Audit Risk and Assurance Committee Main Meeting

Tuesday 24 November 2026, 09:30 - 12:30

Microsoft Teams

Audit, Risk and Assurance Committee Main Meeting

1. PRELIMINARY MATTERS

1.1. Welcome and Introductions

Oral *Chair*

1.2. Apologies for Absence

Oral *Chair*

1.3. Declarations of Interest

Oral *Chair*

1.4. Draft Minutes of the last Meeting held on 15th September 2026

Attached *Chair*

ARAC 20261124 1.4 20260915 Minutes - IJ approved.pdf (14 pages)

1.5. Committee Action Log

Attached *Chair*

ARAC 20261124 1.5 20260915 Action Log - IJ approved.pdf (3 pages)

1.5.1. To Receive a complete review of outstanding clinical audit actions, including those from previous years.

To Follow *Medical Director*

ARAC 20261124 1.5.1 National Clinical Audit Actions Look Back Report.pdf (6 pages)
ARAC 20261124 1.5.1a Appendix A 2019_2026 National Clinical Audit Activity Nov 2026.pdf (17 pages)

2. Items for APPROVAL/RATIFICATION/DECISION

2.1. To Approve the Corporate Clinical Audit Plan

Attached *Medical Director*

ARAC 20261124 2.1 ARAC SBAR Corporate Clinical Audit Framework and Annual Corporate Clinical Audit Plan 2026.27 Nov 2026.pdf (8 pages)
ARAC 20261124 2.1a ABUHB Corporate Clinical Audit Framework and Annual Plan 2026-27 FINAL.pdf (35 pages)

2.2. To Approve Reviewed and Updated Financial Control Procedures

Attached *Director of Finance and Procurement*

- Capital Procedures and Guidance Notes
- Cash and Bank
- Patients' Travel Costs

ARAC 20261124 2.2 Finance Governance Report - Nov 2026.pdf (10 pages)
ARAC 20261124 2.2a Appendix 1 ABUHB_Finance_0243 Capital Procedures and Guidance_Final.pdf (121 pages)
ARAC 20261124 2.2b Appendix 2 ABUHB_Finance_0250 Cash and Bank_Final.pdf (29 pages)
ARAC 20241124 2.2c Appendix 3 ABUHB_Finance_0247 Patients Travel_Final.pdf (27 pages)

2.3. To Receive Q2 Audit Recommendation Tracking Report

Attached *Director of Corporate Governance*

ARAC 20261124 2.3 Internal_External Audit Recommendations Cover Report.pdf (6 pages)
ARAC 20261124 2.3a Completed Recommendations (21) .pdf (2 pages)
ARAC 20261124 2.3b Revised Deadline Requests.pdf (2 pages)

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3. ITEMS FOR DISCUSSION

3.1. To Receive report of the use of Single Tender Action

Attached *Director of Finance and Procurement*

ARAC 20261124 3.1 Single Tender Action Report - 01.09.2026 - 31.10.2026 (002).pdf (5 pages)

3.2. To Receive report of Losses and Special Payments

Attached *Director of Finance and Procurement*

ARAC 20261124 3.2 Losses Report Sept 26.pdf (9 pages)

3.3. Governance and Compliance Assurance

Attached *Director of Corporate Governance*

- To review and report upon the adequacy of arrangements for declaring, registering and handling interests, including gifts and hospitality
- To receive assurance on compliance with Ministerial Directions and Welsh Health Circulars (WHC)

ARAC 20261124 3.3 WHC and Min Dir Update Nov 26.pdf (5 pages)
ARAC 20261124 3.3a Appendix 1a 2024.pdf (1 pages)
ARAC 20261124 3.3b Appendix 1b 2025.pdf (4 pages)
ARAC 20261124 3.3c Appendix 1c 2026.pdf (4 pages)
ARAC 20261124 3.3d Appendix 2 MDs.pdf (4 pages)
ARAC 20261124 3.3e DoI Update ARAC November 2026.pdf (6 pages)
ARAC 20261124 3.3f Attachment One Master register Nov 2026 (2).pdf (28 pages)
ARAC 20261124 3.3g Attachment Two Board Member DoI Register Nov 2026.pdf (1 pages)
ARAC 20261124 3.3h Attachment 3 Register of Gifts and Hospitality November 2026.pdf (2 pages)
ARAC 20261124 3.3i Attachment 3b Honoraria Nov 2026.pdf (1 pages)
ARAC 20261124 3.3j Attachment Four SoBC Implementation Plan Nov 2026 Update.pdf (3 pages)
ARAC 20261124 3.3k Attachment Five Standards of Business Conduct Amended Nov 2026.pdf (28 pages)

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

Attached *Director of Finance and Procurement*

ARAC 20261124 3.4 ABUHB Mid Year PPV 2026-2027.pdf (4 pages)
ARAC 20261124 3.4a ABuHB Mid-year PPV Report 2026-2027 - Anonymised.pdf (7 pages)

3.5. To Receive Internal Audit Progress Report

Attached *Head of Internal Audit*

ARAC 20261124 3.5 ABUHB November 2026 Internal Audit Progress Report.pdf (9 pages)

3.6. To Receive Internal Audit Reports

Attached *Head of Internal Audit*

- Job Evaluation
- Divisional Budgetary Control
- Benefits Realisation (excluding digital)

ARAC 20261124 3.6a ABUHB 2627 20 Final Job Evaluation Report.pdf (14 pages)
ARAC 20261124 3.6b ABU-2526-01 Divisional Budgetary Control FINAL Internal Audit Report for Client.pdf (14 pages)
ARAC 20261124 3.6c ABU-2526-05 Benefits Realisation Final Internal Audit Report for Client.pdf (7 pages)

3.7. To Receive External Audit Progress Report 2025-26

Attached *Audit Wales*

ARAC 20261124 3.7 ABUHB Audit Committee Update November 2026.pdf (10 pages)

3.8. NHS Estates Report

Attached *Audit Wales*

ARAC 20261124 3.8 ABUHB NHS Estates Report (FT) including management response.pdf (54 pages)

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4. Items for INFORMATION

4.1. Zeroing in? Follow-up on public sector decarbonisation report

Attached *Audit Wales*

ARAC 20261124 4.1 Zeroing_in_Follow-up_on_public_sector_decarbonisation.pdf (44 pages)

4.2. NHS digital delivery not matching ambition

Oral *Audit Wales*

4.3. National Fraud Initiative Report - Finding the right match

Attached *Audit Wales*

This article is available to view on the Audit Wales website

ARAC 20261124 4.3 NFI_eng_report_0.pdf (51 pages)

4.4. Upcoming Internal Audit Briefs

Attached *Head of Internal Audit*

- Governance of Escalation Levels
- Welsh Risk Pool Lessons
- Procurement of Digital Services
- HSDU
- Primary Care, Community Services, and Complex and Long-Term Care

ARAC 20261124 4.4a ABU Governance of Escalation Final Internal Audit Brief for client issue.pdf (3 pages)
ARAC 20261124 4.4b ABU-2627-08 Welsh Risk Pool Lessons Final Internal Audit Brief .pdf (4 pages)
ARAC 20261124 4.4c ABU-2627-24 Procurement of Digital Services Final IA Brief.pdf (3 pages)
ARAC 20261124 4.4d Final Internal Audit Brief ABU-2627-09 HSDU.pdf (3 pages)
ARAC 20261124 4.4e Final Internal Audit Brief ABU-2627-15 PCCS Review.pdf (3 pages)

4.4.1. Charitable Funds Internal Audit Report

Attached *Head of Internal Audit*

ARAC 20261124 4.4.1 ABU-2627-04 Final Charitable Funds Internal Audit Report.pdf (12 pages)

4.5. Review of Committee Programme of Business 2026/27

Attached *Head of Corporate Governance*

ARAC 20261124 4.5 Committee Programme of Business.pdf (3 pages)
ARAC 20261124 4.5a ARA Committee Work Programme 2026-27 Final.pdf (7 pages)

5. OTHER MATTERS

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

Oral *Chair*

5.2. Any Other Urgent Business

Oral *Chair*

5.3. Date of the Next Meeting: Thursday 11th February 2026 09:00-12:00

Oral *Chair*

BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN/ANEURIN BEVAN UNIVERSITY HEALTH BOARD

MINUTES OF THE AUDIT, RISK AND ASSSURANCE COMMITTEE

DATE OF MEETING	**Tuesday 15th September 09.30-12.00**
VENUE	**Microsoft Teams**

PRESENT	Iwan Jones, Committee Chair Neil Patrick, Independent Member Dafydd Vaughan, Independent Member Helen Sweetland, Independent Member Helen Cunningham, Independent Member
IN ATTENDANCE	Lucy Windsor, Head of Corporate Risk and Assurance Murray Gard, Auditor Internal Audit Eifion Jones, Deputy Head of Internal Audit Stephen Chaney, Head of Internal Audit Robert Holcombe, Director of Finance and Procurement Andrew Doughton, Head of Audit Wales Rani Dash, Director of Corporate Governance Gareth Lavington, Head of Counter Fraud Rani Dash, Director of Corporate Governance Robert Jones, Assistant Director of Finance Tomos Jones, Auditor Audit Wales (*Item 3.8*) Danielle Jackson, Secreteriat Naomi Murtagh, Head of Board Business
OBSERVER	None to note
APOLOGIES	None to note

ARAC/1509/01	**Welcome and Introductions** Iwan Jones (IW), Chair, welcomed everyone to the Committee.
ARAC/1509/02	**Apologies for Absence**

