AD which will disable their access to the Healthboards systems. The new RIS/PACS access is dependant on being added to the appropraite AD groups which will be disabled when they leave the Healthboard. June 2024- the position remains the same, any leavers within Radiology we are informed alongside their Nadex being deactivated by the admin Team in Radiology. In the new PACS/RIS solution provided by Philips and Soliton the accounts will be linked to active directory. This will stop their access to Radiology systems alongside with their access to any PC's in ABUHB.			
2021.12	Internal	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R8	R8 The Health Boardshould request that this logging function be developed and should consider feeding WRIS events into the SIEM.	The health board have raised this at DHCW CAB along with other health boards. This is with DHCW to develop it is not in any Live RadIS version currently.	PACS & RADIS Manager	31/03/2022	31/05/2026		Overdue	Not Yet Due	5	"June 2025 - RadIS is no longer being developed so this functionality will never be available in RadIS. The new RIS (Soliton) has a full and robust audit trail so this risk will remain until we have the new RIS. Aug 2024: There is no adequate audit functionality within RadIS and with the product being soon end of life there will be no solution until the new PACS/RIS is in place which has thorough audit functionality. June 2024- the position remains the same and would be with DHCW to develop for RadIS. Any enhancements and developments have been stopped by DHCW as they work to migrate the RadIS data over to our new RIS Soliton. DHCW would need to develop this and with RadIS no longer being an NHS system once the new PACS/RIS is in place it won't be an issue then as the audit trail is full and comprehensive in the new solution.			
2021.12	Internal	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R9	R9 A formal disaster recovery plan for WRIS should be developed.	The Disaster recovery plan is to fail over to a mirrored system however, since the upgrade this needs to be re-visited and formally set out. ABUHB have a VMware environment where this is hosted.The Radiology departments have disaster recovery by using emergency packs in each department and a policy that explains how to use these emergency packs in a Radis downtime scenario.	PACS & RADIS Manager	30/04/2022	31/05/2026		Overdue	Not Yet Due	5	"June 2025 - we still do not have a mirrored DR system and won't be developed with RadIS no longer being developed. The new RIS will be primarily cloud based with that being mirrored and failing over to kit in a primary DC in GUH If there are issues with full functionality. If there are further issue in our primary DC it will then fail over to the secondary DC in YAB with full functionality with the planned solution.			

2022.25	Internal	Integrated Wellbeing Networks	Reasonable	Director of Public Health	Medium	R2	Management should clearly identify what a successful IWN project is, and future projects undertaken by the local IWN communities (e.g. projects identified within the IWN annual plans) should state SMART goals whereby the success of the project can clearly be defined. Management should also identify what success of the IWN programme in each community looks like and once that target is achieved be able to move to other areas of need and implement the programme within those locations	"An independent advisory group of academics has been created due to meet in July 2023 to advise on (a) measures of evaluating progress towards the strategic objectives of the IWN programme in each place-based area of operation and (b) longitudinal methods for measuring community wellbeing in an evidence-based manner to understand how and whether the IWN programme is impacting on population wellbeing in its place-based areas. It is anticipated by September 2023 that a new evaluation framework will be proposed by this advisory group, with funding now apportioned for the appointment of a commissioned researcher to undertake an evaluation and embed this framework in programme monitoring for IWN into the longer-term. This will set the direction of success for local IWN projects, allow SMART goal planning and measure the success of the programme to enable exploration of working in other geographic areas in future. The evaluation work will be complete by 31st October 2023. The programme is planning to apply the King's Fund model for community-orientated needs assessment in defining	IWN Programme Manager	01/10/2023	31/12/2026	28/04/2026	Overdue	Not Yet Due	3	March 2026: The new community model is being implemented, as part of the health board's commitment to place based working. The IWN programme has four distinct functions within the PBC programme: 1. Community engagement and capacity building; 2. Community asset mapping and organising; 3. Bridging, linking and co-ordinating well-being assets; and 4. Individual and group behaviour change. The IWN programme is central to delivery of these four functions and engagement has continued over the last year with RPB development sessions, workshops with ISPBs, GAVO and TVA to ensure a universal model of well-being, proportionate to need. To address the four functions, the IWN team continue to work with communities to identify local issues and priorities to inform decision making and action by strengthening the skills, resources and abilities of communities, and the individuals within them, to be able to thrive; identify, connect and mobilise existing strengths within a community that can be leveraged to enable communities to thrive; and create stronger, integrated support networks that enhance health, wellbeing and resilience of individuals and communities. The IWN programme evidences its impact through regular reporting to RIF, with progress captured against the RIF national dataset and any project and system-level measures to demonstrate project impact; details of inputs, outputs, outcomes and enablers which capture the intended and unintended impacts of the programme; and the provision of case studies to demonstrate impact of the IWN programme in a real-world context. Notable progress has been made with the alignment of behaviour change practitioners (BCPs) to locality areas over the last 6 months. BCPs provide specialist behaviour support and advice to people who want to quit smoking, as well as being equipped with the ability to support people to make changes to their diet, physical activity and alcohol use where appropriate. BCPs will be a core part of a place-based neighbourhood teams and will support building the capability of behaviour change			
2023.06	Internal	Estates Condition - Jan 2024	Limited	Director of Strategy, Planning & Partnerships	Medium	R4.2	Management should update the Estates Strategy (or equivalent) for continued relevance to estates condition as appropriate.	Agreed – this forms part of forward work plan for the Planning, Population Health and Partnerships Committee.	Director of Strategy, Planning and Partnerships	31/03/2024	30/09/2026	20/05/2025	Overdue	Not Yet Due	3	"November 2025: Work is underway to re-establish estate baseline information in order to then align with strategy. Alongside this the specification for the Facet Survey is being developed in order to procure a company to undertake the surveys on behalf of the Health Board. This work will commence in the new year and is likely to conclude in approx 6-8 months. Following this findings will then be aligned in order to develop the HEalth Boards Estates Strategy.May 2025: Agreement that Estate Strategy refresh follows Organisational Strategy. Aug 2024: Aa per the June update, the Organisational Strategy is expected to be completed by the end of the calendar year. The PPHPC is considering estates development in detail and receives regular updates on the strategy's progress. Update on plans for all owned Estate presented to PPHPC. Board Development session on Estates. Estates Strategy to follow Organisational Strategy. June 2024: Work is ongoing to maintain premises which will remain in the Health Board Estate Portfolio with no immediate plans in place. Plans are currently being progressed for Nevill Hall Hospital and St Woolos in line with the Estate Strategy where estate condition is poor. Organisational Strategy will be complete end of calendar year. March 2024: mCapital priorisiation complete. Estate Strategy will follow org. strat.""			
2021.01EA	External	Audit of Accounts Report, 2020-21 – Addendum issued December 2021	Not Rated	Director of Workforce & OD	High	R1	The Health Board should review the arrangements in place toensure that annual leave for all staff is accurately recorded and held centrally	The introduction of Medical E-Systems will ensure that all leave is recorded. The Health Board have agreed to procure a suite of Medical E-Systems with roll out in April 2022. However, departments have started recording leave in Electronic Staff Record (ESR). Communications will be sent to Medical Leaders in December 2021 to ensure that leave is recorded onto ESR pending the introduction of full Medical E-Systems.	N/A	30/04/2022	31/12/2026	20/05/2025	Overdue	Not Yet Due	3	The Health Board are currently in the early stages of entering sickness absences via the roster following a period significant development and testing with Patchwork and ESR. Within the next 6 months the testing of annual leave recording will be undertaken via rostering into ESR. The intention will be to roll this out to all Divisions following successful testing.			
2023.34	Internal	Waiting List Management Final Internal Audit Report.	Reasonable	Chief Operating Officer	High	1.1a	Management should review the process of managing waiting lists. A targeted approach to continual validation of patients ensuring they are on the correct pathways and are not duplicates should be undertaken.	The Planned Care Academy purpose is to ensure that education and training of staff becomes embedded into ways of working, to develop and support staff as well as improving the effectiveness and compliance with national requirements relating to management of patients on their pathways. The development of tools, bespoke training packages, policies and standard operating procedures has now been completed. Initial training will provide basic RTT knowledge targeted at new starters and staff whose dealings with patient pathways are minimal. This cohort must still understand the concept of the 26 week pathway and the consequences of failing to record information correctly and in real time. Advanced RTT training is aimed at staff who require a full understanding of the 26 Week Rules. A comprehensive range of WPAS modules have been developed mirroring the patient pathway and designed to be role based i.e. tailored training. The training will include DNA's, how to rebook, the rules around Non-Admitted, Admitted and Incompletes, how to validate a PTL and what to look for within the data of a PTL to help manage pathways. Staff will learn how to record patient pathways correctly using the appropriate National RTT Status codes on WPAS. Refresher training will be provided to existing staff and competency assessed.	Head of Health Records/Referral & Booking Centres.	30/09/2024	31/01/2027	28/04/2026	Overdue	Not Yet Due	3	Mar 2026: Progress continues across the WPAS training workstream, with core lesson plan development moving forward and wider training materials being refreshed to ensure consistency and alignment with current operational requirements. Userguides are undergoing further revision, and related updates on ABPulse, including the expansion of RTT guidance are now in place. Phase one of the training programme remains fully operational, supported by the booking app and appropriate training facilities, and additional materials, including updated pathway content, are nearing completion. Planning is progressing for the next phase of refresher and review activity, alongside the commencement of inpatient training, which is helping to broaden the overall training offer. Work is also underway to strengthen organisational support through RBC's dedicated training resource, to support raising awareness and promote consistent standards across booking processes. Additionally, a Training Hub has been developed within the RBC ABPulse page, providing a central repository for SOPs covering outpatient booking, reception and validation processes. A Validation strategy is also in development to ensure a more consistent and structured approach to validation activity across services			

ABUHB Ref Number	Audit Type	Report Title	Assurance Rating	Responsible Executive Director	Recommendation Priority	Recommendation Number	Recommendation	Management Response	Responsible Handler	Original Completion Deadline	Proposed Revised Deadline	Date Revised Deadline accepted by Committee	Original completion date status	Revised Deadline Status	Number of Revised Timescales	Progress of work underway	Barriers to implementation	Evidence to complete or close recommednation	Reporting Date
2021.05	Internal	Pathology	Reasonable	Chief Operating Officer	Low	R8	R8 The Health Board should complete a refresh of the latest workforce planning exercise(including associated laboratory space and equipment), to ensure the service requirements can still be met over the next five years and beyond.Where additional resourcing / facilities arerequired, theseshould be factored into the IMTP process.	To review and updateworkforce plans as appropriate. Workforce is factored into the IMTP	Assistant Directorate Manager	24/02/2022	01/09/2026	08/02/2024	Completed	Completed	3	"January 2024: Workforce model to address Demand and Capacity gap for Cellular Pathology laboratory has been developed that will allow annual laboratory demand to repatriated from outsourcing from April 2024. Equipment requirements to support repatriation of outsourcing are identified and included in Divisional Capital request for 24/25. Plan in progress to reconfigure current accommodation in Pathology block in RGH to provide suitable medium term accommodation (ETA for accommodation plan 31/03/24). Wider Cell Path workforce plan to include Digital Cell Path future challenges to be developed (ETA end of 24/25). Microbiology WFP has been developed and continues to be reviewed and updated, with HR input, as the landscape regarding Health Protection Services (HPS [formally COVID]) develops. Current core, HPS and Hot lab WFP being reviewed to define impact to service if current funding streams are not recurrent. All managers were asked to review their workforce plans following the audit. The Cellular Pathology workforce plan is included in sustainability paper, JH has confirmed the paper will need to be re-reviewed if 7 day working is planned. Mortuary workforce plan in progress with follow up meeting 6 weeks from 27/9/22. Microbiology workforce plan in progress to be completed by 5/10/22. Blood Sciences workforce plan in progress to be reviewed 5/10/22 prior to completion. All additional workforce requirements are already factored into annual plan/IMTP."		Significant increase in Cellular Pathology laboratory staffing following the Dem/Cap exercise, with cessation of outsourcing in January 2024. Workforce planning is in place for each pathology discipline, with Dem/Cap reviews for cellular pathology now undertaken at regular intervals to ensure staffing remains aligned to demand. Laboratory accommodation at RGH has been mitigated as far as possible. Issues relating to integrity and fire safety have been escalated to Estates as required, with mitigation applied where feasible. Further progress is not currently anticipated due to All-Wales agendas and potential movements related to PrHW and regionalisation, which may or may not progress. Closure of the action is suggested, with the Pathology Performance and Operations Manager in post to ensure continuation of the above.	
2021.12	Internal	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R7	R7 The success of the use of the leavers list should be monitored to ensure that it works as anticipated and that all leaver accounts are removed on a timely basis.	We monitor this as much possible in Radiology. We have recently started receiving consultant leaver'slists from the Health Board and action these also.The success of the process will be tracked and evaluated to ensure it is working.	PACS & RADIS Manager	30/04/2022	31/05/2026		Completed	Completed	5	"June 2025 - we have reviewed active users in RadIS to only create required users in the new RIS (Soliton) and are trying to work through this to replicate and make users inactive when appropriate. This is a manual task so dependant on admin work and us being made aware of recent leavers. Aug 2024: We are still limited to users outside of Radiology but there is communication for those internal to Radiology though it's not automated and dependant on people informing us of this. Outside of Radiology IT should disable their account in AD which will disable their access to the Healthboards systems. The new RIS/PACS access is dependant on being added to the appropriate AD groups which will be disabled when they leave the Healthboard. June 2024- the position remains the same, any leavers within Radiology we are informed alongside their Nadex being deactivated by the admin Team in Radiology. In the new PACS/RIS solution provided by Philips and Soliton the accounts will be linked to active directory. This will stop their access to Radiology systems alongside with their access to any PC's in ABUHB.		Propose to close on the basis that a process is in place , No change to current practice with the relience on regular 'leavers lists' to allow manual update of the system.	
2022.25	Internal	Integrated Wellbeing Networks	Reasonable	Director of Public Health	Medium	R2	Management should clearly identify what a successful IWN project is, and future projects undertaken by the local IWN communities (e.g. projects identified within the IWN annual plans) should state SMART goals whereby the success of the project can clearly be defined. Management should also identify what success of the IWN programme in each community looks like and once that target is achieved be able to move to other areas of need and implement the programme within those locations	"An independent advisory group of academics has been created due to meet in July 2023 to advise on (a) measures of evaluating progress towards the strategic objectives of the IWN programme in each place-based area of operation and (b) longitudinal methods for measuring community wellbeing in an evidence-based manner to understand how and whether the IWN programme is impacting on population wellbeing in its place-based areas. It is anticipated by September 2023 that a new evaluation framework will be proposed by this advisory group, with funding now apportioned for the appointment of a commissioned researcher to undertake an evaluation and embed this framework in programme monitoring for IWN into the longer-term. This will set the direction of success for local IWN projects, allow SMART goal planning and measure the success of the programme to enable exploration of working in other geographic areas in future. The evaluation work will be complete by 31st October 2023. The programme is planning to apply the King's Fund model for community-orientated needs assessment in defining success in each of the IWN areas to set goals for local areas and establish measures of success from 2024/25."	IWN Programme Manager	01/10/2023	31/12/2026	28/04/2026	Completed	Completed	3	The IWN programme has four distinct functions within the PBC programme: 1. Community engagement and capacity building; 2. Community asset mapping and organising; 3. Bridging, linking and co-ordinating well-being assets; and 4. Individual and group behaviour change. The IWN programme is central to delivery of these four functions and engagement has continued over the last year with RPB development sessions, workshops with ISPBs, GAVO and TVA to ensure a universal model of well-being, proportionate to need. To address the four functions, the IWN team continue to work with communities to identify local issues and priorities to inform decision making and action by strengthening the skills, resources and abilities of communities, and the individuals within them, to be able to thrive; identify, connect and mobilise existing strengths within a community that can be leveraged to enable communities to thrive; and create stronger, integrated support networks that enhance health, wellbeing and resilience of individuals and communities. The IWN programme evidences its impact through regular reporting to RIF, with progress captured against the RIF national dataset and any project and system-level measures to demonstrate project impact; details of inputs, outputs, outcomes and enablers which capture the intended and unintended impacts of the programme; and the provision of case studies to demonstrate impact of the IWN programme in a real-world context. Notable progress has been made with the alignment of behaviour change practitioners (BCPs) to locality areas over the last 6 months. BCPs provide specialist behaviour support and advice to people who want to quit smoking, as well as being equipped with the ability to support people to make changes to their diet, physical activity and alcohol use where appropriate. BCPs will be a core part of a place-based neighbourhood teams and will support building the capability of		The IWN programme has four distinct functions within the PBC programme: 1. 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2023.34	Internal	Waiting List Management Final Internal Audit Report.	Reasonable	Chief Operating Officer	High	1.1a	Management should review the process of managing waiting lists. A targeted approach to continual validation of patients ensuring they are on the correct pathways and are not duplicates should be undertaken.	The Planned Care Academy purpose is to ensure that education and training of staff becomes embedded into ways of working, to develop and support staff as well as improving the effectiveness and compliance with national requirements relating to management of patients on their pathways. The development of tools, bespoke training packages, policies and standard operating procedures has now been completed. Initial training will provide basic RTT knowledge targeted at new starters and staff whose dealings with patient pathways are minimal. This cohort must still understand the concept of the 26 week pathway and the consequences of failing to record information correctly and in real time. Advanced RTT training is aimed at staff who require a full understanding of the 26 Week Rules. A comprehensive range of WPAS modules have been developed mirroring the patient pathway and designed to be role based i.e. tailored training. The training will include DNA's, how to rebook, the rules around Non-Admitted, Admitted and Incompletes, how to validate a PTL and what to look for within the data of a PTL to help manage pathways. Staff will learn how to record patient pathways correctly using the appropriate National RTT Status codes on WPAS. Refresher training will be provided to existing staff and competency assessed.	Head of Health Records/Referral & Booking Centres.	30/09/2024	31/01/2027	28/04/2026	Completed	Completed	3	Mar 2026: Progress continues across the WPAS training workstream, with core lesson plan development moving forward and wider training materials being refreshed to ensure consistency and alignment with current operational requirements. Userguides are undergoing further revision, and related updates on ABPulse, including the expansion of RTT guidance are now in place. Phase one of the training programme remains fully operational, supported by the booking app and appropriate training facilities, and additional materials, including updated pathway content, are nearing completion. Planning is progressing for the next phase of refresher and review activity, alongside the commencement of inpatient training, which is helping to broaden the overall training offer. Work is also underway to strengthen organisational support through RBC's dedicated training resource, to support raising awareness and promote consistent standards across booking processes. Additionally, a Training Hub has been developed within the RBC ABPulse page, providing a central repository for SOPs covering outpatient booking, reception and validation processes. A Validation strategy is also in development to ensure a more consistent and structured approach to validation activity across services		We are proposing to close this action relating to the management of waiting lists. Significant progress has been made in strengthening training, guidance, and processes, as outlined in the progress update, and these are now embedded within business-as-usual activity	

ABUHB Ref Number	Audit Type	Report Title	Assurance Rating	Responsible Executive Director	Recommendation Priority	Recommendation Number	Recommendation	Management Response	Responsible Handler	Original Completion Deadline	Proposed Revised Deadline	Date Revised Deadline accepted by Committee	Original completion date status	Revised Deadline Status	Number of Revised Timescales	Progress of work underway	Barriers to implementation	Evidence to complete or close recommednation	Reporting Date
2021.12	Internal	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R10	R10 The WRIS backups should be subject to regular testing / restore to ensurevalidity.	A request to ensure that a process for regular testing of the back up to ensure their validity will be made.	PACS & RADIS Manager	30/04/2022	31/05/2026		Overdue	Not Yet Due	5	"June 2025 - Same as previous RadIS is no longer being developmed and the risk will remain until the new RIS is rolled out in ABUHB in line with our current go live date of 24/11/2025 April 2025 - Radis is no longer being developed with the RISP project with all resource being focused on the data migration and rolling up of the RadIS team. We are expected to go live with a new RIS to replace RadIS November 24th 2025 at the moment. The ABUHB RISP Project Board meet monthly and feed into a National Project Board on a monthly basis.January 2024: Please refer to completed assurance report. Nov 2023: WRIS backups with recent upgrade work proved to be reliable. "	Same as previous - RadIS is no longer being developmed and the risk will remain until the new RIS is rolled out in ABUHB in line with our current go live date of 22/6/26. DHCW continuing to support RadIS until the end of the RISP project.It is challenging to provide an expected completion date, as a number of elements are dependent on national programmes and external factors.		
2021.12	Internal	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R5	R5 The Board should investigate an electronic solution to uploading requests into WRIS.	Radiology have requested CWS to work with WCP for fully electronic requesting.	PACS & RADIS Manager	31/03/2022	31/05/2026	09/07/2024	Overdue	Not Yet Due	5	"June 2025- Software Development in ABUHB are developing an electronic request for that will integrate with the new RIS (Soliton) we will have as a part of RISP. The electronic request from CWS will cover all requests made in CWS in Secondary Care. This was planned for our go live date of 24/11/2025 but is no longer achievable and is planned for early stage of 2026. WCP are rolling out their electronic requesting solution through primary care and currently have 6 GP practices in ABUHB requesting electronically. This Risk will remain until we have the new RIS (Soliton) to replace RadIS and the electronic form has been developed by ABUHB in CWS and DHCW have completed the roll out in primary care with the WCP electronic form. June 2024- we are currently live in two GP practice using WCP's electronic requesting solution that integrates with our RIS so we it process the request electronically. We will be looking to roll this out in another two GP practices over the next 6 months. This is the chosen solution of RISP or whatever we currently have. There will be discussions with software development and the CCIO over the summer along with Philips and Soliton our new PACS/RIS providers to discuss true electronic requesting. Integrated electronic requesting was a part of RISP. The solution provided by Solton the new RIS provider was not selected. There will be meetings between ABUHB and Philips/Soliton do discuss a live fully integration electronic requesting solution for the go live date of November 2025.	Software Development in ABUHB are working on an electronic request via CWS2 that will integrate with the new RIS (Soliton) we will have as a part of RISP. The electronic request from CWS2 will cover all requests made in Secondary Care apart from ED which uses the symphony system. This was planned for our go live date of 11/5/26 but this is no longer achievable. Despite further delaying the 'Go Live' to 22/6/26 there was no guarantee from AB Software Development that the CWS2 system would be integrated. As such the decision to moved to WCP ETR as an extended BCP was agreed. It has been noted that the impact of WCP ETR for Radiology has a wider impact on the services outside of Radiology and business change work is ongoing to mitigate the risks identified. WCP are rolling out their electronic requesting solution through primary care and currently have a number of GP practices in ABUHB requesting electronically. This Risk will remain until we have the new RIS (Soliton) to replace RadIS and the full ETR system has been developed by ABUHB in CWS2 and DHCW have completed the roll out in primary care with the WCP electronic form. It is challenging to provide an expected completion date, as a number of elements are dependent on national programmes and external factors.		
2021.12	Internal	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R8	R8 The Health Boardshould request that this logging function be developed and should consider feeding WRIS events into the SIEM.	The health board have raised this at DHCW CAB along with other health boards. This is with DHCW to develop it is not in any Live RadIS version currently.	PACS & RADIS Manager	31/03/2022	31/05/2026		Overdue	Not Yet Due	5	"June 2025 - RadIS is no longer being developed so this functionality will never be available in RadIS. The new RIS (Soliton) has a full and robust audit trail so this risk will remain until we have the new RIS. Aug 2024: There is no adequate audit functionality within RadIS and with the product being soon end of life there will be no solution until the new PACS/RIS is in place which has thorough audit functionality. June 2024- the position remains the same and would be with DHCW to develop for RadIS. Any enhancements and developments have been stopped by DHCW as they work to migrate the RadIS data over to our new RIS Soliton. DHCW would need to develop this and with RadIS no longer being an NHS system once the new PACS/RIS is in place it won't be an issue then as the audit trail is full and comprehensive in the new solution.	No change - RadIS is no longer being developed so this functionality will never be available in RadIS. The new RIS (Soliton) has a full and robust audit trail so this risk will remain until we have the new RIS.It is challenging to provide an expected completion date, as a number of elements are dependent on national programmes and external factors.		
2021.12	Internal	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R9	R9 A formal disaster recovery plan for WRIS should be developed.	The Disaster recovery plan is to fail over to a mirrored system however, since the upgrade this needs to be re-visited and formally set out. ABUHB have a VMware environment where this is hosted.The Radiology departments have disaster recovery by using emergency packs in each department and a policy that explains how to use these emergency packs in a Radis downtime scenario.	PACS & RADIS Manager	30/04/2022	31/05/2026		Overdue	Not Yet Due	5	"June 2025 - we still do not have a mirrored DR system and won't be developed with RadIS no longer being developed. The new RIS will be primarily cloud based with that being mirrored and failing over to kit in a primary DC in GUH If there are issues with full functionality. If there are further issue in our primary DC it will then fail over to the secondary DC in YAB with full functionality with the planned solution.	No change - we still do not have a mirrored DR system and won't be developed with RadIS no longer being developed. The new RIS will be primarily cloud based with that being mirrored and failing over to kit in a primary DC in GUH If there are issues with full functionality. If there are further issue in our primary DC it will then fail over to the secondary DC in YAB with full functionality with the planned solution. It is challenging to provide an expected completion date, as a number of elements are dependent on national programmes and external factors.		
2023.06	Internal	Estates Condition - Jan 2024	Limited	Director of Strategy, Planning & Partnerships	Medium	R4.2	Management should update the Estates Strategy (or equivalent) for continued relevance to estates condition as appropriate.	Agreed – this forms part of forward work plan for the Planning, Population Health and Partnerships Committee.	Director of Strategy, Planning and Partnerships	31/03/2024	30/09/2026	20/05/2025	Overdue	Not Yet Due	3	"November 2025: Work is underway to re-establish estate baseline information in order to then align with strategy. Alongside this the specification for the Facet Survey is being developed in order to procure a company to undertake the surveys on behalf of the Health Board. This work will commence in the new year and is likely to conclude in approx 6-8 months. Following this findings will then be aligned in order to develop the HEalth Boards Estates Strategy.May 2025: Agreement that Estate Strategy refresh follows Organisational Strategy. Aug 2024: Aa per the June update, the Organisational Strategy is expected to be completed by the end of the calendar year. The PPHPC is considering estates development in detail and receives regular updates on the strategy's progress. Update on plans for all owned Estate presented to PPHPC. Board Development session on Estates. Estates Strategy to follow Organisational Strategy. June 2024: Work is ongoing to maintain premises which will remain in the Health Board Estate Portfolio with no immediate plans in place. Plans are currently being progressed for Nevill Hall Hospital and St Woolos in line with the Estate Strategy where estate condition is poor. Organisational Strategy will be complete end of calendar year. March 2024: mCapital priorisiation complete. Estate Strategy will follow org. strat.""			
2021.01EA	External	Audit of Accounts Report, 2020-21 – Addendum issued December 2021	Not Rated	Director of Workforce & OD	High	R1	The Health Board should review the arrangements in place toensure that annual leave for all staff is accurately recorded and held centrally	The introduction of Medical E-Systems will ensure that all leave is recorded. The Health Board have agreed to procure a suite of Medical E-Systems with roll out in April 2022. However, departments have started recording leave in Electronic Staff Record (ESR). Communications will be sent to Medical Leaders in December 2021 to ensure that leave is recorded onto ESR pending the introduction of full Medical E-Systems.	N/A	30/04/2022	31/12/2026	20/05/2025	Overdue	Not Yet Due	3	The Health Board are currently in the early stages of entering sickness absences via the roster following a period significant development and testing with Patchwork and ESR. Within the next 6 months the testing of annual leave recording will be undertaken via rostering into ESR. The intention will be to roll this out to all Divisions following successful testing.	The roll our of medical e-rostering has been delayed due to on-going developments. However we are now in a position to continue the roll out from May-26 at pace across the organsiation for completion by Dec-26. On-going interface testing between Patchwork and ESR has been successful and therefore will support the interface with absence management and controls. Annual leave policies remain extant and ESR is accessible to all staff. External Audit are reviewing to confirm if the recommendation can be closed.		

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	19 May 2026
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Strategic Risk and Assurance Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Head of Corporate Risk and Assurance

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

Er Sicrwydd/For Assurance

The Strategic Risk Report provides the Committee with an overview of the key strategic risks facing the Health Board, aligned to the priorities and objectives within the 2025–28 Integrated Medium-Term Plan (IMTP).

It seeks to provide assurance that these risks are being identified, monitored, and managed effectively, with proportionate actions in place to mitigate potential impacts on service delivery, financial sustainability, and patient safety.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report provides the Committee with an update on the Health Board's strategic risk position and associated assurance arrangements since the last report to ARAC in December 2025. It draws on the Strategic Risk Reports presented to the Board in January and March 2026, with a focus on changes in risk exposure, emerging risks, and developments in governance and assurance.

Cefndir / Background

Since December 2025, the Health Board's overall strategic risk profile has remained broadly stable. The Strategic Risk Register continues to comprise nine strategic risks with twenty-one sub-risks.

This stability at an aggregate level mask continued volatility and pressure within specific risk domains. The operating environment remains highly challenging, with

sustained pressures relating to financial sustainability, system performance, estate infrastructure, and enabling systems. These pressures continue to drive elevated levels of risk exposure across a number of areas, six of which remain outside the Health Board's defined risk appetite.

Their persistence reflects the structural and long-term nature of these risks, which are not readily mitigated through short-term interventions but require sustained organisational focus and investment.

Detailed information is provided in **Appendix A** (Strategic Risk Dashboard and individual risk assessments).

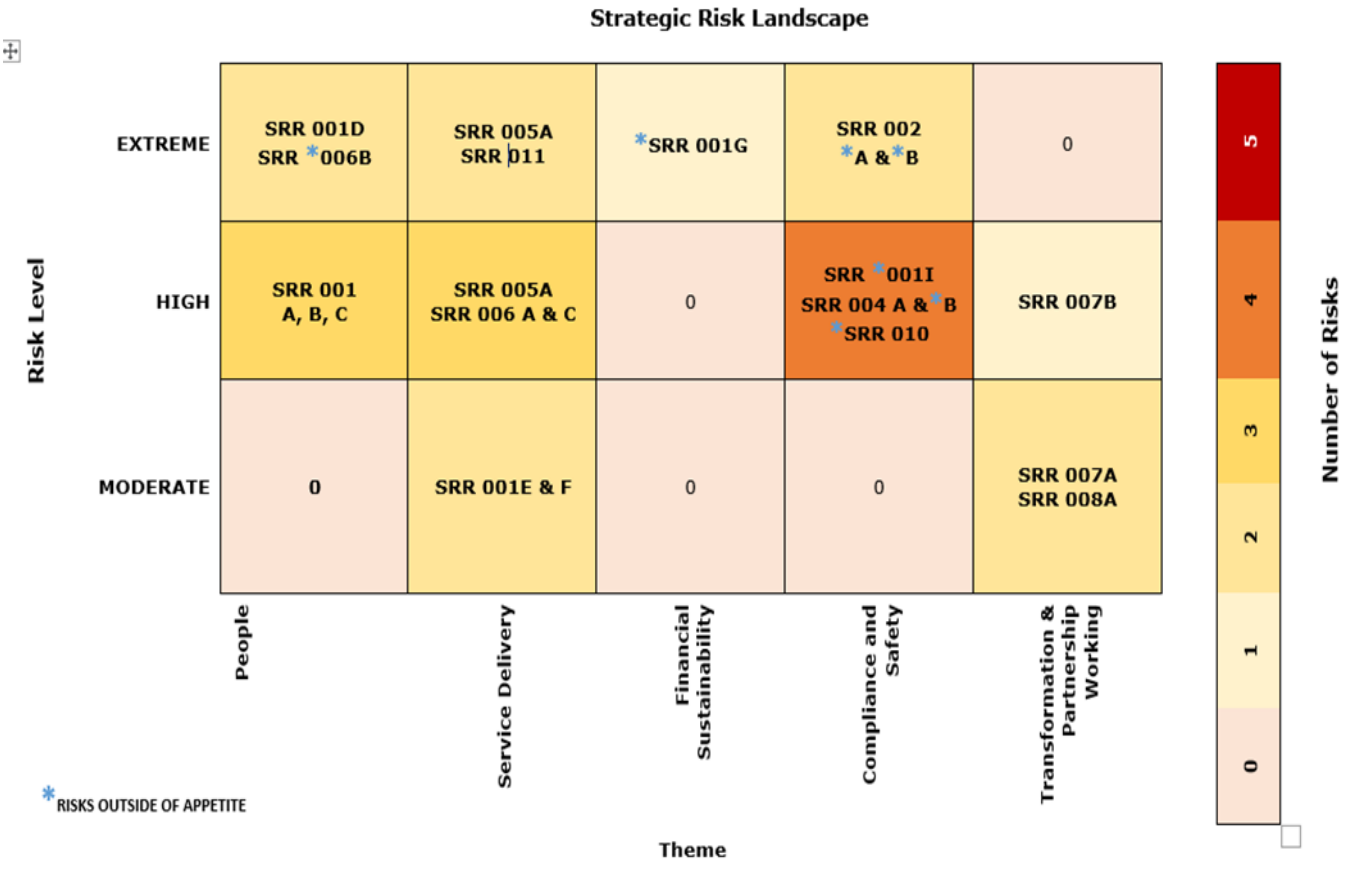
Asesiad / Assessment

Current Risk Profile

The Health Board's strategic risk profile continues to reflect the scale and complexity of system-wide challenges. Most risks sit within the High category, particularly within Service Delivery and Compliance & Safety domains. These remain areas of sustained strategic focus and oversight.

Fewer risks are rated Extreme, but these represent the greatest potential threat to organisational resilience, patient safety, and delivery of IMTP objectives. These are subject to enhanced monitoring and reporting through the Executive Committee and relevant thematic committees.

The Heat Map, below, illustrates the current distribution of strategic risks and their relative severity.



Key Changes in Risk Exposure

While the overall profile has remained stable, there have been a number of notable developments in individual risks since December.

The most significant movement relates to digital infrastructure risk **(SRR 006B),** where the risk score increased from 16 to 20, moving the risk outside the Health Board's defined appetite. This change reflects growing uncertainty and delays associated with national digital programmes, specifically the Radiology Information System Programme and the Laboratory Information Management System.

As these programmes are critical to diagnostic services and broader clinical pathways, delays have increased reliance on ageing systems and heightened operational and patient safety risks. In response, additional corporate risks have been established to strengthen oversight and mitigation planning, although delivery timelines remain largely outside organisational control.

Financial sustainability risk **(SRR 001G)** has also remained at a heightened level throughout the period. Although there was a temporary improvement earlier in 2025, the position deteriorated again due to ongoing cost pressures, service demand, and challenges in delivering planned savings. The risk remains at a score of 20, reflecting the scale of the financial challenge and its pervasive impact across the organisation.

Strengthened financial governance arrangements have been implemented, including enhanced oversight and recovery planning, but the underlying risk remains significant.

Operational pressures, particularly within urgent and emergency care **(SRR 005A),** have continued to intensify. Increased patient acuity, delays in discharge, and system-wide capacity constraints have contributed to deterioration in performance and escalation to Level 4 monitoring status by Welsh Government. This risk is closely interdependent with performance and financial risks, reinforcing the systemic nature of the challenges faced.

Workforce-related risks have also increased in prominence during the period, driven by national developments in pay and the potential for industrial action. While the immediate risks relate to service disruption, there are also broader implications for financial sustainability and workforce stability, further compounding existing pressures.

In contrast, a number of risks have remained relatively stable, albeit at levels above appetite. These include estate-related risks such as Reinforced Autoclaved Aerated Concrete (RAAC) and backlog maintenance, as well as risks relating to business continuity and governance compliance. The stability of these risks should not be interpreted as reduced concern; rather, it reflects their entrenched and systemic nature, requiring long-term mitigation strategies and sustained investment.

Appendix B show risk activity across the last 12 months April 2025 to April 2026.

The Table below sets out the six sub-risks that currently exceed the acceptable thresholds for their respective domains, all of which are under active management. Ongoing assessments are in place to monitor residual risk, ensuring that new threats and vulnerabilities are promptly identified and addressed.