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	Iwan Jones (IW), Chair, **NOTED** that there were no apologies received.
ARAC/1509/03	**Declarations of Interest** There were no Declarations of Interest to record.
ARAC/1509/04	**Draft Minutes of the last Meeting held on 23rd June 2026** The minutes of the meeting held on the 23rd of June 2026 were agreed as a true and accurate record, it was requested than an action be added against the clinical audit item.
ARAC/1509/05	**Committee Action Log and Matters Arising** The Committee reviewed the action log, noting actions completed, actions in progress, and actions not yet due.
ITEMS FOR APPROVAL/RATIFICATION/DECISION	
ARAC/1509/06	**To Approve Reviewed and Updated Financial Control Procedures** Robert Jones (RJ), Assistant Director of Financepresented the report outlining the current position in relation to financial control procedures and governance arrangements. The Committee was advised that all financial control procedures were up to date, there had been no payments exceeding £100k requiring reporting, and compliance with Standing Financial Instructions remained satisfactory. It was noted that the Health Board continued to demonstrate strong performance against the Public Sector Payment Policy. Attention was drawn to a recent claim relating to historic late payment charges associated with agency nursing providers used during the COVID-19 pandemic. The Committee noted that claims management organisations were purchasing debt books from defunct agencies and

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	pursuing statutory late payment fees. Members discussed the potential implications across the wider public sector and the need to review historical payment data and engage with Welsh Government regarding the issue. The Committee **NOTED** the report and **APPROVED** the reviewed Financial Control Procedures.
ARAC/1509/07	**To Receive Q1 Audit Recommendation Tracking Report** Lucy Windsor (LW), Head of Corporate Risk and Assurance, presented the Quarter 1 Audit Recommendation Tracking Report. The Committee noted that updates had been requested for 66 recommendations. Of these, 30 had reached their original implementation date and 36 had exceeded either their original or revised implementation date. An in-depth review of overdue recommendations had been undertaken. Members welcomed the comprehensive analysis and discussed the proposed closure of several historic recommendations. Discussion focused on an Audit Wales recommendation relating to the central recording of annual leave for consultants and medical staff. Whilst acknowledging significant progress and the governance arrangements already in place through the People and Culture Committee, Members sought assurance that completion of consultant leave recording arrangements would continue to be monitored. Internal Audit confirmed its support for the revised approach and advised that future audit work relating to

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	consultant job planning would include consideration of this issue. The Committee **APPROVED** the closure of the recommendations identified in the report and **AGREED** that assurance relating to consultant annual leave recording should continue through established governance arrangements, future audit reviews and should be highlighted to the People and Culture Committee to ensure continued oversight.
ARAC/1509/08	**To Receive Report for Managing and Approving Extensions** Lucy Windsor (LW), Head of Corporate Risk and Assurance, presented the revised procedure for managing audit recommendation extension requests. The Committee was advised that the revised procedure had been developed following concerns regarding the frequency of extension requests. The updated arrangements introduced stronger quality assurance processes and greater challenge of implementation dates at the point recommendations were agreed, with the aim of ensuring that extensions become the exception rather than the norm. Members welcomed the strengthening of governance arrangements and recognised the significant improvements made in audit recommendation management over recent years. The Committee **APPROVED** the revised Audit Recommendation Tracking Procedure.
ITEMS FOR DISCUSSION	

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ARAC/1509/09	**To Receive and Discuss the Full Suite of Risk Management Documents** Lucy Windsor (LW), Head of Corporate Risk and Assurance, presented the revised Risk Management Framework, Risk Management Procedure, Risk Management Guidance Handbook and Risk Appetite Statement. The Committee recognised the considerable work undertaken to strengthen and mature the Health Board's risk management arrangements. Members welcomed the revised risk appetite methodology and the clearer articulation of appetite thresholds. Discussion focused on the application of risk appetite across a range of digital, cyber and transformation risks, he need for greater guidance regarding the allocation of risks to specific domains where risks span multiple themes, ensuring risk appetite thresholds accurately reflected organisational risk tolerance and maturity and, the role of reputation, confidence and public trust within risk management arrangements. Members agreed that further guidance would be beneficial to support consistent application of risk domains and appetite thresholds. The Committee also noted ongoing debate regarding whether reputation should be treated as a standalone risk theme or as a consequence of other risks materialising. The Committee requested that a supplementary guide to support consistent allocation of risks across risk domains and application of risk appetite statements was developed, particularly where risks span multiple domains. **ACTION: Head of Corporate Risk and Assurance**

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	The Committee **ENDORSED** the suite of risk management documents for submission to the Board highlighting concerns regarding the treatment of reputation, public confidence and trust within the Risk Appetite Statement.
ARAC/1509/10	**To Receive Committee Risk and Assurance Report** Lucy Windsor (LW), Head of Corporate Risk and Assurance, presented the Committee Risk and Assurance Report. The Committee noted the revised dashboard format, which provided a clearer overview of strategic and corporate risks, their alignment to the Integrated Medium-Term Plan and associated risk appetites. Members discussed the proposed refresh of strategic risk statements using bow-tie methodology and considered the proposed escalation and de-escalation of a number of risks. Specific discussion took place regarding the proposed de-escalation of the Reinforced Autoclaved Aerated Concrete (RAAC) risk at Nevill Hall Hospital, with management advising that the risk was now operational in nature and being effectively managed at divisional level. The Committee also discussed whether a standalone strategic cyber security risk was required. Members were assured that cyber security risks were already captured appropriately within the existing strategic and corporate risk structure and through a dedicated corporate risk.

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	The Committee **NOTED** the proposed revised strategic risk statements and associated risk structure for submission to the Board.
ARAC/1509/11	**To Receive Report on the use of Single Tender Action** Robert Jones (RJ), Assistant Director of Finance and Procurement, presented the report. The Committee noted that Single Tender Action (STA) activity remained consistent with previous reporting periods. Members were advised that governance arrangements had been extended to encompass Service Level Agreements (SLAs) entered into under the Provider Selection Regime, enabling greater scrutiny and assurance over these arrangements. It was reported that use of the STA process had assisted in identifying opportunities to improve SLA quality, governance and value. The Committee **NOTED** the report.
ARAC/1509/12	**To Receive a Progress Report on Counter Fraud Activity** Gareth Lavington (GL), Head of Counter Fraud, presented the mid-year Counter Fraud Report. The Committee noted the strong performance against mandatory counter fraud training requirements, with compliance exceeding 90%. Members also received an update on ongoing investigations, proactive counter fraud exercises and awareness activity. Particular attention was drawn to work relating to prescription security and inappropriate use of prescription forms, reviews of consultant additional duties and agency

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	nursing arrangements, positive management responses to findings arising from proactive reviews, preparations for the forthcoming National Fraud Initiative exercise. Members welcomed the breadth of proactive work undertaken and commended the Counter Fraud Team's performance. During discussion, concerns were raised regarding recurring job planning issues identified through multiple assurance reports, including internal audit and counter fraud reviews. Members expressed continued concern regarding the adequacy of assurance available in relation to consultant job planning arrangements. The Committee requested that concerns regarding consultant job planning, recurring assurance findings and adequacy of controls are escalated to the Board for formal discussion and determination of further action. **ACTION: Head of Board Business** The Committee **NOTED** the report.
ARAC/1509/13	**To Receive Internal Audit Progress Report** Stephen Chaney (SC), Head of Internal Audit, presented the Internal Audit Progress Report. The Committee noted that a number of audits had reached completion and several further reviews were progressing well. It was reported that there had been good engagement from management teams over the summer period and that audit fieldwork was progressing as planned.

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	Internal Audit advised that no significant concerns had arisen during the reporting period and highlighted that a number of reviews were concluding with reasonable assurance opinions. The Committee welcomed the positive progress being made against the Internal Audit Plan. The Committee **NOTED** the report.
ARAC/1509/14	**To Receive Internal Audit Review Reports** **Falls Management Audit Report (Reasonable Assurance)** Eifion Jones (EJ), Deputy Head of Internal Audit, presented the Falls Management Audit Report which had received an overall Reasonable Assurance opinion. The Committee noted that significant progress had been made since the previous audit review, with policies aligned to national guidance and strong reporting and oversight arrangements in place across the organisation. However, six findings had been identified, comprising one high-priority recommendation and five medium-priority recommendations. The high-priority finding related to inconsistencies and omissions in falls documentation and investigations, including gaps in risk assessments, post-fall reviews and completion of concise investigations. While the issues identified were limited in number, Internal Audit advised that the significance of the subject matter warranted a high-priority recommendation. Members sought clarification regarding the implementation timescales associated with the recommendations and

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expressed concern that certain actions appeared to have implementation dates extending up to twelve months. Internal Audit confirmed that there was likely a distinction between immediate actions and completion of a full assurance cycle and agreed to review the implementation dates for clarity.

The Committee requested that clarity around the implementation timescales associated with Falls Management recommendations be sought, distinguishing between immediate corrective actions and completion of the full assurance cycle.
ACTION: Internal Audit

The Committee welcomed the improvements identified and **NOTED** the report.

Satellite Radiotherapy Centre, Neville Hall Hospital (Reasonable Assurance)

Murray Gard (MG), Internal Audit, presented the final review of the Satellite Radiotherapy Centre at Nevill Hall Hospital, which had received an overall Reasonable Assurance opinion.

The Committee noted that the facility was operational and delivering services to patients and that all previous audit recommendations had been implemented. The project had been delivered within the approved funding envelope, albeit six months later than originally anticipated.

While noting the positive progress made, Members discussed the remaining outstanding actions, including finalisation of the Service Level Agreement between the Health Board and Velindre and resolution of outstanding

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	defects and lessons learned arising from water quality issues experienced during the project. The Committee was advised that work to complete the Service Level Agreement was nearing conclusion and that mechanisms existed to resolve any outstanding issues should they arise. The Committee **NOTED** the report and the continuing work required to conclude project closure activities.
ARAC/1509/15	**To Receive External Audit Progress Report 2025-26** Andrew Doughton (AD), Audit Wales, presented the External Audit Progress Report. The Committee noted that the financial accounts audit for 2025/26 had concluded and that charitable funds audit work would commence in October 2026. Members were advised that planning work for the 2026/27 accounts audit would begin early in the new year. Updates were provided on the Estate Management Review, Structured Assessment 2026 and upcoming reviews relating to Diabetes Services and Operating Theatres. Audit Wales confirmed that the Structured Assessment would focus on the impact and effectiveness of organisational arrangements, particularly those supporting delivery of the Integrated Medium-Term Plan (IMTP). The Committee also noted the Audit Wales consultation on proposed audit fee increases. The Committee **NOTED** the report.
ARAC/1509/16	**To Receive External Audit Review Report**

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	Tomos Jones (TJ), Audit Wales, presented the Cancer Services Review. The review found that the Health Board had worked hard to manage increasing demand and avoid significant deterioration in cancer performance. However, performance remained below the national target for patients commencing treatment within 62 days of suspicion of cancer. Members noted that whilst leadership and oversight arrangements had strengthened, the Health Board did not yet have a sufficiently developed long-term cancer services plan supported by integrated workforce, estate and financial planning. The report also highlighted opportunities to improve use of data, service planning, scrutiny and performance reporting arrangements. The Committee noted the seven recommendations included within the report and that management had accepted all recommendations. As the relevant Executive Lead was unavailable to attend, Members agreed that detailed consideration of the report should take place at the next meeting of the Finance and Performance Committee, with appropriate management attendance, and that the report should also be considered through the Patient Quality and Safety Oversight Committee from a quality perspective. **ACTION: Secretariat** The Committee **NOTED** the report and recommendations.
ITEMS FOR INFORMATION	
ARAC/1509/17	**Update on Financial Grip and Control**

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	Robert Jones (RJ), Assistant Director of Finance and Procurement, presented the update on Financial Grip and Control arrangements. The Committee noted the extensive work undertaken across the organisation to strengthen financial governance arrangements, including engagement with budget holders and divisional management teams. Members heard that the approach adopted by the Health Board extended beyond simple compliance and aimed to embed greater financial awareness and accountability throughout the organisation. Whilst recognising the considerable progress that had been made, Members discussed the continuing financial challenges faced by the organisation and the need to balance compliance, control and delivery of services. The Committee **NOTED** the report
ARAC/1509/18	**Structured Assessment 2026 Audit Brief** The Committee **NOTED** the Structured Assessment 2026 Audit Brief and the update provided under the External Audit Progress Report. Members highlighted the value of sharing emerging findings where possible to inform development of the Health Board's Integrated Medium-Term Plan.
ARAC/1509/19	**Internal Audit Briefs** The Committee **NOTED** the Internal Audit Briefs relating to: • Vaccination Programme Audit. • Policy Management Audit. • Value and Sustainability Audit.

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	• Patient Experience Audit.
ARAC/1509/20	**Review of Committee Programme of Business 2026/27** The Committee **NOTED** the Programme of Business.
OTHER MATTERS	
ARAC/1509/21	**Items to be Brought to the Attention of the Board and Other Committees** The Committee agreed the following matters should be escalated: • Ongoing concerns regarding consultant job planning arrangements and the level of assurance available should be escalated to the **Board** for further discussion and consideration. • The Cancer Services Review should be considered by both the **Finance and Performance Committee** and the **Patient Quality and Safety Oversight Committee** through their respective governance lenses. • Assurance relating to consultant annual leave recording should continue to be monitored through the **People and Culture Committee**
ARAC/1509/22	**Any Other Urgent Business** There was no other urgent business raised
ARAC/1509/23	Date of the Next Meeting: **Tuesday 24th November 09.30-12.00**

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Outstanding	Overdue: In Progress	Not Due	Completed	Transferred to another Committee

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
June 2026	**ARAC 0623/17**	**Undertake a review of outstanding clinical audit actions, including those from previous years** Complete a comprehensive review of all open clinical audit actions, with particular focus on longstanding actions. Confirm ownership, progress and relevance of each action, and develop clear plans for completion or closure where appropriate.	Medical Director	November 2026	**Completed** Included within Novembers Agenda

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
June 2026	**Email from Lucy 31/07**	To develop and share with the Committee a Local (Corporate) Clinical Audit Plan for Approval	Medical Director	November 2026	**Completed** Included within Novembers Agenda
September 2026	**ARAC/1509/09**	To develop a supplementary guide to support consistent allocation of risks across risk domains and application of risk appetite statements was developed, particularly where risks span multiple domains.	Head of Corporate Risk and Assurance	November 2026	**Completed** Added in to the Risk Appetite Framework which was approved by the Board in September.
September 2026	**ARAC/1509/12**	Escalate concerns relating to consultant job planning arrangements, recurring assurance findings and adequacy of controls to the Board.	Head of Board Business	Next Board meeting	**Completed** Reported through Committee chairs report to board
September 2026	**ARAC/1509/14**	Review and clarify implementation timescales for Falls Management recommendations, distinguishing immediate corrective actions from full assurance cycle completion.	Internal Audit	November 2026	**In Progress**

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 at each Committee meeting.

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	24 November 2026
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	**National Clinical Audit Action Implementation Look Back Report**
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Dr Seema Srivastava Executive Medical Director
SWYDDOG ADRODD: **REPORTING OFFICER:**	Joanne Stimpson - Clinical Audit Lead Leeanne Lewis - Assistant Director for Quality & Patient Safety

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

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

Clinical audit is an important component of the Health Board's Quality Management System and provides a structured means of assessing whether clinical services are safe, effective and delivered in accordance with evidence-based standards.

National clinical audit enables the Health Board to benchmark local performance, identify variation and areas of good practice, and determine where improvement action is required to support better patient outcomes.

The Health Board is required to participate in all mandatory audits included within the Welsh Government National Clinical Audit and Outcomes Review Plan. This report presents a retrospective look-back exercise for all national clinical audit programmes from 2019/20 to 2026/27.

Its purpose is to provide the Audit, Risk and Assurance Committee with assurance on the governance arrangements applied to national clinical audit findings and to report the position regarding the recommendations and improvement actions arising from published audit reports.

The final position is set out in **Appendix A** and summarised within this report, showing the number of recommendations identified, the actions agreed following CSEG review, and the number of actions completed and outstanding by audit year.

Cefndir / Background

The National Clinical Audit and Outcome Review Plan is published annually by Welsh Government and is a key mechanism for improving the quality and safety of healthcare in Wales. It sets out the national clinical audits and outcome reviews in which NHS organisations are expected to participate and supports the use of audit findings to assess the quality and effectiveness of care, benchmark performance and demonstrate improvement over time.

Executive leadership for clinical audit is delegated to the Medical Director. Oversight of national clinical audit activity and associated improvement is provided through the Health Board's quality governance arrangements, including the Clinical Standards and Effectiveness Group (CSEG), the Quality Management Group (QMG) and the Patient Quality and Safety Outcomes Committee (PQSOC), with assurance and escalation to the Audit, Risk and Assurance Committee (ARAC) as appropriate.

The Audit Management and Tracking system (AMaT) supports the recording and monitoring of agreed national clinical audit actions. AMaT was implemented in 2022/2, which provides a central mechanism through which action owners, implementation deadlines, progress updates and evidence of completion can be recorded and reported.

Audit actions are routinely monitored and followed up by the Clinical Audit Team, which sits within the Medical Director's Quality and Patient Safety Team, providing central oversight of progress and completion.

Asesiad / Assessment

The Health Board has an established governance process for considering published national clinical audit findings and determining the action required. National clinical audit reports are received and presented to the Clinical Standards and Effectiveness Group (CSEG), where the findings and recommendations are reviewed with the relevant clinical leads.

CSEG considers the Health Board's performance against the national findings and agrees which recommendations require further action. Actions arising from this review are then uploaded to AMaT for monitoring and reporting, including the allocation of responsible leads and implementation timescales.

A summary of completed audits is reported through QMG and PQSOC using a standardised audit reporting template, providing consistent oversight of audit results, key findings and the associated SMART action plans.

Recommendations reviewed by CSEG and deemed not to require further action are not recorded on AMaT. This distinction is important when interpreting the data, as the number of actions held on AMaT will not necessarily correspond to the total

number of recommendations contained within the published national clinical audit reports.

Assurance is provided through a structured approach to the oversight, monitoring and closure of audit actions. Historical actions may be closed following a change in Clinical Lead where an appropriate handover has taken place, with the new Clinical Lead sighted on the audit findings, learning and associated actions. This ensures that a change in clinical leadership does not result in loss of organisational learning or oversight.

Actions may also be appropriately closed where delivery is dependent on a tertiary service or pathway outside ABUHB's direct remit and control, and where there are no further reasonable actions that can be progressed within the Health Board. In these circumstances, the rationale for closure is clearly documented.

Importantly, closure does not remove the governance or audit trail. All actions, progress updates and closure decisions remain recorded and time-stamped within AMaT, providing a transparent and auditable record of the position and the basis on which closure was agreed.