Risk ID & Score Threshold	Sub Risk Description	Current Score	Management of the Risk
SRR 001G Score 12 and below	Due to the failure to deliver a sustainable financial position and longer-term financial plan.	**20**	The residual risk is being **treated** through strengthened financial controls, while **opportunities are being taken** to redesign services for long-term sustainability.
SRR 001I Score 8 and below	Due to a failure to implement the required performance improvements in some areas of the organisation in line with the Health Board's Performance Management Framework domains of Quality and Safety, Operational Delivery, and Finance.	**12**	The residual risk is being **treated** and opportunities taken to strengthen services and accountability structures.
SRR 002A Score 8 and below	Due to the presence of Reinforced Autoclaved Aeriated Concrete (RAAC) within structures	**15**	The risk is being **tolerated** pending completion of remediation plans.
SRR 002B Score 8 and below	Due to significant levels of backlog maintenance and structural impairment.	**12**	The risk is being **treated** through proactive estate investment and maintenance planning.
SRR 004B Score 8 and below	Due to ineffective and insufficient arrangements across all service areas to respond to a Business Continuity or Critical Incident	**12**	The risk is being **treated** through the development, standardisation, and testing of business continuity and incident response plans.
SRR 010 Score 8 and below	Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act.	**12**	The risk is being **treated** through strengthening governance and **taking the opportunity** to enhance staff safety culture.

Strategic Risk Development and Maturity

A notable development during the period has been the reframing of the strategic risk relating to climate change and sustainability (SRR 011). This has broadened the scope of the risk to reflect the increasing importance of climate resilience, decarbonisation, and environmental sustainability within healthcare delivery. The revised articulation aligns more closely with national policy expectations and the longer-term strategic context within which the Health Board operates. While the risk remains within appetite, it is rated as extreme, reflecting both its complexity and potential impact.

Governance and Assurance

Governance arrangements for strategic risk have remained robust throughout the period. Risks continue to be subject to regular review through established structures, including Board and Committee oversight, with clear Executive ownership and accountability for each risk. This provides a consistent framework for scrutiny, escalation, and assurance.

Internal Audit has provided reasonable assurance that the Health Board's arrangements for strategic risk and assurance are fundamentally sound. However,

the review has also identified opportunities to strengthen the quality, consistency, and strategic focus of assurance. In particular, further work is required to enhance Executive-level scrutiny, improve alignment between risk and long-term strategy, and strengthen the clarity and quality of reporting.

In response, a programme of work has been initiated to strengthen assurance over the next three to six months. This includes formalising Executive scrutiny of the Strategic Risk Register, improving the quality and transparency of reporting, and strengthening the evidence base demonstrating the effectiveness of controls and mitigating actions. Collectively, these actions are intended to enhance the reliability and depth of assurance available to the Board and its Committees.

Conclusion

In summary, the period since December 2025 has been characterised by relative stability in the overall strategic risk profile, set against a backdrop of sustained operational and financial pressure. While there have been no fundamental changes to the principal risks, there have been important shifts in specific areas, most notably digital infrastructure, financial sustainability, and system performance.

A number of risks remain persistently outside appetite, reflecting long-standing structural challenges rather than short-term fluctuations. At the same time, governance and assurance arrangements remain well established, with a clear programme of improvement underway to enhance their effectiveness further.

Taken together, this provides a position of reasonable but not complete assurance, with continued reliance on the successful delivery of mitigation plans and the strengthening of assurance processes over the coming months.

Argymhelliad / Recommendation

The Audit, Risk and Assurance Committee is asked to:

- **NOTE** the strategic risk position and developments since December 2025;
- **CONSIDER** whether it has sufficient assurance regarding the effectiveness of risk management and internal control; and
- **NOTE** the programme of work underway to strengthen strategic risk and assurance arrangements.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	The Strategic Risk Report is informed by Datix, ensuring a bottom-up approach to risk escalation.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.

Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Choose an item. The Strategic Risk Register assesses risk that could impact achievement of all strategic priorities.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	N/A
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	At each meeting, the relevant Committee will monitor the risk theme relevant to its responsibilities.

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• **Workforce**	Not Applicable
• **Service Activity & Performance**	Not Applicable
• **Financial**	Not Applicable
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk

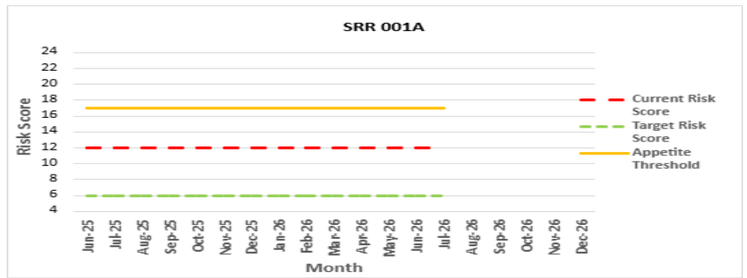
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives Choose an item.

Risk ID and Description				IMTP Link	Risk Score												
					2	3	4	5	6	8	9	10	12	15	16	20	25
SRR 001	Director of workforce and OD	There is a risk that the Health Board will be unable to deliver and maintain high quality safe and sustainable services which meet the changing needs of the population	a) Due to an inability to recruit and retain staff across all disciplines and specialities.	Workforce & Culture					X				●		◊		
			b) Due to a deterioration in, and a failure to improve, the well-being of our staff								×		●		◊		
			c) Due to insufficient and ineffective leadership levels throughout the organisation.						X				●		◊		
			d) Due to the threat of Industrial Action during ongoing disputes and negotiations at a national level							X					◊ ●		
	Director of Strategy, Planning and Partnerships.		e) Due to inadequate strategic plans which respond to population health and socio-economic needs	System Change					X	●					◊		
			f) Due to unsustainable service models						X				●		◊		
	Director of Finance and Procurement		g) Due to the failure to deliver a sustainable financial position and longer-term financial plan	Finance						X			◊			●	
	Director of Strategy, Planning and Partnerships.		I) Due to a failure to implement the required performance improvements in some areas of the organisation in line with the Health Board's Performance Management Framework domains of Quality and Safety, Operational Delivery, and Finance.	Performance Expectations & Workforce & Culture						X ◊			●				
SRR 002	Chief Operating Officer	There is a risk that there will be significant failure of the Health Board's estate	a) Due to the presence of Reinforced Autoclaved Aeriated Concrete (RAAC) within structures	Estates	X					◊				●			
			b) Due to significant levels of backlog maintenance						X	◊			●				
SRR 004	Director of Strategy, Planning and Partnerships.	There is a risk that the Health Board is unable to respond in a timely, efficient and effective way to a major incident, business continuity incident or critical incident	a) Due to emergency planning arrangements at both the corporate and operational level not being sufficiently robust to respond to a Major Incident	System Change					X	● ◊							
			b) Due to ineffective and insufficient arrangements across all service areas to respond to a Business Continuity or Critical Incident.						X	◊			●				
SRR 005	Chief Operating Officer	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system	a) Due to inadequate arrangements to support system-wide patient flow	System Change							X				● ◊		
SRR 006	Director of Digital	There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery	a) Due to the full or partial failure of existing digital infrastructure and systems	Digital, Data & Technology						X					● ◊		
			b) Due to an adverse impact on service delivery in the implementation of new digital systems						X						◊	●	
			c) Due to a failure to develop digital solutions that are sustainable and fit for the future							X			●		◊		
SRR 007	Director of Strategy, Planning and Partnerships.	There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population	a) Due to the likelihood of further austerity measures impacting effective collaboration with strategic partners across the Health Board footprint.	System Change & Regional Plans			X			●					◊		
			b) Due to the impact of fragile services across the regional and supra regional geography				X				●		◊				
SRR 008	Director Of Nursing	There is a risk that the Health Board fails to build positive relationships with patients, staff and the public	a) Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement	Quality			X			●					◊		
SRR 010	Director of Allied Health Professions and Health Science	There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in-line with its duties under the Health and Safety at Work Act 1974	a) Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.	Quality & Workforce & Culture					X	◊			●				
SRR 011	Director of Finance and Procurement	There is a risk that the Health Board does not adequately anticipate, plan for, and respond to the impacts of climate change, green health requirements, and the need to adapt and decarbonise its services, estate and infrastructure.	a) Due to an ageing and complex estate, competing capital and revenue pressures, climate-related service demand and the absence of an organisation-wide climate adaptation approach.	Green Health						X					● ◊		

Key	
Current Score	●
Target Score	×
Appetite Threshold	◊

RISK THEME	**PEOPLE**			
LINK TO IMTP	**SECTION 4: ENABLER – WORKFORCE AND CULTURE**			
Strategic - SRR 001 A	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**		**Publication Status**	**Public**
Threat *(As a result of)*	**Due to an inability to recruit and retain staff across all disciplines and specialties.**		**Risk Appetite Level – Open** Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.	
Impact *(Consequences of the threat)*	**Patient** • Adverse impacts on delivery of care to patients across acute and non-acute settings	**Staff** • Non-compliance with safe staffing principles and standards. • Increased Workload	**Organisation** • Operational Disruptions • Quality of Services • Reputational Damage • Financial strain – use of agency and bank staff	**Risk Appetite Threshold - Score 17 and below.** Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing. **SUMMARY** The current risk level is **OUTSIDE** of target level but **WITHIN** the appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.

Lead Director	Director of Workforce & Organisational Development	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee / Group	People & Culture Committee	**Likelihood**	**3** *(Possible)*	**3** *(Possible)*
Initial Date of Assessment	June 2023	**Impact**	**4** *(Major)*	**2** *(Minor)*
Last Reviewed	April 2026	**Risk rating**	**= 12** ***(High)***	**= 6** ***(Moderate)***
Next Review (Quarterly based on risk score)	July 2026			



Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Monitoring Framework to support roll-out of the People Plan. • Workforce Dashboard to track activity – recruitment, turnover, sickness absence. • Supply and demand tracker (Nursing and HCSW). • People Plan tracker to support delivery of actions within the People Plan 2025-2030 • Variable Pay Reduction Plan approved June 2022 and supported by the Programme Board. • Management of attendance through All Wales Management Attendance at Work Policy. • Duty of Quality - Section 6.8.2 Workforce and Section 6.8.3 Culture. • Nurse Staffing Levels (Wales) Act 201625b/25c. • Review of staffing and recruitment plan internally in line with Royal College Guidance, i.e., RCP. • Workforce planning supported by Compendium of new roles to support innovative workforce models. • Recruitment KPI's. • IMTP (Integrated Medium-Term Plan) Educational Commissioning. • Workforce Establishment controls national working group has been instigated and will be launching dashboard in April 2026 • Value and Sustainability Board. • Implementation of the Collective Agreement (Non-Pay Deal) 2022/24. • Real Living Wage Employer. • Workforce Supply Oversight Group (WSOG) established led by HEIW with HB executive membership • **Recruitment** • Engagement with national recruitment campaigns such ~~as BAPIO,~~ M&D Kerela Initiatives, Train, Work, Live and Student Streamlining for Registered Nurses, Physician's Associates, Midwives, and therapy staff and with HEIW (Health Education and Improvement Wales) for Resident Doctor. • Annual programme of Apprentice and RCN Connect recruitment. • Overseas Nursing (All Wales Recruitment programme). • Nursing Workforce Strategy 2023 – 2026	**Recruitment** • Approval to overrecruit to newly qualified nurses in September 2025, March 2026 and September 2026 resulting in zero forecasted RN vacancies in rostered areas. • Flexible RN training routes circa 35 predicted to complete training each year • Exploring potential of Overseas clinical attachments in other Divisions at both Junior and Senior grades (currently only Medicine) offering NHS experience to IMGs and provides a pipeline of suitable candidates to fill vacancies in future, particularly senior grades. • Working closely with HEIW for earlier notification of unfilled and part-time training posts. • Expand talent pools into areas with high turnover such as Facilities and Health Records. **Retention** • Development of career pathways (e.g., non-clinical to clinical). • Implementation of Talent Management and succession planning workshops. • NHS Wales Nurse Retention Plan quarterly updates being reviewed, submission update in September 2025. • HCSW retention plan developed in collaboration with Nursing focusing on areas of high turnover being reviewed monthly. • Introduction of new starter surveys in collaboration with Nursing and Midwifery directorate • Over 50 positive retention stories across all divisions collated and on the intranet. • Organisational turnover and exit reviewed and analysed leading to an initial deeper dive into estates and facilities. **Variable Pay Reduction** • Development of action plan based on WHC to support the reduction in bank and agency usage. **E- Systems** • Utilise benefits of roll out Safe Care staffing to support effective and efficient staff deployment within adult ward areas. • Roll out of medical rostering will resume in October 2025. This will help to predict junior doctor gaps and look for alternative ways to fill.

- Streamlining and improving recruitment timescales through recruitment modernisation programme (started Oct 2022)
- Partnerships with employability schemes and FE/HE to widen access.
- Actively working with Local Authorities to promote joint recruitment activities via Gwent Workforce Board.
- Working with partners to improve visibility and attraction.
- DBS Policy in place with DBS risk assessment form November 2024.
- Recruitment & Selection Policy published September 2025.
- Introduced centralised HCSW talent pools from September 2023.
- Future Nurse Academy introduced in January 2024.
- Fixed term Rotational posts for Registered Nurses to be introduced March 2026
- Internal Lateral Transfer Scheme for B5 Registered Nurses introduced January 2026

Retention

- Retention lead appointed with programme action plan in place for the next two years.
- Internal Retention group has been established with a view to 1) interrogating data from multiple sources to fully understand the issues 2) Turn the data into intelligence so that we can understand and respond to organisational and local level impacts.
- Changes in pension regulation and flexile retirement options from October 2023 and reduced break in service required following retire and return.
- Development of HCSW skills matrix and career framework has commenced.
- Talent management and succession planning framework and resources now live and available on SharePoint. Framework signed off by Executive Committee.
- Career conversations and succession planning resources designed; Talent management succession planning workshop dates available with spaces for 120 people (with monthly training sessions available). Sessions are nearly fully booked with 114/120 places booked**.** Further workshops planned until the end of the year.
- All Wales self-assessment retention tool completed and submitted to HEIW with assessment at organisational level for Nursing and Midwifery to provide a baseline.
- Launch and support of the NHS Wales Staff Survey (October and November 2025).

Variable pay reduction

- Plan in place to monitor and review all agency, bank pay incentives supply and demand reporting to Value and Sustainability Board.

E- Systems

- Effective deployment of current staff - Programme Plan implemented to introduce Workforce Medical E-Systems to support effective deployment of medical staff. E-Locum Bank, E-Job Planning, E-Agency systems are all 'live' and rolled out within the Health Board.
- Medical E-Rostering roll out is still not fully rolled out due to some development delays with the provider, but the first areas should be live by Summer of 2026

Development of Alternative and New Roles

- Development of alternative and new roles.
- A Gwent Strategic Workforce Action plan has been developed through co-production with our partners across Gwent and now forms the basis of the Gwent Workforce Board programme of work and agenda. The Action plan has been developed around the 7 key principles of A Healthier Wales: Our Workforce Strategy for Health and Social Care.
- Mental Health Workforce plan development in line with new Models of Care.

Training

- The HEIW Education & Training Plan 2025/26 continues the investment in education and training in Wales that has been increasing over past years.
- The 2025/26 education training plan demonstrated increases in a number of medical training places in medical, surgical, diagnostics and mental health specialities. This is to support areas of high vacancies, population health predictions and Welsh Government Priorities. The draft 2025/26 education and training plan proposes further increases in Wales training numbers in all branches of Nursing (adult, health visiting, practice. Training numbers in Therapies and Health Care Science programmes will remain static at previous year's numbers.
- HEIW have increased Health Care Support Workforce Development funding and there have been further changes for accelerated training pathways in some areas so support entry graduate level qualifications. Improved HCSW funding has enabled clinical induction to be delivered in house from April 2024 to accelerate time to effectiveness and improve employee experience.
- Ongoing investment in the Primary and Community Care Academy Network will be a key enabler to delivering innovation and transformation through the Strategic Workforce Plan for Primary Care and the Strategic Programme for Primary Care.
- Flexible routes to RN training in place through USW and Open University
- Cadet Nursing programme in place – 16 candidates attended for the 2024 induction and work is ongoing to support all 16 to achieve accreditations. - 16 RCN cadets attending All Wales HCSW Clinical Skills Induction, currently 12 active.
- K102 bridging model now being offered to support HCSW pathways into registered nursing.
- Development of Leadership Development programmes for key roles such as the Clinical Director post (CDx). Similar program for Directorate Managers (DMx) a 10-month leadership development program to support the capability of this key group commenced 23 April 2024 with cohort 2 launching June 2025. Nursing and Midwifery Academy for senior level nurses and midwifes, Leadership Development program (entry level) and Leading People (advanced Level) programmes fully booked. Core Leadership programme currently delivering to 200 staff per year.
- Delivery of workforce planning training.

Vacancy Numbers and establishment control

- Quarterly reporting of vacancy numbers have improved from 442wte to 330wte vacancies as of September 25 (all staff groups)

- Ensure compliance increase in e-job planning to optimise current resources and identify any gaps in provision.
- E-Job Planning compliance has remained static, and February's compliance was 54%. A Revised trajectory has been commissioned by the Medical Director for improvement to 80% in 26/27.
- Review and analyse the electronic Bank & Agency data from Patchwork to identify areas with high usage, reasons for use and potentially convert to substantive roles.
- Due to delays in development to allow for roll out of live rosters for Medical and Dental, a contract improvement notice has been issued to Patchwork.

Development of alternative and new roles

- Continued implementation and increase in new roles such as ~~Physician Associates~~, CAAPs, Enhanced and Advanced,consultant roles to support workforce skills gaps in line with IMTP.
- Updating of compendium of new roles and benchmarking is available via workforce planning intranet site and HEIW portal.
- Looking to increase Assistant band 4 in Community/Mental Health and areas such as Cardiology Physiology.
- Continue to extend scope of Advanced Clinical Practitioners to undertake new procedures, reporting etc reducing medical capacity.
- Increasing consultant therapy and nurse practitioners.
- RCN introduction of Registered Nursing Associate role to help build the capacity of the nursing workforce with placements from September 2027.
- Development of new roles and career pathways to support hard to fill roles in Health Visiting.
- Re-design of the Health Board's work experience programme with 246 applicants since March 2024 and 75 placements confirmed
- Development of Medical & Dental Recruitment & Retention Strategy 2025 – 2030.
- Looking to further widen access by partnering with DWP to offer 12-week unpaid placements to the unemployed with a view to offering training, support and guaranteed interviews – further promoting ABUHB as an employer of choice at entry level roles. This programme attracts £1000* per candidate and there is a maximum of 50 candidates we can support per year *(*as at July 2025).*
- Regional planning supporting a number of strategic workforce plans (Orthopaedics, Endoscopy, Women's Health Units, Vascular).

Workforce Supply and Demand Modelling

- 10-year draft predictions undertaken for future workforce requirements based on previous trends and training pipelines.
- HEIW leading several workforce initiatives to improve supply and demand modelling.

Training

- HEIW are increasing the capacity of training through creating more spaces for training the future Primary Care workforce, including Primary Care Academy.
- Workforce planning training prospectus of local and online training launched May 2025 and HEIW Workforce Planning Hub launched June 2025 with dates for 2026.
- Development opportunity being scoped for Business support staff.
- Suite of learning masterclasses launched with 5 topics now available to book, including influencing skills, setting up teams for success, giving feedback, having courageous conversations, having a meaningful PADR.
- Recruitment training for managers to streamline campaigns as much as possible to reduce time to hire.
- Development of training doctor fill rate dashboard to monitor and improve fill rate or to inform alternative recruitment strategies.
- A review and action plan underway to consider how to address instances where nurse streamlining preferences for specific posts exceed the number of vacancies available, to promote recruitment and retention.
- 31 staff enrolled on workforce planning online training modules level 1. 15 managers enrolled on level 2 training delivered locally March 2025. A capacity and capability workforce planning action plan are being developed to support 25/26 programme of activity.
- Launch of Admin Together staff network (now at 100 members) supporting administrative staff to connect, develop and address organisational challenges. Continued support of all staff networks.

• Development of ESR establishment control model commenced. Local delivery action plan has been agreed by the Executive Committee with expected 90% roll out completed by 31 October 2025. Dashboard to be launched late April 2026 A bespoke model will be developed to support medical staffing. **Staff attendance** • Support for staff who are absent in line with Managing Attendance at Work Policy, including those on long term absence with a view to signposting to self-help support, and adapting/adjusting roles to enable a safe return to work. • "Hot spot" areas identified and plans in place to support. **Band 2/3** • Implementation of the national Health Care Support Worker Job Description Framework has commenced and 98% completed for staff in post as 1st January 2026. This will re-band many Band 2 staff in nursing, maternity, and theatres to Band 3, improving engagement, retention, and recruitment.	

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*		**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*			
• Workforce reports to the Nurse Strategic Workforce Group. • Monthly sickness monitoring reports. • Weekly filled and unfilled shift reports (RN) and reports of agency for HCSW/RN. • Medical Staffing Co-ordinator review of medical rotas. • Cross site operational calls.	• Occupational Health and Wellbeing dashboards report KPIs. • Recruitment KPIs • Medical & Dental and Student Streamlining fill rate reports		
Level 2 Organisational *(Executed by risk management and compliance functions)*			
• Reports to the People and Culture Committee and the Board on the progress of the People Plan 2022-25 • Workforce Dashboard presented to the Executive Committee, P&CC Committee, and the Board. • Workforce and OD (Organisational Development) group established to support delivery and implementation of workforce plans to support Clinical Futures Service transformation. • Measurements of Wellbeing through the ABUHB	• (Aneurin Bevan University Health Board) Staff Survey • Routine Reporting against nurse staffing levels. • Variable Pay Programme Board reporting to Value and Sustainability Board • Resident Doctor Contract Reform Steering Group	• Governance processes • risk management input (register, risk assessment)	
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*			
• Internal Audit Reviews 2023 -24 • Long Term Sickness Absence Management (Q4) • Flexible Working (Q4) • External quarterly vacancy reporting to WG • National Workforce Implementation Plan: Addressing NHS Wales Workforce Challenges. The Strategic Workforce Implementation Board will report to the Minister for Health and Social Services with a collective view from a range of key partners including policy and professional leads in WG, and representatives of NHS employers, staff organisations and professional representative.	• External reporting on Nursing Staffing Levels • National Acuity Audits (Nursing) • Workforce planning external audit action plan 2024 and Structured Assessment Response August 2025 • Resident Doctor Contract Reform	• Latest local survey saw a reduction in staff wellbeing • Resident Doctor Contract Reform – element still in negotiation with BMA • 1000 new trainee posts in NHS England to commence in August 2026 which may impact on NHS Wales and the additional capacity required as a result of the new Resident Doctor Contract Reform	• Internal Audit Staff Culture Q3 2024/25 • Audit on Right to Work and International recruitment processes April 2026

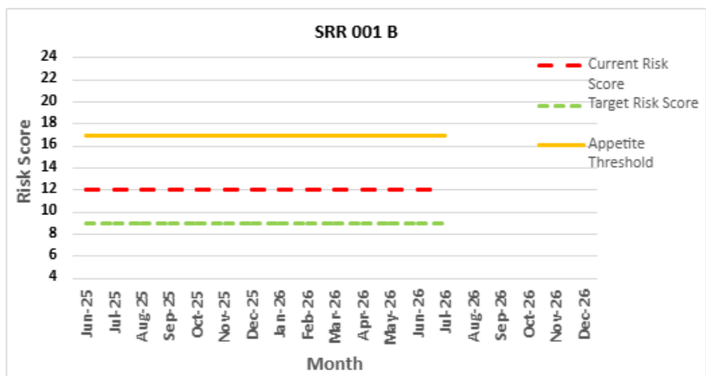
Assurance Rating (*Overall Assessment of controls and assurances)* *Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**POSITIVE ASSURANCE**

RISK THEME	**PEOPLE**			
LINK TO IMTP	**SECTION 4: ENABLER – WORKFORCE AND CULTURE**			
Strategic - SRR 001 B	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**		**Publication Status**	**Public**
Threat *(As a result of)*	**Due to a deterioration in, and a failure to improve, the well-being of staff.**			
Impact *(Consequences of the threat)*	**Patient** • Adverse impacts on delivery of care to patients across acute and non-acute settings	**Staff** • High absence levels, with some sustained long periods • Non-compliance with safe staffing principles and standards	**Organisation** • Reputational damage to the health board as an employer • Work-related claims • Financial Implications	
Lead Director	Director of Workforce & Organisational Development	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee / Group	People & Culture Committee	**Likelihood**	**3** *(Possible)* *x*	**3** *(Possible)* x
Initial Date of Assessment	June 2023	**Impact**	**4** *(Major)*	**3** *(Moderate)*
Last Reviewed	April 2026	**Risk rating**	**= 12** ***(High)***	**= 9** ***(High)***
Next Review (Quarterly based on risk score)	July 2026			

Risk Appetite Level – Open
Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.

Risk Appetite Threshold - Score 17 and below. Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.

SUMMARY
The current risk level is **OUTSIDE** of target level but **WITHIN** the appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.



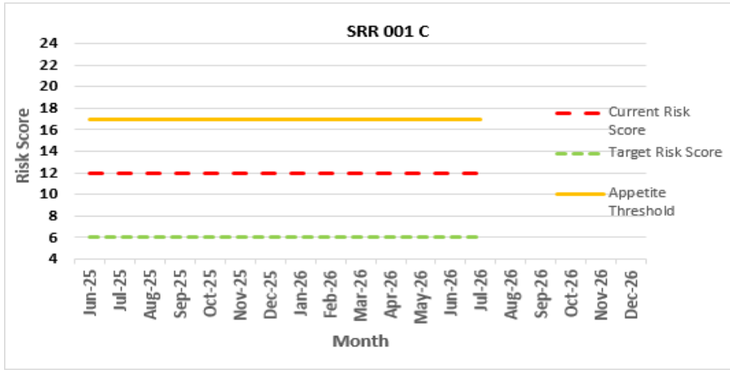
Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
General • Monitoring of absence, reasons for absence and trends in referrals to Occupational Health and Employee Well-being Service through Workforce Performance Dashboard • Dashboard reported to Executive Team, TUPF and LNC colleagues and People and Culture Committee with regular summary of Well-being and Occupational Health activity • Regular meetings with divisions to ensure staff are well supported and staff wellbeing is a priority • Strategic Equality Plan • Rest and Facilities Charter – monitoring and compliance • Staff related policies • National Staff Survey outcomes • External Employee Assistance Programme • Speaking up Safely Action Plan • Race/LGBT groups • Wellbeing resources • Staff diversity networks • Regular Schwartz rounds arranged across the Health Board • Taking Care giving care Rounds integrated into our leadership offers and available for teams to undertake either with support or on their own • Close links with the Arts in Health programme • Chaplaincy service for staff • Establishment of new bilingual Health and Well-being AB Pulse page on the intranet with library of resources for staff well-being Support offered to Trade Union Representatives and their members to ensure a positive experience of work and rapid escalation when appropriate • Support availability of "Safe Space" conversations for senior medical leaders from Faculty of Medical Leadership & Management. • An externally commissioned SUS hotline	**General** • Increase wellbeing initiatives, including long term strategic programmes within large departments (e.g., Maternity) • Identify, training and develop Respect and Resolution advocates (like Mental Health first aiders) • Take a data-based approach to improve our approach to Respect and Resolution processes, and supporting resources • Work with Professional Nurse Advocates (PNA) to explore ways to offer high quality support to nursing colleagues • Trained mediators so there is team and organisational resilience and network • Enhanced our financial well-being offer • Support offered to Trade Union Representatives and their members to ensure a positive experience of work and rapid escalation when appropriate • Support availability of "Safe Space" conversations for senior medical leaders from Faculty of Medical Leadership & Management • The Avoidable Employee Harm Programme, launched on 05 July 2022 initially focusing on HR processes has consistently resulted in a 60-70% reduction in investigations and a wide range of other organisational benefits over 3 years. The next phase of this programme will involve transferring the benefits to Respect and Resolution processes. • Implement, develop and embed the Speaking up Safely process in line with the Welsh Government Framework • We are planning a series of events to celebrate 10 Years of Schwartz Rounds within ABUHB • 'Safe atmospheres' training has been piloted to support the ongoing psychological safely focused work taking place in theatres and linked to 'never events' and team debriefing • Working with trade union and national partners to improve attendance at work and prevent absence through a variety of initiatives including Wellbeing Passport, alternative roles and health promotion. **Occupational Health.** • Regional occupational health partnership working being explored with Cardiff and Vale and also Cwm Taff, Phase 1 collaborative physician procurement process completed and implemented • Support equality and diversity of workforce

• An external Employee Assistance Programme (Vivup) has been commissioned for a further 12 months to offer additional psychosocial wellbeing support to staff, including a waiting list initiative **Occupational Health** • Additional occupational health resources secured to reduce waiting times • Occupational Health and NWSSP are working in partnership to implement a new Occupational Health Software system across Wales called OPASG2. OPASG2 provides benefits to employment and recruitment processes • SEQUASH accreditation applied for QTR 4 2025/2026. **Other** • Assessment of compliance against BMA Rest and Facilities charter complete with action plan developed, reporting to LNC	• Review of staff diversity networks • Development of a buddy system to assist international medical staff with induction and orientation and support values and current norms • Development of an empowerment passport to support disabled staff and reasonable adjustments and wellbeing **Staff Survey Action Plan** • Findings from the staff survey 2024/25 indicate improvements with culture and diversity • An ABUHB action plan has been developed to address staff engagement, work related stress and to improve retention of staff • Planning for 2026 staff survey underway to improve compliance and value of outcomes

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Dashboard reporting • Reporting to monitor the rollout of the People Plan 22-25 • Reporting to monitor of demand on wellbeing services	• Understand if support is reaching all staff	• Meetings with Divisions ongoing to ensure all areas are aware of what's available.
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• People and Culture Committee reports (People Plan 22-25) • Local wellbeing surveys • LNC – reporting of compliance of BMA Rest and • Facilities		
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
• National workforce surveys • Monitoring and compliance of BMA Rest and Facilities via NHS Employers • Staff Welfare Charter • Sickness Absence Audit 2023/24 – Outcome: Reasonable Assurance	• Latest local survey saw a reduction in staff wellbeing	• Internal Audit Staff Culture Q3 2024/25

Assurance Rating (*Overall Assessment of controls and assurances*) *Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**POSITIVE ASSURANCE**

RISK THEME	**PEOPLE**				
LINK TO IMTP	**SECTION 4: ENABLER – WORKFORCE AND CULTURE**				
Strategic - SRR 001 C	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**			**Publication Status**	**Public**
Threat *(As a result of)*	**Due to insufficient and ineffective leadership levels throughout the organisation**			**Risk Appetite Level – Open** Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.	
Impact *(Consequences of the threat)*	**Patient** • Adverse impacts on delivery of care to patients across acute and non-acute settings;	**Staff** • Adverse impacts on staff recruitment and retention	**Organisation** • Failure to deliver health board priorities, required improvements and achieve sustainability; • Poor levels of accountability and delivery; • Reputational damage to the health board as an employer;	**Risk Appetite Threshold - Score 17 and below.** Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.	
				SUMMARY The current risk level is **OUTSIDE** of target level but **WITHIN** the appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	
Lead Director	Director of Workforce & Organisational Development	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee / Group	People & Culture Committee	**Likelihood**	**3** *(Possible)*	**3** *(Possible)*	
Initial Date of Assessment	June 2023	**Impact**	**4** *(Major)*	**2** *(Minor)*	
Last Reviewed	April 2026	**Risk rating**	**= 12** ***(High)***	**= 6** ***(Moderate)***	
Next Review (Quarterly based on risk score)	July 2026				



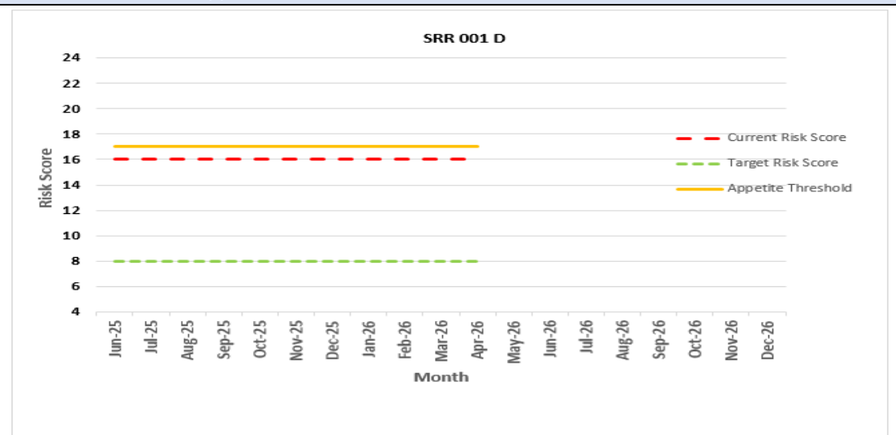
Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Talent and Succession Planning framework published • Monitoring Framework to support roll out of the People Plan – Focus on Talent and Succession Planning. • Monitoring Frameworks with HEIW • HEIW leadership programmes including for aspiring Directors and CEOs • Leadership journey and programmes mapped, variety of programmes and resources available ranging from aspiring to senior leaders. Including bespoke for Leading people and staff groups including Clinical Directors, Directorate Managers and Administrative Network. • Nursing Leadership Academy well established • Learning masterclasses have been designed and developed for the organisation addressing ley themes such as giving feedback, developing team and having courageous conversations. • OD and training available for local management levels as well as corporate organisational wide programmes.	**Talent and Succession Planning** • Development workshops being rolled across the Health Board, open for all leaders to attend. Ongoing and planned throughout 2026/27 • Designated Talent and Management succession planning resources available on ABUHB intranet and updated regularly. **Development leadership capabilities** • Currently exploring leadership funding options with USW to maximise Governmental Grants and utilisation of the apprentice levy. • Continued commitment to NHS graduate schemes. • Continued bespoke development and support for senior management teams in clinical and non-clinical settings focusing on leadership, team dynamics and thriving. • Working with HEIW to inform a national development programme for managers • Engagement with the management competency framework which will be adopted in Wales (following implementation in NHS England). • Review of current leadership journey and training with planning starting to develop a very senior leadership development programme in 2026/27 • Specific leadership and culture work starting in MHLD division with methods being developed to scale across the Health Board in 2026.

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• WOD Divisional reporting • Evaluation of internal leadership programmes and regular review of our internal offer		
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Reporting to People and Culture Committee - progress against People Plan 22-25 / 2025 – 2028.		
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
• Internal Audit Review • Talent and Succession Board		

Assurance Rating (*Overall Assessment of controls and assurances*) *Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**POSITIVE ASSURANCE**

RISK THEME	**PEOPLE**			
LINK TO IMTP	**SECTION 4: ENABLER – WORKFORCE AND CULTURE**			
Strategic - SRR 001 D	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**		**Publication Status**	**Public**
Threat *(As a result of)*	**Due to the threat of Industrial Action during ongoing disputes and negotiations at a national level**		**Risk Appetite Level – Open** Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.	
Impact *(Consequences of the threat)*	**Patient** • Adverse impacts on delivery of care to patients across acute and non-acute settings	**Staff** • Non-compliance with safe staffing principles and standards	**Organisation** • Litigation & Financial Penalties • Reputational damage to the health board and loss of public confidence	**Risk Appetite Threshold - Score 17 and below.** Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.
				SUMMARY The current risk level is **OUTSIDE** of target level but **WITHIN** the appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.

Lead Director	Director of Workforce & Organisational Development	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee / Group	People & Culture Committee	**Likelihood**	**4 (Likely)**	2 *(unlikely)*
Initial Date of Assessment	June 2023	**Impact**	**4** *(Major)*	**4** *(Major)*
Last Reviewed	April 2026	**Risk rating**	**= 16** ***(Extreme)***	**= 8** ***(Moderate)***
Next Review (Monthly based on risk score)	May 2026			

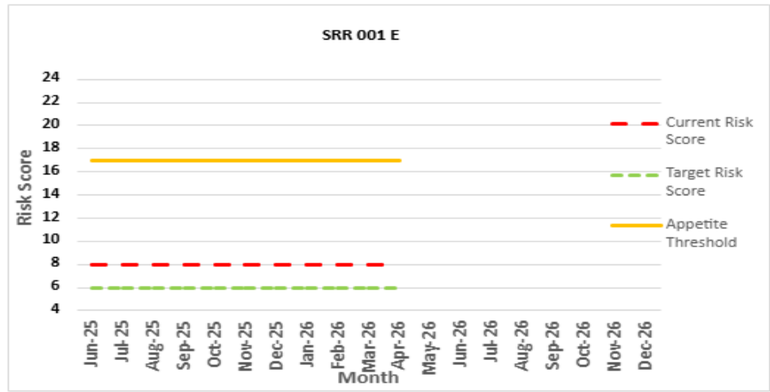


Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• All Wales Industrial Action Planning Group. • Local Health Board planning arrangements. • Section 234A of the Trade Union and Labour Relations (Consolidation) Act 1992; and • CODE OF PRACTICE Industrial Action Ballots and Notice to Employers. • Business Continuity Plans • Duty of Quality - Section 6.8.2 Workforce and Section 6.8.3 Culture. • Effective derogation processes including Christmas Day cover definition. • Local Negotiating Committee (LNC) and Trade Union Partnership Forum (TUPF) • Terms and conditions agreements in place for medical cover supported by NHS Wales Employer guidance. All Wales training sessions provide by legal and risk to support industrial action. • Picketing guidance supported and agreed. • Workforce Peer Networks – WOD's and DEWOD's. • Resident Doctor Contract agreed and implementation plan issued • Living Wage uplift to be applied from April 2026 as per WHC • Band 2/Band 3 assessments initiated • AFC pay award for 2026/27 announced for Agenda for change and Medical and Denral staff.	• Issue of WHC AFC non pay elements of collective agreement 2022-24. • . • Early notification of consultative ballot outcomes via NHS Employers/WG. • Local negotiation and response to grievances related to band 2/band 3 job descriptions for HCSWs. • Awareness of national TU ballot responses regarding pay dispute – early notification ahead of any strike action ballots for planning purposes. • Resident Doctor contract reform planning structure in place in conjunction with Medical Director. • CPD/Statutory and Mandatory training review in progress with TU colleagues. • Review of Health Visitor Job Description in partnership with Tus • Contribution to national Health Visitor working group • Resident Doctor contract implementation readiness assessment Contractual reviews/disputes supported with guidance from NHS Wales Employers

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Local Staff re-deployments assessment • Divisional engagement and service planning arrangements in place • Local Negotiating Committee (LNC) • Trade Union Partnership meetings • Established processes and tools used for previous industrial action.		Further industrial action
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Reporting to Executive team • Business Continuity groups • Command and control structure in place to be implemented as required		
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
• All Wales IA group and Welsh Government planning group. • Debriefing session planned to reflect and capture learning for any potential future action • Resident Doctor Contract Reform • Band 2/3 Implementation Framework – DRAFT, subject to Cabinet Secretary review/approval		

Assurance Rating (*Overall Assessment of controls and assurances*) *Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE ASSURNACE**

RISK THEME	SERVICE DELIVERY				
LINK TO IMTP	SECTION 3: SYSTEM CHANGE				
Strategic/ Corporate Risk SRR 001 E	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**			**Publication Status**	**Public**
Threat *(As a result of)*	**Due to inadequate strategic plans which respond to population health and socio-economic needs.**			**Risk Appetite Level – OPEN** Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.	
Impact *(Consequences of the threat)*	**Patient** • Increased patient acuity levels • Worsening of health inequalities • Worsening of health outcomes	**Staff**	**Organisation** • Failure to train teams in multi-morbidity management • Failure to comply with the Wellbeing of Future Generations Act (Wales) • Reputational damage and loss of public confidence • Increased demand	**Risk Appetite Threshold – SCORE 17 AND BELOW** Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.	
				SUMMARY The current risk level is **OUTSIDE** of target level but **WITHIN** the appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	
Lead Director	Director of Strategy, Planning and Partnerships	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee / Group	Partnerships, Public Health and Planning Committee	**Likelihood**	**2** *(Unlikely)* x	**2** *(Unlikely)* x	
Initial Date of Assessment	June 2023	**Impact**	***4*** *(Major)*	**3** *(Moderate)*	
Last Reviewed	November 2025	**Risk rating**	**= 8 *(Moderate)***	***= 6 (Moderate)***	
Next Review (Six monthly based on risk score)	May 2025				

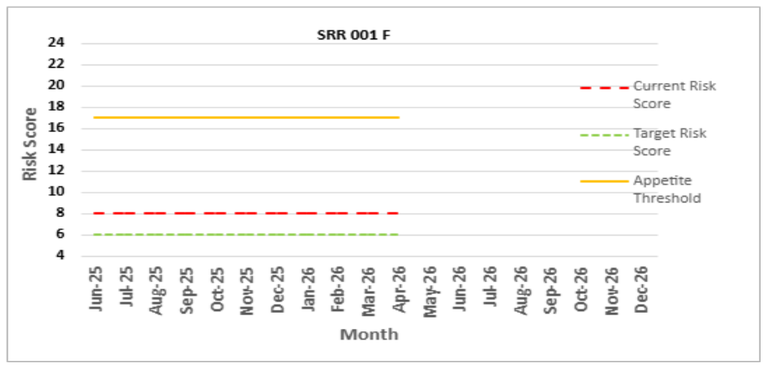


Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Health Board IMTP and associated KPIs • Public Health Wales surveillance data • Qliksense – performance dashboard • Population Needs Assessment and Area Plan • Marmot Region Programme	• Area plan is being refreshed through the RPB • Marmot Region Implementation Plan • Population health management – test and learn using segmentation and risk satisfaction using linked data to target resource. • Refresh organisational strategy with a central focus on population health and wellbeing. • Action through SEW Regional Collaborative to identify additional service areas where collaboration and networking would support sustainability

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Qliksense – performance information • SFN – performance information		• Effectiveness of the plans in delivering improvements
Level 2 Organisational *(Executed by risk management and compliance functions)*		

• IMTP Delivery and Outcomes Reporting to Board • Marmot Region Programme • RPB reporting to Board and Population Health, Planning and Partnerships Committee	• Regional Planning reporting to Population Health, Planning and Partnerships Committee		
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*			
Internal Audit Reviews 2023-24 • IMTP Planning (Q1) Outcome – Reasonable Assurance **Internal Audit Reviews 2024-25** • Internal Audit Partnership Arrangements – **Limited Assurance**		• Outcome of the Internal Audit Partnership Arrangements scheduled for Q1 2024/25 Plan	
Assurance Rating (*Overall Assessment of controls and assurances) Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE ASSURNACE**

RISK THEME	**SERVICE DELIVERY**				
LINK TO IMTP	**SECTION 3: SYSTEM CHANGE**				
Strategic Risk **SRR 001 F**	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**			**Publication Status**	**Public**
Threat *(As a result of)*	**Due to unsustainable Service Models**			**Risk Appetite Level – OPEN** Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.	
Impact *(Consequences of the threat)*	**Patient** • Increased demand • Increased patient acuity levels • Worsening of health inequalities • Worsening of health outcomes	**Staff** N/A	**Organisation** • Failure to train teams in multi-morbidity management • Failure to comply with the Wellbeing of Future Generations Act (Wales) • Reputational damage and loss of public confidence	**Risk Appetite Threshold – SCORE 17 AND BELOW** Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.	
				SUMMARY The current risk level is **OUTSIDE** of target level but **WITHIN** the appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	
Lead Director	Director of Strategy, Planning and Partnerships.	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee / Group	Partnerships, Public Health & Planning Committee	**Likelihood**	**2** (Unlikely) x	**2** (Unlikely) x	
Initial Date of Assessment	June 2023	**Impact**	***4** (Major)*	**3** (Moderate)	
Last Reviewed	November 2025	**Risk rating**	**= 8** **(Moderate)**	***= 6*** ***(Moderate)***	
Next Review (Six monthly based on risk score)	May 2026				



Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• The Health Board's Integrated Medium-Term Plan (IMPT) and associated KPIs • Strategic Programmes in place • Public Health Wales surveillance data – Covid, flu and other communicable diseases. • Qliksense – performance information. • Population needs assessment and area plan development by the RPB. • Southeast Wales Plan for fragile services.	• Area plan is being refreshed through the RPB. • Population health management – test and learn using segmentation and risk satisfaction using linked data to target resource. • Review of enhanced local general hospital service models to ensure sustainable quality services. • Development of SEW plan for fragile. • Review of organisational strategy

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Public Health Wales surveillance data – COVID, flu and other communicable diseases. • Qliksense – performance information		• Evidence of individual arrangements in place to deliver service plans.
Level 2 Organisational *(Executed by risk management and compliance functions)*		

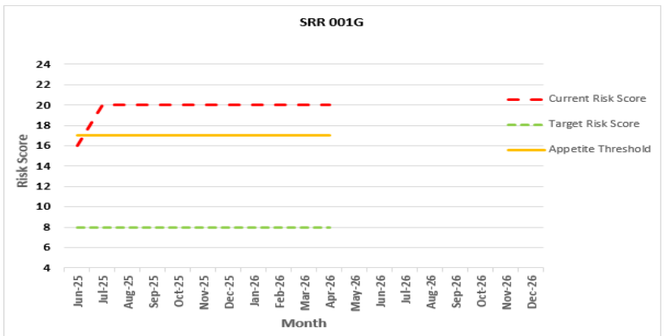
• IMTP delivery and outcomes reporting to Board. • RPB reporting to Board and Population Health, Planning and Partnerships Committee. • Clinical Futures Programme Reporting to Population Health, Planning and Partnerships Committee.	• Regional Planning reporting to Population Health, Planning and Partnerships Committee. • Clinical Futures Programme Reporting to Population Health, Planning and Partnerships Committee.		
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*			
Internal Audit Reviews 2023-24 • IMTP planning Q1. Outcome – Reasonable Assurance. **Internal Audit Reviews 2024-25** • IMTP – Service Plans (Q2) – Outcome - Reasonable Assurance • Partnership Arrangements. Outcome – Limited Assurance		• Recommendations identified in the Limited and Reasonable Assurance Internal Audit Reports from the 2024/25 Audit Plan	• Implementation of the management responses to close off recommendations
Assurance Rating (*Overall Assessment of controls and assurances) Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE ASSURNACE**

RISK THEME	**FINANCIAL SUSTAINABILITY**			
LINK TO IMTP	**SECTION 4: ENABLER - FINANCE**			
Strategic - SRR 001 G	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**		**Publication Status**	**Public**
Threat *(As a result of)*	**Due to the failure to deliver a sustainable financial position and longer-term financial plan.**			
Impact *(Consequences of the threat)*	**Organisation** • Breach of statutory duty to breakeven over 3 years. • Instigation of NHS Wales Escalation & Intervention Arrangements. • Non–delivery of Health Board priorities, required improvements, and achieving longer-term sustainability. • Prioritisation and possible disinvestment in service delivery. • Reputational damage and loss of public confidence.			
Lead Director	Director of Finance and Procurement	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee / Group	Finance and Performance Committee	**Likelihood**	**5 (Almost certain)** x	2 (Unlikely) x
Initial Date of Assessment	June 2023	**Impact**	***4** (Major)*	**4** (Major)
Last Reviewed	April 2026	**Risk rating**	**= 20 (Extreme)**	***= 8*** **(Moderate)**
Next Review (Monthly based on risk score)	May 2026			

Risk Appetite Level – CAUTIOUS
Preference for safe, though accept there will be some risk exposure: medium likelihood of occurrence of the risk after application of controls

Risk Appetite Threshold – Score 13 and Below
Risks relating to all aspects of the Health Board's financial performance and its ability to manage cost and efficiencies.

SUMMARY
The current risk level is **OUTSIDE** of target and appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.



Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• IMTP 25/26-27/28 • IMTP Delivery Framework • Sustainability Route Map revision • Accountability Framework • Performance Framework • 3-year route map to sustainable recovery developed and approved by Board July 24. • Scheme of Delegation • Standing Financial Instructions (SFIs) • Standing Orders (SOs) • Final budget delegation • Financial Control Procedure (FCP) Budgetary control • Financial Budget Intelligence (FBI) • Appropriately trained Finance Team (capacity & capability) • Budget holder training & other business training tools • Cost intervention procedures • 25/26 savings plans & opportunities. • Health Board financial escalation processes. • Health Board Pre-Investment Panel (PIP) process. • Financial assessment and review to incorporate the financial impact of COVID-19 and other key costs. • Executive groups and structures established to deliver statutory duties. • Assessment of financial control environment within divisions and corporate teams. • Financial Escalation Meetings • Regular organisational Recovery plan meetings and briefings • Value & Sustainability Board established. • Revised accountability arrangements part of Executive governance. • Budget holder financial recovery deep dive meetings,	• Revised V&SB approach for 2025/26 to help drive financial recovery, separating thematic and divisional scrutiny. • Service Redesign disaggregated as a V&SB theme • Review of programme structures to match V&SB thematic areas • Updated Route Map development • Focus on future opportunity development to deliver 3-year financial plan – through programmes under the VS&B structure.

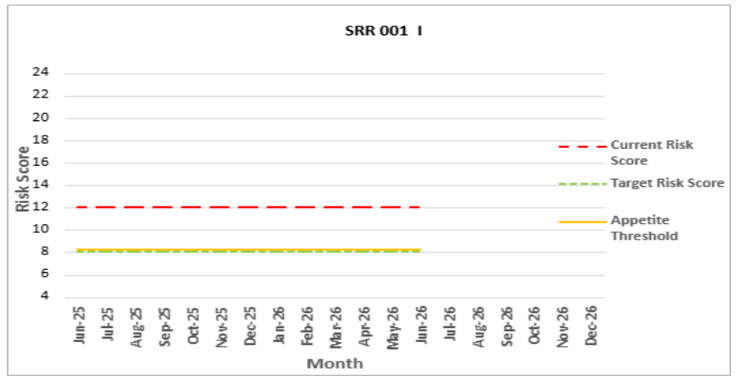
• Enhanced forecasting and planning processes	

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Adherence to SO/SFI/FCPs • Regular AFD meetings to discuss position and performance. • Day 5 comprehensive financial performance review – DoF led. • Divisional Assurance meetings are in place to implement savings plans and deliver service and workforce plans within available resources – part of Chief Operating Officer governance	None	• Greater focus is required on service, workforce, and financial plans all balancing to achieve financial sustainability. • Development of detailed 3-year recovery plan.
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Regular monitoring at the Executive Team reviewing the level of deliverable recurrent savings along with assessing cost avoidance and deferred investments. • Performance escalation meetings established. • Financial assessment and review report to the Board and Finance & Performance Committee • Financial Governance and Accounting reports to the Audit, Risk and Assurance Committee. • Board Briefing sessions on the financial position.	None	• 2025/26 – 27/28 IMTP plans focussed on 'living within' budget levels. • 2025/26 savings plan to be delivered. • Detailed delivery plans will be a constant development over next 3 years.
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
Internal Audit • Annual Report • 2024/25 Financial Sustainability – **Reasonable Assurance** Sept 2025 • 2025/26 - Audit Reviews **External Audit Reports** • 2024 -25 – Annual Report • 2025/26 - Audit Reviews **Welsh Government** • Financial assessment and review reports to Welsh Government – monthly • Enhanced monitoring T.I. meetings with Welsh Government monthly • IMTP plan to WG end of March 2025	• Recommendations from audits	• Implement management actions to complete the recommendations from audit reports

Assurance Rating (*Overall Assessment of controls and assurances*) *Guidance*

Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE ASSURNACE**

RISK THEME	**COMPLIANCE AND SAFETY**				
LINK TO IMTP	**SECTION 2: DRIVERS – PERFORMANCE EXPECTATIONS**			**SECTION 4: ENABLERS – WORKFORCE & CULTURE**	
Strategic Risk **SRR 001 I**	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, sustainable services that meet the needs of the population.**			**Publication Status**	**Public**
Threat *(As a result of)*	**Due to a failure to implement the required performance improvements in some areas of the organisation in line with the Health Board's Performance Management Framework domains of Quality and Safety, Leadership, Corporate Governance, Operational Performance and Delivery, and Finance.**			**Risk Appetite Level – MINIMAL** Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurrence of the risk after application of controls.	
Impact *(Consequences of the threat)*	**Patient** • Unintended Patient Harm. • Negative Public/Patient Experience.	**Staff** • Reduced Staff Morale leading to potential absence from work.	**Organisation** • Loss of patient/public trust and confidence. • Scrutiny from external organisations. • Adverse publicity. • Punitive Actions. • Financial implications.	**Risk Appetite Threshold – SCORE 8 AND BELOW** Risks relating to all aspects of patient safety but also including safeguarding, staff & public security in addition to risks relating to compliance and/or legal implications.	
				SUMMARY The current risk level is **OUTSIDE** of target and the appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	
Lead Director	Director of Strategy, Planning and Partnerships.	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee	Finance and Performance Committee.	**Likelihood**	3 (Possible) x	**2** (Unlikely x	
Initial Date of Assessment	April 2024.	**Impact**	***4*** *(Major)*	**4** (Major)	
Last Reviewed	March 2026	**Risk rating**	**= 12** **(High)**	**= 8** **(Moderate)**	
Next Review (Quarterly based on risk score)	June 2026				

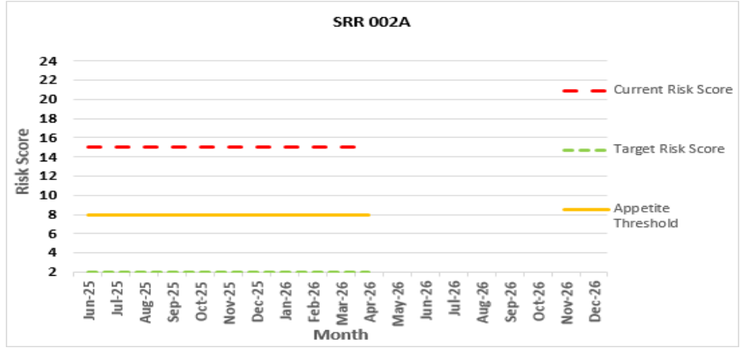


Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Performance Management and Assurance Framework- revised, updated and approved in 2025 • Executive Accountability letters • Divisional Directors Accountability letters • Monthly Assurance meetings with weekly meetings for Urgent Care • Escalation processes triggered for Divisions in escalation – including improvement plans and fortnightly oversight (as above) with agendas that focus on priority areas. Reviewed at 6 months with proposed adjustments awaiting sign off • Reporting through to Finance and Performance Committee via Executives • Specific areas of focus are discussed at Value and Sustainability Board • System wide way of working to progress an operational framework, develop winter plans, escalation processes, etc. • External scrutiny via Welsh Government and NHS Executive through revised Escalation Framework • Capacity to run the performance framework and reporting requirements has been strengthened with revised corporate performance team structure, accountability and reporting processes	• 6-month review of Performance Management and Assurance • Alignment of internal mechanisms to national escalation linked to transformation programmes with clear deadlines • Focussed agendas targeting specific areas of concern and areas for improvement – working with the Business Partners to ensure a joined-up approach. • Standardised Divisional Assurance Templates (pre-populated) and revised as part of the Performance Management Framework review • Commission external reviews to support improvements where required. • Appropriate Business Partnering Support and analytical support • Realign capacity and/or redefine roles to provide explicit support and in line with the revised triggers for escalation

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*		Gaps in Assurance *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	Actions to Address Gaps *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*			
• DMTs in place for all Divisions • Divisional oversight arrangements – monthly/fortnightly meetings • Divisional plans in place and focussed agendas • Cross Divisional meeting monthly – progress the wider system way of working.	• System Leadership Team for awareness and updates • Divisional Assurance • Escalation meetings/Deep Dives as appropriate • Revised internal PMF • Update National Escalation Framework		
Level 2 Organisational *(Executed by risk management and compliance functions)*			
• Established reporting to the Executive Committee • Established reporting to the Finance and Performance, Quality Management Group, People and Culture Committee , and Patient, Quality and Safety and Learning Committee • Established reporting to the Board • Routine reporting through the IQPD process and Escalation meetings , for example Planning monthly Touchpoint and Finance monthly touchpoint •		None	N/A
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*			
• Internal Audit 2024/25 Plan • Divisional Governance Arrangements • HIW Inspections • Llais for feedback		• Findings and recommendations from the PMF review launched Q4 • Findings and recommendations from Directorate Reviews in line with escalation statuses	

Assurance Rating (*Overall Assessment of controls and assurances)* *Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE ASSURNACE**

RISK THEME	**COMPLIANCE AND SAFETY**				
LINK TO IMTP	**SECTION 4: ENABLERS - ESTATES**				
Strategic Risk SRR 002 A	**There is a risk that there will be significant failure of the Health Boards Estates.**			**Publication Status**	**Public**
Threat *(As a result of)*	**Due to the presence of Reinforced Autoclaved Aeriated Concrete (RAAC) within structures.**			**Risk Appetite Level – MINIMUM** Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurrence of the risk after application of controls.	
Impact *(Consequences of the threat)*	**Patient** • Harm or injury to patients • Adverse impacts on delivery of care to patients across acute and non-acute settings	**Staff** • Harm or injury to staff	**Organisation** • Litigation & Financial Penalties • Loss of estate	**Risk Appetite Threshold –** Score 8 and below Risks relating to all aspects of patient safety but also including safeguarding, staff & public security in addition to risks relating to compliance and/or legal implications.	
				SUMMARY The current risk level is **OUTSIDE** of the target level and appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold	
Lead Director	Chief Operating Officer	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee / Group	Partnerships, Public Health and Planning Committee	**Likelihood**	**3** (Possible) x	**1** (Rare) x	
Initial Date of Assessment	June 2023	**Impact**	***5*** *(Catastrophic)*	**2** (Minor)	
Last Reviewed	April 2026	**Risk rating**	**= 15 (Extreme)**	**= 2 *(Low)***	
Next Review (Monthly based on risk score)	May 2026				



Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Work to assess the risk has been undertaken with expert external surveyor advice. Repeat surveys undertaken on 6 monthly intervals (surveys in December 25 and January 26) • Funding agreed from Welsh Government to implement actions related to surveys and specific actions relating to 'skylights'. Some will require more substantial work -which are being scoped. • Current measures including props and additional support have been put in place in line with the latest guidance and learning from other organisations working through RAAC issues. Plans will be modified in line with any further guidance • Remediation work to areas of high-risk areas undertaken • Controlled access to roof areas which is being enhanced with proposals around cameras and designated walkways • Implemented toolbox talks for awareness for estate teams and contractors to work in area where RAAC is present. • Ongoing engagement with expert surveyor • Estates and Facilities Divisional Compliance team engaged in supporting the estate's function response to the ongoing management • Risk assessments completed by the Health and Safety function in departments with props to manage any consequences of the presence of props. Note: H&S assessments are around the location of props have been reviewed by H&S team and feedback provided to departments • Links with NHS England and other Health Boards in Wales for shared learning. • Regular dialogue with Welsh Government and Shared Services Estates. • Management Action Plan agreed following Internal Audit including the development of a Management Strategy and submitted to the ABUHB Health and Safety 'Committee' in March 2025	• Additional Surveys continue to take place with expert surveyors to inform the next steps relating to further remediation of the issues and monitor existing issues • Management Strategy and the Management Plan are completed and was approved at the Health & Safety Committee in April 2025

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Monthly checks in place for the props albeit fortnightly checks in new prop locations in OPD 2 department • Outcome of surveys continuing, and reinspection of conditions (a regular 6 monthly inspection) • Review of existing arrangements in place supported by external body	• Ongoing management of the issues. • Latest report (received March 2026 has recommended additional works as well as a need to take more substantive actions proactively due to the duration of the presence of temporary steps previously taken •	Recommendations from latest report to be developed into proposals for action Recommendation is to now form the works as a capital scheme as opposed to a series of reactive works and this will be scoped for formal consideration through capital processes onto Executive Committee
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Health Board Fire and Health and Safety function engaged in fortnightly governance group to monitor • risks and issues associated with any remedial measures implemented. • Outcome of H&S risk assessment in place and reviewed May 2025. H&S team reissued the assessments to Department Leads in January 26 to review locally • Formal reporting to the Board/Committees in place • SOC approved by Health Board and submitted to Welsh Government, autumn 2025	None	N/A
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
• Internal Audit 2024/25 Plan – report received as Reasonable Assurance (albeit Substantial Assurance on the process relating to surveys. Report submitted to Audit Committee November 2024. • Internal Audit also commented that the risk appetite needs to reflect the current position of monitoring and managing the RAAC pending SOC and FBC hence appetite of 15 should be considered by Board.	• Recommendations identified in the Reasonable Assurance Internal Audit Reports from the 2024/25 Audit Plan	• Repeat surveys have been completed and once the latest report from these surveys is received any necessary additional actions will be implements **Internal Audit 2024/25 Plan** • Implementation of the management responses to close off recommendations been concluded.

Assurance Rating (*Overall Assessment of controls and assurances*) *Guidance*

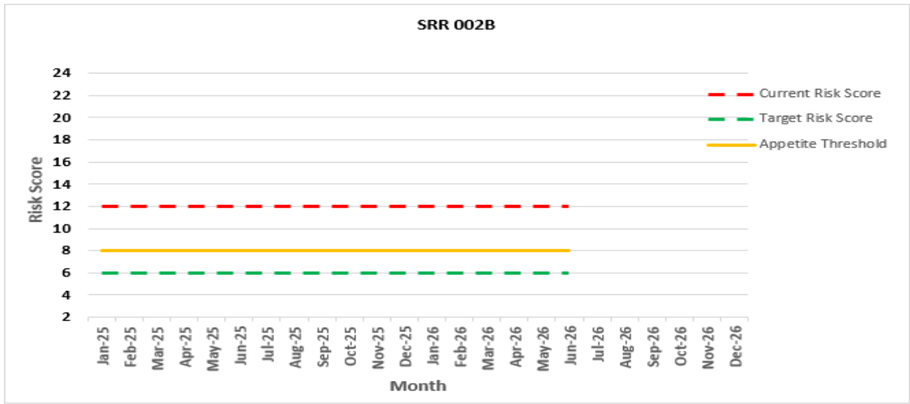
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE ASSURNACE**

RISK THEME	**COMPLIANCE AND SAFETY**			
LINK TO IMTP	**SECTION 4: ENABLERS - ESTATES**			
Strategic Risk SRR 002 B	**There is a risk that there will be significant failure of the Health Boards Estates.**		**Publication Status**	**Public**
Threat *(As a result of)*	**Due to significant levels of backlog maintenance and structural impairment.**			
Impact *(Consequences of the threat)*	**Patient** • Harm or injury to patients. • Adverse impacts on the delivery of care to patients across acute and non-acute settings.	**Staff** • Harm or injury to staff.	**Organisation** • Non-compliance with health and safety legislation. • Litigation and financial penalties. • Loss of estate	
Lead Director	Chief Operating Officer	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee / Group	Partnerships, Health Protection & Planning Committee	**Likelihood**	**3** (Possible) x	**3** (Possible) x
Initial Date of Assessment	June 2023	**Impact**	***4*** *(Major)*	**2** (Minor)
Last Reviewed	April 2026	**Risk rating**	**= 12 (High)**	**= 6 (Moderate)**
Next Review (Quarterly based on risk score)	July 2026			

Risk Appetite Level – MINIMAL
Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurrence of the risk after application of controls.

Risk Appetite Threshold – SCORE 8 AND BELOW
Risks relating to all aspects of patient safety but also including safeguarding, staff & public security in addition to risks relating to compliance and/or legal implications.

SUMMARY
The current risk level is **OUTSIDE** of the target level and appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.



Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Health Board Estates Rationalisation Strategy • Health Board Estates Strategy • Health Board policies and procedures related to the maintenance of Health Board estate. • 6 Facet survey completed in 2019. • Divisional Risk Register • Multiple policies and SOPs published and communicated to staff. • A robust internal training programme in place covering all aspects of estate management including food hygiene. • Improved statutory compliance processes and forum led by Designated Person - DP (Divisional Director) • Asbestos reinspection programme (over the next 3 years) • Additional capital allocation to Estates and Facilities for backlog maintenance reduction of £500k from discretionary allocation • HB-wide groups on compliance (such as Ventilation and water) are widened in membership to ensure clinical services are active participants	• Active estate rationalisation (including leases) is required to reduce estate demands and help prioritise capital spend to reduce backlog maintenance. • Ongoing attempts to recruit to workforce gaps and a new model of Estate Officer also being developed to assist with recruitment and retention of staff in the workforce. • Planning function leading a review of capital priorities which may help identify additional funding priority given to backlog maintenance. • Policies being reviewed and priority given to out-of-date policies, but all policies will be reviewed for effectiveness and compliance with HTM. • Drive clinical service engagement in compliance meetings where engagement is low. • Additional escalation for capital funding by the Division Estates and Facilities to support the prevention of seasonal issues and plant failure if possible. • Continuation of the additional £500k backlog maintenance allocation by the Board to the Estates and Facilities Division in 2026/27 • Informed by the risk assessment processes of the Estates and Facilities Division, the Health Board has secured significant investment in estate during 2025/26 and 2026/27 from the All-Wales Targeted Estates Fund (TEF). Discussions commencing with WG relating to any TEF monies for 27/28 and additional bids being submitted for additional monies for Mental Health in 2026/27 • Elements of St Woolos Hospital estate beien closed as part of the Board agreement to rationalise the site and remove use of old and poor estate. Business case for WG investment being developed to further rationalise the estate • Condition survey (commonly referred to as 6 facet) being scoped for completion in early 2026/27 to inform the estates strategy

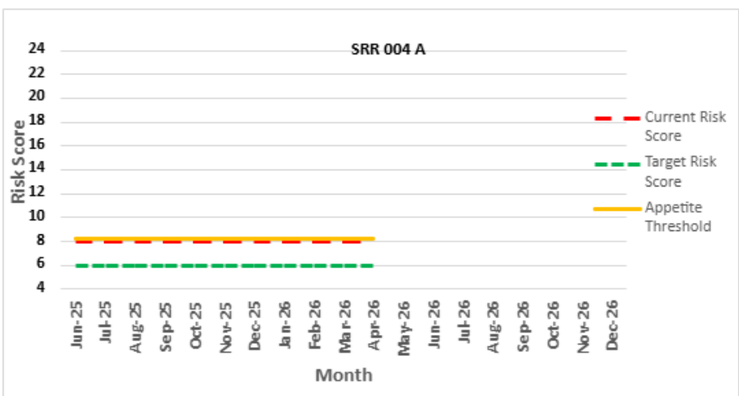
• A clear approach to compliance monitoring and escalation of AE reports has been implemented	

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Divisional reporting of Statutory and Mandatory training of staff • Staff training levels are monitored and reported regularly. If areas of non-compliance are noted, targeted training can be resourced to ensure compliance.	• If the revised approach for monitoring and escalation of AE reports is effective in reducing the level of a deterioration.	• Performance reporting
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• The divisional risk register is reviewed quarterly by the Senior Management Board this is reported to the Quality & Patient Safety Operational Group. • Regular reporting on estate condition to the Executive Committee and Partnerships, Health Protection & Planning Committee. • Divisional Director Estates and Facilities presented to Committee in December 2024 and February 2026 • Divisional Director Estates and Facilities presented to Committee on St Woolos Hospital project in October 2025.	None	N/A
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
Internal Audit Reviews 2023- 24 • Estates Assurance - Estate Condition. Audit completed and been shared with Audit Committee and • Finance and Performance Committee Internal Audit Plan 2024-25 • Estates Assurance – Energy Management (Q2) Outcome = Reasonable Assurance. Reported to the November ARA • Authorising Engineer (Shared Service Estates) reports in line with normal timelines, but active engagement with AEs through compliance processes. • Health Board contributes to annual Estates Facilities and Performance Managements (EFPMS) at all Wales level	• Recommendations identified in the Reasonable Assurance Internal Audit Reports from the 2024/25 Audit Plan	**Internal Audit 2024/25 Plan** • Implementation of the management responses to close off recommendations • Audit Wales completing an all-Wales audit on estate condition in Q4 2025/26

Assurance Rating (*Overall Assessment of controls and assurances*) *Guidance*

Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE ASSURNACE**

RISK THEME	**COMPLIANCE AND SAFETY**				
LINK TO IMTP	**SECTION 3: SYSTEM CHANGE**				
Strategic Risk SRR 004 A	**There is a risk that the Health Board is unable to respond in a timely, efficient and effective way to a business continuity incident or critical incident**			**Publication Status**	**Public**
Threat *(As a result of)*	**Due to emergency planning arrangements at both the corporate and operational levels lacking the necessary robustness to ensure an effective response.**			**Risk Appetite Level – MINIMAL** Ultra-safe leading to only minimum risk exposure as far as practicably possible; a negligible/ low likelihood of occurrence of the risk after application controls.	
Impact *(Consequences of the threat)*	**Patient** • Adverse impacts on delivery of care to patients across acute and non-acute settings • Harm or injury to patients	**Staff** • Inability to respond to a major incident to meet needs of those affected • Harm or injury to staff	**Organisation** • Health Board breaches statutory duties under the Civil Contingencies Act 2004 • Litigation & Financial Penalties • Reputational damage and loss of public confidence	**Risk Appetite Threshold – SCORE 8 AND BELOW** Risks relating to all aspects of patient safety but also including safeguarding, staff and public security in addition risks relating to compliance and/or legal implications.	
				SUMMARY The current risk level is **OUTSIDE** of target level but **WITHIN** the appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	
Lead Director	Director of Strategy, Planning and Partnerships	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee / Group	Partnerships, Public Health & Planning Committee	**Likelihood**	2 (Unlikely) x	2 (Unlikely) x	
Initial Date of Assessment	June 2023	**Impact**	*4 (Major)*	3 (Moderate)	
Last Reviewed	November 2025	**Risk rating**	**= 8 (Moderate)**	**= 6 *(Moderate)***	
Next Review (Six-monthly based on risk score)	May 2026				



Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Local/Divisional action cards are in place in key areas • Training undertaken service-specific relating to local response. • Major incident exercise 'Euclid' undertaken 20 June 24. Approx. 100 participants and external observers, demonstrated that the Health Board was able to successfully respond to an incident. As a result of the exercise action cards refreshed and renewed with teams to incorporate learning • Internal strategic on call training • Executive Team attending 2-day strategic training. • Loggist training is provided and accessed regularly • New all Wales logbooks are in place for use • Regular liaison with Gwent Local Resilience Forum (Strategic and tactical) • Joint Planning and Training with LRF and across Wales. • Ongoing Participation in exercises UK, Wales, LRF and HB. • Provide quarterly training sessions for on call gold and silver managers, to maintain skills in incident management, update knowledge in relation to risks and learning from local and national incidents. Test and exercise using the multiagency Joint decision model and the principles of joint working (JESIP)	• Continue to deliver training programmes to support staff preparedness to response to an incident. • Additional 'local' team and intra team exercises to take place for areas to practice and embed their response to a major incident together • Embed an alert, activation and escalation pathway that follows the Health Board predefined C3 (Command, control, and Coordination) structure of strategic, tactical, and Operational. • BCPs in place across all services. Work with the Corporate Governance Directorate (Head of Corporate Risk and Assurance) to support improvements in the development of BCP's across key operational areas. • National pandemic exercise Pegasus Autumn 2025 • Development of a pan plan to support pandemic pathways (HCIDs e.g., MPOX)

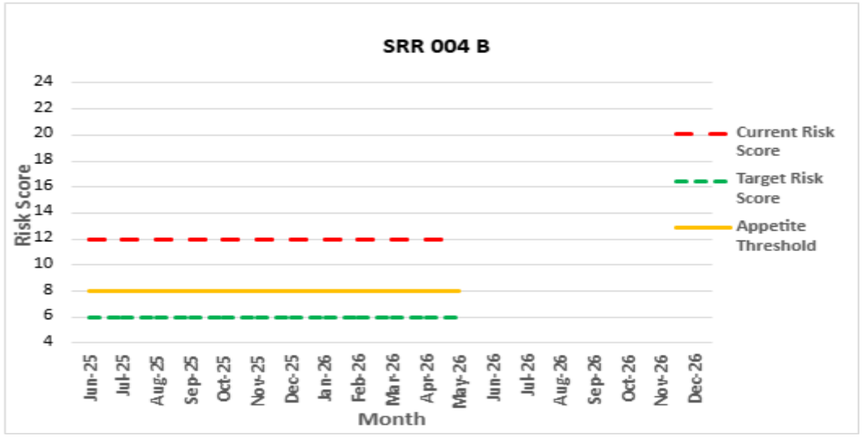
• Continuing to work with the communication team to improve incident cascade during an event to ensure Health Board wide awareness in a timely manner • LRF Pandemic Solaris undertaken	

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Departmental debrief following an incident to inform learning and enhance controls. • Training records • Plans and action cards in place and up to date • Debrief with key stakeholders following an incident to inform learning and enhance controls.	• All key operational departments could actively respond to a BC incident without EP intervention due to the absence of BSPs.	• Work with key areas to support development of BCP's and action cards with the support of Corporate Governance Directorate.
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Report to the EPRR Group from debrief of incidents • Reports to the PPHP Committee on Emergency Planning Preparedness	• EPRR Thematic Risk Register	• Develop an EPRR
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
Internal Audit Review(s) • Business Continuity Planning 2023-24 (Q2) outcome report published – included MI response - **Reasonable Assurance** • Outcome and feedback from national exercises	• Identification of recommendations to ensure the Health Board is prepared and has the capabilities ato respond effectively.	• Implementation of the recommendations and subsequent management responses.