Actions arising from audits completed within the previous 12 months may appropriately remain ongoing while implementation is completed and evidence of improvement is established. These actions continue to be monitored and should not be interpreted as overdue or unaddressed solely because they remain open. This provides assurance that audit actions are subject to continued oversight, with a clear distinction between actions that are ongoing within their agreed implementation period and those requiring further escalation or follow-up.

Clinical audit findings are actively considered through a risk and assurance lens. Where an audit identifies a material risk, or where actions require continued oversight, these are escalated for consideration and inclusion on the relevant Directorate Risk Register.

A review of the Health Board's live Datix risk registers identified a number of operational and service risks relating to themes highlighted through national clinical audits, including stroke services, cancer pathways, cardiology services, maternity and neonatal care, respiratory services and workforce capacity. This provides assurance that key risks identified through national audit activity are being recognised and managed through the Health Board's established risk management arrangements.

Ongoing work with the Corporate Governance Team is strengthening the interface between clinical audit and organisational risk management, ensuring that risks identified through audit are formally transferred, owned and monitored within the appropriate governance structure. This provides assurance that significant audit findings do not remain solely within the audit process but are visible to Directorates and subject to appropriate risk management, scrutiny and escalation.

Appendix A presents the final position from 2019/20 to 2026/27. Across the period, 454 recommendations were identified. Following CSEG review, these generated 290 actions for monitoring through AMaT. The year-by-year position is summarised below.

The summary provides assurance that the majority of actions arising from the earlier audit years have been completed. The remaining open position is concentrated in the more recent audit cohort, with 52 ongoing for 2025/26. These actions require continued oversight through CSEG and PQSOC, with material risks, barriers to delivery or exceptions escalated to ARAC as appropriate.

Table 1: National Clinical Audit Recommendations and Actions by Audit Year

Audit year	Recommendations Identified	Actions Agreed	Actions Completed	Actions Closed	Actions Ongoing
2019-20	0	0	0	0	0
2020-21	28	9	9	0	0
2021-22	46	22	22	0	0
2022-23	100	70	62	8	0
2023-24	23	23	18	5	0
2024-25	131	69	61	6	2
2025-26	126	97	38	7	52
2026-27	Not been through the governance process – data unavailable				
Total	**454**	**290**	**210**	**26**	**54**

Measure	Number
Recommendations made	454
Actions agreed	290
Actions completed	210
Actions closed	26
Actions ongoing	54
Completed or closed	236
% Completed or closed	**81%**
% Ongoing	**19%**

Note: the figures distinguish between recommendations identified in published national reports and actions agreed by CSEG for monitoring on AMaT. The completed and outstanding columns reproduce the classifications recorded in Appendix A.

The annual clinical audit plan will continue to support participation in all mandatory national clinical audits and national confidential enquiries, including audits within the National Clinical Audit and Patient Outcomes Programme.

Published findings will continue to be considered through CSEG, with progress and exceptions reported through QMG, PQSOC and escalated to ARAC where assurance is required.

Argymhelliad / Recommendation

The Audit, Risk and Assurance Committee is asked to:

- **RECEIVE** the report and take assurance from the governance arrangements in place for the review, monitoring and escalation of actions arising from national clinical audit reports;
- **NOTE** the final position set out in Appendix A and summarised in Table 1, including the outstanding actions by audit year; and,
- **NOTE** that the remaining actions will continue to be monitored through CSEG, QMG and PQSOC, with material risks, barriers or exceptions escalated to ARAC as appropriate.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	Clinical Audit is a mechanism for identifying risks and ensuring robust management and escalation where appropriate.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability 3.1 Safe and Clinically Effective Care 2.1 Managing Risk and Promoting Health and Safety Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Every Child has the best start in life Adults in Gwent live well healthily and age well
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prrioritise areas where evidence shows take up of services is lower or outcomes are worse 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:	Clinical Standards and Effectiveness Group

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/	Involvement - The importance of involving people with an interest in achieving the well-being goals, and ensuring that those people reflect the diversity of the area which the body serves Choose an item.

Appendix A: National Clinical Audit Overview 2019/20 to 2026/27

Purpose: To provide a detailed position of National Clinical Audit activity from 2019/2020 to 2026/27 showing whether agreed actions have been completed, formally closed without implementation, or remain ongoing.

Key:

Completed	All agreed actions have been implemented and evidenced.
Closed	No action remains open, but one or more actions were not implemented and have been formally concluded, for example because delivery is outside ABUHB control, no longer applicable or cannot reasonably be progressed.
Ongoing	One or more actions remain open. This includes actions recorded as partially complete.
No Recommendations or Actions required	Either there were no recommendations, or, recommendations were reviewed but no additional actions were agreed for monitoring on AMaT.

Governance note: "Closed" does not mean "Completed". A closed action has been formally concluded without being fully implemented. Since AMaT was introduced in 2022, all governance decisions and supporting rationale for action closure have been recorded within the system.

Audit year 2019-2020

Audit code	Audit title	Recommendations identified	Actions agreed	Actions completed	Actions closed	Actions ongoing	Overall governance status
GS/CA/2019-20/01	National Audit of Breast Cancer in Older Patients	**0**	**0**	**0**	**0**	**0**	**No Recommendations recorded** Audit merged into the new NATCAN audits.
T&O/CA/2019-20/01	The National Hip Fracture Database Report on 2020 - Facing New Challenges	**0**	**0**	**0**	**0**	**0**	**No Recommendations recorded**

Year total: 0 recommendations; 0 actions agreed;

Audit year: 2020-2021

Audit code	Audit title	Recommendations identified	Actions agreed	Actions completed	Actions closed	Actions ongoing	Overall governance status
GS/CA/2020-21-01	Eighth Patient Report of the National Emergency Laparotomy Audit	11	4	4	0	0	**Completed**
Med/CA/2020-21/01	Fracture Liaison Service Database Annual report: Rebuilding FLS's to meet local patient need (FLS-DB) Jan - Dec 2021	12	3	3	0	0	**Completed**
Cardio/CA/2022-23/01	National Heart Failure Audit 2022 Summary Report Data 2020/2021	0	0	0	0	0	**No recommendations recorded**
GS/CA/2020-21/02	National Lung Cancer Audit (NLCA) – State of the nation report 2023 Results of the National Lung Cancer Audit for patients in England during 2021 and Wales during 2020 Published: 12 Apr 2023	5	2	2	0	0	**Completed**

Year total: 28 recommendations; 9 actions agreed; 9 completed; 0 closed; 0 ongoing.

Audit year: 2021-2022

Audit code	Audit title	Recommendations identified	Actions agreed	Actions completed	Actions closed	Actions ongoing	Overall governance status
MED/CA/2021/22/01	[Planned re-audit: 23/05/2024] Annual report - Improved FLS identification with gaps in monitoring: a call to action for national and regional planners Data - Jan 2022 to 31 Dec 2022 Published - Feb 2024	7	3	3	0	0	**Completed**
CARDIO/CA/2021/22/01	Management of Heart Attack: analyses from the Myocardial Ischaemia National Audit Project (MINAP)	9	9	9	0	0	**Completed**
DIAB/CA/2021-22/01	National Diabetes Audit 2021-22, Type 1 Diabetes	3	1	1	0	0	**Completed**
RHEUM/CA/2021-22/02	National Early Inflammatory Arthritis Audit (NEIAA) Year 4	12	0	0	0	0	**No actions required** All recommendations ongoing within the service.
CARDIO/CA/2021-22/02	National Heart Failure Audit 2022 Summary Report Data 2021/2022	5	6	6	0	0	**Completed**
PD/CA/2021-22-01	National Paediatric Diabetes Audit (NPDA) report on Care and Outcomes 2021/2022	5	2	2	0	0	**Completed**
GS/CA/2021-22-01	NBoCA – National Bowel Cancer Audit – State of the Nation Report An audit of the care received by people with bowel cancer in England and Wales focusing on people diagnosed between 1 April 2021 and 31 March 2022. Published 8 February 2024.	5	1	1	0	0	**Completed**

Year total: 46 recommendations; 22 actions agreed; 22 completed; 0 closed; 0 ongoing.

Audit year: 2022-23

Audit code	Audit title	Recommendations identified	Actions agreed	Actions completed	Actions closed	Actions ongoing	Overall governance status
DIAB/CA/2022-23-02	Local audit data re - National Diabetic Foot Audit	3	0	0	0	0	**No actions required** All recommendations ongoing within the service.
CARDIO/CA/2022/23/02	Myocardial Ischaemia National Audit Project (MINAP)	9	9	9	0	0	**Completed**
GS/CA/2022-23/04	National Audit of Breast Cancer in Older Patients 2022	0	0	0	0	0	**No recommendations recorded** Moved to NATCAN
COTE/CA/2022-23/02	National Audit of Dementia (NAD) Care In General Hospitals 2022-23 Round 5 Audit Report was published in August 2023.	15	27	27		0	**Completed**
ComplGS/CA/2022-23/02	National Bowel Cancer Audit Annual Report 2021 An audit of the care received by people with bowel cancer in England and Wales	0	0	0	0	0	**No recommendations recorded**
DIAB/CA/2022-23/03	National Diabetes Foot Care Audit (NDFA) Are services providing effective diabetes foot care? England and Wales, 2018–23 Published 9 May 2024	3	0	0	0	0	**No actions required** All recommendations ongoing within the service.
RHEUM/CA/2022/23/01	National Early Inflammatory Arthritis Audit (NEIAA) Year 5 State of the Nation Report	6	1	1	0	0	**Completed**
GS/CA/2022-23/01	National Oesophago-Gastric Cancer Audit 2021 - An audit of the care received by people with Oesophago Gastric Cancer in England and Wales	5	5	2	3 **Unable to Complete**	0	**Closed** Action closed as delivery relates to a tertiary service and pathway outside ABUHB's direct remit and control. There are no further actions that can reasonably be progressed by the Clinical Lead within ABUHB.