Assurance Rating (*Overall Assessment of controls and assurances*) *Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE ASSURNACE**

RISK THEME	**COMPLIANCE AND SAFETY**			
LINK TO IMTP	**SECTION 3: SYSTEM CHANGE**			
Strategic Risk SRR 004 B	**There is a risk that the Health Board is unable to respond in a timely, efficient, and effective way to Business Continuity (BC) incidents.**		**Publication Status**	**Public**
Threat *(As a result of)*	• **Due to ineffective and insufficient arrangements across all service areas to respond to a Business Continuity (BC) or Critical Incident**			**Risk Appetite Level – MINIMAL** Ultra-safe leading to only minimum risk exposure as far as practicably possible; a negligible/ low likelihood of occurrence of the risk after application controls.
Impact *(Consequences of the threat)*	**Patient** • Harm or injury to patients • Adverse impacts on delivery of care to patients across acute and non-acute settings	**Staff** • Staff absence (injury, wellbeing) • Harm or injury to staff	**Organisation** • Operational flow if services fail to prepare BCPs against the 5 key themes • Loss of infrastructure; • Financial implications due to staff absence • Health Board breaches statutory duties under the Civil Contingencies Act 2004; • Litigation & Financial Penalties; • Reputational damage and loss of public confidence	**Risk Appetite Threshold – SCORE 8 AND BELOW** Risks relating to all aspects of patient safety but also including safeguarding, staff and public security in addition risks relating to compliance and/or legal implications.
				SUMMARY The current risk level is **OUTSIDE** of target and appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.

Lead Director	Director of Strategy, Planning and Partnerships	Risk Exposure	**Current Level**	**Target Level**
Monitoring Committee / Group	Partnerships, Public Health & Planning Committee	**Likelihood**	3 (Likely) x	2 (Unlikely) x
Initial Date of Assessment	June 2023	**Impact**	*4 (Major)*	3 (Moderate)
Last Reviewed	March 2026	**Risk rating**	**= 12 (High)**	**= 6 (Moderate)**
Next Review (Quarterly based on risk score)	June 2026			



Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Business Continuity Policy • Business Continuity Response Guidance • Business Continuity Template & guidance (reviewed and updated April 2025) • Divisional, Directorate & Service Business Continuity Plans across a number of key operational areas • Business Continuity Exercises • Business Continuity debrief learning. • Health Board and Local Resilience Forum (LRF) Plans. • 3C (Command/Control, Communication) structure in place to respond to incidents. • 1-2-1 training with Divisional BC leads and delivering BC workshops for services. • Health Board EPRR Group Established. • Repository on intranet for BC plans to be added to by areas for audit, maintenance, and review of interdependencies. • Awareness raising of the requirement for BC across the Health Board through various training programmes • Infectious Diseases plan • Joint plan with PH in response to infectious diseases and public health incidence response overall • Internal strategic on call training • Executive Team attending 2-day strategic training. • Regular liaison with Gwent Local Resilience Forum (Strategic and tactical) • Joint Planning and Training with LRF and across Wales. • Ongoing Participation in exercises UK, Wales, LRF and HB.	• Ongoing support to develop business continuity plans – BC templates & guidance has been reviewed to make them more user friendly and easier to access via the HB's sharepoint. • Continued engagement with Divisions, Directorates, and service areas to embed contingency planning into the culture of the organisation, Conduct BIAs, develop plans, train staff, test & exercise, and review plans to mitigate the risks and threats to service delivery. • Embed an alert, activation and escalation pathway that follows the Health Board predefined C3 (Command, control, and Coordination) structure of strategic, tactical, and Operational. • Continue to engage with the communication team to improve incident cascade during an event to ensure a Health Board wide awareness in a timely manner. • Each Division to identify on their risk register any outstanding business continuity plans against the 5 key themes for their areas and escalate any identified risks to the HB risk group for review. • Development of a business continuity dashboard that enables divisions & directorates to manage, RAG rate and provide assurance of their BC planning arrangements. • Joint working with partners – Exercise Pegasus • Pull together a task and finish group to review and plan for the BC recommendations from the Ex Mighty Oak exercise debrief. The Health Board are part of the LRF group to develop a multiagency response plan for the critical themes – loss of power and loss of water supply – this will feed into the Health Boards estates planning. • Develop an off the shelf BC exercise for divisions, directorates & services. • Work with the Corporate Governance Directorate (Head of Corporate Risk and Assurance) to support improvements in the development of BCP's across key operational areas.

• Provide quarterly training sessions for on call gold and silver managers, to maintain skills in incident management, update knowledge in relation to risks and learning from local and national incidents. Test and exercise using the multiagency Joint decision model and the principles of joint working (JESIP). • Ability to warn & inform the organisation of critical BC incidents via the Health Board communications team. • Health Board service BC supporting plan – to provide a generic response framework if they have no specific plans are in place. • A dedicated business continuity lead for IT applications and networks to reduce the highest key theme risk. • The introduction of a business continuity Incident Response Group in the event that a BC incident that escalates to critical. • Joint working with LRF partners – Exercise Solaris, Exercise Pegasus	• Services are being audited against the organisational BC dashboard – level of plans in place and the test/exercise of those plans. • We have delivered 2 BC exercises (loss of IT applications/networks) for service senior managers – further exercises are planned for 26/27 • Services will be required to have tested & exercised at least 2 key theme plans and the alert, coordinate & escalate procedures in 2026. • Creation of any BC lessons learned repository for services to populate and learn from. • Training Operational Management teams to enable them to respond to and coordinate BC incidents that are impacting patient flow/care. (This has commenced) • Work with the wider planning team to influence them to consider BC requirements when developing new processes, initiatives or the introduction of new technology.

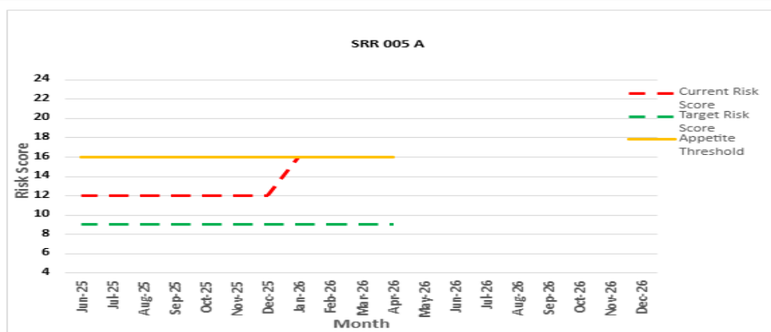
Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Plans and action cards in place and up to date. • Div/Service BC risk registers • Service BC training records • Departmental debrief following an incident to inform learning and enhance controls. • Debrief with key stakeholders following an incident to inform learning and enhance controls.	• All key operational departments could actively respond to a BC incident without EP intervention due to the absence of BSPs.	• Work with key areas to support development of BCP's and action cards with the support of Corporate Governance Directorate.
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Report to the EPRR Group from debrief of incidents • Reports to the PPHP Committee on Emergency Planning Preparedness (most recent Jan 2026) •	• EPRR Thematic Risk Register	• Develop an EPRR Risk Register
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
Internal Audit Review(s) Business Continuity Planning 2025-26 outcome report published – **Reasonable Assurance** • Outcome and feedback from national exercise	• Identification of recommendations to ensure the Health Board is prepared and has the capabilities to respond effectively.	• Implementation of the recommendations and subsequent management responses.

Assurance Rating (*Overall Assessment of controls and assurances*) *Guidance*

Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE ASSURNACE**

RISK THEME	**SERVICE DELIVERY**			
LINK TO IMTP	**SECTION 3: SYSTEM CHANGE**			
Strategic Risk **SRR 005 A**	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system**		**Publication Status**	**Public**
Threat *(As a result of)*	**Due to inadequate arrangements to support system-wide patient flow**			**Risk Appetite Level – OPEN** Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.
Impact *(Consequences of the threat)*	**Patient** • Avoidable deaths and significant harm. • Delayed discharges from acute and non-acute settings resulting. in deteriorating patients. • Delays in releasing ambulances from hospital sites back into the community.	**Staff** • Increased workload • Fatigue & burnout	**Organisation** • Litigation & Financial Penalties • Reputational damage and loss of public confidence	**Risk Appetite Threshold – OPEN SCORE 17 AND BELOW** Risk related to all aspects of our ability to deliver, manage, and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.
				SUMMARY The current risk level is **OUTSIDE** of target level but WITHIN appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.

Lead Director	Chief Operating Officer	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee / Group	Patient Quality, Safety and Outcomes Committee	**Likelihood**	**4** (Possible) x	3 (Possible) x
Initial Date of Assessment	June 2023	**Impact**	***4** (Major)*	3 (Moderate)
Last Reviewed	April 2026	**Risk rating**	**= 16** **(Extreme)**	***= 9*** ***(High)***
Next Review (Monthly based on risk score)	May 2026			



Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*

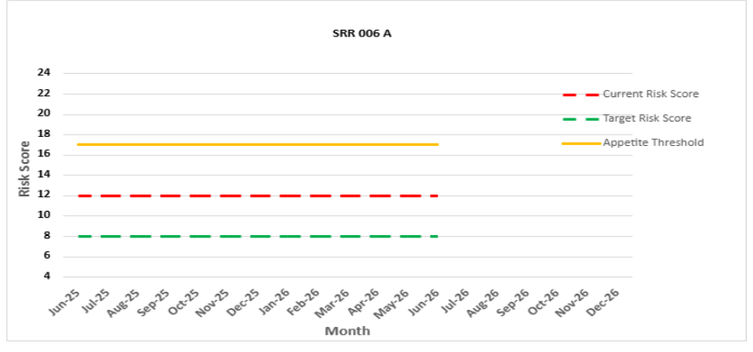
• Escalation Policy.
• Performance and Accountability Framework
• Operational Framework
• Major incident Procedures
• Daily ONP flow meetings - Twice daily ONP calls to receive updates from all acute sites as well as community services. Allowing opportunity for escalation of risks.
• Escalation communications – ambulance focussed email escalation when congestion begins to build up on the GUH forecourt. Aim to escalate to senior management to aid in quick risk-based decision making. Includes members of the Executive team.
• Weekly system safety flow forum – Cross divisional focused forum to look at priority areas to improve flow from across the system. Data driven. action focussed and task driven.
• Enhanced monitoring in place for U&EC – level 4
• Range of performance measures/metrics in place
• Repatriation mechanism with neighbouring Health boards – Daily repatriation calls between head of operations and counterparts in south Wales to ensure regular dialogue to repeat patients between hospitals and health boards.
• Maximum Capacity Plan – Executive team agreed maximum capacity (including risk assessed boarding) plan to ensure there is clear description ad guide for where extra capacity can be accessed to ensure patient flow is maintained. Full Capacity Protocol is in place.
• Planned care delivery plan agreed and recovery meetings with the NHS execs to support activity.
  • 26-week OP programmehas finished, and HB is exceeded numbers for first outpatient appoints.
• Regular Dialogue with WAST regarding flow across the patch/regional and attending national calls.
• WG – IQPD meetings to review areas of focus
  • Regular meetings with Local Authorities to review POC delays and LOS concerns.
	➢ **Continue Refocus on Our New Patient and key pieces of work: -**
	Discharge Acceleration:
	➢ Daily board rounds identify definite and potential discharges early to free up beds before peak demand
	➢ Weekend discharge lists are shared proactively to maintain flow across all sites.
	Full Capacity Protocol:
	➢ Boarding continues across sites under strict risk assessment, with escalation to use dayrooms or therapy spaces only as a last resort.
	➢ Red lines for boarding (e.g., avoiding high-risk patients) are reinforced in SOP discussions.
	Step-Down Coordination:
	➢ Flow Centre actively books and allocates step-downs; priority is given to patients who can safely move to community beds or lower-acuity settings.
	➢ Community bed usage is maximized, with reablement teams engaged to expedite transfers.
	➢ Contingency for Delays - where step-downs stall, escalation includes opening additional community beds and using SDEC for low-acuity patients.
	Rapid Offload Strategy:
	➢ Flow Centre monitors ambulance waits and redistributes crews to minimise delays.
	➢ Plans include prioritizing high-risk patients for cubicles and using lounges for temporary placement.
	Standard Operating Procedure (SOP):
	➢ A simplified SOP is being finalised to standardise escalation pathways, boarding criteria, and discharge prioritisation across divisions.
	➢ Divisional “red lines” (e.g., elective bed protection, infection control limits) are being formalised for consistent decision-making.
	Data-Driven Oversight:
	➢ Flow Centre dashboards and live trackers are used to monitor patient movement, discharge progress, and capacity in real time.
	➢ Development of new dashboards to track EDDs and Red Reasons to inform system flow decisions.
	➢ New ED extension opened on the 17th December with phase 2 to start in the new financial year
	➢ Additional ED consultants in place

	➢ New expanded transfer lounge is progressing well, supporting with transport booking and supporting early movement of patients. Focus Areas for the next month: ➢ Develop Our Next Patient UEC recovery plan – Board Development Session April 2026 ➢ Programme of work has Divisional projects across the system to support flow ➢ Work with social care and PCC division on joint assessment and community bed delays to consistently improve discharge reliability. ➢ Reset regularly — ONP highlights the need for routine reset days/fortnights to correct worsening patterns in flow, WTBS, and handovers.

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• The Escalation Framework has been enacted and ineffective in mitigating threats and impact to services. • Performance report against measures/metrics • Regular ONP meetings to review flow • S2S meeting - creates a consistent, standardised process for assessing readiness, escalating issues, and agreeing collective plans, fostering clear accountability from ward to board level. • Weekly weekend planning meetings in place to plan for the weekend capacity	• Evidence that the Escalation Framework is delivering improvements across all areas of patient flow e.g., ambulance handovers. Now working to KPI WG plan. • The impact of the Performance and Accountability framework in improving patient flow • Outputs and progression of actions from ONP and S2S meetings to sustain system flow	• Close monitoring and reporting of the frameworks in practice to support learning and improvements.
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Monthly Divisional Assurance reviews. • Mid and EoY Reviews for Divisions • Performance against measures/metrics reported to the Executive Committee • Planning and Performance Committee • Cross Divisional Meetings – cross divisional thinking, learning and sharing best practice	• The Operational Framework is being developed to define how individual services meet demand and outline the actions required during escalation. This framework is currently under refinement through the Our Next Patient (ONP) work.	• The Operational Framework process commenced in November 2024, initiating a series of in-depth reviews across specific services. This is an iterative approach designed to remain active and adaptable, ensuring it continues to meet the evolving needs of the services.
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
Independent Reviews • Intra-site Patient Transfers – Reasonable Assurance accepted by the ARAC on 9th July 2024. • External inspections/visits. • IQPD Monthly Meetings focus on key areas • GIRFT visit Report • Accelerated Design Event / Programme of work • Winter Sprint – December 2025 and January 2026 • MAG Report - focus areas for ABUHB	• **Clinical Leadership & Patient Experience:** Strong emphasis on clinically led, data-driven change, with patient stories highlighting the real-world impact of delays. • **Mandated Targets:** The 45-minute ambulance handover target is to be mandated, with an ambition to reach a 15-minute standard for patient safety. • **System-Wide Responsibility:** Improvement requires engagement across all sectors—ED, primary care, community, acute medicine, surgery, and ambulance services. Improving Performance Together (MAG Report) • 45 min hand overs, • Clarity over fragile services asks and delivery • Accountability for regional working in our region • Asks around data sharing and use of comparative data sets – definitions are still work in progress • Indicates population health management tools will be available – Alignment locally • Breathlessness and lung cancer alignment with our own plans • Integrated care hubs • Define the funding and delivery shift from Secondary to Primary Care– with a plan	N/A

Assurance Rating (*Overall Assessment of controls and assurances)* *Guidance*

Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE ASSURNACE**

RISK THEME	**SERVICE DELIVERY**				
LINK TO IMTP	**SECTION 4: ENABLER – DIGITAL, DATA & TECHNOLOGY**				
Strategic Risk SRR 006 A	**There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.**			**Publication Status**	**Public**
Threat *(As a result of)*	**Due to the full or partial failure of existing digital infrastructure and systems.**			**Risk Appetite Level – OPEN** Willing to consider all potential options, subject continued application and /or establishment of controls; recognising that there could be a high-risk exposure.	
Impact *(Consequences of the threat)*	**Patient** • Unintended harm or Injury to Patients.	**Staff** • Unintended harm or injury to staff	**Organisation** • Data Breaches • Litigation and Financial Penalties. • Reputational damage and loss of public confidence.	**Risk Appetite Threshold – Score 17 and Below** Risk related to all aspects of our ability to deliver, manage and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.	
				SUMMARY The current risk level is **OUTSIDE** of target level but WITHIN appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	
Lead Director	Director of Digital	Risk Exposure	**Current Level**	**Target Level**	
Monitoring Committee / Group	Finance and Performance Committee	**Likelihood**	3 (Possible) x	2 (Unlikely) x	
Initial Date of Assessment	June 2023	**Impact**	*4 (Major)*	4 (Major)	
Last Reviewed	April 2026	**Risk rating**	**= 12 (High)**	***= 8 (Moderate)***	
Next Review (Quarterly based on risk score)	July 2026				

Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Remedial Action Plan revised and updated to capture further recommendations against NIS CAF assessment in Jun 2025. This Action Plan has also supported ABUHB risk remediation responses to ABUHB's NIS CAF Risk Register which by CRU to address risks identified during the NIS CAF assessment. The remedial actions proposed have been accepted by CRU and progress will be reviewed regularly. • Director of Digital (SIRO) and Chief Information Officer (Deputy SIRO) SIRO trained. • Information Governance and Cyber Security governance and assurance processes reviewed and implemented. • Governance group terms of reference agreed. Meetings started in November 2023. • Cyber is fully engaged with IG colleagues to implement the recommendations of the Templar report. Cyber now supports all the Governance and Assurance Groups intending to increase cyber security awareness and build cyberculture amongst non-ICT staff • Scheduled monthly vulnerability scans of all ABUHB-managed servers to include third-party servers. The results of these scans will now be reported in the Monthly Cyber Report. • Working with Business Systems and Desktop Teams to ensure that patching compliance for internally managed systems and third-party systems is monitored and reported monthly. Monthly review meetings are held between Cyber, and the Teams review compliance levels against policy. Results are captured within the monthly Cyber Report and presented at monthly Service Delivery Management Group. • Work with Information Governance around implementing the controls required to align DDaT to the ISO27001 standard. • Battle tested ABUHB cyber incident response, communication cascade and reporting to Cyber Resilience Unit. • Working with ICT Support Teams and the Log4j version 2 vulnerability has been resolved within the Health Board. The least important service impacting Version 1 is being managed through ICT Departmental risk management process. · Risk impact reduced as recent loss of power at key sites, incorporating our data Centre allowed to failover in a seamless fashion from one DC to the other with no service impact. • Microsoft Defender provides inspection and protection from malicious links embedded within emails using telemetry from the whole NHS Wales tenant. • Microsoft Sentinel security event and incident management tool in use to analyse systems and provide alerts.	• Cyber Resilience Unit (CRU) Audit undertaken in June 2025 showed an overall improvement. Progress continues with finding outcomes from past audits. Bi-Monthly meetings (NIS Assurance Group) with the responsible action owners to provide updates against the findings, some key recommendations such as incident management testing have been actioned. The next NIS CAF Audit is scheduled for June 2026. • Work with Information Governance around implementing the controls required to align DDaT to the ISO27001 standard, implement NIS CAF controls, and CIS (Centre for internet security) benchmarks for operating systems. • Internal Audit review on Shadow IT scheduled for 2026. • Daily firewall reports on suspicious traffic, internet usage. Stats and trends reported monthly to the Service Delivery Management Group (SDMG) • Improvements to Vulnerability Management Service (VMS) to identify vulnerable 3rd party applications • Internet of Things reporting to show device security posture now being developed as new firewalls are being deployed. • Ingest NHS England Security Operations Centre (SOC) Indicators of compromise (IOC) feed into the Health Boards security tooling to provide additional early warnings. • Improvements in mandatory training compliance for Information Governance and Cyber Security. • Monthly Phishing simulations have identified colleague susceptibility and additional training and awareness needs. requirements - a Phishing simulation tool with inbuilt cyber training has been procured to support this • Incident management;

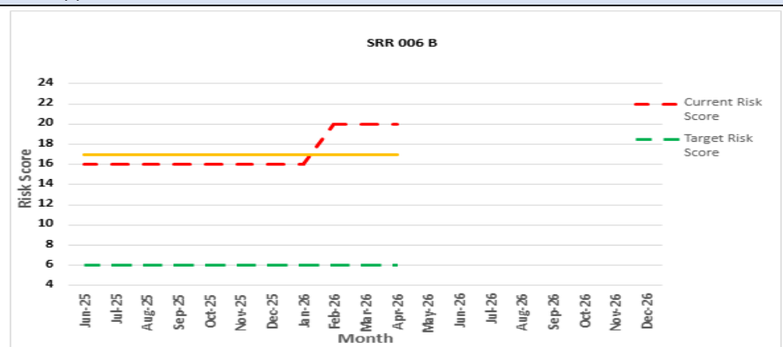
• At least monthly simulated phishing emails to check email security awareness among staff. Scenario-based incident response exercising using National Cyber Security Centre developed 'Exercise in a box' to assess our current skills in responding to real-life cyber security incident scenarios and to identify improvements. Cyber to run quarterly exercises.	○ 2x members of Cyber security now CIPR (Cyber Incident Panning & response) accredited ○ Cyber attend regular NHS England hosted Immersive labs tabletop exercises. ○ 2x tabletop exercises for technical teams conducted in 2025 by Tarian (SW Police Cyber unit) ○ Rubrik hosting a "Save the data" tabletop exercise planned for April 2026 Quarterly inhouse scenario-based tabletop exercises hosted by Cyber for technical teams and wider responders – 2 exercises have been conducted as of April 2026, one regarding a malware incident on CWS and one around a senior finance manager account compromise

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Internal directorate meetings setup monthly to monitor risks to regularly update and to provide assurance over outstanding action plans. • Single directorate risk registers now in place.	• None	• N/A
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Regular reporting on progress to the Finance & Performance Committee on the cyber security action plan. • Annual Senior Information Risk Owner report.	• None	• N/A
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
• Cyber security Audit in April 2023 provided Digital with a substantial audit for its cyber security improvement plan, reporting and backup systems. Internal Audit 2024/25 • DHCW CRU NIS CAF Audit June 2026 • Oversight from NHS Wales Cyber Resilience Unit. • Infrastructure and Network controls Audit by Audit Wales.	• None	• N/A

Assurance Rating (*Overall Assessment of controls and assurances*) *Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE ASSURNACE**

RISK THEME	SERVICE DELIVERY				
LINK TO IMTP	SECTION 4: ENABLER – DIGITAL, DATA & TECHNOLOGY				
Strategic Risk SRR 006 B	**There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.**			**Publication Status**	**Public**
Threat *(As a result of)*	**Due to an adverse impact on service delivery in the implementation of new digital systems.**			**Risk Appetite Level – OPEN** Willing to consider all potential options, subject continued application and /or establishment of controls; recognising that there could be a high-risk exposure.	
Impact *(Consequences of the threat)*	**Patient** • Unintended harm or Injury to Patients. • Adverse impacts on delivery of care to patients across acute and non-acute settings.	**Staff** • Unintended harm or injury to staff	**Organisation** • Data Breaches • Litigation and Financial Penalties. • Reputational damage and loss of public confidence.	**Risk Appetite Threshold – Score 17 and Below** Risk related to all aspects of our ability to deliver, manage and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.	
				SUMMARY The current risk level is **OUTSIDE** of target level and appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	

Lead Director	Director of Digital	Risk Exposure	**Current Level**	**Target Level**
Monitoring Committee / Group	Finance and Performance Committee	**Likelihood**	4 (Major) x	2 (Unlikely) x
Initial Date of Assessment	June 2023	**Impact**	*5 (Major)*	3 (Moderate)
Last Reviewed	April 2026	**Risk rating**	**= 20 (Extreme)**	***= 6 (Moderate)***
Next Review (Monthly based on risk score)	May 2026			



Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Adoption of formal project management methodologies to ensure project plans are developed in conjunction with services. • Formal governance arrangements in place through project boards and programme boards where risks and issues are managed and mitigated. • Each project has a senior responsible officer from the service who can provide challenge and assurance over the delivery of the project work packages. • Each clinical project has a clinical lead who would advise and support potential impacts on service delivery caused by the implementation of new digital services. • Business change team in place to support services in improvement of clinical and administrative processes. • Benefits team in place who identify, track, and ensure any benefits are realised which will ultimately improve service delivery. • Projects support backfilling of clinical time where required. • Assurance activities included in project framework including clinical safety, information governance, health records and cyber security. • An overarching Digital Portfolio Progress Group is in place to receive programme updates, manage risk and issue escalations and provide multi-disciplinary assurance over digital projects. • Business change work includes a service readiness impact assessment to enable the project team to develop a realistic plan that incorporates service change requirements. • Aggregated view of risks and issues available to pick up common themes and impact for early intervention or escalation. • Aggregated view of digital Lessons Learned available, and lessons are reviewed during project initiation for best chance of success. • Formal divisional engagement meetings in place monthly to discuss new programmes of work and provide update on critical programmes/projects • Digital benefits Board development session held in 2025. • A Digital Prioritisation and Optimisation Meeting (DPOM) introduced monthly to review capacity and priorities to support decision making and early escalation if required.	• Additional governance being put in place with the Digital, Data and Technology Group which will report to the Finance & Performance Committee - Terms of reference developed. • Senior attendance at national contract meetings with RISP and LIMS suppliers • Regular meeting with RISP supplier being scheduled weekly to manage and mitigate risks to delivery

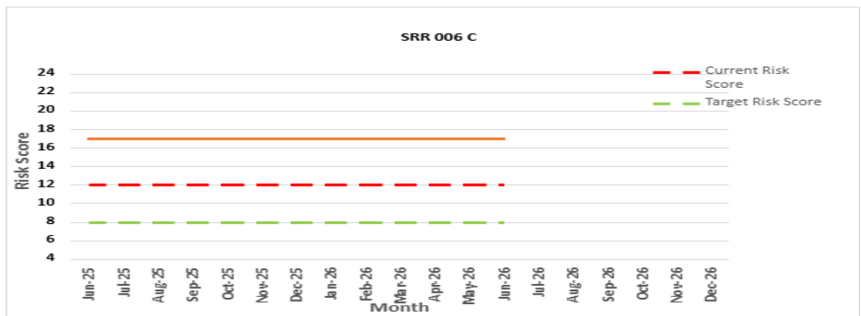
• Digital transformation development programme provided to the Board in January 2026. • Welsh Government strengthening national governance with the introduction of a DDaT Leadership Board and supporting groups. • Regular reporting now in place to Chief Executive Management Team and Welsh Government DDAT Leadership Board due to concerns over timescales and deliverability to LIMS and RISP. • Local project tolerance levels changed to zero for both RISP and LIMS to ensure immediate escalation processes are enacted for risks or issues impacting delivery / timelines.	

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
○ Project Boards meet monthly and report into the bi-monthly Digital Portfolio Progress Group (DPPG) ○ Digital Directorate meetings being held monthly to monitor risks to regularly update and to provide assurance over outstanding action plans. ○ Risk management approach and escalation processes in place in line with the Health Board's Risk Framework ○ Regular escalation reporting in place to Chief Executive Management Team and Welsh Government DDAT Leadership Board due to concerns over timescales and deliverability to LIMS and RISP.	• Escalation of risks and issues done on an Ad hoc basis to Director of Digital and Executive Committee in the absence of DDaT Sub-committee.	• Additional governance being put in place with the Digital, Data and Technology Sub-Committee which will report to the Finance & Performance Committee
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Regular Reporting to the Finance & Performance Committee • Regular reporting to Executive Committee • Corporate risks logged for LIMS and RISP programmes	• None	• Not Applicable
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
Internal Audit 2023/24 • Benefits Management review – Outcome Substantial Assurance • Stakeholder Engagement on IT Projects 2023/24 Q3 – Outcome Substantial Assurance **Internal Audit 2024/25** • Implementation of the Welsh Intensive Care System – future of programme to be decided	• Recommendations identified through audit work	• Recommendations identified through audit work

Assurance Rating (*Overall Assessment of controls and assurances*) *Guidance*

Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE ASSURNACE**

RISK THEME	**SERVICE DELIVERY**				
LINK TO IMTP	**SECTION 4: ENABLER – DIGITAL, DATA & TECHNOLOGY**				
Strategic Risk **SRR 006 C**	**There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.**			**Publication Status**	**Public**
Threat *(As a result of)*	**Due to failure to develop digital solutions that are sustainable and for the future.**			**Risk Appetite Level – OPEN** Willing to consider all potential options, subject continued application and /or establishment of controls; recognising that there could be a high-risk exposure.	
Impact *(Consequences of the threat)*	**Patient** • Unintended harm or injury to patients. • Adverse impacts on delivery of care to patients across acute and non-acute settings	**Staff** • Unintended harm or injury to staff.	**Organisation** • Data breaches • Litigation & Financial Penalties • Reputational damage and loss of public confidence	**Risk Appetite Threshold – Score 17 and Below** Risk related to all aspects of our ability to deliver, manage and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.	
				SUMMARY The current risk level is **OUTSIDE** of target level but **WITHIN** appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	
Lead Director	Director of Digital	Risk Exposure	**Current Level**	**Target Level**	
Monitoring Committee / Group	Finance and Performance Committee	**Likelihood**	**3** (Possible) x	**2** (Unlikely) x	
Initial Date of Assessment	June 2023	**Impact**	***4*** *(Major)*	**4** (Major)	
Last Reviewed	April 2026	**Risk rating**	**= 12** **(High)**	***= 8*** ***(Moderate)***	
Next Review (Quarterly based on risk score)	July 2026				



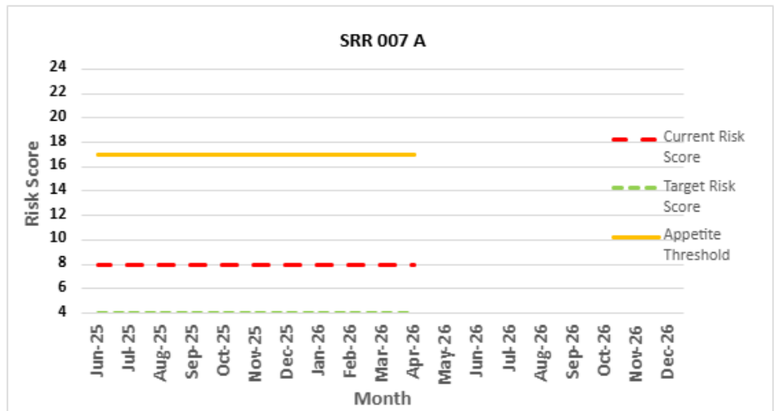
Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
○ New Digital Service Request process in place which provides governance in several key areas: ○ Automation of request process via 'Seren' the ICT Portal ○ Information Governance – ensuring new services have appropriate controls to keep patient information safe. ○ Cyber Security – ensuring new services adopted or developed meet the requirements of the cyber assessment framework. ○ Patient Safety – ensuring services do not introduce any patient safety risks. ○ Records – ensuring new systems comply with the requirements of records management. ○ Strong business analysis function in operation which ensures the "as-is" and "to-be" process mapping is undertaken which provides assurance that new services implemented are fit for purpose and delivery what stakeholders require. ○ Business change function which ensures implemented systems are effective and deliver the benefits required. ○ Formal framework in place for the adoption of new digital services and best practice guidance followed. ○ Annual planning processes include formal DDAT Annual Operational Plan aligned with service priorities identified in IMTP process ○ New Digital Request processes include fortnightly senior leadership scrutiny of requests, ○ New prioritisation framework & tool Monthly/quarterly Operational delivery aligned to ITIL standards ○ Annual operational plan completed and aligned with IMTP ○ Divisional Digital Oversight meetings with senior Digital & Divisional staff to support identification of digital alignment with service priorities for Urgent Care, MH & LD, CSS, Division of Surgery & PCCS in place ○ Software Development uses an agile product management methodology using DevOps software for managing its backlog, delivery plan and sprints. ○ Monthly divisional digital engagement meetings are in place with senior digital and divisional staff to support digital alignment with service priorities. ○ Digital Portfolio optimisation meetings in place to ensure digital resources are aligned to key priorities	• New Digital Request quarterly reporting to DDAT Group • Development of product management approach to delivery of core software applications and extending use of agile processes to ICT • Development of digital strategies including Digital Transformation Strategy linked to ABUHB 2035 – the new Health Board 10 year strategy and associated component strategies and plans including Electronic Health & Care Record and Infrastructure strategy.

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Assurance *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	Actions to Address Gaps *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Quarterly reporting to DDAT Group	• The outcome of the EDRMS audit	• Monitor the performance of the NDSR process • Audit into the effectiveness and appropriateness of the electronic document and records management solution (EDRMS) in use for the management of digital health records and the provision of scanning services.
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Regular Reporting to the Finance & Performance Committee	• None	• Not Applicable
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
Internal Audit 2023/24 • LINC Programme– **Outcome Reasonable assurance** • Network Infrastructure (VPN) - **Outcome Reasonable assurance** **Internal Audit 2024/25** • Electronic document and records management solution - planned for Q4	• Recommendations identified through audit work	• Regular Reporting to the Finance & Performance Committee

Assurance Rating (*Overall Assessment of controls and assurances*) *Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE ASSURNACE**

RISK THEME	**TRANSFORMATION AND PARTNERSHIP WORKING**			
LINK TO IMTP	**SECTION 3: SYSTEM CHANGE**		**SECTION 4: ENABLERS - REGIONAL PLANS**	
Strategic Risk: SRR 007A	**There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population.**		**Publication Status**	**Public**
Threat *(As a result of)*	**Due to the likelihood of further austerity measures impacting effective collaboration with strategic partners across the Health Board footprint.**		**Risk Appetite Level – OPEN** Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.	
Impact *(Consequences of the threat)*	**Patient** • Unmet patient need resulting in harm	**Staff** N/A	**Organisation** • Ineffective use of combined resource Delayed decision making • Adverse impacts on delivery of care to patients across acute and non-acute settings • Failure to deliver health board priorities, required improvements and achieve longer-term sustainability • Reputational damage and loss of public confidence	**Risk Appetite Threshold – SCORE 17 AND BELOW** All risks relating to our ability to engage effectively with other organisations including development of collaborations and partnerships along with all risks associated with innovation, transformation, and strategic change.
				SUMMARY The current risk level is **OUTSIDE** of target level but **WITHIN** appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.

		Risk Exposure	Current Level	Target Level
Lead Director	Director of Strategy, Planning, and Partnerships.			
Monitoring Committee	Partnerships, Public Health & Planning Committee	**Likelihood**	**2** (Unlikely) x	**2** (Unlikely) x
Initial Date of Assessment	June 2023	**Impact**	**4** (Major)	**2** (Minor)
Last Reviewed	November 2025	**Risk rating**	**= 8 (Moderate)**	***= 4 (Moderate)***
Next Review (Six Months based on risk score)	May 2026			



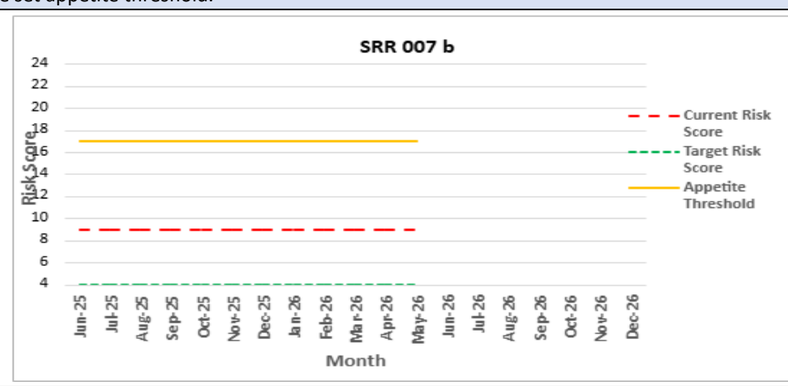
Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
The Health Board plays an active role in a range of formal partnership arrangements to enable integrated working for the population including: • The Gwent Public Services Board (Gwent PSB) brings public bodies together to work to improve the economic, social, environmental, and cultural well-being in Gwent. They are responsible, under the Wellbeing of Future Generations (Wales) Act, for overseeing the development of the new Local Wellbeing Plan which is a long-term vision for the area. • The Gwent Regional Partnership Board As set out in the Partnership Arrangements (Wales) Regulations 2015, local authorities and local health boards (RPB) manage and develop services to secure strategic planning and partnership working. RPBs also need to ensure effective services and care, and support is in place to best meet the needs of their respective population. Through these statutory forums formal partnership arrangements take place. • In addition to these statutory forums the Health Board has a range of interfaces with key stakeholder bodies, including regular liaison with local authorities, neighbouring Health Boards, housing associations, and third-sector partners. • Joint working between operational teams including integrated operational arrangements and combined multidisciplinary teams, for example, Community Resource Teams	• Governance review of Regional Partnership Board undertaken in August 2023. • Renewed Strategy for strategic partnership Capital in place and revised governance processes. • New Long-Term Strategy for Health Board to focus on Partnership approach.

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• PMO reporting to the Director of Strategy, Planning and Partnerships. • Regional Leadership Group Reporting	• Systematic reporting of outcomes • Systematic evaluation of schemes • Governance of financial control arrangements	• Implementation plan to be developed following RPB governance review. • Health Board strategy development approach to focus on partnership approach
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Assurance reporting to the Population Health, Partnerships, and Planning Committee. • Assurance reporting to the Board.	None	N/A
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
Internal Audit Plan 2024/25 • RPB Governance Review (Q4) – **Outcome = Limited Assurance.** Reported to ARAC September 2024 • Partnership Arrangements Review (Q1) Deferred	• Recommendations identified in the Limited Assurance RPB Governance Revie	• Implementation of the management responses to close off recommendations

Assurance Rating (*Overall Assessment of controls and assurances*) *Guidance*

Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE ASSURNACE**

RISK THEME	**TRANSFORMATION AND PARTNERSHIP WORKING**				
LINK TO IMTP	**SECTION 3: SYSTEM CHANGE**			**SECTION 4: ENABLERS – REGIONAL PLANS**	
Strategic/ Corporate Risk SRR 007 B	**There is a risk that the Health Board will be unable to deliver truly integrated regional health and care services for the population.**			**Publication Status**	**Public**
Threat *(As a result of)*	**The impact of service fragility across the regional footprint and health board systems which work autonomously of regional working**			**Risk Appetite Level – OPEN** Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.	
Impact *(Consequences of the threat)*	**Patient** • Unmet patient need resulting in harm • Adverse impacts on delivery of care to patients across acute and non-acute settings	**Staff** N/A	**Organisation** • Failure to deliver health board priorities, required improvements and achieve longer-term sustainability • Reputational damage and loss of public confidence • Ineffective use of combined resources • Delayed decision making • Variable partner alignment	**Risk Appetite Threshold – SCORE 17 AND BELOW** All risks relating to our ability to engage effectively with other organisations including development of collaborations and partnerships along with all risks associated with innovation, transformation, and strategic change.	
				SUMMARY The current risk level is OUTSIDE of target level but WITHIN appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.	
Lead Director	Director of Strategy Planning and Partnerships	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee / Group	Partnerships, Public Health & Planning Committee	**Likelihood**	**3** (Possible) x	**2** (Unlikely) X	
Initial Date of Assessment	January 2024	**Impact**	***3** (Moderate)*	**2** (Minor)	
Last Reviewed	March 2026	**Risk rating**	**= 9 (High)**	***= 4 (Low)***	
Next Review (Quarterly based on risk score)	June 2026				

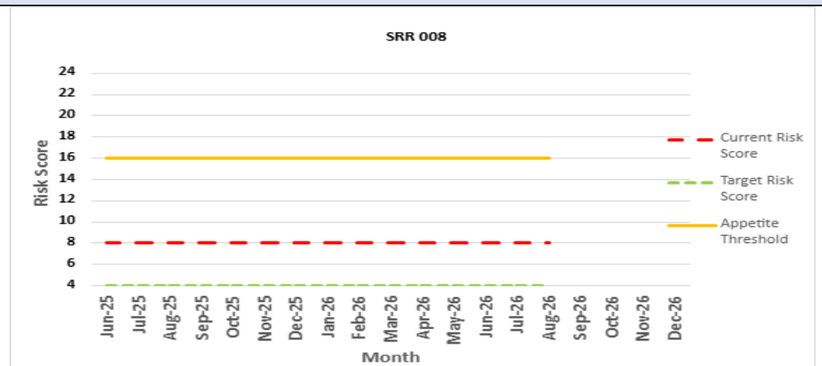


Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
A robust South-east Wales regional planning infrastructure has been established with clear governance mechanisms including an agreed Terms of Reference in place. The Regional Joint Committee is attended by Health Board Chairs and Chief Executives on a bi-monthly basis. The Executive Management Group reports to the Regional Joint Committee and requires at least one Chief Executive and one Executive representative from each organisation to be present for quoracy. The Executive Management Group and the and Regional Development Group which provides the first line of assurance on progress of programmes , bring the participating Health Boards together: - to review all regional service projects - to assess progress against agreed timelines and; - to agree additional measures / escalations in the event of identified issues and risks. • Whilst Cwm Taf Morgannwg UHB is the lead accountable organisation for the development of Llantrisant Health Park (LHP), it is a key regional infrastructure development and is therefore included in the Regional Joint Committee Governance model. The majority of service planning for the services that will operate from LHP will take place within the appropriate regional programme. • Four workstreams are established (Orthopaedics, Ophthalmology, Diagnostics and Cancer) and the UHB is well represented and engaged on all. • Where appropriate, workstreams are underpinned by a Memorandum of Understanding between the participating Health Boards setting out their respective commitment to collaborative regional planning where this can enhance service sustainability, quality, and efficiency. • When service issues span regions, arrangements are set up on a bespoke basis, for example the Vascular Project Board and the Interventional Radiology (IR) project.	Following the first Regional Joint Committee, the following three Task & Finish groups were established to develop proposals to address cross cutting risks related to regional working: • Regional Contracting and Commissioning: developing a proposed framework for the region • Digital: Establish shared patient treatment lists with a minimum viable product being proof of concept for cataracts and lower limb arthroplasty • Digital: Ability for clinical teams to see patient records across health board boundaries Following support from ABUHB of the Regional Diagnostic and Treatment Centre Outline Business Case at Llantrisant Health Park (LHP) in November 2025, there is a requirement to regionally develop a full business case. This will include a clear outline strategy, comprehensive demand & capacity modelling for the proposed diagnostic services including an Endoscopy Academy, future development opportunities and programme governance arrangements. Given the challenges in delivering Cellular Pathology services, a Strategic outline case will be developed regionally to be taken through the regional governance structure and then onto Welsh Government. More widely, a consistent framework is to be developed and used across the region for assessing fragility of acute services. This will enable a common approach to scoring against a defined set of criteria which will lead to identifying service areas where regionalisation may provide a solution.

• In addition to these arrangements, the Health Board has a range of informal planning networks and communication channels, with an ongoing commitment to communication, sharing best practice and advising of anticipated service issues and risks.	

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Service Divisions reporting to the Chief Operational Officer • Service attendance at regional operational meetings and workshops	• Alignment and effectiveness of partners to deliver integrated services	
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Executive Oversight of all Regional Developments at the monthly Internal Regional Planning Oversight Group. • Assurance reporting to the Population Health, Partnerships, and Planning Committee. • Assurance reporting to the Board. • Regular touchpoint meetings of all key players to review progress and issues arising.	None	N/A
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		

Assurance Rating (*Overall Assessment of controls and assurances*) *Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE ASSURNACE**

RISK THEME	TRANSFORMATION AND PARTNERSHIP WORKING				
LINK TO IMTP	**SECTION 4: ENABLER - QUALITY**				
Strategic Risk SRR 008	**There is a risk that the Health Board fails to build positive relationships with patients, staff and the public.**			**Publication Status**	**Public**
Threat *(As a result of)*	**Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement.**				**Risk Appetite Level – OPEN** Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.
Impact *(Consequences of the threat)*	**Patient** • Unmet patient needs resulting in patient harm. • Ineffective use of combined resources • Delayed decision making • Adverse impacts on delivery of care to patients across acute and non-acute settings • Negative experience of care • Distress and frustration. • Carer stress.	**Staff** Staff dissatisfaction Frustration Increased absence. Loss of confidence.	**Organisation** • Failure to deliver health board priorities, required improvements and achieve longer-term sustainability • Reputational damage and loss of public confidence		**Risk Appetite Threshold – OPEN SCORE 17 and Below** All risks relating to our ability to engage effectively with other organisations including development of collaborations and partnerships along with all risks associated with innovation, transformation, and strategic change.
					SUMMARY The current risk level is **OUTSIDE** of target but **WITHIN** the appetite threshold. Target level is **WITHIN** the set appetite threshold.
Lead Director	Director of Nursing	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee	Patient Quality, Safety and Outcomes Committee	**Likelihood**	**2** (Unlikely) x	**2** (Unlikely) x	
Initial Date of Assessment	June 2023	**Impact**	***4** (Major)*	**2** (Minor)	
Last Reviewed	March 2026	**Risk rating**	**= 8 (Moderate)**	***= 4 (Low)***	
Next Review (Six monthly based on risk score)	September 2026				

Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Corporate Engagement Team • Patient Experience and Involvement Strategy- organisational ownership • Person Centred Care (PCC) Surveys and National surveys via CIVICA • PCC KPI's (support PCC Quality pillar) • 'You said…… we did' public facing information for service areas. • PLO service at GUH • Introduction of PALS Service (Oct 23) • Volunteer Patient Experience Feedback • Collaboration to recruit community listeners to support Dementia Awareness • Digital patient stories to support listening and learning. • DATIX • Oversight of Medical Examiner reports to determine patient experience actions • Public Engagement- Big Conversation Bereavement held 20th March 2024, Big Conversation Sepsis Sept 2025 and Big Conversation Care Homes December 2025 • People Participation Panel ED in Progress, PPP for Deaf People established • Patient Experience and Involvement Team oversee patient experience through dedicated work programme and link in with divisional teams. • Dementia Person centred Care team dedicated e mail address.	• Structured graduated approach to roll out of Civica to ensure divisional teams can use and access data. This will ensure sustainable progress. • PCCT staff training to support Civica data entry and retrieval in progress. Short Term grant funding for Band 2 data entry support • Programme Manager for Dementia working regionally to improve public engagement and promote the role of Community Listeners. • Employment of dedicated PALS team who will have a key role in gaining feedback from patients, staff, and relatives. Monthly reporting in place and quarterly updates to Quality Management Group and IQPD • Completion of surveys limited to QR code access or physical presence of PCCT to manually ask and in-put data. SMS provision to be implemented in Feb 2025 across ED and all MIU's. 5 National Maternity Surveys launched via SMS 1st Sept 2025 • National directives around new national surveys that need to be managed additional to internal roll out programme – National People's Experience Survey live 1st May 2025 and default survey for majority of live areas. Continued participation in national meetings • Volunteer feedback to be reviewed to identify themes. This happens weekly • End of Life and Bereavement models published and meets Bereavement Standards. • EOLCB refresh completed to meet National Palliative and End of Life Care Specification and National Competency Framework • Community of Practice for Patient Experience and People Participation Panels (PPP) now agreed and to be progressing. BSL version of PPP leaflet secured.

• Dementia Information and signposting through webpages. • Patient feedback on the agenda for each of the dementia workstream meetings. • Dementia - QR code for feedback at each training event and session. • Dementia Thematic review from CIVICA team requested to inform actions and improvements in care. • Dementia - Multi agency partnership workstreams measuring impact of service. • Graces places set up across all 5 boroughs	• Dementia community hubs in each borough of Gwent enable accessible opportunities for feedback and signposting, plans to increase hubs in more areas of Gwent. Annual Dementia Report scheduled for Board March 2026

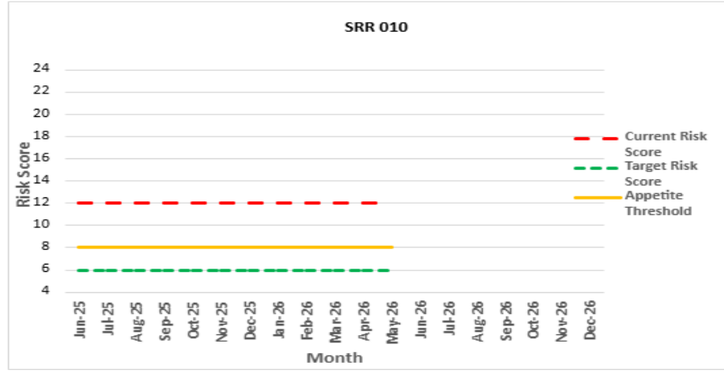
Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		

• Concerns are fed back to divisional teams when identified.
• Outcome of the volunteer feedback to drive improvements.
• Patient Experience and Involvement Team undertaking Culturally Competent Accreditation, receiving a silver distinction award in Oct 2024
• Immediate feedback and escalation to clinical teams following PALS queries and concerns
• Civica patient feedback in in the process of being rolled out across all – all divisional leaders receive reports for their live areas monthly.
• Bereavement survey built with CIVICA – Nov 2024
• CIVICA SMS launched 3rd March 2025 across ED and MIU'S
• People Participation Panels
• Bespoke Big Conversations
	• Currently there is limited SMS provision to increase the number of surveys.
	  • No single point of contact or 'drop in' provision for patients/families/staff to raise initial patient experience concerns. This is being reviewed in light of the new Listening to People framework
	  • Survey of bereaved people needs to be developed and rolled out to meet Bereavement Standards.
	  • CIVICA team have the ability to pull and view feedback that has been left by patients/family. The listening and learning from the feedback to be shared by each department/directorate/division i.e., / 'you said, we did' / quality improvement projects.
		• SMS provision for patient experience feedback launched in ED and all MIU's in February 2025. Civica lead in regular contact with National Leads and risks identified through Director of Nursing Meetings/SBARs
		• PALS Single point of contact is established. PALS officers have key role in patient experience and involvement- including establishing 'drop in' clinics on hospital sites should patients/staff/relatives wish to discuss concerns. Need to have discussions with facilities around rooms.
		• PALS and Chaplaincy Team undertaking BSL training to support Deaf Community
		• Patient experience KPI's and common themes by department/directorate/division need to be identified and pulled from the civica system left on surveys feedback. These will be added to a template patient experience report and CIVICA surveys have been built into ward accreditation.
		• Development of a ABUHB bereavement survey has been built within CIVICA and tested. This is being reviewed to better align with the national Patient Experience Survey- anticipated to go live from April 2026
		• Community of Practice for Patient Experience commencing March 2026. Topics will include supporting teams to publicise 'You Said/We Did'.

Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Regular reporting to the Patient Quality, Safety & Outcomes Committee (PQSCO) • Listening and Learning reported through QPSOG/ Outcomes Committee • Implemented PALS DATIX Module	None	N/A
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
• Bi-monthly LLais Reports • HIW inspections • Advocacy reports	None	N/A

Assurance Rating (*Overall Assessment of controls and assurances*) *Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE ASSURNACE**

RISK THEME	**COMPLIANCE AND SAFETY**				
LINK TO IMTP SECTION 4: ENABLER	**QUALITY**			**WORKFORCE & CULTURE**	
Strategic Risk: SRR 010	**There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in line with its duties under the Health and Safety at Work Act 1974**			**Publication Status**	**Public**
Threat *(As a result of)*	**Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements**			**Risk Appetite Level – MINIMAL** Any risk that has a MINIMAL risk appetite level should be managed to a Score of 8 or below.	
Impact *(Consequences of the threat)*	**Patient** • Unintended physical harm to patients • Psychological trauma	**Staff** • Unintended physical harm to staff • Psychological trauma • Increased levels of staff sickness	**Organisation** • Punitive actions from the Health and Safety Executive (HSE) • Loss of estates due to unsafe environments • Financial implications • Adverse publicity • Reputational damage.	**Risk Appetite Threshold – SCORE OF 8 or Below** Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible / low likelihood of occurrence of the risk after application of controls.	
				SUMMARY The current risk level is **OUTSIDE** of target level and appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	
Lead Director	Director of Allied Health Professions and Health Science	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee	Patient Quality, Safety and Outcomes Committee	**Likelihood**	3 (Possible) x	2 (Unlikely) x	
Initial Date of Assessment	December 2023	**Impact**	*4 (Major)*	3 (Moderate)	
Last Reviewed	March 2026	**Risk rating**	**= 12 (High)**	**= 6 (Moderate)**	
Next Review (Quarterly based on risk score)	June 2026				



Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Attendance at Divisional Quality & Patient Safety meetings provides a forum to discuss Health and Safety concerns/best practices. • Health and Safety Policies and Procedures • Dedicated Health and Safety site on ABPULSE • Provision of dedicated health and safety expertise and advice to meet the requirements of the Management of Health and Safety at Work Regulations 1999, Regulation 7 'Health and Safety Assistance'. • Health and Safety training for all staff (include general H&S, fire safety, manual handling, violence & aggression) • Partial Programme of Health and Safety Monitoring (Active & Reactive) • Corporate and Directorate Health and Safety Risk Register established. • Board Training /development (Completed 24 April 2024) • Implementation of Health, Safety, and Fire Improvement Plan for 2023/24 to address 7 risk areas of concern. • Health and Safety Governance and reporting arrangements (Health and Safety Committee)	• Develop and implement a 3-year health and safety culture plan, including the implementation of a new Health and Safety Management System • Suitable and Sufficient Risk assessments (including local risk assessments, specific fire risk assessments, and fire risk assessments) • Consultation and communication with the workforce regarding compliance with the Act • New ways of working with Divisions to ensure accountability for health and safety is recognised. • Implement key performance indicators to monitor health and safety compliance. • Review the governance arrangements for the Health & Safety Committee • Health and Safety Policies and Procedures to be reviewed. • Onboard further Manual Handling trainers across the organisation to improve compliance. • Scope for training non-Health Board staff • Learning from events to be documented and communicated to the organisation.

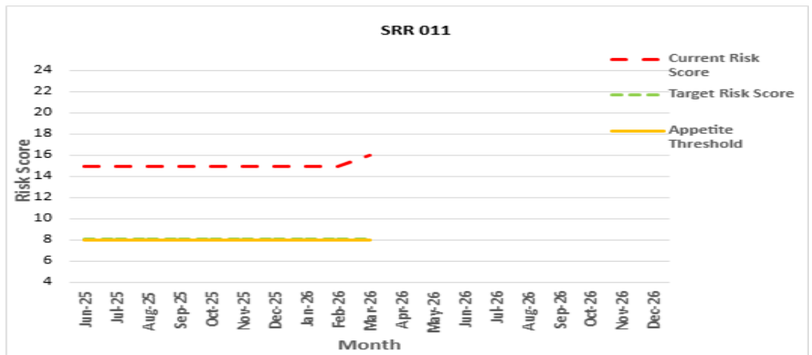
Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Assurance *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	Actions to Address Gaps *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
Health and Safety compliance data extracted from ESR and Datix and reported Statutory reporting data reports and dashboards	• Implementation of a health and safety performance report • Health and Safety Committee Membership and governance to be reviewed to ensure there is robust scrutiny and challenge on compliance with the Act • Compliance on completion of risk assessments and mitigating actions • Consistent adherence and application of policies	• Revise accountability arrangements for Health and Safety being progressed as part of the organisational Health & Safety Governance Framework. • Review the membership and ToRs of the Health and Safety Committee • Risk assessments and mitigating actions to be documented and reported regularly to demonstrate progress against the Improvement Plan
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Established monitoring of H&S at the Executive Committee • Corporate H&S Team report risk and assurance to the Health and Safety Group • Health and Safety Annual Report • Health and Safety Improvement Plan • Established monitoring of H&S at the PQSO Committee	• Thematic Risk Register	• Development of a thematic risk register
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
Internal Audit 2024/25 Plan • Health and Safety Internal Audit – **Concluded Limited Assurance** • Performance reviews at All Wales Health and Safety Management Steering Group • South Wales Fire & Rescue Service fire safety audit programme. Health and Safety Executive reviews/inspections.	• Recommendations from the 2024/25 Internal Audit	• Implement actions to address the findings and recommendations set out in the Limited Assurance Internal Audit Report

Assurance Rating (*Overall Assessment of controls and assurances*) *Guidance*

Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE ASSURNACE**

RISK THEME	SERVICE DELIVERY				
LINK TO IMTP	**SECTION 4: ENABLER – GREEN HEALTH**				
Risk (reframed) **SRR 011**	**There is a risk that the Health Board does not adequately anticipate, plan for, and respond to the impacts of climate change, green health requirements, and the need to adapt and decarbonise its services, estate and infrastructure.**			**Publication Status**	**Public**
Cause *(As a result of)*	**Due to an ageing and complex estate, competing capital and revenue pressures, climate-related service demand and the absence of an organisation-wide climate adaptation approach.**			**Risk Appetite Level – OPEN:** Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure	
Impact *(Consequences of the threat)*	**Patient / population** • Increased safety risks to patients arising from inadequately adapted buildings and infrastructure. • Reduced access to clinical services • Poor patient experience	**Staff** • Increased safety risks to staff arising from inadequately adapted buildings and infrastructure. • Low morale • Increased workload from staff absences	**Organisation** • Disruption to clinical services and business continuity • Greater demand on healthcare services • Non-compliance with Welsh Government policy and statutory duties under the Well-being of Future Generations (Wales) Act. • Increased operational and capital costs due to reactive rather than planned interventions. • Reputational damage • Missed opportunities to improve population health and prevention through green health approaches.	**Risk Appetite Threshold – SCORE 17 AND BELOW.** Risk related to all aspects of our ability to deliver, manage and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.	
				SUMMARY The current risk level is **OUTSIDE** of target level but **WITHIN** the appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	

		Risk Exposure	Current Level	Target Level
Lead Director	Director of Finance and Procurement			
Monitoring Committee / Group	Finance and Performance Committee	**Likelihood**	4 x Likely	4 x Likely
Initial Date of Assessment	November 2025	**Impact**	4 Moderate	2 Minor
Last Reviewed	April 2026	**Risk rating**	**= 16 Extreme**	**= 8 Moderate**
Next Review (Monthly based on risk score)	May 2026			



Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Integrated Medium Term Plan (IMTP) and Annual Planning processes incorporating sustainability and green health priorities • Participation in NHS Wales and Welsh Government climate emergency, decarbonisation and sustainability programmes • Decarbonisation Programme Board and reporting arrangements • Carbon emissions measurement and reporting (Carbon Neutral metrics) • Capital planning, business case approval and estate management processes incorporating sustainability and resilience considerations • Estate's maintenance and backlog management • Health and safety, emergency planning and business continuity arrangements • Statutory environmental and sustainability reporting • Regulatory inspection and audit activity • Climate adaptation risk embedded in annual business planning • Estates Condition Survey (if up to date) • Environmental Management System (EMS) controls (ISO 14001)	• Development of a Board-approved, organisation-wide climate adaptation and green health strategy and plan • Completion of systematic climate risk assessments across all major sites and services • Strengthening alignment between capital investment prioritisation and climate resilience risks • Completion of bi-annual internal ISO 14001 audit to assess EMS effectiveness • Refit investment • Prioritise repairing weather damaged buildings. • Alteration to planning documents to include consideration of climate adaptation. • Adaptation KPI's being developed by Welsh Government with reporting required from 2026/27 • Direct reporting of risk assessment and adaptation plan progress to Welsh Government on an annual basis. • Review governance structure • Develop comms strategy to share adaptation advice, guidance and expectations. • Pull together a task and finish group to review and plan Climate Adaptation Risks identified in the Gwent PSB Climate Adaptation Plan

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Assurance *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	Actions to Address Gaps *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Minutes of the subgroups to discuss position, monitor and new ideas • Minutes from the Estates operational meetings	• Detailed level metrics and measures are limited due to data capture equipment. • Each Division to identify on their risk register any outstanding climate risks on their risk register and share those risks with the Climate Adaptation Group	
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Finance & Performance Committee and Board Papers and Minutes • Decarbonisation Programme Board Papers and minutes • Executive Committee Papers and minutes • Strategic Risk Assessment • Corporate risk assessments • Audit recommendation tracking report • Incident reports	• Routine inclusion of Climate Adaptation risks on all Departmental Risk Registers.	• Commission baseline climate risk assessment across all divisions • Introduce divisional reporting on adaptation progress • Develop measurable climate adaptation KPIs • Improve real-time monitoring data availability
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
• Audit Wales reports and management letters • Head of Internal Audit Annual Opinion • Regulatory inspection outcomes • Well-being of Future Generations (Wales) Act Reporting • Bi-annual ISO14001 audit report	• Funding for a comprehensive ABUHB decarbonisation strategy is not available. • No external climate adaptation maturity assessment • Limited external validation of climate resilience at site level	• REFIT invest to Save capital opportunities being progressed. • Commission baseline climate risk assessment across all divisions

Assurance Rating (*Overall Assessment of controls and assurances*) *Guidance*

Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE ASSURNACE**


All 21 Risks: Monthly Scores (Apr 2025 – Apr 2026)
Risk Score
20
18
16
14
12
10
8
Apr-2025
May-2025
Jun-2025
Jul-2025
Aug-2025
Sep-2025
Oct-2025
Nov-2025
Dec-2025
Jan-2026
Feb-2026
Mar-2026
Apr-2026
Month
SRR 006 B
SRR 00 1 G
SRR 005 A
SRR 001 D
SRR 011 A
SRR 002 A
SRR 002 B
SRR 00 1 I
SRR 001 C
SRR 001 B
SRR 001 A
SRR 004 B
SRR 006 A
SRR 006 C
SRR 010 A
SRR 007 B
SRR 004 A
SRR 008 A
SRR 007 A
SRR 00 1 F
SRR 00 1 E

Internal Audit Plan 2026/27

Aneurin Bevan University Health Board

Contents

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

1. Introduction

This document sets out the Internal Audit Plan for 2026/27 (the 'Plan') detailing the audits to be undertaken and information of the corresponding resources. It also contains the Internal Audit Mandate and Charter which defines the over-arching purpose, authority and responsibility of Internal Audit and the Key Performance Indicators for the service.

The Accountable Officer (the Chief Executive) is required to certify, in the Annual Governance Statement, that they have reviewed the effectiveness of the organisation's governance arrangements, including the internal control systems, and provide confirmation that these arrangements have been effective, with any qualifications as necessary including required developments and improvement to address any issues identified.

The purpose of Internal Audit is to provide the Accountable Officer and the Board, through the Audit, Risk and Assurance Committee, with an independent and objective annual opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control. The opinion should be used to inform the Annual Governance Statement.

Additionally, the key findings and agreed actions from internal audit reviews may be used by Aneurin Bevan University Health Board's (ABUHB) management to improve governance, risk management, and control within their operational areas.

The Global Internal Audit Standards (the 'Standards') require that a risk based internal audit plan is created that supports the achievement of the organisation's objectives. Accordingly, this document sets out the risk-based approach and the Plan for 2026/27. The Plan will be delivered in accordance with the Internal Audit Mandate and Charter and the agreed KPIs, which are monitored and reported to you. All internal audit activity will be provided by Audit & Assurance Services, a part of NHS Wales Shared Services Partnership (NWSSP).

1.1 National Assurance Audits

The proposed Plan includes assurance audits on some services that are provided by other organisations on behalf of NHS Wales. These are: Digital Health and Care Wales (DHCW); NHS Wales Shared Services Partnership (NWSSP); and the NHS Wales Joint Commissioning Committee (JCC). These audits are part of the risk-based programme of work for DHCW, NWSSP and Cwm Taf Morgannwg UHB (for the JCC), but the results, as in previous years, are reported to the relevant health organisations and are used to inform the overall annual Internal Audit opinion for those organisations.

2. Developing the Internal Audit Plan

2.1 Link to the Global Internal Audit Standards

The Plan has been developed in accordance with Principle 9: Plan Strategically, which includes Standard 9.4 – Internal Audit Plan, of the Standards, and the accompanying Application Note, which provides public sector interpretations and additional requirements for the Standards, to enable the Head of Internal Audit to meet the following key objectives:

- the need to establish risk-based plans to determine the priorities of the internal audit activity, consistent with the organisation's goals.
- provision to the Accountable Officer of an overall independent and objective annual opinion on the organisation's governance, risk management, and control, which will in turn support the preparation of the Annual Governance Statement;
- audits of the organisation's governance, risk management, and control arrangements which afford suitable priority to the organisation's objectives and risks.
- improvement of the organisation's governance, risk management, and control arrangements by providing line management with recommendations arising from audit work.
- confirmation of the audit resources required to deliver the Internal Audit Plan.
- effective co-operation with Audit Wales as external auditor and other review bodies functioning in the organisation; and
- provision of both assurance (opinion based) and consulting engagements by Internal Audit.

2.2 Risk based internal audit planning approach

Our risk-based planning approach recognises the need for the prioritisation of audit coverage to provide assurance on the management of key areas of risk, and our approach addresses this by considering:

- the organisation's risk assessment and maturity;
- the organisation's response to key areas of governance, risk management and control;
- the previous years' internal audit activities; and
- the audit resources required to provide a balanced and comprehensive view.

Our planning considers the NHS Wales Planning Framework and other NHS Wales priorities and is mindful of significant national changes that are taking place. In addition, the Plan aims to reflect the significant local changes occurring as identified through the Integrated Medium-Term Plan (IMTP) and other changes within the organisation, assurance needs, identified concerns from our discussions with management, and emerging risks.

We will ensure that the plan remains fit for purpose by recommending changes where appropriate and reacting to any emerging

issues throughout the year. Any necessary updates will be reported to the Audit, Risk and Assurance Committee in line with the Internal Audit Mandate and Charter.

While some areas of governance, risk management and control will require annual consideration, our risk-based planning approach recognises that it is not possible to audit every area of an organisation's activities every year. Therefore, our approach identifies auditable areas (the 'audit universe'). The risk associated with each auditable area is assessed and this determines the appropriate frequency for review.

In addition, we will, if requested, also agree a programme of work through both the Director of Corporate Governance (Board Secretary) and Directors of Finance networks. These audits and reviews may be undertaken across all NHS bodies or a particular sub-set, for example at Health Boards only.

Therefore, our Plan is made up of several key components:

1) Consideration of key governance and risk areas: we have identified several areas where an annual consideration supports the most efficient and effective delivery of an annual opinion. These cover the Governance, the Board Assurance Framework, Risk Management, Clinical Governance and Quality, Financial Sustainability, Performance Monitoring & Management, and an overall assessment of Digital and Information Technology. In each case we anticipate a short overview to establish the arrangements in place including any changes from the previous year with detailed testing or further work where required.

2) Organisation based audit work – this covers key risks and priorities from the Board Assurance Framework and the Strategic Risk Register, together with other auditable areas identified and prioritised through our planning approach. This work combines elements of governance and risk management with the controls and processes put in place by management to effectively manage the areas under review.

3) Follow up - this is follow-up work on previous 'limited' and 'unsatisfactory' assurance reports as well as other medium and high priority recommendations. Our work here also links to the organisation's recommendation tracker and considers the impact of their implementation on the systems of governance and control.

4) Work agreed with the Directors of Corporate Governance, Directors of Finance, other executive peer groups, or Audit Committee Chairs in response to common risks faced by several organisations. This may be advisory work to identify areas of best practice or shared learning.

5) The impact of audits undertaken at other NHS Wales bodies that may impact on the Health Board, namely NHS Wales Shared Services Partnership (NWSSP), Digital Health and Care Wales (DHCW), and the Joint Commissioning Committee (JCC).

6) Where appropriate, Integrated Audit & Assurance Plans will be agreed for major capital and transformation schemes and charged for separately. Health bodies are able to add a provision for audit and assurance costs into the final business case for major capital bids.

These components are designed to ensure that our internal audit programmes comply with all of the requirements of the Standards, supports the maximisation of the benefits of being an all-NHS Wales wide internal audit service, and allows us to respond in an agile way to requests for audit input at both an all-Wales and organisational level.

2.3 Link to Aneurin Bevan University Health Board systems of assurance

The risk based internal audit planning approach integrates with the Health Board's systems of assurance; therefore, we have considered the following:

- A review of ABUHB's vision, values and forward priorities as outlined in the Integrated Medium Term Plan (IMTP).
- An assessment of ABUHB's governance and assurance arrangements and the contents of the strategic risk register.
- Risks identified in papers to the Board and its Committees (in particular the Audit, Risk and Assurance Committee).
- Key strategic risks identified within the strategic risk register and assurance processes.
- Discussions with Executive Directors regarding risks and assurance needs in areas of corporate responsibility, including compliance and ethics programmes.
- Cumulative internal audit knowledge of governance, risk management, and control arrangements (including a consideration of past internal audit opinions).
- New developments and service changes.
- Legislative requirements to which the organisation is required to comply.
- Planned audit coverage of systems and processes provided through NWSSP, DHCW, and the JCC.
- Work undertaken by other supporting functions of the Audit and Assurance Committee including Local Counter-Fraud Services (LCFS) and the Post-Payment Verification Team (PPV), where appropriate.
- Work undertaken by other review bodies, including Audit Wales.
- Coverage necessary to provide assurance to the Accountable Officer in support of the Annual Governance Statement.

2.4 Audit planning meetings

In developing the Plan, in addition to consideration of the above, the Head of Internal Audit has met and spoken with the executive team and independent members to discuss current areas of risk and related assurance needs.

3. Audit risk assessment

The prioritisation of audit coverage across the audit universe is based on both our and the organisation's assessment of risk and assurance requirements as defined in the Board Assurance Framework and strategic risk register.

The maturity of these risk and assurance systems allows us to consider both inherent risk (impact and likelihood) and mitigation (adequacy and effectiveness of internal controls). Our assessment also considers strategic risk, materiality or significance, system complexity, previous audit findings, and potential for fraud.

4. Planned internal audit coverage

4.1 Internal Audit Plan 2026/27

The Plan is set out in Appendix A and identifies the audit assignments, lead executive officers, outline scopes, and proposed timings. It is structured under the six components referred to in section 2.2.

Where appropriate the Plan refers to key strategic risks identified within the strategic risk register and related systems of assurance, together with the proposed audit response within the outline scope.

When developing the audit scope, in discussion with the responsible executive director(s) and operational management, the scope, objectives and audit resource requirements, and timing will be refined in each area.

The scheduling takes account of the optimum timing for the performance of specific assignments in discussion with management, and Audit Wales requirements if appropriate.

The Audit, Risk and Assurance Committee will be kept appraised of performance in delivery of the Plan, and any required changes, through routine progress reports to each Audit, Risk and Assurance Committee meeting.

Most of the audit work will be undertaken by our regionally based teams with support from our national capital and estates team, in terms of capital audit and estates assurance work, and from our IM&T team, in terms of information governance, IT security and digital work.