Audit code	Audit title	Recommendations identified	Actions agreed	Actions completed	Actions closed	Actions ongoing	Overall governance status
GS/CA/2022-23/06	National Oesophago-Gastric Cancer Audit 2022 An audit of the care received by people with oesophagogastric cancer in England and Wales 1 April 2019 – 31 March 2021	5	1	0	1 **Unable to Complete**	0	**Closed** Action closed as delivery relates to a tertiary service and pathway outside ABUHB's direct remit and control. There are no further actions that can reasonably be progressed by the Clinical Lead within ABUHB.
PD/CA/2022-23/01	National Paediatric Diabetes Audit (NPDA) Report on Care and Outcomes 2022/23	6	5	5	0	0	**Completed**
GS/CA/2022-23/03	National Prostate Cancer Audit - Annual Report 2022 Prostate Cancer services during the COVID-19 Pandemic (published January 2023)	19	2	2	0	0	**Completed**
GS/CA/2022-23/09	NELA - Ninth Patient Report of the National Emergency Laparotomy Audit (NELA)	5	2	2	0	0	**Completed**
UROL/CA/2022-23/03	National Prostate Cancer Audit (NPCA) State of the Nation Report - An audit of the care received by people with prostate cancer in England and Wales from 01/01/2019 to 31/01/2023 Published January 2024	6	1	0	**1** **Unable to Complete**	0	**Closed** Business case required added to action tracker in AMaT

Audit code	Audit title	Recommendations identified	Actions agreed	Actions completed	Actions closed	Actions ongoing	Overall governance status
AUDIOLOGY/CA/2022-23/01	Report on the 2022 National Audit of Quality Standards for Adult Hearing Rehabilitation Audiology (Wales)	2	2	0	2	0	**Closed** Business case required added to action tracker in AMaT
AS/CA/2022-23/01	SSNAP Annual Report 2023 - State of the Nation Sentinel Stroke National Audit Programme Stroke care received between April 2022 to March 2023	5	4	1	3 **Unable to Complete**	0	**Closed** Ongoing assurance provided at Stroke Board
T&O/CA/2022-23/03	The National Hip Fracture Database report on 2021 - Improving Understanding	11	11	11	0	0	**Completed**

Year total: 100 recommendations; 70 actions agreed; 62 completed; 8 closed; 0 ongoing.

Audit year: 2023-24

Audit code	Audit title	Recommendations identified	Actions agreed	Actions completed	Actions closed	Actions ongoing	Overall governance status
Cardio/CA/2023-24/01	National Audit of Percutaneous Coronary Intervention (NAPCI) Data from April 2021-March 2022 Published June 2023	4	4	1	3	0	**Closed** Business case required added to action tracker in AMaT
Primary Care/CA/2023-24/01	National Diabetes Audit 2021-22, Report 1: Care Processes and Treatment Targets	3	4	4	0	0	**Completed**
Rheum/CA/2023-24/01	National Early Inflammatory Arthritis Audit (NEIAA) State of the Nation Summary Report 2024 Data Collection Period: 1 April 2023 – 31 March 2024 Year 6	1	0	0	0	0	**No actions required**
Neonates/CA/2023-24/01	National Neonatal Audit Programme (NNAP) Summary report on 2022 data	5	2	1	1	0	**Closed** Action closed as delivery relates to a tertiary service and pathway outside ABUHB's direct remit and control. There are no further actions that can reasonably be progressed by the Clinical Lead within ABUHB.
Vasc/CA/2023-24/01	National Vascular Registry State of the Nation Report 2023 Results for patients who had vascular procedures during 2022 in NHS hospitals in England, Wales, Scotland and Northern Ireland	5	5	4	1	0	**Closed** Action closed as delivery relates to a tertiary service and pathway outside ABUHB's direct remit and control. There are no further actions that can reasonably be progressed by the Clinical Lead within ABUHB.

Audit code	Audit title	Recommendations identified	Actions agreed	Actions completed	Actions closed	Actions ongoing	Overall governance status
T&O/CA/2023-24/08	The National Hip Fracture Database Report on 2022 - 15 years of quality improvement	5	8	8	0	0	**Completed**

Year total: 23 recommendations; 23 actions agreed; 18 completed; 5 closed; 0 ongoing.

Audit year: 2024-25

Audit code	Audit title	Recommendations identified	Actions agreed	Actions completed	Actions closed	Actions ongoing	Overall governance status
GS/CA/2024-25/01	[Planned re-audit: 25/07/2024] An audit of care received by patients diagnosed with Lung Cancer in England and Wales during 2022 - State of the Nation Report 2024 Published April 2024 - Summary	5	4	4	0	0	**Completed**
Vasc/CA/2024-25/01:	2024 NVR State of the Nation Report	7	0	0	0	0	**No actions required**
Paediatrics/CA/2024-25/03	Epilepsy12 - 2024 combined organisational and clinical audits: Report for England and Wales	5	0	0	0	0	**No actions required**
Med/CA/2024-25/01	Fracture Liaison Service Database (FLS-DB) Annual report - You've had a fracture; how can we prevent another?	5	2	2	0	0	**Completed**
Maternity/CA/2024-25/10	MBRRACE-UK - Perinatal mortality surveillance 2024 - State of the nation report - UK perinatal deaths of babies born in 2022	9	9	9	0	0	**Completed**
Maternity/CA/2024-25/09	MBRRACE-UK - Saving Lives, Improving Mothers' Care - State of the Nation report 2025 - Summary	3	0	0	0	0	**No actions required**
COTE/CA/2024-25/12	National Audit of Dementia - Care in General Hospitals 2023-24: Round 6 Audit Report - Published December 2024 - Summary	3	0	0	0	0	**No actions required**
GS/CA/2024-25/16	National Audit of Metastatic Breast Cancer (MBC) - State of the Nation Report 2024	5	3	3	0	0	**Completed**
GS/CA/2024-25/15	National Audit of Primary Breast Cancer - State of the Nation Report 2024 An audit of care received by people diagnosed with primary breast cancer in England and Wales during 2019-2021 Published September 2024 - Summary	5	5	5	0	0	**Completed**

Audit code	Audit title	Recommendations identified	Actions agreed	Actions completed	Actions closed	Actions ongoing	Overall governance status
GS/CA/2024-25/24	National Bowel Cancer Audit - State of the Nation Report An audit of care received by people with bowel cancer in England and Wales focusing on people diagnosed between 1 April 2022 and 31 March 2023. - Summary	7	4	4	0	0	**Completed**
Pysc/CA/2024-25/01	National Clinical Audit of Psychosis - Early Intervention in Psychosis Audit 2021/2022 - National Report for Wales - Summary	6	6	6	0	0	**Completed**
Podiatry/CA/2024-25/01	National Diabetes Foot Care Audit (NDFA) - Are services providing effective diabetes foot care? England and Wales, 2018–23 Published 9 May 2024 - Summary	3	0	0	0	0	**No actions required**
Rheum/CA/2024-25/01	National Early Inflammatory Arthritis Audit (NEIAA) State of the Nation Summary Report 2024	5	1	1	0	0	**Completed**
Neonates/CA/2024-25/01	National Neonatal Audit Programme (NNAP 2024) Summary Report 2023 data - Summary	5	0	0	0	0	**No actions required**
GS/CA/2024-25/05	National Oesophago-Gastric Cancer Audit - State of the Nation Report An audit of the care received by people with oesophago-gastric cancer in England and Wales 1 April 2020 – 31 March 2022 Published January 2024 - Summary	5	0	0	0	0	**No actions required**

Audit code	Audit title	Recommendations identified	Actions agreed	Actions completed	Actions closed	Actions ongoing	Overall governance status
Gynaecology/CA/2024-25/01	National Ovarian Cancer Audit - State of the Nation Report 2024	6	3	3	0	0	**Completed**
PD/CA/2024-25/01	National Paediatric Diabetes Audit (NPDA) 2025 Report on Care and Outcomes 2023/24 - Summary	6	1	0	1 **Unable to complete**	0	Business case required added to action tracker in AMaT.
GS/CA/2024-25/30	National Pancreatic Cancer Audit State of the Nation Report 2024 Published September 2024 - Summary	5	5	5	0	0	**Completed**
Obs/CA/2024-25/05	National Pregnancy in Diabetes Audit Report 2023 - Summary	0	0	0	0	0	No recommendations were identified by NPID.
Primary Care/CA/2024-25/07	National Respiratory Audit Programme (NRAP) Wales Primary Care Clinical Audit Report 2021–23 Publication year: 2024 - Summary	7	7	6	1 **Unable to complete**	0	**Closed**
Paediatrics/CA/2024-25/04	National Respiratory Audit Programme (NRAP) - Breathing well - An assessment of respiratory care in England and Wales - PAEDIATRIC ASTHMA Published June 2025 - Action plan	5	3	3	0	0	**Completed**
Vasc/CA/2024-25/02	National Vascular Registry State of the Nation Report 2025 An audit of care received by people who had vascular procedures during 2024 in NHS hospitals in England, Wales, Scotland and Northern Ireland. Published 13/11/25	1	1	1	0	0	**Completed**
Gynaecology/CA/2024-25/05	NCEPOD - Endometriosis: A Long and Painful Road - A review of the quality of care provided to adult patients diagnosed with endometriosis - Action plan	8	7	5	0	2	**Ongoing**

Audit code	Audit title	Recommendations identified	Actions agreed	Actions completed	Actions closed	Actions ongoing	Overall governance status
GS/CA/2024-25/02	NCEPOD - Twist and Shout – Testicular Torsion - Summary	8	1	1	0	0	**Completed**
T&O/CA/2024-25/16	The National Hip Fracture Database Report on 2023 data - A broken hip – three steps to recovery - Using the National Hip Fracture Database to understand and improve hip fracture care in 2024 - Action plan	7	7	3	4 **Unable to complete**	0	**Closed** Business case required added to action tracker in AMaT.

Year total: 131 recommendations; 69 actions agreed; 61 completed; 6 closed; 2 ongoing.

Audit year: 2025-26 - Actions from audits completed within the previous 12 months may remain ongoing while implementation and evidence of sustained improvement are completed; these should not be interpreted as overdue or unaddressed.

Audit code	Audit title	Recommendations identified	Actions agreed	Actions completed	Actions closed	Actions ongoing	Overall governance status
Paediatrics/CA/2025-26/03	Epilepsy12 2025 combined Organisational and Clinical Audits: Report for England and Wales Clinical Cohort 6 – The first year of care for children and young people following a first paediatric assessment undertaken between 1 December 2022 and 30 November 2023 - Summary	5	2	1	1 **Unable to complete**	0	**Closed** Business case required added to action tracker in AMaT.
Med/CA/2025-26/04	Fracture Liaison Service Data Base - (FLS-DB) - Steps to fracture liaison service effectiveness: importance of treatment recommendations Data 01/01/2024 - 31/12/2024 Published Jan 2026 - Summary	5	5	2	0	3	**Ongoing**
Cardio/CA/2025-26/03	Management of Heart Attack: Myocardial Ischemia National Audit Project (MINAP) – 2025 Annual Report data up to 2023/2024	4	2	0	0	2	**Ongoing**
Cardio/CA/2025-26/04	National Audit of Cardiac Rhythm Management (NACRM) Annual Report 2025 Published December 2025 - Summary	6	6	1	1 **Unable to complete**	4	**Ongoing**

Audit code	Audit title	Recommendations identified	Actions agreed	Actions completed	Actions closed	Actions ongoing	Overall governance status
GS/CA/2025-26/11	National Audit of Metastatic Breast Cancer - State of the Nation Report – 2025 An audit of care received by people diagnosed with metastatic breast cancer between 1 January 2020 and 31 December 2022 in England and Wales - Summary	7	7	1	0	6	**Ongoing**
Cardio/CA/2025-26/05	National Audit of Percutaneous Coronary Intervention (NAPCI) Data up to 2024/25 Published April 2025 - Summary	4	4	2	1 **Unable to complete**	1	**Ongoing**
GS/CA/2025-26/12	National Audit of Primary Breast Cancer - State of the Nation Report 2025 An audit of care received by people diagnosed with primary breast cancer between 1 January 2020 and 31 December 2022 in England and Wales. - Action plan	7	7	2	0	5	**Ongoing**
GS/CA/2025-26/13	National Bowel Cancer Audit - State of the Nation Report An audit of care received by people with bowel cancer in England and Wales focusing on people diagnosed between 1 January 2023 and 31 December 2023. Published October 2025 - Summary	5	5	4	0	1	**Ongoing**
Cardio/CA/2025-26/02	National Heart Failure Audit (NHFA) 2025 Annual Report – Data up to 2023/2024 Published April 2025 - Summary	8	16	8	1 **Unable to complete**	7	**Ongoing**

Audit code	Audit title	Recommendations identified	Actions agreed	Actions completed	Actions closed	Actions ongoing	Overall governance status
Med/CA/2025-26/05	National Lung Cancer Audit - State of the Nation 2025 - An audit of care received by people diagnosed with lung cancer in England and Wales during 2023 Published April 2025 - Summary	7	7	4	0	3	**Ongoing**
GS/CA/2026-27/01	National Lung Cancer Audit - State of the Nation 2026 - An audit of care received by people diagnosed with lung cancer between 1 January 2024 to 31 December 2024 in England and Wales Published 12/02/26 - Summary	7	0	0	0	0	**No actions required**
Maternity/CA/2025-26/04	National Maternity & Perinatal Audit – State of the Nation Report based on births in NHS maternity services during 2023 - Published September 2025 - Summary	5	6	3	0	3	**Ongoing**
Neonates/CA/2025-26/01	National Neonatal Audit Programme (NNAP) Summary report on 2024 data - October 2025 - Summary	8	2	0	0	2	**Ongoing**
Haematology/CA/2025-26/02	National Non-Hodgkin Lymphoma Audit- State of the Nation Report 2024	5	0	0	0	0	**No actions required**
Haematology/CA/2025-26/01	National Non-Hodgkin Lymphoma Audit- State of the Nation Report 2024	3	1	1	0	0	**Completed**
Haematology/CA/2025-26/03	National Non-Hodgkin Lymphoma Audit- State of the Nation Report 2025	2	2	1	0	1	**Ongoing**
GS/CA/2025-26/14	National Oesophago-Gastric Cancer Audit (NOGCA) - State of the Nation Report 2025 Version 2	6	2	1	0	1	**Ongoing**
Gynaecology/CA/2025-26/04	National Ovarian Cancer Audit - State of the Nation Report 2025 Published 11/09/25 - Summary	0	0	0	0	0	**No recommendations recorded**

Audit code	Audit title	Recommendations identified	Actions agreed	Actions completed	Actions closed	Actions ongoing	Overall governance status
PD/CA/2025-26/02	National Paediatric Diabetes Audit (NPDA) Report on Care and Outcomes 2024/25 Published 12/03/26	5	4	0	0	4	**Ongoing**
GS/CA/2024-25/29	National Pancreatic Cancer Audit State of the Nation Report 2025 Published 11/09/2025	0	0	0	0	0	**No recommendations recorded**
Vasc/CA/2025-26/03	National Vascular Registry State of the Nation Report 2025	2	0	0	0	0	**No actions required**
GS/CA/2025-26/10	NELA - Tenth Patient Report of the National Emergency Laparotomy Audit April 2023 to April 2024	7	3	1	0	2	**Ongoing**
Paediatrics/CA/2025-26/05	Room to breathe - KPI over time: children and young people asthma	7	7	5	0	2	**Ongoing**
MH&LD/CA/2025-26/03	The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)	6	4	0	0	4	**Ongoing**
COTE/CA/2025-26/14	The National Hip Fracture Database Report on 2024 data - Room for Improvement: hip fracture care in 2024 – a report from the National Hip Fracture Database (NHFD) January 2024 – December 2024 Published September 2025 - Summary	5	5	1	0	4	**Ongoing**

Year total: 126 recommendations; 97 actions agreed; 38 completed; 7 closed; 52 ongoing.

Audit year: 2026-27

Audit code	Audit title	Recommendations identified	Actions agreed	Actions completed	Actions closed	Actions ongoing	Overall governance status
No audits have been through the governance process - data unavailable.							

Year total: 0 recommendations; 0 actions agreed; 0 completed; 0 closed; 0 ongoing.

Agenda Item:

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	24 November 2026
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Corporate Clinical Audit Framework and Annual Corporate Clinical Audit Plan 2026/27
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Dr Seema Srivastava, Executive Medical Director
SWYDDOG ADRODD: **REPORTING OFFICER:**	Leeanne Lewis, Assistant Director for Quality & Patient Safety

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

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this paper is to present the Corporate Clinical Audit Framework and Annual Corporate Clinical Audit Plan 2026/27 to the Audit, Risk and Assurance Committee for scrutiny and assurance. This can be found as an Appendix.

The Framework establishes a consistent, risk-informed approach to the selection, prioritisation, delivery, reporting and follow-up of Corporate Clinical Audit across Aneurin Bevan University Health Board. It brings together the enduring governance framework and the proposed 2026/27 Corporate Clinical Audit Plan within a single controlled document.

The Framework positions Corporate Clinical Audit as a systematic quality-improvement process that measures clinical practice against explicit standards, identifies variation and non-compliance, supports improvement action and uses re-audit or another agreed follow-up method to establish whether improvement has been achieved and sustained. It also makes clear that Corporate Clinical Audit

informs organisational assurance but does not provide an independent audit opinion equivalent to Internal Audit, Audit Wales or Healthcare Inspectorate Wales.

The proposed 2026/27 plan contains the planned Corporate Clinical Audits, with two additional audits identified for consideration should capacity become available. The programme remains subject to formal approval, final clinical scoping and verification of relevant risk references and mandatory requirements.

The Annual Plan should therefore be understood as a firm commitment for 2026/27 within an iterative planning framework, rather than as a fixed year on year programme. The Health Board is keen to make visible the full quantum of corporate audit requirements and potential demand; however, it would not be credible to determine in detail every audit that should be undertaken over an extended period. Priorities will change as new risks, incidents, mortality intelligence, complaints, claims, external reviews, national findings and other Quality Management System intelligence emerge.

The longer-term direction is aligned with the Health Board's digital strategy and wider transformation, providing an opportunity to embed best practice and evidence-based standards within the digital health record. Over time, this could enable more automated capture and extraction of audit information, reducing reliance on manual review.

Corporate Clinical Audit is therefore expected to evolve substantially over the next few years, with greater use of digital assurance and more timely intelligence, and less reliance on retrospective manual review of case notes.