4.2 Keeping the plan under review

Our risk assessment and resulting Plan is limited to matters emerging from the planning processes indicated above.

Audit & Assurance Services is committed to ensuring its service focuses on priority risk areas, business critical systems, and the provision of assurance to management across the medium term and in the operational year ahead. As in any given year, our Plan will be kept under review and may be subject to change to ensure it remains fit for purpose. To this end, the need for flexibility and a revisit of the focus and timing of the proposed work will be necessary at some point during the year.

Consistent with previous years, and in accordance with best professional practice, an unallocated contingency provision has been retained in the Plan to enable Internal Audit to respond to emerging risks and priorities identified by the executive team

and endorsed by the Audit, Risk and Assurance Committee. Any changes to the Plan will be based upon consideration of risk and need and will be presented to the Audit, Risk and Assurance Committee for approval.

Regular liaison with Audit Wales, as your External Auditor, will take place to coordinate planned coverage and ensure optimum benefit is derived from the total audit resource.

5. Resource needs assessment

The Plan has been put together based on the planning process described in this document. The Plan includes sufficient audit work to be able to give an annual Head of Internal Audit opinion in line with the requirements of Standard 11.3 – Communicating Results, and Application Note 10B – Overall conclusions and annual reporting.

Audit & Assurance Services confirms that it has the necessary human, financial and technological resources to deliver the agreed plan.

Provision has also been made for other essential audit work including planning, management, reporting and follow-up.

If additional work, support or further input necessary to deliver the plan is required during the year over and above the total indicative resource requirement a fee may be charged. Any change to the plan will be based upon consideration of risk and need and presented to the Audit, Risk and Assurance Committee for approval.

The Standards enable Internal Audit to provide consulting services to management. The commissioning of these additional services by ABUHB, unless already included in the plan, is discretionary. Accordingly, a separate fee may need to be agreed for any additional work.

In addition, any capital audit work in relation to specific projects will be charged for separately on the basis of a separately agreed Integrated Audit & Assurance Plan. Where this is the case, a provision for this work would have been included by ABUHB in its business case submission.

6. Action required

The Audit and Assurance Committee is invited to consider the Internal Audit Plan for 2026/27 and:

- approve the Internal Audit Plan for 2026/27;
- approve the Internal Audit Mandate and Charter; and
- note the associated Internal Audit resource requirements and Key Performance Indicators.

Stephen Chaney
Head of Internal Audit
NHS Wales Shared Services Partnership

Appendix A: Internal Audit Plan 2026/27

Planned output, Outline scope, Review reference	Strategic Priority (SP)/BAF Risk / [Strategic Risk Register (SRR)] / Rationale	Executive Lead/Responsible Director	Planned start
1. Policy Management (Assurance) To ensure the policy management arrangements at the Health Board are effective and consistently applied to support compliance and governance – reflecting on recommendations raised at the Limited assurance report issued in 2022/23.	SRR 001 C Leadership Effectiveness	Director of Corporate Governance	Q4
2. Governance of Escalation Level (Assurance) A review of the Health Board's governance and processes for managing, monitoring and reporting progress around the escalation framework and de-escalation actions.	SRR 001 G SRR 001 I SRR 005 A Financial Sustainability, System Change	Director of Strategy, Planning and Partnerships	Q2
3. Sustainable Funding (Assurance) The audit will assess the adequacy and effectiveness of the Health Board's financial grip and control arrangements, focusing on budget management, forecasting, decision-making governance, and compliance with NHS Wales financial policies. It will also review the completeness, accuracy, and reliability of the self-assessment completed.	SRR 001 G Financial Sustainability	Executive Director of Finance & Procurement / Chief Operating Officer	Q4
4. Charitable Funds (Assurance) To assesses the adequacy and effectiveness of key controls over donations, restricted funds, financial reporting, and decision-making by the Charitable Funds Committee.	SRR 001 G Financial Sustainability Rotational	Executive Director of Finance & Procurement	Q3

Planned output, Outline scope, Review reference	Strategic Priority (SP)/BAF Risk / [Strategic Risk Register (SRR)] / Rationale	Executive Lead/Responsible Director	Planned start
5. Stakeholder Engagement (Assurance) To ensure stakeholder engagement arrangements within the Health Board are effective, inclusive, and embedded in decision-making, supporting transparency and service improvement.	SRR 007 A & B Collaboration and Strategic Partnerships	Director of Strategy, Planning and Partnerships / Executive Director of Public Health and Strategic Partnerships	Q1
6. Duty of Quality (Assurance) To provide assurance that the Health Board is implementing the requirements of the Duty of Quality.	SRR 001 D Maintain High Quality, Safe and Sustainable Services	Medical Director / Executive Director of Allied Health Professions & Health Science / Executive Director of Nursing / Director of Public Health and Strategic Partnerships	Q1
7. Value and Sustainability (Assurance) To review the value and sustainability approach to savings identification, reporting, monitoring and delivery.	SRR 001 G Financial Sustainability	Executive Director of Finance & Procurement	Q1
8. Welsh Risk Pool Lessons (Assurance) The overall objective is to determine if lessons learnt and associated actions from Welsh Risk Pool claims are fully implemented, to prevent a re-occurrence.	SRR 001 G SRR 008 Financial Sustainability, Patient Experience	Executive Director of Nursing	Q3

Planned output, Outline scope, Review reference	Strategic Priority (SP)/BAF Risk / [Strategic Risk Register (SRR)] / Rationale	Executive Lead/Responsible Director	Planned start
9. Hospital Sterilisation and Disinfection Unit (HSDU) (Assurance) This audit will evaluate the processes and procedures that support the delivery of the Hospital Sterilisation & Disinfection Unit (HSDU) across the Health Board.	SRR 001 F SRR 005 A Service Delivery	Chief Operating Officer	Q1
10. Patient Experience (Assurance) To review the arrangements and processes in place within the Health Board for capturing and utilising patient experience. Time will also be allocated for a possible extension of the scope / separate audit to include staff experience.	SRR 008 Patient Experience	Executive Director of Nursing	Q4
11. Dementia Care (Assurance) To provide assurance on whether the Health Board has effective processes to adhere to the All-Wales Dementia Care Pathway of Standards, ensuring consistent, equitable and person-centred dementia care across all settings.	SRR 008 Transformation and Partnership Working Rotational	Executive Director of Nursing	Q3
12. Mental Capacity Act - Deprivation of Liberty Safeguards (Assurance) To ensure the processes for Deprivation of Liberty Safeguards (DoLS) applications are managed in accordance with the DoLS Code of Practice, Welsh Government guidance and Health Board procedures.	SRR 005 Service Delivery	Executive Director of Nursing	Q3

Planned output, Outline scope, Review reference	Strategic Priority (SP)/BAF Risk / [Strategic Risk Register (SRR)] / Rationale	Executive Lead/Responsible Director	Planned start
13. Cancer Referrals (Assurance) To provide assurance over the effectiveness of cancer pathway delivery, referral processes, and demand forecasting, to ensure waiting list targets are achieved. This will build on the 2025/26 audit of referral rates.	SSR 001 F Service Sustainability Ministerial Delivery Commitment	Chief Operating Officer	Q4
14. Discharge Planning To provide further assurance over the Health Board's discharge planning arrangements, building on the recent 2025/26 review to assess revised governance arrangements, processes, multidisciplinary working and performance in supporting timely, safe and patient-centred discharges.	SRR 005 Service Delivery Ministerial Delivery Commitment	Chief Operating Officer	Q3
15. Primary Care and Community Services Divisional Review (Assurance) An assessment of a sample of operational and functional management arrangements, including the delivery of divisional IMTP objectives and the management of key risks.	SSR 001 F Service Sustainability	Chief Operating Officer	Q3
16. Clinical Audit (Assurance) To provide an opinion over whether there are effective processes in place to manage and deliver local clinical audit plans, including the assessment of clinical risk.	SRR 001F Service Models	Medical Director	Q3

Planned output, Outline scope, Review reference	Strategic Priority (SP)/BAF Risk / [Strategic Risk Register (SRR)] / Rationale	Executive Lead/Responsible Director	Planned start
17. Job Planning (Assurance) To provide assurance that arrangements are in place and operating effectively for consultant job planning.	SRR 001F Service Models	Medical Director	Q2
18. Rostering & Operational Workforce Management (Assurance) To ensure rostering arrangements are effective, compliant, and optimised to support safe staffing, workforce wellbeing, and efficient use of resources (e.g. reduce agency requirement). We will also consider workforce plans for a sample of areas across the Health Board and consider how demand and capacity plans are linked to these.	SRR 001F Service Models	Executive Director of Nursing / Medical Director	Q4
19. Vaccination Programme Evaluate the processes in place to monitor and promote the uptake of vaccinations and immunisations amongst the public.	SRR 001 E Ministerial Delivery Commitment	Executive Director of Public Health and Strategic Partnerships	Q3
20. Job Evaluation (Assurance) To ensure the requirements of the NHS Job Evaluation Handbook are being applied in a fair, consistent and equitable manner by the Health Board.	SRR 001A SRR 001B Staff Wellbeing, Recruitment and Retention	Director of Workforce and Organisational Development	Q3
21. Follow-up of Agreed Actions To assess whether high priority internal audit recommendations have been implemented.	Annual review of audit recommendation		Q4

Planned output, Outline scope, Review reference	Strategic Priority (SP)/BAF Risk / [Strategic Risk Register (SRR)] / Rationale	Executive Lead/Responsible Director	Planned start
	implementation as set out within the Global Internal Audit Standards	Director of Corporate Governance	
22. Electronic Prescribing and Medicines Administration To determine if Electronic Prescribing and Medicines Administration (ePMA) is governed and delivered effectively, with appropriate controls to support safe implementation, clinical benefit realisation, and value for money.	SRR 001 G Financial Sustainability SRR 006 B Implementation of new systems	Director of Digital	Q4
23. Project Management Office (Digital) To determine whether a sample of programmes and projects establish clear, measurable milestones and defined outputs at initiation, supported by robust planning and governance arrangements. It will also evaluate controls in place to prevent scope creep, ensuring changes are formally assessed, approved, and aligned to agreed programme objectives.	SRR 001 G Financial Sustainability SRR 006 B Implementation of new systems	Director of Digital	Q3
24. Procurement of Digital Services To ensure that the procurement of digital services complies with the new NHS Wales procurement regulations, including governance, controls, and adherence to statutory and organisational requirements.	SRR 001 G Financial Sustainability SRR 006 B Implementation of new systems	Director of Digital / Executive Director of Finance & Procurement	Q4

Planned output, Outline scope, Review reference	Strategic Priority (SP)/BAF Risk / [Strategic Risk Register (SRR)] / Rationale	Executive Lead/Responsible Director	Planned start
25. Networks To provide assurance over how the network is provided, managed, monitored and supported to enable digital connectivity across the Health Board.	SRR 006 A Existing Digital Infrastructure	Director of Digital	Q2
26. Capital Systems (Assurance) The audit will focus on the targeting of TEF funding and the delivery of the resulting projects in line with local/ national procedures and the conditions of funding.	SSR 001 G, Financial Sustainability SSR002 B Backlog maintenance and structural impairment	Chief Operating Officer/ Director of Strategy, Planning and Partnerships/ Director of Allied Health Professions and Health Science	Q2
27. Estates Assurance (Assurance) We will await the outcome of the Audit Wales review of Estates prior to confirming the focus of this audit. One potential area of review might be the Control of Contractors, ensuring that they comply with contractual, performance, financial and health & safety requirements.	SSR 001 G Financial Sustainability SSR002 B Backlog maintenance and structural impairment Compliance with H&S requirements	Chief Operating Officer / Executive Director of Finance & Procurement	Q2
Audit management, reporting, Audit, Risk and Assurance Committee attendance, development of Integrated Audit Plans, attendance at associated project/programme boards meetings and associated UHB Committees etc.			

Appendix B: Key performance indicators (KPI)

KPI	SLA required	Target 2026/27
Audit plan 2026/27 agreed/in draft by 30 April	✓	To deliver plan
Audit opinion 2025/26 delivered by 31 May	✓	To deliver opinion
Audits reported versus total planned audits, and in line with Audit Committee expectations	✓	varies
% of audit outputs in progress	No	varies
Report turnaround fieldwork to draft reporting [10 working days]	✓	95%
Report turnaround management response to draft report [15 working days maximum]	✓	80%
Report turnaround draft response to final reporting [10 working days]	✓	95%

Appendix C: Internal Audit Mandate and Charter

1 Introduction

1.1 This Mandate and Charter is produced and updated annually to comply with the Global Internal Audit Standards (introduced from 1 April 2025 for the UK Public Sector). The Standards (with specific reference to Standard 6.1 Internal Audit Mandate and 6.2 Internal Audit Charter) require the production and maintaining of an Internal Audit Mandate and Charter that, at a minimum, sets out:

- The purpose of Internal Auditing;
- a commitment to adhere to the Global Internal Audit Standards;
- the Mandate, including the scope and types of services to be provided, and the Board's responsibilities and expectations regarding management's support of the internal audit function; and
- the organisational position and reporting relationships, including Independence.

The Mandate and Charter are complementary to the relevant provisions included in the organisation's own Standing Orders and Standing Financial Instructions.

1.2 The terms 'board' and 'senior management' are required to be defined under the Standards and therefore have the following meaning in this Mandate and Charter:

- Board means the Board of Aneurin Bevan University Health Board with responsibility to direct and oversee the activities and management of the organisation. The Board has delegated authority to the Audit, Risk and Assurance Committee in terms of providing a reporting interface with internal audit activity; and
- Senior Management means the Chief Executive as being the designated Accountable Officer for Aneurin Bevan University Health Board. The Chief Executive has made arrangements within this Mandate and Charter for an operational interface with internal audit activity through the Director of Corporate Governance (Board Secretary).

1.3 Internal Audit seeks to comply with all the appropriate requirements of the Welsh Language (Wales) Measure 2011. We are happy to correspond in both Welsh and English.

2 Purpose and responsibility

2.1 Internal audit is an independent, objective assurance and advisory function designed to add value and improve the operations of the Health Board. Internal audit helps the organisation accomplish its objectives by bringing a systematic and disciplined approach to evaluate and improve the effectiveness of governance, risk management and control processes. Its mission is to enhance and protect organisational value by providing risk-based and objective assurance, advice and insight.

2.2 Internal Audit is responsible for providing an independent and objective assurance opinion to the Accountable Officer, the Board and the Audit, Risk and Assurance Committee on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. In addition, internal audit's findings and recommendations are beneficial to management in securing improvement in the audited areas.

2.3 The organisation's risk management, internal control and governance arrangements comprise:

- the policies, procedures and operations established by the organisation to ensure the achievement of objectives.
- the appropriate assessment and management of risk, and the related system of assurance.
- the arrangements to monitor performance and secure value for money in the use of resources.
- the reliability of internal and external reporting and accountability processes and the safeguarding of assets.
- compliance with applicable laws and regulations; and
- compliance with the behavioural and ethical standards set out for the organisation.

2.4 Internal audit also provides an independent and objective consulting service specifically to help management improve the organisations risk management, control and governance arrangements. The service applies the professional skills of internal audit through a systematic and disciplined evaluation of the policies, procedures and operations that management have put in place to ensure the achievement of the organisations objectives, and through recommendations for improvement. Such consulting work contributes to the opinion which internal audit provides on risk management control and governance.

3 Independence and Objectivity

3.1 Independence is described in the Global Internal Audit Standards as the freedom from conditions that threaten the ability of the internal audit activity to carry out internal audit responsibilities in an unbiased manner. To achieve the degree of independence necessary to effectively carry out the responsibilities of the internal audit activity, the Head of Internal Audit will have direct and unrestricted access to the Board and Senior Management, in particular the Chair of the Audit, Risk and Assurance Committee and Accountable Officer.

3.2 Organisational independence is effectively achieved when the auditor reports functionally to the Audit, Risk and Assurance Committee on behalf of the Board. Such functional reporting includes the Audit, Risk and Assurance Committee:

- approving the internal audit mandate and charter.
- approving the risk based internal audit plan.
- approving the internal audit resource plan.
- receiving outcomes of all internal audit work together with the assurance rating and

- reporting on internal audit activity's performance relative to its plan.

3.3 While maintaining effective liaison and communication with the organisation, as provided in this Mandate and Charter, all internal audit activities shall remain free of untoward influence by any element in the organisation, including matters of audit selection, scope, procedures, frequency, timing, or report content to permit maintenance of an independent and objective attitude necessary in rendering reports.

3.4 Internal Auditors shall have no executive or direct operational responsibility or authority over any of the activities they review. Accordingly, they shall not develop nor install systems or procedures, prepare records, or engage in any other activity which would normally be audited.

3.5 This Mandate and Charter makes appropriate arrangements to secure the objectivity and independence of internal audit as required under the standards. In addition, the shared service model of provision in NHS Wales through NWSSP provides further organisational independence.

3.6 In terms of avoiding conflicts of interest in relation to non-audit activities, Audit & Assurance has produced a Consulting Protocol that includes all of the steps to be undertaken to ensure compliance with the relevant Standards that apply to non-audit activities.

4 Authority and Accountability

4.1 Internal Audit derives its authority from the Board, the Accountable Officer and Audit, Risk and Assurance Committee. These authorities are established in Standing Orders and Standing Financial Instructions adopted by the Board.

4.2 The Minister for Health and Social Services has determined that internal audit will be provided to all health organisations by the NHS Wales Shared Services Partnership (NWSSP). The service provision will be in accordance with the Service Level Agreement agreed by the Shared Services Partnership Committee and in which the organisation has permanent membership.

4.3 The Director of Audit & Assurance leads the NWSSP Audit and Assurance Services and after due consultation will assign a named Head of Internal Audit to the organisation. For line management (e.g. individual performance) and professional quality purposes (e.g. compliance with the Global Internal Audit Standards), the Head of Internal Audit reports to the Director of Audit & Assurance.

4.4 The Head of Internal Audit reports on a functional basis to the Accountable Officer and to the Audit, Risk and Assurance Committee on behalf of the Board. Accordingly, the Head of Internal Audit has a direct right of access to the Accountable Officer, the Chair of the Audit, Risk and Assurance Committee and the Chair of the organisation if deemed necessary.

4.5 The Audit, Risk and Assurance Committee approves all Internal Audit plans and may review any aspect of its work. The Audit, Risk and Assurance Committee also has regular private meetings with the Head of Internal Audit.

4.6 In order to facilitate its assessment of governance within the organisation, Internal Audit is granted access to attend any

committee or sub-committee of the Board charged with aspects of governance.

5 Relationships

5.1 In terms of normal business the Accountable Officer has determined that the Director of Corporate Governance will be the nominated executive lead for internal audit. Accordingly, the Head of Internal Audit will maintain functional liaison with this officer.

5.2 In order to maximise its contribution to the Board's overall system of assurance, Internal Audit will work closely with the organisation's Director of Corporate Governance in planning its work programme.

5.3 Co-operative relationships with management enhance the ability of internal audit to achieve its objectives effectively. Audit work will be planned in conjunction with management, particularly in respect of the timing of audit work.

5.4 Internal Audit will meet regularly with the external auditor, Audit Wales, to consult on audit plans, discuss matters of mutual interest, discuss common understanding of audit techniques, method and terminology, and to seek opportunities for co-operation in the conduct of audit work. Internal Audit will make available their working files to the external auditor for them to place reliance upon the work of Internal Audit where appropriate.

5.5 The Head of Internal Audit will establish a means to gain an overview of other assurance providers' approaches and output as part of the establishment of an integrated assurance framework.

5.6 The Head of Internal Audit will take account of key systems being operated by organisation's outside of the remit of the Accountable Officer, or through a shared or joint arrangement, such as the Digital Health and Care Wales, NHS Wales Shared Services Partnership, the Joint Commissioning Committee.

5.7 Internal Audit strives to add value to the organisation's processes and help improve its systems and services. To support this Internal Audit will obtain an understanding of the organisation and its activities, encourage two-way communications between internal audit and operational staff, discuss the audit approach and seek feedback on work undertaken.

5.8 The Audit, Risk and Assurance Committee may determine that another Committee of the organisation is a more appropriate forum to receive and action individual audit reports. However, the Audit, Risk and Assurance Committee will remain the final reporting line for all our audit and consulting reports.

6 Standards, Ethics, and Performance

6.1 Internal Audit must comply with the Global Internal Audit Standards and the UK Public Sector Application Note in discharging its responsibilities.

6.2 Internal Audit will operate in accordance with the Service Level Agreement (updated 2024) and associated performance standards agreed with the Audit, Risk and Assurance Committee and the Shared Services Partnership Committee. The Service Level Agreement includes several Key Performance Indicators, and we will agree with each Audit Committee

which of these they want reported to them and how often.

7 Scope

7.1 The scope of Internal Audit encompasses the examination and evaluation of the adequacy and effectiveness of the organisation's governance, risk management arrangements, system of internal control, and the quality of performance in carrying out assigned responsibilities to achieve the organisation's stated goals and objectives. It includes but is not limited to:

- reviewing the reliability and integrity of financial and operating information and the means used to identify measure, classify, and report such information.
- reviewing the systems established to ensure compliance with those policies, plans, procedures, laws, and regulations which could have a significant impact on operations, and reports on whether the organisation is in compliance.
- reviewing the means of safeguarding assets and, as appropriate, verifying the existence of such assets.
- reviewing and appraising the economy and efficiency with which resources are employed, this may include benchmarking and sharing of best practice.
- reviewing operations or programmes to ascertain whether results are consistent with the organisation’s objectives and goals and whether the operations or programmes are being carried out as planned.
- reviewing specific operations at the request of the Audit, Risk and Assurance Committee or management, this may include areas of concern identified in the strategic risk register.
- monitoring and evaluating the effectiveness of the organisation's risk management arrangements and the overall system of assurance.
- ensuring effective co-ordination, as appropriate, with external auditors and other regulators. and
- reviewing the Annual Governance Statement prepared by senior management.

7.2 Internal Audit will devote particular attention to any aspects of the risk management, internal control and governance arrangements affected by material changes to the organisation’s risk environment.

7.3 If the Head of Internal Audit or the Audit, Risk and Assurance Committee consider that the level of audit resources or the Mandate and Charter in any way limit the scope of internal audit or prejudice the ability of internal audit to deliver a service consistent with the definition of internal auditing, they will advise the Accountable Officer and Board accordingly.

8 Approach

8.1 To ensure delivery of its scope and objectives in accordance with the Mandate and Charter and Standards, Internal Audit has produced an Audit Manual (called the Quality Manual). The Quality Manual includes arrangements for planning the audit work. These audit planning arrangements are organised into a hierarchy as illustrated in Figure 1.

Figure 1: Audit planning hierarchy

NHS Wales Level	NWSSP overall audit strategy	Arrangements for provision of internal audit services across NHS Wales equirements of the Mandate & Charter
Organisation Level	Entity strategic 3-year audit plan	Entity level medium term audit plan linked to organisational objectives priorities and risk assessment
	Entity annual internal audit plan	Annual internal audit plan detailing audit engagements to be completed in year ahead leading to the overall HIA opinion
Business Unit Level	Assignment plans	Assignment plans detail the scope and objectives for each audit engagement within the annual operational plan

8.2 NWSSP Audit & Assurance Services has developed an overall audit strategy which sets out the strategic approach to the delivery of audit services to all health organisations in NHS Wales. The strategy also includes arrangements for securing assurance on the national transaction processing systems including those operated by DHCW and NWSSP on behalf of NHS Wales.

8.3 The main purpose of the Strategic 3-year Audit Plan is to enable the Head of Internal Audit to plan over the medium term on how the assurance needs of the organisation will be met as required by the Standards and facilitate:

- the provision to the Accountable Officer and the Audit, Risk and Assurance Committee of an overall opinion each year on the organisation's risk management, control and governance, to support the preparation of the Annual Governance Statement.
- audit of the organisation's risk management, control and governance through periodic audit plans in a way that affords suitable priority to the organisation's objectives and risks.
- improvement of the organisation's risk management, control and governance by providing management with

constructive recommendations arising from audit work.

- an assessment of audit needs in terms of those audit resources which 'are appropriate, sufficient and effectively deployed to achieve the approved plan'.
- effective co-operation with external auditors and other review bodies functioning in the organisation. and
- the allocation of resources between assurance and consulting work.

8.4 The Strategic 3-year Audit Plan will be largely based on the Board Assurance Framework where it is sufficiently mature, together with the organisation-wide risk assessment.

8.5 An Annual Internal Audit Plan will be prepared each year drawn from the Strategic 3-year Audit Plan and other information and outlining the scope and timing of audit assignments to be completed during the year ahead.

8.6 The strategic 3-year and annual internal audit plans shall be prepared to support the audit opinion to the Accountable Officer on the risk management, internal control and governance arrangements within the organisation.

8.7 The annual internal audit plan will be developed in discussion with executive management and approved by the Audit, Risk and Assurance Committee on behalf of the Board.

8.8 The NWSSP Audit Strategy is expanded in the form of a Quality Manual and a Consulting Protocol which together define the audit approach applied to the provision of internal audit and consulting services.

8.9 During the planning of audit assignments, an assignment brief will be prepared for discussion with the nominated operational manager. The brief will contain the proposed scope of the review along with the relevant objectives and risks to be covered. In order to ensure the scope of the review is appropriate it will require agreement by the relevant Executive Director or their nominated lead and will also be copied to the Director of Corporate Governance.

9 Reporting

9.1 Internal Audit will report formally to the Audit, Risk and Assurance Committee through the following:

- An annual report will be presented to confirm completion of the audit plan and will include the Head of Internal Audit opinion provided for the Accountable Officer that will support the Annual Governance Statement.
- The Head of Internal Audit opinion will:
  a) State the overall adequacy and effectiveness of the organisation's risk management, control and governance processes.
  b) Disclose any qualification to that opinion, together with the reasons for the qualification.
  c) Present a summary of the audit work undertaken to formulate the opinion, including reliance placed on work by other assurance bodies.

d) Draw attention to any issues Internal Audit judge as being particularly relevant to the preparation of the Annual Governance Statement.

e) Compare work undertaken with the work which was planned and summarise performance of the internal audit function against its performance measurement criteria. and

f) Provide a statement of conformity in terms of compliance with the Global Internal Audit Standards and associated internal quality assurance arrangements.

- For each Audit, Risk and Assurance Committee meeting a progress report will be presented to summarise progress against the plan. The progress report will highlight any slippage and changes in the programme. The findings arising from individual audit reviews will be reported in accordance with Audit, Risk and Assurance Committee requirements; and
- The Audit, Risk and Assurance Committee will be provided with copies of individual audit reports for each assignment undertaken unless the Head of Internal Audit is advised otherwise. The reports will include an action plan on any recommendations for improvement agreed with management including target dates for completion.

9.2 The process for audit reporting is summarised below:

- Following the closure of fieldwork and the resolution of any queries, Internal Audit will discuss findings with operational managers to confirm understanding and shape the reporting stage.
- Operational management will receive discussion draft reports which will include any proposed recommendations for improvement within 10 working days following the discussion of findings. A copy of the draft report will also be provided to the relevant Executive Director.
- The draft report will give an assurance opinion on the area reviewed in line with the criteria at Appendix B (unless it is a consulting review). The draft report will also indicate priority ratings for individual report findings and recommendations.
- Operational management will be required to respond to the draft report in consultation with the relevant Executive Director within 15 working days of issue, identifying actions, identifying staff with responsibility for implementation and the dates by which action will be taken.
- The Head of Internal Audit will seek to resolve any disagreement with management in the clearance of the draft report. However, where the management response is deemed inadequate, or disagreement remains then the matter will be escalated to the Director of Corporate Governance. The Head of Internal Audit may present the draft report to the Audit, Risk and Assurance Committee where the management response is inadequate or where disagreement remains unresolved. The Head of Internal Audit may also escalate this directly to the Audit, Risk and Assurance Committee Chair to ensure that the issues raised in the report are addressed appropriately.
- Reminder correspondence will be issued after the set response date where no management response has been

received. Where no reply is received within 5 working days of the reminder, the matter will be escalated to the Director of Corporate Governance. The Head of Internal Audit may present the draft report to the Audit, Risk and Assurance Committee where no management response is forthcoming.

- Internal Audit issues a Final report to Executive Director within 10 working days of receipt of complete management response. Within this timescale Internal Audit will quality assess the responses, and if necessary, return the responses, requiring them to be strengthened.
- Responses to audit recommendations need to be SMART:
  - Specific
  - Measurable
  - Achievable
  - Relevant / Realistic
  - Timely.
- The relevant Executive Director, Director of Corporate Governance and the Chair of the Audit, Risk and Assurance Committee will be copied into any correspondence.
- The final report will be copied to the Accountable Officer and Director of Corporate Governance and placed on the agenda for the next available Audit, Risk and Assurance Committee.

9.3 Internal Audit will make provision to review the implementation of agreed action within the agreed timescales. However, where there are issues of particular concern provision maybe made for a follow-up review within the same financial year. Issue and clearance of follow up reports shall be as for other assignments referred to above.

9.4 Timescales are to be included in all initial scopes sent prior to commencing an audit.

10 Access and Confidentiality

10.1 Internal Audit shall have the authority to access all the organisation's information, documents, records, assets, personnel and premises that it considers necessary to fulfil its role. This shall extend to the resources of the third parties that provide services on behalf of the organisation.

10.2 All information obtained during a review will be regarded as strictly confidential to the organisation and shall not be divulged to any third party without the prior permission of the Accountable Officer. However, open access is granted to the organisation's external auditors.

10.3 Where there is a request to share information amongst the NHS bodies in Wales, for example to promote good practice and learning, then permission will be sought from the Accountable Officer before any information is shared.

11 Irregularities, Fraud & Corruption

11.1 It is the responsibility of management to maintain systems that ensure the organisation's resources are utilised in the manner and on activities intended. This includes the responsibility for the prevention and detection of fraud and other illegal acts.

11.2 Internal Audit shall not be relied upon to detect fraud or other irregularities. However, Internal Audit will give due regard to the possibility of fraud and other irregularities in work undertaken. Additionally, Internal Audit shall seek to identify weaknesses in control that could permit fraud or irregularity.

11.3 If Internal Audit discovers suspicion or evidence of fraud or irregularity, this will immediately be reported to the organisation's Local Counter Fraud Service (LCFS) in accordance with the organisation's Counter Fraud Policy & Fraud Response Plan and the agreed Internal Audit and Counter Fraud Protocol.

12 Quality Assurance

12.1 The work of internal audit is controlled at each level of operation to ensure that a continuously effective level of performance, compliant with the Global Internal Audit Standards, is being achieved.

12.2 The Director of Audit & Assurance will establish a quality assurance and improvement programme designed to give assurance through internal and external review that the work of Internal Audit is compliant with the Global Internal Audit Standards and to achieve its objectives. A commentary on compliance against the Standards will be provided in the Annual Audit Report to the Audit, Risk and Assurance Committee.

12.3 The Director of Audit & Assurance will monitor the performance of the internal audit provision in terms of meeting the service performance standards set out in the NWSSP Service Level Agreement. The Head of Internal Audit will periodically report service performance to the Audit, Risk and Assurance Committee through the reporting mechanisms outlined in Section 9.

13 Resolving Concerns

13.1 NWSSP Audit & Assurance was established for the collective benefit of NHS Wales and as such needs to meet the expectations of client partners. Any questions or concerns about the audit service should be raised initially with the Head of Internal Audit assigned to the organisation. In addition, any matter may be escalated to the Director of Audit & Assurance. NWSSP Audit & Assurance will seek to resolve any issues and find a way forward.

13.2 Any formal complaints will be handled in accordance with the NWSSP complaint handling procedure. Where any concerns relate to the conduct of the Director of Audit & Assurance, the NHS organisation will have access to the Managing Director of Shared Services.

14 Review of the Internal Audit Mandate and Charter

14.1 This Internal Audit Mandate and Charter shall be reviewed annually and approved by the Board, taking account of advice from the Audit, Risk and Assurance Committee.

Simon Cookson
Director of Audit & Assurance
NHS Wales Shared Services Partnership
March 2026

Disclaimer

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Mandate and Charter as approved by the Audit, Risk and Assurance Committee.

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

The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given regarding the advice and information contained.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management of the Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Global Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023. Please note that new Global Internal Audit Standards apply from April 2025, and all future audit work will comply to these new Standards.

Internal Audit Progress Report

Audit, Risk and Assurance Committee

May 2026

Aneurin Bevan University Health Board

NWSSP Audit and Assurance Services

Contents

1. Introduction

The purpose of this report is to:

- confirm the status of the audit work for the 2025/26 Internal Audit Plan for Aneurin Bevan University Health Board (the 'Health Board') to the May 2026 Audit, Risk and Assurance Committee (the 'Committee');
- confirm the unchanged position on the draft Head of Internal Audit Opinion;
- highlight the final 2026/27 Internal Audit Plan for information purposes; and
- note the specific issues relating to the Shadow IT audit.

2. Progress against 2025/26 Internal Audit Plan

The following final reports have been issued since the meeting of the Audit, Risk and Assurance Committee on 28th April 2026:

AUDIT ASSIGNMENT	ASSURANCE RATING
Follow Up of Agreed Actions	Non-opinion
Space Utilisation	Non-opinion

Further information over the assurance rating detailed above is included within Appendix B.

The current position of the 2025/26 Internal Audit Plan is summarised below, with further detail within Appendix A.

Audit Status	Number
Final reports	19
Draft reports	5
Work in progress	3
Planning	0
Deferred	3
Total number of audits planned	30

3. Summary of Findings for Recently Completed Work

Limited assurance reports are considered by the Audit, Risk and Assurance Committee in detail. The following summary provides the Committee with the main conclusions from the final reports issued since 28th April 2026.

Follow Up of Agreed Actions (advisory)

The report follows up on high and medium priority findings from internal audits issued during the 2024/25 financial year for the Health Board. It is an advisory review, meaning it does not provide an assurance rating, but offers feedback to

management for corrective action. There were no significant issues to be brought to the attention of the Committee.

Space Utilisation (advisory)

The review aimed to evaluate how effectively the Health Board manages and controls space utilisation, with the goal of supporting efficiency, cost reduction, and improved patient care. It is an advisory review, and as such, we have not provided an assurance rating, but instead offered feedback to management and shared learning from across NHS Wales to provide best practice guidance. The report highlights the need for a strategic utilisation framework, improved governance, and enhanced data-driven decision-making, especially as the Health Board invests in monitoring technology and refreshes its Estates Strategy.

4. Shadow IT

We have completed our audit of Shadow IT to a draft report stage. However, due to a long term sickness absence within, the audit report can not be fully issued / finalised until the availability of the next available specialised resource. This will impact the conclusion timing of the audit, but it is still expected to be fully incorporated into the Head of Internal Audit Opinion.

5. Draft Head of Internal Audit Opinion

Based on the current audit position, and the work completed since presenting the draft Head of Internal Audit Opinion to the April 2026 Audit, Risk and Assurance Committee, the overall position remains as previously presented – at reasonable assurance. This will be finalised over the coming weeks.

6. Final 2026/27 Internal Audit Plan

The 2026/27 Draft Internal Audit Plan was presented to the Audit, Risk and Assurance Committee in April 2026 for review and approval.

Comments received during the meeting and subsequently from management have been incorporated within the 2026/27 Final Internal Audit Plan which is presented to this Committee for noting.

7. Summary of Audit Briefs Recently issued

No additional briefs have been issued since the last Audit, Risk and Assurance Committee.

8. Recommendation

The Audit, Risk and Assurance Committee is invited to **note** the above points within the report.