Cefndir / Background

The Health Board requires a clear and consistent approach to Corporate Clinical Audit so that finite audit capacity is directed towards areas of greatest clinical, organisational and patient-safety significance.

The Framework has been developed to:

- focus corporate audit capacity on issues of corporate significance and cross-organisational concern;
- complement, but not replace, Local and Divisional Clinical Audit or mandatory participation in National Clinical Audits;
- establish a transparent Corporate Clinical Audit Universe;
- introduce a structured, weighted and risk-informed prioritisation methodology;
- clarify Executive, clinical, service and corporate responsibilities;
- define the full audit lifecycle, from proposal and scoping through to action monitoring, evidence-based closure and re-audit;
- strengthen the reporting and escalation of significant findings, persistent non-compliance and overdue actions; and

- ensure that reporting demonstrates what was found, what changed and whether improvement has been sustained.

The governance model retains clinical ownership and responsibility for improvement actions within the relevant Division, Directorate or service. The Corporate Clinical Audit Team coordinates methodology, programme delivery, reporting, action monitoring and escalation. Routine management oversight is proposed through the Quality Management Group, while PQSOC will scrutinise material findings, patient impact, improvement action and evidence of sustained change.

The Framework also proposes twice-yearly reporting to the Audit, Risk and Assurance Committee on programme delivery, performance, risks and the governance of the Corporate Clinical Audit Programme. The precise routine oversight route between the Clinical Standards and Effectiveness Group and the Quality Management Group, together with the formal approval route for the Framework and Annual Plan, requires confirmation before final approval.

The Framework represents a positive step towards a more systematic, transparent and risk-informed approach to Corporate Clinical Audit. Over the next 12 months, it will guide the development and refinement of the Corporate Clinical Audit Universe, establishing a stronger foundation for audit planning and assurance. The initial Universe will be tested and refined rather than treated as complete or fixed. The priorities will be to:

- Refine the Corporate Clinical Audit Universe to identify the range of topics that may require corporate audit.
- Apply the risk-based scoring methodology to prioritise potential audit topics transparently and consistently.
- Define a firm annual programme setting out the audits the Health Board commits to delivering.
- Develop an indicative forward look that provides visibility of potential future audit areas while allowing priorities to change.
- Undertake an annual dynamic assessment, drawing on incidents, mortality, complaints, claims, Healthcare Inspectorate Wales and Audit Wales findings, risk registers, national audit findings and wider Quality Management System intelligence to keep the Universe and priorities relevant.
- Assess the resources required to deliver the programme against available capacity, making any shortfall explicit.

Together, these priorities provide assurance that a structured approach is being established to align corporate audit activity with risk and capacity. They do not imply that the Audit Universe is complete or that all identified audit needs can yet be met. Progress over the next 12 months will focus on strengthening this foundation, supported by an annual refresh of the Universe and forward look, with material programme changes documented through the agreed governance route.

Asesiad / Assessment

The framework provides:

A clearer and more robust governance framework has been established. The Framework defines the respective responsibilities of the Executive Medical Director, Assistant Director for Quality and Patient Safety, Corporate Clinical Audit Team, Executive sponsors, clinical leads, services and action owners. It confirms that responsibility for operational improvement remains with the relevant service and is not transferred to the Corporate Clinical Audit Team through audit registration or reporting.

The proposed programme is explicitly risk-informed. Potential audit topics will be assessed against patient safety, serious incidents and complaints, statutory or regulatory requirements, performance concerns, Executive or Committee requests, evidence gaps, national priorities, external review findings, corporate or strategic risks, previous audit results and the time elapsed since the previous audit. Greater weighting is applied to patient safety, mandatory requirements and material organisational

The scoring methodology supports transparent decision-making but does not replace professional judgement. Audit topics are scored against 11 criteria, producing a priority score out of 100. Scores will inform programme selection alongside the suitability of Clinical Audit as the methodology, the availability of measurable standards, the reliability of intelligence, potential duplication, data feasibility, capacity, dependencies, re-audit commitments and emerging risks. Any departure from the ranked order will require a documented rationale and approval through the agreed governance route.

The proposed core programme provides a minimum of ten Corporate Clinical Audits for 2026/27. The planned topics are Decision Making and Consent; DNACPR; NG Tube; Coroner Discharge Notifications; Coroner Death Notifications; Seven-day Rolling Re-admission Rate; Consent for Blood Transfusion; Medicines Documentation and Storage in Mental Health; Learning from Serious Incidents in Neonates; and the Deteriorating Patient.

The programme reflects known quality, safety and assurance priorities. The proposed audits include areas linked within the draft to legal or mandatory requirements, Healthcare Inspectorate Wales findings, external scrutiny, evidence gaps and corporate risks outside appetite. However, the Framework appropriately requires risk reference numbers and any description of an audit as mandated to be verified against current sources before approval. Additional audits can be identified, if there is capacity to undertake these.

Audit completion will no longer be defined solely by the issue of a report. Completion requires proportionate improvement actions, named owners, agreed

dates, evidence-based closure and re-audit or another agreed follow-up method where appropriate. Actions will be reported as open, in progress, overdue, reprofiled, awaiting evidence or closed under defined closure categories.

The escalation arrangements are proportionate to clinical significance. Significant findings, including failure against critical standards, actual or potential serious harm, statutory or regulatory non-compliance, widespread failure or repeated failure despite previous action, will require prompt notification, immediate safety measures where necessary, a SMART improvement plan and escalation to PQSOC where material.

The Framework has a clear person-centred and equitable focus. Audit scoping and interpretation will consider patient experience, accessibility, equality, Welsh-language needs and variation between populations where relevant. The Audit Universe includes safe, effective, equitable, person-centred, timely and efficient care.

There are risks to successful delivery. These include limited corporate or clinical capacity, poor data access or quality, unclear ownership, competing urgent requests, weak evidence supporting action closure, failure to undertake re-audit, duplication with other review activity, information-governance failure and ambiguity in governance routes. The Framework sets out corresponding controls, including annual capacity assessment, core and reserve programmes, named owners, evidence-based closure, early data testing, controlled reprioritisation and escalation through established governance arrangements.

Overall, the Framework provides a more systematic and transparent basis for Corporate Clinical Audit. It strengthens the connection between audit selection, organisational risk, clinical ownership, improvement action, evidence-based closure and sustained impact. The proposed governance arrangements also give PQSOC a clearer basis on which to scrutinise material findings, patient impact and whether agreed improvements have been implemented and sustained.

Next steps:

- **Strengthening planning over the next 12 months.** The Framework will guide work to refine the Audit Universe, apply the risk-based scoring methodology and assess delivery capacity. This will distinguish the firm annual programme from wider potential demand, making audit coverage, assurance gaps and resource shortfalls explicit. It will support transparent decisions about prioritisation, deferral, commissioning, digital solutions and resource needs, while establishing a credible planning process rather than treating the initial Universe as complete or fixed. This will form part of the organisation's Quality Planning in the Quality Management System.

- **Maintaining direction and developing the schedule.** Clinical priorities, organisational risks, external requirements, available data and digital

capability will change both what needs to be audited and how audits are undertaken. The approach will therefore combine a firm annual programme with an indicative forward look and annual dynamic reassessment. This retains longer-term visibility while allowing priorities and methods to evolve; material programme changes and their rationale will be documented through the agreed governance route.

- **Preparing for digitally enabled audit.** As the Health Board moves to a digital patient record, Corporate Clinical Audit will develop alongside it. The aim is to design evidence-based best-practice standards into structured clinical documentation from the outset, so that recording care also captures the information needed to assess compliance. As this capability develops, audit information could be extracted digitally from electronic case notes, reducing reliance on retrospective manual review and providing more timely evidence of variation and improvement. The ambition is that, in five years' time, audit will look materially different from today. Planning will therefore be refined as digital capability develops, with the pace and benefits dependent on implementation, data quality and the ability to extract reliable audit information.

- **Demonstrating progress and strengthening assurance.** The proposed twice-yearly reports to ARAC will demonstrate progress in translating the Framework into practice, bringing together developments in the Audit Universe, prioritisation, annual and forward planning, capacity and digital readiness, alongside programme delivery, risks and governance. This will give the Committee a clearer view of audit coverage, the strengthening of planning and the actions needed to build further assurance. The Framework represents a positive step forward, providing a clear direction for the next 12 months and a foundation for an increasingly responsive, risk-informed and digitally enabled approach to Corporate Clinical Audit.

Argymhelliad / Recommendation

The Committee is asked to:

- **NOTE** the development of the draft Corporate Clinical Audit Framework and the proposed Annual Corporate Clinical Audit Plan 2026/27.
- **SUPPORT** the principles and governance arrangements set out within the Framework, including risk-informed prioritisation, clear clinical ownership, SMART improvement actions, evidence-based closure and re-audit or alternative follow-up where appropriate.
- **RECEIVE ASSURANCE** that the proposed Framework establishes a structured approach through which Corporate Clinical Audit findings, material non-compliance, associated patient-safety risks, improvement actions and evidence of sustained change will be monitored and escalated.

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):	2.1 Managing Risk and Promoting Health and Safety 2.6 Medicines Management 2.9 Medical Devices, Equipment and Diagnostic Systems 3.1 Safe and Clinically Effective Care
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Getting it right for children and young adults Adults in Gwent live well healthily and age well
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prrioritise areas where evidence shows take up of services is lower or outcomes are worse 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:	Clinical Standards and Effectiveness Group

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**	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/	Involvement - The importance of involving people with an interest in achieving the well-being goals, and ensuring that those people reflect the diversity of the area which the body serves Choose an item.