Appendix A: Progress against 2025/26 Internal Audit Plan

Reviews	Assurance Rating	Status
1. Divisional Budgetary Control		Work in Progress
2. Standing Orders Compliance	Substantial	Final Report
3. Strategic Risk and Assurance	Reasonable	Final Report
4. Subject Access Requests	Limited	Final Report
5. Benefits Realisation (excluding digital)		Draft Report
6. Business Continuity Plan	Reasonable	Final Report
7. Capital Projects: Service Readiness	Reasonable	Final Report
8. Falls Management		Draft Report
9. Directorate Review - CAMHS	Reasonable	Final Report
10. Professional Staff Registration		Work in Progress
11. Clinical Audit	N/A	Deferred
12. Directorate Review – Ophthalmology / ENT	N/A	Deferred / delayed
13. Public Health	Advisory	Final Report
14. Six Goals Programme	N/A	Deferred
15. Discharge Planning	Substantial	Draft Report
16. Safeguarding	Reasonable	Final Report
17. Cancer Referral Rates		Work in Progress
18. Occupational Health	Reasonable	Final Report
19. Overseas Recruitment	Reasonable	Draft Report
20. Speaking up Safely	Limited	Final Report
21. Follow-up of High Priority Recommendations	Advisory	Final Report
22. Cyber Security (Including cyber incident response)	Reasonable	Final Report
23. Shadow IT		Draft Report
24. Welsh Intensive Care Information System	Substantial	Final Report
25. RGH Central Decontamination Unit (capital systems from 2024/25)	Reasonable	Final Report
26. Estates Assurance – Space Utilisation	Advisory	Final Report
27. Financial Sustainability (b/fwd from 2024/25)	Reasonable	Final Report
28. Waiting List Management (b/fwd from 2024/25)	Reasonable	Final Report
29. The Grange Emergency Department	Limited	Final Report
30. NHH Regional Satellite Centre (deferred from 2024/25)	Reasonable	Draft Report

Appendix B: Audit Assurance Ratings

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

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

Follow Up of Agreed Actions
Final Internal Audit Report
2025/26

Aneurin Bevan University Health Board

Advisory

Contents

Review Reference	ABU-2526-21
Fieldwork	February 2026
Executive Sign Off	April 2026
Audit Committee	May 2026
Executive Lead	Rani Dash, Director of Corporate Governance
Audit Team	Stephen Chaney, Head of Internal Audit
	Mair Evans, Principal Auditor

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Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Executive Summary

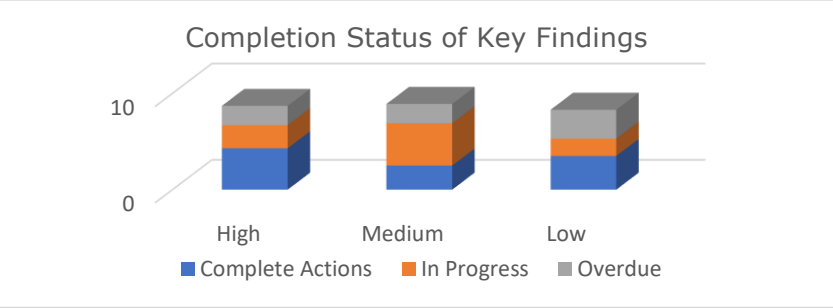
Purpose

To follow-up a sample of high and medium priority findings raised within internal audits issued during the 2024/25 financial year. This is a non-opinion / advisory review and therefore the review does not provide an assurance rating – however feedback has been provided to management where appropriate to allow corrective action to be taken.

Overview

We examined recent internal audit findings due for completion by October 2025 to verify management's reported implementation status. This included 31 internal audit reports issued, encompassing 131 key findings as follows:

	High	Medium	Low	Total	Sample
Actions Closed by Committee	3	58	13	**74**	5
Actions in Progress	8	19	0	**27**	9
Actions Overdue	9	16	5	**30**	14
Total Actions	**20**	**93**	**18**	**131**	**28**



Our review found the Tracker to be generally accurate, with some minor administrative errors, one missing recommendation, and misclassified priorities occurred due to character limits for management actions - all were corrected during the review. We sampled three reports with seven high and seven medium priority recommendations and found no issues with supporting evidence or premature closure.

We also reviewed the total approvals for extensions from November 2024 to February 2026:

	High	Medium	Low	Total
Extended Once	1	9	1	11
Extended Twice	0	2	0	2
Extended Three Times (breach)	2	2	0	4
Total	**3**	**13**	**1**	**17**

Furthermore, a sample of 14 of the 30 overdue actions were tested, five did not have a corresponding approved extension – but still remain on the Tracker.

Overall, we found good progress has been made to close agreed audit actions in a timely manner, with adequate supporting information provided to demonstrate action taken. The following matters have been raised for management consideration:

- To be cognisant of the character limit within the Tracker when transposing agreed actions - ensuring the intent behind these actions is preserved.
- Management would benefit from a clear specification setting out the minimum supporting information required when applying for formal extensions.
- To review those recommendations that have been extended multiple times to understand the rationale/ reasonableness.
- To review the five overdue actions without a corresponding approved extension.

Appendix A

Assurance Opinion

Substantial

Follow up: all recommendations implemented and operating as expected.

Reasonable

Follow up: all high priority recommendations implemented and progress on the medium and low priority recommendations.

Limited

Follow up: no high priority recommendations implemented but progress on most of the medium and low priority recommendations.

Unsatisfactory

Follow up: no action taken to implement recommendations.

Advisory

Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate.

These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

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Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

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

Space Utilisation

Final Advisory Report

2025/26

Aneurin Bevan University Health Board

Contents

Review Reference	ABU-SSU-2526-26
Fieldwork	October-November 2025
Executive Sign Off	14th April 2026
Audit Committee	28th April 2026
Executive Lead	Leanne Watkins, Chief Operating Officer
Audit Team	Huw Richards, Deputy Director, SSu
	Murray Gard, Deputy Head of Internal Audit
	Paul Stocker, Audit Manager

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Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

Optimising space utilisation within NHS Wales is crucial to support improved efficiency, cost reductions and to benefit patient care.

This advisory review sought to evaluate the effectiveness of the management and control of space utilisation within the University Health Board (UHB), share learning across the NHS Wales organisations at which this review is taking place, and where possible provide best practice guidance and suggested opportunities for improvement.

The review originated from the 2025/26 internal audit plan, agreed with management, and approved by the Audit Committee.

Overview

The UHB's arrangements for managing space utilisation were found to be less mature than those observed in some other NHS Wales organisations. More broadly, NHS Wales remains less advanced than NHS England in terms of the availability of estate data and the maturity of processes used to optimise space utilisation. Space utilisation surveys completed to date within the UHB indicate an average utilisation of approximately 25% within admin and clerical office space as reviewed. If reflective of the wider estate, this suggests significant potential for improved efficiency and cost savings through better use and rationalisation of existing space. In the context of identified backlog maintenance pressures and constrained capital funding, there is a clear opportunity for the UHB, and NHS Wales more widely, to strengthen its understanding of space utilisation to inform strategic estate planning.

As this was an advisory review, no assurance opinion or formal recommendations have been provided. Instead, the report highlights areas for management consideration focused on enhancing existing processes rather than requiring fundamental change.

Scope & Assurance Summary

	Objectives	Related Considerations
1	**Strategy and Governance:** To consider whether the UHB's strategy for space utilisation across its estate is adequately defined and approved. That measurable targets and objectives have been established for the short, medium and long term. That there are supporting policies and procedures in place. That appropriate governance arrangements have been defined and are operating effectively.	1,2,3,4
2	**Data Capture and Monitoring:** That a robust baseline for space occupancy and associated costs has been established, together with robust ongoing monitoring mechanisms. Processes are in place for the ongoing monitoring of space utilisation, to provide up to date data to enable monitoring against performance targets, inform decisions, e.g. via surveys, audits, monitoring software etc. Demonstration that evaluation data is collated from post-completion project reviews to confirm whether new build spaces are being utilised in accordance with the agreed business case objectives. Assess the utilisation of monitoring tools to track space utilisation.	5,6,7
3	**Management and Compliance:** Review processes and technological tools for managing space utilisation, including compliance with policies and procedures for space allocation, changes in use, surplus space management, and decision-making around leasing/SLAs to enable optimisation of space. Evaluate the integration of cost considerations in decisions and the assessment of available space in project planning stages.	8,9,10
4	**Performance Evaluation and Reporting:** Assess how space utilisation data is used to monitor performance against established targets. Assess how data informs strategic planning for the estate. Evaluate the effectiveness of reporting mechanisms, including actions taken to address under-utilisation.	

Management Considerations

10

Themes

Risk Types

Financial Loss

Quality or Safety Issues

Public Perception & Reputational Risk

Findings & Management Considerations

Objective 1: Strategy & Governance

Overview / Summary of Observations

The UHB has an overarching Estates Strategy, which was being refreshed at the time of fieldwork. The proposed future 'Estates Strategy' is expected to adopt a "three-lens approach", considering estate utilisation, estate condition, and service design and population need. The strategy is anticipated to cover a ten-year period, with completion of the strategy projected by May 2026. Progress on the refresh was reported to the UHB Planning, Population Health and Partnership Committee in October 2025.While utilisation is identified as a key component of the developing strategy, there is currently no standalone utilisation framework that defines measurable standards, establishes clear roles and escalation routes, sets performance indicators, or provides a structured approach for reviewing and challenging space allocation.

Governance oversight of estate usage is supported through the Land and Property Group, which oversees lease arrangements and property transactions, and the Accommodation Group, chaired at Divisional Director level, which manages office space reallocation. However, the Accommodation Group does not consider outpatient clinic rooms or scheduling on hospital sites, limiting the scope of utilisation oversight across some clinical areas.

The UHB had put in place governance arrangements intended to support the development of agile working through the Agile Programme Board, led by Workforce. Estates were identified as a dedicated workstream, appropriately recognising the importance of workspace configuration to the effective implementation of agile working. Programme documentation also set out ambitions for the development of agile working hubs and highlighted the need to assess the availability and suitability of estate space to support this.

However, despite these arrangements being established, the Agile Programme Board has met only infrequently over the past three years, with gaps of up to 12 months between meetings. This limited oversight has reduced the Board's effectiveness in driving delivery and maintaining momentum. Consequently, key programme ambitions, including the development of agile working hubs, have not been progressed as intended and remain outstanding

The UHB has introduced several positive control improvements to strengthen oversight of space allocation. These include revised and centralised space request forms reviewed through the Accommodation Group, a digital submission process to improve visibility and consistency, and enhanced information requirements to support decision-making.

Overall, the UHB had established several positive governance and control arrangements that supported the management of estate space. However, these arrangements are not currently brought together within a single, coherent utilisation framework linking strategic intent, performance expectations, and operational processes.

While the current arrangements provide a sound foundation, targeted enhancements would further strengthen assurance and support more consistent and proactive management of estate utilisation as the Future Estates Strategy is developed and implemented.

Management Consideration 1: Establishing a Strategic Space Utilisation Framework

The development of a proportionate space utilisation framework aligned with the Future Estates Strategy. This would be aligned to Estatecode Wales and the NHS Wales planning framework, to provide a consistent basis for assessing how effectively estate space is being used across clinical and non-clinical settings.

The framework should include clear governance and reporting arrangements; a standard space classification methodology; routine utilisation assessments using both Estate code-style qualitative ratings and quantitative occupancy data; defined performance indicators and escalation thresholds; and a requirement to link space utilisation findings to service planning, business case development, agile working arrangements, and estate rationalisation decisions. This should be supported by a regular review cycle, an action tracker with named ownership, and benefits realisation reporting to demonstrate delivery of efficiency and service improvement outcomes

Management Consideration 2: Strengthening Governance and Oversight of Estate Utilisation

Consideration whether the remit and interaction of existing governance groups provide sufficient oversight of utilisation across all significant space types, including office accommodation, clinical environments, and emerging agile working spaces. Noting the infrequency of meetings of the Agile Programme Board.

Management Consideration 3: Enhancing Utilisation Insight to Support Decision-Making

The introducing of periodic reporting on key utilisation indicators to relevant governance forums. This could support improved visibility of estate usage patterns and enable more proactive identification of opportunities for optimisation or reconfiguration.

Management Consideration 4 : Aligning Agile Working Development with Estates Planning

As agile working initiatives progress, estates planning and utilisation analysis should be closely integrated with the development of agile hubs to support informed decisions on future workspace configuration and capacity requirements

Objective 2: Data Capture & Monitoring

Overview / Summary of Observations

The risk of under-utilisation of non-clinical estate following the COVID-19 pandemic was recognised by Welsh Government. In August 2023, Welsh Government wrote to NHS Wales organisations (*'Estate Rationalisation of Non-Clinical Space'*) requesting that organisations review estate utilisation and identify opportunities for rationalisation.

Limited availability of reliable space utilisation data across the NHS Wales estate has, however, constrained effective planning. In recognition of this, and the limited data held locally (including within the Aneurin Bevan UHB), Welsh Government commissioned NWSSP Specialist Estates Services (SES) to support organisations in collecting utilisation data through the OccupEye monitoring system. This service is provided free of charge to NHS Wales organisations.

The UHB first utilised OccupEye sensors in 2023 through SES. Given the limited availability of these devices, the Director of Estates, Facilities Division subsequently approved the purchase of 200 sensors by the UHB, with licences initially running to January 2026. The Director of Estates, Facilities Division confirmed that licensing has recently been extended for a further three years, to 2029.

The UHB has undertaken two monitoring exercises with SES at Chepstow Hospital and has also completed several further surveys using its own sensors. These being:

- St Woolos Hospital Reconfiguration
- Review of occupancy within B, C & D blocks at the Royal Gwent Hospital (RGH)
- Further review of occupancy at the RGH site, within blocks 9 & 10.

The St Woolos space utilisation exercise was commissioned by the Service Workstream, a core subgroup of the St Woolos Hospital Reconfiguration Project Board. The workstream's role is to determine the clinical and operational requirements of services currently delivered from the St Woolos Hospital site, without being constrained by existing space limitations. This analysis informed the development of the Strategic Outline Case (SOC), including the future service model, dependencies, and impacts on patient care, workforce, and clinical quality.

The OccupEye study at Royal Gwent Hospital ('Review of Occupancy within B Block Royal Gwent Hospital', November 2024) was undertaken to better understand office space usage within the B Block Royal Gwent Hospital. The review aimed to support both the Health Board's agile working agenda and estate rationalisation planning.

The OccupEye studies completed at St Woolos and Royal Gwent Hospital identified significant under-utilisation of space, with average room utilisation of approximately 25% across the areas surveyed. These findings suggest that, if replicated more widely across the estate, there may be significant opportunities to rationalise non-clinical space and realise associated cost savings.

Management Consideration 5: Targeted utilisation review programme

The UHB has invested in 200 OccupEye sensors, with licences recently extended to 2029, demonstrating a continued commitment to data-driven estate optimisation. However, each deployment cycle takes approximately 12 weeks**,** and seasonal factors limit viable monitoring periods. Given current workforce capacity constraints, the UHB should produce a plan of the resources required both in staffing and technology in order to deliver a programme of utilisation reviews.

Management Consideration 6: Maximising value from utilisation data

Early studies identified average room utilisation of approximately 25%**,** indicating potential under-utilisation of non-clinical space. Management consideration should be given to how utilisation data can be systematically incorporated into estate planning, service reconfiguration, and business case development.

Management Consideration 7: Alignment with agile working and estate efficiency objectives

Where underutilisation of space is identified, this should be considered in the context of any updated Estates or Utilisation Strategy. This should include opportunities to consolidate nonclinical accommodation, expand shared or agile working spaces, repurpose space for clinical services, or rationalise the estate footprint, ensuring alignment with strategic objectives for efficiency and modern ways of working.

Objective 3: Management & Compliance

Overview / Summary of Observations

The provision of accommodation space is managed through the Accommodation Group, with requests for accommodation or changes in use submitted via an electronic proforma. Following each meeting, a highlight report is produced and presented to the Capital & Estates Board by the Director of Estates and Facilities, summarising submissions received and including a RAG-rated assessment to monitor the status of outstanding requests and actions. In addition, lease arrangements are centrally managed through the Land & Property Group, which oversees acquisitions, disposals and land-related matters, with Specialist Estates Services (SES) representatives attending in an advisory capacity.

It was noted from the Agile Working Group Action Plan that a proposal had been made to introduce a hot-desk or agile workspace booking system, although this has not yet been progressed. The introduction of a formal booking platform could provide improved visibility of workspace utilisation and generate management information to support future estates planning. More broadly, some public sector organisations are exploring approaches to strengthen strategic oversight of property assets, such as the Corporate Landlord Model, which centralises estates budgets, property management and decision-making. A contemporary University Health Board within NHS Wales has recently begun implementing this model, working with a local authority that had previously adopted the approach to draw on lessons learned. As this initiative develops, it may provide opportunities for shared learning across the wider NHS Wales system regarding strategic estate management.

Management Consideration 8: Escalation hierarchy in respect of Accommodation Group actions.

Whilst noting the reporting through the Capital & Estates Board, the UHB should reflect on its remit as regards escalation of items arising from the Accommodation Group as these do not universally relate to the provision of capital bids. This was noted and minuted at the Capital Board meeting of August 2025 with the Acting Chair commenting that these were more around service reorganisation and wider Health Board planning.

Management Consideration 9: Integration of estate governance arrangements

Robust arrangements are in place for the management of leases, acquisitions and disposals through the Land & Property Group, with advisory input from Specialist Estates Services (SES). There are opportunities to further align the work of the Accommodation Group and Land & Property Group, ensuring that space allocation decisions are consistently informed by wider estate strategy, utilisation data and lease commitments. (See also Management Consideration 2)

Management Consideration 10: Implementation of an agile working booking system

The Agile Working Group has previously proposed introducing a hot desk/agile workspace booking platform**,** although this has not yet been progressed. Progressing this initiative, as a formal booking platform could improve visibility of workspace utilisation, support coordinated team attendance, and generate management information to inform future estate planning and space optimisation.

Objective 4: Performance Evaluation & Reporting

Overview / Summary of Observations

The UHB currently reports and monitors aspects of space utilisation through several forums, as outlined in Objectives 1–3, with opportunities for management to enhance oversight and reporting. The Estates Strategy is being refreshed, and there is scope to develop a dedicated space utilisation strategy to complement the overarching Estates Strategy and provide a clear focus on non-clinical estate efficiency.

As noted in Objective 2, the UHB currently holds limited SMART data on space utilisation, restricting the ability to set benchmarks or performance targets. Once such targets are established, reporting can be structured to incorporate data-driven performance measurement using OccupEye results and other relevant sources, supporting informed decision-making and strategic estate planning

Noting the Management Considerations raised in respect *Objectives 1-3*, no further actions have been suggested in this section.

Appendix A

Assurance Opinion

Substantial

Few matters require attention and are compliance or advisory in nature.

Low impact on residual risk exposure.

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Limited

More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Unsatisfactory

Action is required to address the whole control framework in this area.

High impact on residual risk exposure until resolved.

Advisory

Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate.

These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

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The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management of the Aneurin Bevan University Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

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

Archwilio Cymru
Audit Wales

Aneurin Bevan University Health Board – Annual Audit Summary 2025

Date issued: January 2026

Contents

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

Mae'r ddogfen hon hefyd ar gael yn Gymraeg. This document is also available in Welsh.

Foreword

Adrian Crompton

Auditor General for Wales

I am pleased to share my Annual Audit Summary for Aneurin Bevan University Health Board (the Health Board). It summarises the main findings from my 2025 audit work undertaken to fulfil my responsibilities under the Public Audit (Wales) Act 2004 and the Well-Being of Future Generations (Wales) Act 2015.

I provided opinions on whether the accounts were properly prepared and gave a true and fair view, in all material aspects, and whether expenditure and income have been used for the purposes intended and in accordance with the authorities which govern you.

My audit team has also assessed whether the Health Board has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources, and acted in line with the sustainable development principle. In doing so, my audit team has undertaken my annual structured assessment work and reviewed planned care services, eye care services, urgent and emergency care services and quality governance arrangements. As set out in my audit plan, these reviews have been carried out in line with the International Organisation of Supreme Audit Institutions (INTOSAI) standards.

At the time of publishing this summary, the Health Board was escalated to Level 4 for finance, strategy and planning under the Welsh Government's escalation and intervention arrangements. It was also escalated to Level 4 for performance and outcomes related to Urgent and Emergency Care.

The detailed audit findings for each of my reviews are set out in the respective reports which my audit team have presented to the Audit and Risk Assurance Committee throughout the year. The performance audit reports are available on the Audit Wales website and further links are available in the summary.

The Annual Audit Summary should be shared with the Board. I will then make the summary available to the public on the Audit Wales website.

I would like to extend my gratitude to the Health Board's staff for their help and cooperation throughout my audit.

Your audit at a glance

I received the draft accounts in line with the statutory deadline of 2 May 2025. The quality of the draft accounts and working papers was good.

In advance of the statutory deadline of 30 June 2025, I issued an unqualified true and fair opinion, and a qualified regularity opinion. I also issued a substantive report on the accounts.

There were no uncorrected misstatements in the accounts. There were no other significant issues to report.

My performance audit work found that the Health Board has good governance arrangements, and the Board listens well to patients and service users. However, although financial oversight is strong and the Health Board has a good track record of savings delivery, its financial position remains a concern. The Health Board must focus on delivering its strategy as a means to transforming and creating financially sustainable services.

The Health Board is reducing some of the longest elective waits but there is more to do, including reducing the longest ophthalmology waits. Urgent and emergency care services have been altered to better meet demand, supported by strong plans and oversight.

My audit team made several recommendations to the Health Board which focus on strengthening service planning, Management and transformation support, while enhancing operational efficiency and productivity to improve patient care and system sustainability.

There is still some work outstanding from my Audit Plan dated April 2025. My team expects to complete the majority of this work by March 2026.

Audit of accounts findings

Preparing annual accounts is an essential part of demonstrating the stewardship of public money. The accounts show the organisation's financial performance and set out its net assets, net operating costs, gains and losses, and cash flows. My annual audit of those accounts provides opinions on whether the accounts are properly prepared and give and true and fair view, in all material aspects, and the proper use ('regularity') of public monies.

My responsibilities in auditing the accounts are described in my Statement of Responsibilities publications, which are available on the Audit Wales website.

The draft accounts were presented for audit on 2 May 2025. This was in line with the deadline of 2 May 2025 set by the Welsh Government. The quality of the draft accounts presented for audit was good.

My audit opinions

I must report issues arising from my work to those charged with governance for consideration before I issue my audit opinion on the accounts. I reported these issues within my Audit of Accounts Report to the Audit and Risk Assurance Committee and the Board on the 24 and 25 June 2025 respectively.

True and fair

A small number of changes were made to the draft accounts arising from my audit work. There were no uncorrected misstatements and there were no other significant issues to report.

My work did not identify any material weaknesses in internal controls (as relevant to my audit). I have however made recommendations where there is scope to improve working papers and controls further. These were reported to the Audit Risk and Assurance Committee in October 2025.

I concluded that the Health Board's accounts were properly prepared and materially accurate and issued an unqualified audit opinion on them.

Regularity

The Health Board is only allowed to receive income and incur expenditure in ways that follow the rules set by the authorities that govern it. Where a Health Board does not achieve financial balance, its expenditure exceeds its powers to spend and so I must qualify my regularity opinion.

The Health Board did not achieve financial balance for the three-year period ending 31 March 2025, which I deem to be outside its powers to spend, so I have issued a qualified opinion on the regularity of the financial transactions within the Health Board's 2024-25 accounts. The position at the end of the year was a deficit of £7.185 million against a breakeven target from Welsh Government. This combined with the outturns for the previous two years contributed to a three-year deficit position of £93.793 million.

Alongside my audit opinion, I placed a substantive report on the Health Board's accounts to highlight the failure to achieve financial balance and the failure to have an approved three-year plan in place.

Whole of Government Accounts

I also undertook a review of the Whole of Government Accounts return. I concluded that the counterparty consolidation information was consistent with the Health Board's financial position at 31 March 2025 and the return was prepared in accordance with the Treasury's instructions.

Performance audit findings

Structured assessment

My team looked at how well the Health Board is governed and whether it makes the best use of its resources.

I found that the Health Board has good governance arrangements and high-quality information is provided to support scrutiny. There remains a continued commitment to hearing from patients and services users, but the Health Board could do more to hear from staff.

The Health Board is improving how it manages risks and is finalising its corporate risk register. The Health Board has reasonable arrangements to provide assurance on risks and performance, but it needs to strengthen its assurances on the quality and safety of care.

The Health Board has a new and clear long-term strategy. It has also strengthened its medium-term planning approach, although I note that since reporting my structured assessment, a deteriorating financial position subsequently led the Welsh Government to revoke its IMTP approval in December 2025.

Although financial oversight is strong and the Health Board has a good track record of savings delivery, its financial position is getting worse, with a forecast year-end deficit for 2025–26 of £19.9 million. This year, £28.3 million of its £42.5 million planned savings are recurrent.

I made six recommendations focused on:

- introducing reporting on declarations of interest compliance;
- making more use of staff stories at Board and committee meetings;
- formally reporting progress on actions following patient safety leadership walk arounds;
- redeveloping its Quality Outcomes Framework report to better highlight issues and provide assurance;
- improving oversight of local clinical audit activity determined through a risk-based assessment; and
- tracking recommendations from other bodies including Healthcare Inspectorate Wales and Public Services Ombudsman for Wales.

The Health Board has fully implemented 12 outstanding recommendations since my last structured assessment report. Two recommendations remain in progress, three have not yet started, and one has been replaced by a new recommendation made this year.

Managing planned care

My team looked at the progress the Health Board is making in tackling its planned care challenges and reducing its waiting list backlog.

I found that with the assistance of additional short-term funding the Health Board has made good progress in reducing the longest waits. However, the overall number of patients waiting remains high with the majority of national targets not met, in particular those waiting for their first outpatient appointment. The Health Board needs to seek opportunities to improve productivity and efficiency. It also needs to accelerate the introduction of arrangements to support patients who are waiting and to improve how it reports on harm resulting from planned care delays.

I made five recommendations focused on:

- developing a detailed Planned Care improvement plan;
- strengthening it reporting on the use and impact of the additional Welsh Government planned care funding;
- opportunities for further efficiency and productivity improvements;
- establishing a contact centre under the Promote, Prevent and Prepare for Planned Care policy[1] and rolling out the service to all specialties; and
- managing clinical risks associated with long waits, including developing consistent methodologies and routine reporting.

[1] Promote, Prevent and Prepare for planned care. Phase 1 was required to be delivered by March 2024. This included the establishment of a single point of contact for people to access information and support following referral to specialist secondary care.

Eye Care Review

My team looked at whether the Health Board has effective arrangements to improve eye care services. My team reviewed local and regional arrangements.

I found that the regional eye-care strategy sets a positive direction, but progress has been slow. Governance arrangements are in place to oversee regional delivery, but decision-making on business cases can be slow and cumbersome, involving multiple groups across the three health boards. It is worth noting that regional working has shifted away from its original ambition of developing specialist services more broadly, focusing instead on creating short-term service capacity for cataract procedures. While the regional cataract approach aims to reduce long waits, thus far it has not significantly impacted the overall number of patients awaiting treatment.

Whilst the Health Board has been able to reduce its longest ophthalmology waits, it has not met the Welsh Government's planned care recovery targets. Performance against the 'eye care measure' is poor and, as a result, some patients are likely to be coming to avoidable harm.

In the context of these challenges, there is a need to strengthen local planning of eye care services, broaden the scope of regional working, secure further productivity and efficiency gains, and strengthen board and committee oversight of ophthalmology services.

I made seven recommendations focused on:

- regional partners speeding up decision-making processes for agreeing business cases;
- regional partners developing a resource plan to better understand the operational and clinical commitment needed for each partner organisation;
- regional partners agreeing realistic but appropriately ambitious timescales for the three phases of the South East Wales Regional Ophthalmology Strategy;
- urgently completing the development of its eye care plan seeking to address current and future challenges;
- twice-yearly updates being provided to the appropriate committee on the plan's delivery, once approved by the Board;

- reviewing operational and strategic risk registers; and
- the Patient, Quality and Safety Outcomes Committee to receive assurance on how the risk of harm to ophthalmology patients is being managed, lessons learned from reviews and actual harm caused by waiting delays.

Managing urgent and emergency demand

My team looked at how well the Health Board is managing demand for urgent and emergency care to reduce unnecessary pressure on the system.

I found that the Health Board is altering its urgent and emergency care services to better meet demand, supported by strong plans and oversight. However, whilst changes are leading to improvements in some areas, there is a need to make better use of other alternatives to its Emergency Department and to undertake stronger engagement with patients and staff to inform plans.

I made 10 recommendations focused on:

- strengthening risk management within plans;
- funding arrangements for the Six Goals Programme beyond March 2025;
- signposting urgent and emergency care services on GP and dental practices' websites;
- reviewing the communication and referral process between secondary care and GPs;
- ensuring the WAST Directory of Services remains up-to-date and establishing a mechanism to share the Directory with community and care home staff;
- working with key staff, including WAST to improve access and utilisation of referrals for appropriate alternative urgent and emergency care services;
- use of patient feedback to inform urgent and emergency care plans;
- regular mechanisms for staff feedback on service changes, to include key partners such as primary care and WAST;
- primary care representation at the Six Goals for Urgent and Emergency Care Improvement Programme Board; and

- developing and communicating guidance for staff on evaluating benefits of expenditure on projects.

Quality Governance Arrangements

My team considered whether the Board was receiving the necessary assurance that the Health Board is taking appropriate steps to respond to the requirements on the Health and Social Care (Quality and Engagement) (Wales) Act 2020. In doing so, my team also looked at the progress made by the Health Board in addressing my 2022 audit quality governance arrangements recommendations.

I found that the Health Board is making progress implementing the 2022 quality governance recommendations but still has more to do to secure the necessary improvements to its quality governance arrangements. The Health Board is taking reasonable steps to implement the Duties of Quality and Candour but needs to improve the take-up of staff training on the requirements associated with these duties.

The Health Board has fully implemented five of the 16 recommendations from my previous audit. Nine recommendations remain in progress and two have not been implemented. I made four new recommendations focused on:

- improving arrangements for staff to raise concerns, including updating its procedure and monitoring the impact of external support services and accreditation initiatives;
- approving an update or addendum to the current ‘Putting Things Right’ Policy to reflect the current organisational structure and Duty of Quality and Duty of Candour requirements;
- evaluating the impact of centralising the Quality and Patient Safety teams; and
- strengthening arrangements for Duty of Quality and Duty of Candour e-learning training, including increasing staff uptake rates and the monitoring and reporting of these.

Performance audit work still underway

At the time of reporting, the following reviews from the 2025 Audit Plan were still underway at the Health Board:

- estates management;
- digital transformation;
- GP managed contact arrangements; and
- review of cancer services.

Audit quality

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We use three lines of assurance to show how we achieve this. We have set up an Audit Quality Committee to co-ordinate and oversee those arrangements. We subject our work to independent scrutiny by the Institute of Chartered Accountants in England and Wales and our Chair of the Board, acts as a link to our Board on audit quality. For more information see our Audit Quality Report 2024.

Our People

- Selection of right team
- Use of specialists
- Supervisions and review

Arrangements for achieving audit quality
Selection of right team

- Audit platform
- Ethics
- Guidance
- Culture
- Learning and development
- Leadership
- Technical support

Independent assurance

- EQRs
- Themed reviews
- Cold reviews
- Root cause analysis
- Peer review
- Audit Quality Committee
- External monitoring

Further information

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Information on our upcoming work and forward work programme for performance audit.

Data tools to help you better understand public spending trends.

Details of our Good Practice work and events including the sharing of emerging practice and insights from our audit work.

Our newsletter which provides you with regular updates on our public service audit work, good practice, and events.

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Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	19 May 2026
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Audit, Risk and Assurance Committee Forward Work Plan 2026/27
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Head of Corporate Risk and Assurance.

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

Er Gwybodaeth/For Information

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

To support effective governance and oversight, the Audit, Risk and Assurance Committee requires a clear overview of its business, including completed items, changes, and forthcoming matters.

Cefndir / Background

Across the 2026/27 financial year, the Committee has received all items as scheduled in its Forward Work Plan.

Asesiad / Assessment

The Forward Work Programme is designed to support the Committee in managing and overseeing its programme of business. It sets out the scheduled timing of report submissions, highlights any deferred items, and records new requests for reports. The Programme also enables the Committee to monitor progress and review its workload at each meeting.

Between April 2026 and May 2026, there has been one amendment made to the forward work programme – inclusion of item - **Input clear numerical**

implementation dates against recommendations in the Capital Projects Report. To be actioned by Head of Internal Audit
Argymhelliad / Recommendation The Committee is asked to: • **Note** the status of Committee business, including completed business, amendments/changes, and forthcoming business.

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

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

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

ANNUAL PROGRAMME OF BUSINESS 2026/27

AUDIT, RISK & ASSURANCE COMMITTEE

This Annual Programme of Business has been developed with reference to:

- Aneurin Bevan University Health Board's Standing Orders;
- The discharge of the business needs of the individual Directorates
- The Health Board's Integrated Medium-Term Plan and related Annual Delivery Plan;
- The outcomes of the Committee self-assessment for 2025 and the Structured Assessment 2025 recommendations
- The Board's Assurance Framework and Corporate Risk Register; and
- Key statutory, national, and best practice requirements and reporting arrangements.

Area of Focus as per Standing Orders:
The Audit, Risk and Assurance Committee will provide assurance to the Board of the effectiveness of its arrangements for handling reservations and delegations.

The Committee has been established to enable the scrutiny and review of matters related to audit, financial accounting, assurance, and risk management, to a level of depth and detail not possible in Board meetings.

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

- independently monitoring, reviewing, and reporting to the Board on the processes of governance, risk management and internal control in accordance with the standards of good governance determined for the NHS in Wales;
- advising the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further;
- Maintaining an appropriate financial focus demonstrated through robust financial reporting and maintenance of sound systems of internal control; and
- Working with the other committees of the Board to provide assurance that governance and risk management arrangements are adequate and part of an embedded Board Assurance Framework that is ‘fit for purpose’.

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2025/26					
			Quarter 1			Quarter 2	Quarter 3	Quarter 4
			28th April 2026	TBC May 2026 *Draft Accounts*	TBC June 2026 *Final Accounts*	15th Sept 2026	24th November 2026	11th Feb 2027
Preliminary Matters								
Attendance and Apologies	**SI**	Chair	√	√	√	√	√	√
Declarations of Interest		All Members	√	√	√	√	√	√
Minutes of the Previous Meeting		Chair	√	√	√	√	√	√
Action Log and Matters Arising		Chair	√	√	√	√	√	√
Committee Requirements as set out in Standing Orders								
Development of Committee Annual Programme of Business 2025/26	**An**	Chair & DofCG						√
Review of Committee Programme of Business	**SI**	Chair	√	√	√	√	√	
Annual Review of Committee Effectiveness 2024/25 to include a review of the Terms of Reference	**An**	Chair & DofCG	√					
Committee Annual Report 204/25	**An**	Chair & DofCG	√					
Corporate Governance, Risk & Assurance								
Review and report upon the adequacy of arrangements for declaring, registering, and handling interests	**An**	DofCG					√	
Receive full report of all offers of gifts and hospitality as declared	**An**	DofCG	√				√	
Compliance with Ministerial Directions	**BI**	DofCG	√				√	
Compliance with Welsh Health Circulars (WHCs)	**BI**	DofCG	√				√	
Review of Standing Orders, Standing Financial Instructions, and Scheme of Delegation	**An**	DofCG				√		
Compliance with regulatory requirements	**An**	DofCG						√
Audit Recommendations Tracking Report	**Qu**	DofCG	√**Q4**		√Q1	√Q2	√Q3	
Annual Review of Risk Management Framework	**An**	DofCG	√					
Report on the Implementation of the Risk Management Framework	**BI**	DofCG					√	√
Committee Risk & Assurance Report	**SI**	DofCG		√	√	√	√	
Financial Governance and Control								

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2025/26					
			Quarter 1			Quarter 2	Quarter 3	Quarter 4
			28th April 2026	TBC May 2026 *Draft Accounts*	TBC June 2026 *Final Accounts*	15th Sept 2026	24th November 2026	11th Feb 2027
Report of the use of Single Tender Action	**SI**	DofF&P	√			√	√	
Report of Losses and Special Payments *(May report will be included in the Accounts)*	**BI**	DofF&P	√	√			√	
To Approve Reviewed and Updated Financial Control Procedures	**Ad hoc**	DofF&P	√		√	√	√	
Annual Report and Accounts								
To consider the approach and timelines for the Annual Report and Accounts	**An**	DofF&P & DofCG					√	
Review the Health Board's Annual Report (Overview & Performance Section) **(Part 1)**	**An**	DofCG		√	√			
Review Draft/Final Accountability Report, including Annual Governance Statement **(Part 2)**	**An**	DofCG		√	√			
Review Draft/Final Annual Accounts and Financial Statements **(Part 3)**	**An**	DofF&P		√	√			
Audit Enquiries to those charged with Governance and Management	**An**	DofF&P		√				
Audit Wales, Audit of Accounts (ISA 260) including Letter of Representation	**An**	AW			√			
Final Annual Accounts Memorandum	**An**	AW					√	
Receive the Annual Head of Internal Audit Opinion (including Specialised)	**An**	HofIA			√			
Agree a recommendation to the Board in respect of the audited annual report and accounts	**An**	Chair			√			
Counter-Fraud								
Review of the Counter Fraud, Bribery and Corruption Policy *(**Feb 2029**)*	**3-Yearly**	DofF&P	-	-	-	-	-	-
Receive the Counter Fraud Annual Report	**An**	HofCF		√				
Agree the Counter Fraud Annual Workplan	**An**	HofCF						√
Receive a Quarterly Report on Counter Fraud Activity	**Quarterly**	HofCF	√			√	√	√
Agree the Counter Fraud Functional Standard Return Declaration	**An**	HofCF			√			

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2025/26					
			Quarter 1			Quarter 2	Quarter 3	Quarter 4
			28th April 2026	TBC May 2026 *Draft Accounts*	TBC June 2026 *Final Accounts*	15th Sept 2026	24th November 2026	11th Feb 2027
Receive the Post Payment Verification Annual Report, including, the Annual Workplan for 2025-26	**An**	PPV Manager			√			
Receive a Mid-Year update in respect of Post-Payment Verification Activity	**An**	PPV Manager					√	
Clinical Audit								
Receive the Clinical Audit Activity Annual Report 2024 - 2025	**An**	Medical Director			√			
Agree the Clinical Audit Plan 2025 - 2026	**An**	Medical Director			√			
Mid-year Report on the delivery of the Clinical Audit Plan	**An**	Medical Director					√	
Internal Audit (Including Specialised Audit) – NWSSP Audit & Assurance Services								
Agree the Internal Audit Annual Workplan	**An**	HoflA	√					
Receive Internal Audit Progress Reports	**SI**	HoflA	√	√	√	√	√	√
Receive Internal Audit Review Reports, reviewing the adequacy of executive & management responses to any issues identified, ensuring that they are acted upon	**SI**	HoflA	√	√	√	√	√	√
Review and approve Internal Audit terms of reference (charter) and the effectiveness of internal audit	**An**	HoflA with Chair	√					
Input clear numerical implementation dates against recommendations in the Capital Projects Report.	**SI**	HoflA			√			
External Audit – Audit Wales								
Receive the External Audit Annual Audit Report	**An**	AW		√	√			
Agree the External Audit Annual Plan	**An**	AW	√					
Receive the draft external auditor's opinion on the quality account	**An**	AW					√	
Receive the 2025 Structured Assessment	**An**	AW					√	
Receive External Audit Progress Report 2025-26	**SI**	AW	√	√	√	√	√	√
Review of External Audit Reports including results & the adequacy of executive & management responses to any issues identified, ensuring that they are acted upon	**Ad hoc**	AW						
Consider any Audit Wales National Value for Money Examinations & Performance Reports	**Ad hoc**	AW						

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2025/26					
			Quarter 1			Quarter 2	Quarter 3	Quarter 4
			28th April 2026	TBC May 2026 *Draft Accounts*	TBC June 2026 *Final Accounts*	15th Sept 2026	24th November 2026	11th Feb 2027
Total Items Scheduled (excluding preliminary items) -to be updated prior to each meeting			13	16	18	14	16	8
Audit, Risk and Assurance Committee Members to meet Independently with:								
External Audit Team	**BI**	Chair	√			√		
Internal Audit Team	**BI**	Chair		√			√	
Local Counter Fraud Team	**BI**	Chair			√			√

Lead Officer Key	
DofCG	Director of Corporate Governance
DofF&P	Director of Finance and Procurement
HofCF	Head of Counter Fraud
PPV	Post Payment Verification
HofIA	Head of Internal Audit
AW	Audit Wales
Chair	Chair

Frequency of Inclusion Key	
SI	Standing Item
AN	Annually
BI	Biannually
Quarterly	Quarterly

Schedule of Meetings Key	
√	Scheduled agenda item in FWP
√R	Received at the Scheduled meeting
D	Deferred from this agenda
√ D	Deferred Scheduled agenda item Received
W	Withdrawn from FWP
T	Transferred to another Committee
IC	Matter discussed In Committee

Archwilio Cymru
Audit Wales

GMS Contract Challenges

Aneurin Bevan University Health Board's approach to the letting of multiple General Medical Services contracts to a single GP partnership

March 2026

About us

We have prepared and published this report under section 61(3) (b) of the Public Audit Wales Act 2004.

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

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Contents

Audit snapshot

What we looked at

1 We reviewed Aneurin Bevan University Health Board's (the Health Board) approach to awarding General Medical Services (GMS) contracts for a number of general practices to a single GP partnership run by two general practitioners (the Partnership). We have examined the Health Board's contract letting arrangements as well as the ongoing arrangements for contract management for the GP practices concerned.

Why this is important

2 In April 2024 the Partnership, which is associated with the wider eHarley Street Primary Care Solutions management company, were managing eight GP practices. By October 2025 the Partnership had handed back the contracts for five practices to the Health Board.

3 This has placed the Health Board in a challenging position where it has had to take over the management of these practices at relatively short notice to safeguard provision of general practice services to the local population. In the context of GP practices that were previously managed by the Health Board at a greater than normal cost, there have also been further cost implications for the Health Board, and potentially some anxiety from residents over the continuity of their GP services. In addition, concerns have been made public about non-payment of locum doctor and supplier invoices, tax payments and NHS pension contributions within specific practices that were managed by the Partnership.

4 Collectively these issues have led to politicians in both the Senedd and Westminster raising concerns with the Auditor General about the Partnership's operating model and the Health Board's letting and management of the contracts with the Partnership.

What we have found

5 At the time of letting the contracts to the Partnership, the Health Board was in a challenging position of having to manage a number of vacant practices across its resident population. The Partnership has previously managed a practice in Lliswerry without any apparent concerns and was the only bidder for several of the contracts.

6 Nonetheless, the Health Board should have had a greater appreciation of the risk associated with a single Partnership taking on so many new practices over a short timeframe. It should also have undertaken greater due diligence checks on the Partnership's business model and applied greater scrutiny to its business cases and financial plans.

7 Whilst no evidence of fraudulent activity has been identified, the problems experienced by the Partnership have caused financial concerns for staff employed by the Partnership. In addition, in line with nationally agreed approaches to support financially 'at risk' practices, over £1 million of sustainability funding was accessed by the Partnership ahead of them handing five[1] of their eight contracts back to the Health Board.

8 The Health Board has amended some of its commissioning arrangements because of these events and changes to procurement regulations. However, in our view there is a need to further strengthen contract letting processes to minimise the risk of similar events occurring in the future.

[1] Since our fieldwork was completed the Partnership has signalled that it intends to hand the remaining three contracts back to the Health Board.

What we recommend

9 We have made four recommendations to the Health Board based on:

- strengthening business case requirements to ensure sufficient detail to inform decision making;
- strengthening the risk assessment on proposed financial plans, operating model, workforce plans and clinical governance;
- further strengthening its new due diligence process; and
- agreeing clear but proportionate GMS practice performance and operational metrics aligned to Health Board monitoring processes.

Key facts and figures

8	practices were being managed by the Partnership in April 2024.
3	practices remained managed by the Partnership during 2025-26. These were Gelligaer Surgery, Pontypool Medical Centre, and Lliswerry Medical Centre.
February 2026	The partners formally notified the Health Board in February that they will hand back the three remaining practices at the end of March 2026.
£10.1m	the 2024-25 combined annual value of the individual contracts for the eight practices.
£1.2m	total additional sustainability funding support claimed by the Partnership for the eight practices during the 2024-25 financial year.

Our findings

Contract award timeline

Contracts were awarded to the Partnership in line with the Health Board's vacant practice policy and in the context of it having to manage a number of vacant practices at the same time

10 Over a two-year period, the Partnership acquired contracts for the delivery of General Medical Services for eight practices across the Health Board. Whilst the Partnership consisted of two GPs, these GPs did not directly provide local care services. Instead, they were responsible for securing staff to deliver the services. This model had been running within NHS England for some time, and reviews by the Care Quality Commission had not found any concerns. The Partnership's model relies on the delivery of back-office functions via a central team employed by e-Harley Street Primary Care Solutions. The premise being that these back-office arrangements enable the practice teams to focus on service delivery at a local level and achieve cost efficiency.

11 The first practice that the Partnership managed was Lliswerry Medical Practice, Newport, in November 2022. They joined an existing GP partnership independent of the Health Board's involvement, in an approach that follows GMS regulations[2]. Services were delivered in line with expectations and no concerns were raised.

[2] GMS processes allow for current GPs contract holders to transfer their contract to another provider, through a contract variation. These processes also allow individuals to join or resign from partnerships.

12 The Health Board then awarded six contracts to the Partnership between October 2023 to April 2024. In three of these cases (the Bryntirion, Blaenavon and Aberbeeg practices) the Partnership was the only applicant applying to run the practices. The other two practices were a result of more recent contract resignations. **Appendix 2** outlines this in greater detail.

13 Prior to October 2023, the Health Board was directly managing five of these practices and had done so for some time ranging from between one to ten years. Ideally, health boards should only look to directly manage practices to provide short-term stability ahead of finding new independent contractors to run the practice[3]. In addition to drawing on capacity within the Health Board, managed practices are typically more costly to run as staffing costs need to align with Agenda for Change pay scales. The Health Board were overspending against their GMS global sum for these practices due to a high level of reliance on locum staffing. The Health Board also reported that the residents of the managed practices had less access to enhanced service activity[4] due to a lack of regular staffing. Collectively these factors created an imperative for the Health Board to return the practices to independent contractor status.

14 In April 2024, the Partnership also joined the contract for Meddygfa Gelligaer Surgery, independent of the Health Board's involvement.

[3] Increasingly Health Boards are finding it difficult to secure independent contractors to deliver GP services. In this case the Health Board has to step in and run the practice to ensure the service continues to be provided to residents.

[4] Enhanced services could include access to minor surgery and post discharge wound care.

Despite accessing over £1 million of sustainability support funding during 2024-25, the Partnership quickly got into financial difficulties and ultimately handed five practices back

15 As of April 2024, the total annual value of the 8 contracts that the Partnership was responsible for was £10.1 million, although this reduced to £9.8 million as the Partnership transferred three practices back to the Health Board before the end of the 2024-25 financial year. **Appendix 3** contains more details on the 2024-25 contract award values.

16 In discussion with the NHS Wales Counter Fraud team, we are aware that NHS Pensions Agency have been reviewing the GP practices run by the Partnership in respect of underpayment of pension payments. This work had shown that whilst pension payments had been made, they had not been paid at the right level. NHS Wales Counter Fraud staff informed us that outstanding pension contributions for all practices had been paid with the exception of the Tredegar practice for December 2024 only. NHS Wales Counter Fraud staff confirmed that they were content that there was no evidence of fraud in relation to the underpayment of pension contributions.

17 We are also aware that concerns have been raised about underpayments to HMRC and also non-payment of invoices from locum doctors in practices run by the Partnership. Health Board staff confirmed that they have seen evidence of a payment plan from the Partnership to address HMRC underpayments. However, we have not been able to determine whether outstanding locum doctor invoices have been paid.

18 In response to these concerns the Health Board triggered an enhanced monitoring process for all eight of the Partnership's practices. This process included bi-weekly meetings with the Partnership, weekly data reporting, and weekly meetings and assurance visits. Through these the Health Board sought assurance on the arrangements for governance, workforce, and financial sustainability. The Health Board also undertook reviews on clinical capacity, access arrangements, and complaints performance. Overall, whilst the Health Board were receiving sufficient assurance on most of these matters, the financial sustainability of the practices was still of concern.

19 To support the Partnership the Health Board used the Welsh Government's Sustainability Assessment Framework[5] (SAF) to assess the level of support needed for each practice. The level of support is determined by a local assessment panel including the Gwent Local Medical Committee, and GPs must support all claims with evidence of expenditure. Figures for 2024-25 show that the Partnership claimed over £1.2 million of sustainability funding across all the practices it was managing. This funding was largely to cover necessary locum doctor costs but also for other legitimate costs associated with the set up and running of the practices. It should be noted that the Partnership did not claim all the funding that was available to them.

20 Despite the additional financial support provided by the Health Board, there were still concerns regarding the financial stability of the practices. By April 2025, within 15 months, the Partnership had handed back the contracts of five of their practices because they were not financially sustainable.

21 The Health Board managed the transition of the practices that the Partnership returned in an effective manner that stabilised services. It aligned dedicated teams to the practices to support the transition process ensuring access to services and patient safety was prioritised and maintained. This included an operational oversight team formed of clinical directors, nursing staff and management support.

[5] This scheme is available to all GMS practices across Wales. In addition to the Partnership's practices that received SAF funding, three other practices in the Health Board that the GP partnership does not manage were also in receipt of this funding during 2024-25. Additional funding allocations are proportionate to GP practice size and the particular circumstances of individual practices such as the reliance on locum doctors to maintain safe levels.

22 In September 2025, the Health Board awarded the GMS contract for Aberbeeg Medical Practice to a new provider, commencing 1 January 2026. At the time of reporting the Health Board was directly managing four practices Brynmawr Medical Practice, Blaenavon Medical Practice, Tredegar Health Centre and Bryntirion Surgery. In February 2026, the partnership gave formal notice of their intention to hand back the remaining three GMS contracts for Gelligaer Surgery, Pontypool Medical Centre, and Lliswerry Medical Centre to the Health Board effective from the 1st April 2026.

Effectiveness of contract award processes

The Health Board did not fully assess the risk of letting six contracts to a single partnership and the due diligence, scrutiny of financial plans and business cases was insufficient.

23 The Health Board largely adhered to its vacant practice policy when making the contract award. In January 2025, the Health Board requested its Internal Audit service review the letting of the contract award process for five practices (Tredegar, Brynmawr, Blaenavon, Aberbeeg and Bryntirion). The report published in May 2025 gave reasonable assurance overall but, did find deviations from the policy. These deviations included:

- the interval between the advertisement of the contracts and the deadline for submissions was too short;
- whilst not required for quoracy, external Neighbourhood Care Network representation and/or Llais representation was missing at interview panels; and
- there was deviation from the set interview questions although centred around similar themes.

24 In addition, Internal Audit prepared an advisory report[6] in June 2025. This report focussed on areas which were outside of the scope of its original formal review. This included:

- retaining evidence of financial checks both from internal due diligence and medical performers list financial checks;
- agreeing contract monitoring requirements;
- strengthening the business case scoring approach, and applying standardised questions and scoring model for interviewees to reduce this risk of challenge to the contract award process; and
- ensuring sufficient time between the contract award and the date of the contact commencement.

25 The Health Boards's vacant practice policy did reflect the Welsh Government legislative and regulatory requirements. However, Welsh Government issued this guidance in 2006, and it was not sufficiently designed to support consideration of the sort of business model that the business partnership that eHarley street operated. The need to bring the 2006 guidance up to date will be discussed separately with the Welsh Government.

26 The Health Board advertised and awarded each GMS contract separately but the total amount of contracts that the Health Board awarded to the Partnership came to £8.1 million in 2024-25[7]. In our view the Health Board:

- could have been more cognisant of the potential risks in awarding a total of £8.1 million to a single supplier (albeit from separate contracts), given this far exceeds the £1 million threshold for Ministerial approval that is applied to single contracts; and
- did not sufficiently consider the potential impact/risk of awarding the Partnership several practices in a short timeframe and its ability to manage these new commitments.

[6] An advisory report gives no assurance assessment unlike a standard Internal Audit report.

[7] For the practices that were appointed through the vacant practice policy (Pontypool, Tredegar Brynmawr, Aberbeeg, Bryntirion and Blaenavon)

27 The Health Board's processes require any potential GMS provider to produce a financial business case as part of their submission, for consideration by a Vacant Practice interview panel that also includes representation from Llais and the Gwent Local Medical Committee. Whilst the Partnership gave assurance in their business cases there were sufficient funds, there is no evidence that the Health Board undertook any financial stress testing or work to provide assurance on the Partnership's financial resilience. Internal Audit also found no record of the types or depths of checks that the Health Board undertook during the assessment process.

28 Our review of the Partnership's business cases found them to be lacking in detail. The Partnership's financial plans only covered one-year. A three-year business plan would have been more reasonable requirement, to provide assurance. We noted that the business cases did not provide any detail of costs in relation to the back-office functions managed by eHarley Street Primary Care Solutions. The Partnership had not identified in its business case any financial allocation to e-Harley Street Primary Care Solutions for managing the back-office functions.

29 The Health Board should have evaluated the financial plans in more depth. We reviewed the Brynmawr business case, and this raises concerns about the financial viability of the Partnership to support this practice before the contract award. For example, the proposed financial plan indicated that it intended to reduce locum costs by £1 million compared to the previous financial year. If locum costs reduced, then we would expect a plan to consequently set out a corresponding increase in substantive/core GP salary costs. However, the proposed uplift in substantive GP costs only amounted to an additional £16,607 and no workforce planning details were provided to indicate how such a workforce cost reduction would be achieved.

30 Whilst noting the Partnership had operated the Lliswerry practice since 2022, information within the Partnership's business cases also highlighted a lack of understanding of the devolved healthcare arrangements in Wales. Mobilisation documentation written by the Partnership refers to the Care Quality Commission[8], and Clinical Commissioning Groups[9] neither of which operate in NHS Wales.

31 More broadly, we could see no evidence that the Health Board had undertaken any checks of Companies House records in relation to the partners' wider business interests. Noting that neither the Welsh Government circular nor the Health Board's vacant practice policy prompt for such checks, undertaking them should form part of the Health Board's routine due diligence processes for contract letting. Whilst such checks might not have changed the ultimate decision to award the contracts to the Partnership, it would have provided an opportunity to seek further assurance on issues such as the establishment of multiple companies in a short space of time and businesses which have been dissolved shortly after creation. Even following contract award, this type of information could usefully be part of ongoing contract monitoring and management of risk.

32 It should be noted that the NHS Wales Shared Services Partnership added the two GPs to its Medical Performers List (MPL) in 2022 as general practitioners must be on the list in order to hold a GMS contract. The MPL provides assurance on whether GPs are fit to practice in Wales, checking items including their indemnity insurance and qualifications and experiences. However, as the two GPs were not directly treating patients these checks were of limited value.

[8] The independent regulator of health and adult social care services in England. It monitors, inspects, and rates providers like hospitals, care homes, GPs, and dentists to ensure care is safe, effective, and meets national standards

[9] Clinically-led NHS organisations in England (2013–2022) responsible for planning and purchasing healthcare services for local populations. They were made up of GP practices and managed around two-thirds of the NHS budget before being replaced by Integrated Care Systems (ICSs) in July 2022

Learning from events and ongoing management

Arrangements for ongoing contract management have improved, but there remains scope to strengthen financial checks during the award process

Contract award process

33 The Health Board has made some improvements to its policies and procedures, but in our view these do not go far enough. Following recommendations from Internal Audit, the Health Board has strengthened its policies and procedures for managing future GMS contract awards. In July 2025 the Health Board issued a new standard operating procedure and an updated vacant practice policy. These arrangements reflect the new requirements of the Health Services (Provider Selection Regime) (Wales) Regulations 2025[10]. The new procedures implement a formal tender process and map, strengthened governance in relation to evaluation of applications and broader stakeholder engagement. The Health Board has also agreed a preference that future GMS providers are based in the Gwent region.

34 The procedures also provide more clarity on the specific due diligence checks needed. Prior to the contract award these include:

- basic credit checks on the individuals within the partnership;
- copies of audited financial statements for the past 2 years;
- confirmation of no outstanding debts or liabilities that may affect service delivery;
- details of any previous breaches, sanctions or disputes; and
- accountant letter of viability.

35 The Health Board has also introduced checks upon commencement of the contract to ensure that providers have the following:

10 Health Service Procurement (Wales) Act 2024

- payroll system in place for staff payments;
- evidence of PAYE registration and compliance;
- evidence of compliance for HMRC requirements;
- pension scheme arrangements for staff;
- confirmation of account ownership and authorised signatories;
- employers' liability insurance certificate; and
- public liability insurance certificate.

36 These additional checks represent a significant strengthening of the Health Board's arrangements for managing GMS contract awards. However, in our view there is scope to strengthen them further. The guidance still does not require the Health Board to retain a formal record of financial or due diligence checks. Maintaining such a record would be important if the Health Board was ever challenged on its contract award processes. In addition, the guidance also does not extend to checking whether prospective contractors have any business interests or have any financial or commercial history that might warrant a more detailed set of enquiries to provide the necessary assurances on their fitness to be awarded a contract.

Ongoing contract monitoring and management

37 The Health Board has improved its arrangements for monitoring contract delivery. The Health Board has introduced mandatory enhanced monitoring for all new providers for a minimum of 12 months, and this is now part of the commissioning arrangements. However, the Health Board has not described the performance measures or triggers for both escalation and de-escalation that would be in place beyond the initial enhanced monitoring period.

38 The Health Board actively monitors the risks at the practices the Partnership continues to be responsible for, although noting that the remaining practices will be handed back at the end of the financial year. Arrangements included:

- weekly operational escalation meetings monitoring availability of appointments for patients. Attendees include the Head of Primary Care, Deputy Medical Director, Central Operations Manager, Divisional Director

for Primary Care, Community Services, and Complex and Long-Term Care and local practice manager for the partnership;

- bi-weekly assurance meetings with the partnership focusing on governance, workforce, and finance as well as any additional specific practice concerns. Attendees include the Deputy Medical Director, Head of Primary Care and Finance Business Partners with at least one GP partner in attendance alongside the Central Operations Manager;
- monitoring of weekly practice activity data to identify any areas where access standards are not being achieved; and
- practice assurance visits based on the GMS Contract Assurance Framework.

39 The Primary Care Contracting Team use standard arrangements to ensure compliance against core contract requirements for all GMS Practices. We have outlined these arrangements in **Appendix 3.**

40 Welsh Government has developed a Contract Assurance Framework (CAF) as a governance process for the evaluation of assurance on the delivery of services through the GMS Unified Contract used across NHS Wales and by GMS contractors. There are three nationally agreed components:

- data set for quality, safety, governance and contract management; a practice assurance return and IG toolkit;
- process for assessing contractor's compliance against contractual requirements; and
- escalation ladder for managing concerns.

41 The Health Board applied the CAF at each practice. The primary care team have undertaken a series of contract and governance visits and assessed the twelve Health and Care Quality standards[11]. Where the team have found issues, the Health Board has made recommendations, which the practice addressed. The Health Board has paid specific focus to access standards and has also indicated that they have not identified any patient safety issues.

42 The practice visits undertaken as part of the enhanced monitoring arrangements for the Partnership are informed by GP performance information. The practices are up to date with their submission data they as part of the CAF process. The Health Board is also actively monitoring rates of patient concerns and complaints and benchmarking performance to identify any outliers.

[11] Care must be, safe, timely, effective, efficient, equitable, person-centred. Assessments are also made against leadership, workforce, culture, information, learning and whole system approach.

Recommendations

R1 Strengthen GP business case requirements in the vacant practice policy to ensure that potential GP partners include sufficient detail on its workforce, financial and quality plans **(Paragraph 27).**

R2 Strengthen the scrutiny of prospective contractor's financial business plans to include:

2.1 consideration of the realism of financial and workforce projections; and

2.2 risks which might be presented by the nature and complexity of prospective contractors' business interests.

Where concerns are identified, the Health Board should resolve these prior to the letting of the contract **(Paragraph 27 to 30).**

R3 The Health Board should retain evidence of all due diligence checks undertaken when letting any GMS contract. The checks undertaken should include background checks on directors. (**Paragraph 31 and Paragraph 36).**

R4 Agree clear but proportionate GMS practice performance and operational targets for escalation and de-escalation following the initial 12-month contract award review period **(Paragraph 37).**

Appendices

1 About our work

Scope of the audit

Our work considered the steps that the Health Board took to award GMS contracts to a specific GP Partnership between October 2023 and April 2024. We also looked at the ongoing arrangements for managing GP contracts including the monitoring and escalation arrangements.

We did not review the GP appointment process for any other GP practices that the Health Board manages. GP performers list checks, that NHS Wales Shared Services Partnership undertook also fall outside the scope of the review. We have also not reviewed Health Board compliance with new policies for the more recently awarded Aberbeeg contract.

Audit questions and criteria

Questions

Our audit work was system orientated; its overall purpose was to consider:

- The reasonableness of arrangements for appointing the Partnership with consideration of governance, due diligence, compliance with policy and regulations, decision-making and risk management; and
- The Health Board's oversight and management of the GP practices run by the Partnership, and the process for ensuring a smooth transition where the Partnership was returning its GMS contracts to the Health Board.

Criteria

Our audit questions were shaped by requirements set out in Welsh Government Welsh Health Circular guidance, procurement legislation applicable at the time of contract appointment, and the Health Board's own policies. We also considered the recent Internal Audit work both to place assurance on their work where possible, and to inform our questions.

Methods

We reviewed a range of documents, including:

- Board and committee papers and minutes;
- Key governance documents including the Vacant Practice Policy;
- Internal Audit reports;
- Business cases and contract award documentation; and
- Enhanced monitoring information including minutes from meetings.

We interviewed the following key stakeholders:

- Chief Executive;
- Divisional Director of Primary Care, Community Services, and Complex and Long-Term Care;
- Head of Primary Care;
- NHS Counter Fraud;
- Local Counter Fraud;
- Internal Audit;
- NHS Wales Shared Services Partnership;
- NHS Performance and Improvement;
- Senior Medical Officer for Primary Care and Mental Health and Early Years, Welsh Government; and
- Senior Medical Officer for Primary Care, Mental Health, Substance Misuse & Vulnerable Groups Division, Welsh Government,

2 Contract Award timeline

Practice	Contract process	Managed practice since	Contract start date	Contract return date
Lliswerry	Contract taken over from outgoing GP practice	N/A	1 Nov 22	31 Mar 2026
Pontypool	Contract awarded in line with the Vacant Practice Policy	N/A	1 Oct 23	31 Mar 2026
Tredegar	Contract awarded in line with the Vacant Practice Policy	April 2017	1 Jan 24	1 Apr 25
Brynmawr	Contract awarded in line with the Vacant Practice Policy	July 2015	1 Apr 24	1 Mar 25
Aberbeeg	Contract awarded in line with the Vacant Practice Policy	April 2018	1 Apr 24	1 Mar 25
Bryntirion	Contract awarded in line with the Vacant Practice Policy	December 2017	1 Apr 24	1 Apr 25

Practice	Contract process	Managed practice since	Contract start date	Contract return date
Blaenavon	Contract awarded in line with the Vacant Practice Policy	January 2023	1 Apr 24	1 Mar 25
Meddygfa Gelligaer	Contract taken over from outgoing GP practice	N/A	11 April 24	31 Mar 2026

3 Contract values 2024-25

Exhibit 3: 2024-25 contract values and adjusted figures for the eight GP Partnership practices

Practice	Agreed contract Value £ million	Revised contract value £ million
Pontypool	2.47	2.47
Bryntirion	1.59	1.59
Brynmawr	1.56	1.43
Meddygfa Gelliager	1.09	1.09
Tredegar	1.05	1.05
Blaenavon	0.85	0.78
Lliswerry	0.84	0.84
Aberbeeg	0.67	0.61
Totals	**10.1**	**9.85**

Source: Aneurin Bevan University Health Board

Note: The revised contract value reflects a reduction where the practices were handed back to the Health Board prior to the year end.

4 Contract monitoring

The Primary Care Contracting Team monitor compliance against core contract requirements for all GMS practices. These include:

- monitoring of access standards (quarterly);
- updating of the Primary Care Workforce Intelligence System (monthly);
- clinical governance practice self-assessment toolkit (annual);
- Welsh information governance toolkit self-assessment (annual);
- contract assurance framework (annual);
- escalation reporting (monthly);
- GP data activity (monthly);
- attend collaborative meetings (quarterly);
- participate in two quality improvement projects (annual); and
- child health reporting (monthly monitoring, bi-monthly reporting).

Practices upload much of this information to the Primary Care Information Portal. Health boards are then able to review this data at a cluster level but cannot use the data for the performance management of any individual practice. This limits the Health Boards ability to use this information for escalation and monitoring purposes.

5 Key terms in this report

Term	Description
General Practitioners	A medical doctor who provides primary care services, diagnosing and treating a wide range of health conditions. GPs are usually the first point of contact for patients and coordinate ongoing care, including referrals to specialists when needed.
Contract Variation	When a practice is returned to a health board, maybe due to reasons such as retirement of the current contractor, it is responsible for securing a new provider. It does this through a contract award process, where the practice is advertised and independent contractors can apply to run the practice. In some cases, the current contract holder undertakes this process themselves, through a contract variation, where the contract is transferred to a new independent contractor without health board involvement.
GMS Contract	A legal agreement between GP practices and NHS Wales that sets out the core medical services GPs must provide.
Due Diligence	A process of careful investigation and assessment carried out to verify facts, evaluate risks, and ensure informed decision-making—commonly used in financial, legal, and operational contexts such as audits, mergers, or compliance checks.

Managed Practice	A GP practice directly operated by a Health Board in Wales, typically established when a standard GP contract ends and no alternative provider is available. Managed Practices deliver NHS services using salaried and locum staff and are overseen by the Health Board.
Sustainability Assessment Framework	The sustainability assessment framework is a national framework which provides a consistent approach for assessing the sustainability of GP practices and determining the level of support needed for those practices. A local assessment panel determined the eligibility and level of support the Health Board provided. GPs must support all claims with evidence of expenditure.

About us

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Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Management response form

Archwilio Cymru
Audit Wales

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R1	Strengthen GP business case requirements in the vacant practice policy to ensure that potential GP partners include sufficient detail on its workforce, financial and quality plans.	The Health Board recognises the importance of ensuring that business cases submitted by prospective GP partners for vacant practices are sufficiently detailed, robust and capable of withstanding external scrutiny. The Health Board has operated a well-established and robust Vacant Practice Policy, which has been consistently applied throughout vacant practice processes. This policy requires prospective GP partners to submit comprehensive business cases, supported by a structured interview and a due diligence process. These submissions are assessed by a Vacant Practice Panel, which includes external representation from Llais and the Local Medical Committee, providing independent challenge and assurance in relation to workforce sustainability, financial viability and quality of care arrangements. In response to learning from recent vacant practice processes and findings from internal audit, the Health Board has already strengthened the existing Vacant Practice Policy and associated business case requirements. These enhancements have focused on improving the clarity and consistency of information required from applicants, particularly in relation to workforce plans, financial modelling and quality governance arrangements. The Health Board welcomes this further recommendation from Audit Wales and will take it forward as part of a continued programme of improvement. Further refinements	30 April 2026	Head of Primary Care

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		to business case requirements and assessment processes will be incorporated into the Standard Operating Procedure: Management of General Medical Services Practice Vacancies (2025), which sets out the procedural steps for the letting of both vacant and Health Board-managed practices. The SOP ensures that requirements are applied consistently, transparently and in line with relevant regulatory and governance expectations.		
R2	Strengthen the scrutiny of prospective contractor's financial business plans to include: consideration of the realism of financial and workforce projections; and • risks which might be	The Health Board accepts this recommendation and recognises the importance of robust and proportionate scrutiny of prospective contractors' financial and workforce business plans to support the long-term sustainability, safety and quality of General Medical Services (GMS). The Health Board has operated a well-established and robust Vacant Practice Policy, which has been consistently applied throughout vacant practice processes and includes structured assessment of financial viability, workforce proposals and governance arrangements. This process is supported by multi-disciplinary scrutiny and independent challenge through the Vacant Practice Panel membership.	30 April 2026	Head of Primary Care

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	presented by the nature and comple xity of prospective contractors' business interests. • Where concerns are identified, the Health Board should resolve these prior to the letting of the contract	In response to learning from recent vacant practice processes and findings from internal audit, the Health Board has already strengthened the existing Vacant Practice Policy and associated assessment tools. In particular: The financial forecast template that prospective contractors are required to complete has been extended to require a minimum three-year projection, enabling enhanced assessment of the realism of workforce assumptions and future income and expenditure expectations; and A formal due diligence checklist has been introduced, which includes a requirement for individuals within a prospective partnership to commit to undergoing a credit check prior to contract award, where appropriate. The due diligence arrangements will be further developed to incorporate a formal review of Companies House records, to inform whether any additional exploration of wider business interests is required where the nature or complexity of those interests presents a potential risk. The Health Board notes that there is no clause or restriction within The National Health Service (General Medical Services) (Contracts) (Wales) Regulations 2023 that places limitations on the wider business interests of independent contractors. However, the Health Board considers it appropriate to understand and assess such interests where		

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		they may present a material risk to financial sustainability, delivery of services or contractual compliance. Where concerns are identified through enhanced financial, workforce or due diligence scrutiny, these will be fully explored and resolved prior to the letting of any contract, with decisions informed by documented evidence and appropriate governance oversight. These strengthened arrangements are embedded within, and will continue to be reflected in, the Standard Operating Procedure: Management of General Medical Services Practice Vacancies (2025), ensuring that scrutiny processes are transparent, consistent, evidence-based and capable of withstanding internal and external audit scrutiny.		
R3	The Health Board should retain evidence of all due diligence checks undertaken when letting any GMS contract. The checks	The Health Board accepts this recommendation and recognises the importance of retaining clear and auditable evidence of all due diligence checks undertaken when letting any General Medical Services (GMS) contract, including background checks on directors.	Complete	Head of Primary Care

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	undertaken should include background checks on directors.	The Health Board's due diligence arrangements already include a range of checks designed to provide assurance regarding the suitability, probity and capability of prospective providers. This has included checks undertaken through publicly accessible systems, such as Companies House, which may not always generate formal documentary outputs. The Health Board acknowledges the need to ensure that evidence of such checks, particularly those completed via online or public access sources, is consistently recorded and retained to support audit assurance and transparency. In response, the Health Board has strengthened its arrangements by explicitly incorporating into the Standard Operating Procedure: Management of General Medical Services Practice Vacancies (2025) a requirement that all documentation and records collated as part of the due diligence process are formally retained. This includes evidence of background and probity checks on directors and relevant individuals, regardless of whether the source of the check is documentary or publicly accessible. The SOP now makes clear that all due diligence records must be held in accordance with the Health Board's Records Management Code of Practice, ensuring that information is securely stored, retrievable, and retained for the appropriate duration. This approach provides a clear audit trail and strengthens the Health Board's assurance framework in relation to the letting and management of GMS contracts.		

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R4	Agree clear but proportionate GMS practice performance and operational targets for escalation and de-escalation following the initial 12-month contract award review period.	The Health Board acknowledges the importance of agreeing clear, proportionate and transparent performance and operational targets to support escalation and de-escalation decisions following the initial 12-month contract award review period. The Health Board notes that the General Medical Services (GMS) contract is nationally determined, with core performance, quality and operational requirements set at a national level. Any locally applied measures must therefore align with national contractual requirements, avoid unnecessary duplication, and remain proportionate to the risks identified. Within these parameters, the Health Board will develop and apply locally defined indicators to inform escalation and de-escalation decisions following contract awards. These indicators will be designed to complement national requirements and focus on areas such as sustainability, operational resilience and delivery of safe, high-quality care, while ensuring consistency and fairness across practices.	31 July 2026	Head of Primary Care

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
		The Health Board's existing Enhanced Monitoring Framework already demonstrates a strong commitment to proportionate oversight and early intervention where concerns are identified. Building on this framework, further refinements will be made to ensure that escalation and de-escalation thresholds are clear, evidence-based and consistently applied, supporting transparent decision-making and appropriate governance oversight. These amendments will be formally incorporated into the Standard Operating Procedure: Management of General Medical Services Practice Vacancies (2025), ensuring that expectations, processes and decision-making criteria are clearly articulated and embedded within established operational arrangements.		