Corporate Clinical Audit Framework

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Annual Corporate Clinical Audit Plan 2026/27

This document combines the enduring governance framework with the annually refreshed Corporate Clinical Audit Plan.

Appendix E may be updated annually through the approved governance route without rewriting the whole Framework.

Contents:

Executive Summary
1. Introduction
2. Purpose and Scope
3. Strategic Alignment and Principles
4. Governance, Accountability and Responsibilities
5. Corporate Clinical Audit Universe
6. Developing the Annual Corporate Clinical Audit Programme
7. Corporate Clinical Audit Delivery Lifecycle
8. Findings, Improvement Actions and Follow-Up
9. Reporting, Escalation and Learning
10. Programme Management, Resources and Capacity
11. Digital Systems, Data Quality and Information Governance
12. Key Performance Indicators and Measures of Impact
13. Risks to Delivery and Mitigating Actions
14. Annual Programme Review
15. Conclusion
16. References
17. Appendices

Appendix A: Roles and Responsibilities Matrix

Appendix B: Corporate Clinical Audit Universe

Appendix C: Prioritisation and Scoring Methodology

Appendix D: Glossary

Appendix E: Annual Corporate Clinical Audit Plan 2026/27

EXECUTIVE SUMMARY

Corporate Clinical Audit is a systematic quality-improvement process that measures clinical practice against explicit standards, identifies variation and non-compliance, supports improvement action and uses re-audit or another agreed follow-up method to determine whether improvement has been achieved and sustained.

The Framework:

- Focuses finite corporate capacity on matters of organisational significance and cross-Health Board concern;
- Complements, but does not replace, Local or Divisional Clinical Audit and mandatory National Clinical Audit participation;
- Establishes a transparent Audit Universe and risk-informed prioritisation process;
- Clarifies clinical ownership, action ownership and corporate coordination;
- Defines the complete lifecycle from proposal and approval to evidenced closure and follow-up;
- Establishes the approved digital system as the definitive programme record; and,
- Requires reporting to demonstrate what was found, what changed and whether improvement was sustained.

1. INTRODUCTION

The Health Board requires a consistent approach to selecting, delivering, reporting and following up Corporate Clinical Audit. This Framework establishes the methodology, governance, accountability and risk-based planning arrangements for the corporate programme.

Corporate Clinical Audit examines matters of organisational significance where consistent measurement is required across services, Divisions, sites or professional boundaries.

Success is not measured by participation or report production alone. It requires reliable evidence, clear ownership, implementation of improvement actions and

proportionate follow-up that demonstrates impact on practice and patient care.

2. PURPOSE AND SCOPE

2.1 Purpose

The purpose of Corporate Clinical Audit is to improve the quality and safety of care by:

- Evaluating practice against recognised standards,
- Identifying required improvement, supporting implementation and determining whether change has been achieved and sustained;
- Measure compliance with explicit clinical standards;
- Identify unwarranted variation, risk, non-compliance and good practice;
- Provide evidence for quality management, clinical governance and organisational decision-making;
- Support review of strategic and corporate risks and patient-safety priorities;
- Produce SMART actions with named owners, dates and evidence requirements;
- Monitor, escalate and evidence closure of actions; and
- Share learning and good practice across services.

2.2 Scope and Boundaries

Corporate Clinical Audit focuses on matters of corporate significance. It may examine an issue across more than one Division, Directorate, site, pathway or service; respond to a material quality or patient-safety concern; or provide consistent measurement where a Health Board-wide view is required.

It does not remove responsibility from services for local governance, clinical ownership, action delivery or participation in National Clinical Audit.

Activity	Primary purpose	Governance boundary
Corporate Clinical Audit	Measurement against explicit standards for a matter of corporate significance.	Coordinated by the Corporate Clinical Audit Team; clinical ownership and action delivery remain with the relevant service.

Activity	Primary purpose	Governance boundary
Local / Divisional Clinical Audit	Measurement against standards to improve care within a service, Directorate or Division.	Authorised and governed locally. Registration does not transfer ownership to the corporate team.
National Clinical Audit	Participation in a nationally specified audit or outcome-review programme.	National methodology applies; local participation, data quality, action and governance remain necessary.
Service evaluation	Assesses how well a current service is operating, without necessarily testing explicit external standards.	Managed through the relevant service and governance arrangements.
Quality improvement	Tests and implements changes intended to improve care.	Owned by the service or improvement programme; audit may identify need or measure impact.
Research	Generates new, generalisable knowledge.	Governed through Research and Development and ethics arrangements where applicable.
Independent assurance	Independent review of governance, risk management and control.	Outside Corporate Clinical Audit and may provide formal assurance opinions.

Classification will be determined by the activity's primary purpose, scope, methodology and governance requirements. Advice must be sought before work begins where classification is uncertain.

3. STRATEGIC ALIGNMENT AND PRINCIPLES

Corporate Clinical Audit forms part of the Health Board's Quality Management System and aligns with the:

- Duty of Quality;
- Quality Strategy;
- Integrated Medium-Term Plan; and,

- Risk-management arrangements.

Alignment will be evidenced for each audit and will not be described as legal or regulatory compliance unless the applicable requirement has been verified.

Principle	Requirement
Person-centred and equitable	Consider patient experience, accessibility, equality, Welsh-language needs and relevant population variation.
Standards-based	Use explicit, accepted criteria and define the expected level of compliance.
Risk-informed and proportionate	Reflect clinical significance, evidence gaps, feasibility and available capacity.
Clinically owned	Identify an Executive sponsor and clinical/service lead; services retain ownership of actions.
Transparent	Record selection decisions, methodology, limitations, findings, actions and closure evidence.
Improvement-focused	Seek safer, more effective and consistent care, not simply completion of a report.
Evidence-led	Use validated data, report limitations and avoid unsupported conclusions.
Complete-cycle	Require action, evidence-based closure and follow-up or re-audit where appropriate.
Clear assurance boundary	Inform assurance without issuing an independent assurance rating.

4. GOVERNANCE, ACCOUNTABILITY AND RESPONSIBILITIES

4.1 Accountability

The Executive Medical Director is accountable for ensuring appropriate Clinical Audit arrangements are in place.

The Assistant Director for Quality and Patient Safety provides senior operational leadership.

The Corporate Clinical Audit Team coordinates the programme.

The audited Division, Directorate or service retains clinical ownership and responsibility for implementing and evidencing actions.

4.2 Assurance model

Level	Role
Service and Divisional ownership	Identify local requirements, deliver Local and Divisional audits, participate in National Clinical Audits, review findings, implement actions, evidence impact, manage associated risks and escalate significant themes.
Corporate oversight and challenge	Set minimum requirements; coordinate the corporate programme; monitor participation, findings, actions and re-audit; assess information quality; triangulate themes with wider quality and risk intelligence; and escalate systemic concerns.
Independent assurance	Internal Audit, Audit Wales, Healthcare Inspectorate Wales and other independent bodies may assess the adequacy and effectiveness of the Clinical Audit system and related controls.

4.3 Governance and Reporting Route

Each audit will be reported to the governance forum best placed to scrutinise its subject matter, findings and improvement plan. The reporting route will be agreed in the audit protocol and aligned with the Quality Management Framework.

Area / Forum	Responsibilities
Audited service or Division	Owns the response, actions, evidence and related risk management.
Clinical Standards and Effectiveness Group	Scrutinises clinical standards, clinical-effectiveness findings and learning where within its remit.
Quality Management Group	Provides routine management oversight of programme delivery, themes, actions and risks.
Patient Quality, Safety and Outcomes Committee	Scrutinises material findings, patient impact and sustained improvement.
Audit, Risk and Assurance Committee	Receives periodic assurance on the adequacy, delivery and governance of the Corporate Clinical Audit system; it is not part of the routine operational reporting chain.
Board	Receives material escalations and organisational assurance through the approved committee architecture.

Further detail is set out in Appendix A.

5. CORPORATE CLINICAL AUDIT UNIVERSE

The Corporate Clinical Audit Universe at Appendix B identifies potential areas for corporate audit across the six Duty of Quality domains. It is the population from which priorities may be selected and is distinct from the Annual Corporate Clinical Audit Plan.

Inclusion in the Universe does not mean that every topic requires a separate audit, annual review or corporate response. A topic will be considered for the annual programme only where Clinical Audit is an appropriate method and explicit standards and measurable data are available. Topics have one primary domain for counting and planning purposes; relevant secondary domains may be recorded during scoping.

The Universe will be reviewed at least annually and when a material new concern emerges. Changes will reflect current risks, standards, audit findings, evidence

gaps, national requirements and organisational priorities.

6. DEVELOPING AND PRIORITISING THE ANNUAL PROGRAMME

6.1 Sources of Intelligence

Source	Examples
Strategic and planning frameworks	IMTP, Welsh Government priorities, Health Board objectives and Duty of Quality priorities.
Risk profiles	Strategic and Corporate Risk Registers and material Divisional or Directorate risks.
Standards and guidance	National clinical standards, NICE guidance, professional standards and National Clinical Audit requirements.
Independent findings	Audit Wales, Internal Audit, Healthcare Inspectorate Wales, Welsh Risk Pool and other external reviews.
Clinical governance intelligence	Incidents, mortality, complaints, claims, patient experience, performance and emerging themes.
Requests and evidence gaps	Executive or Committee requests and absence, weakness or age of evidence that standards are being achieved.

6.2 Prioritisation Methodology

Potential topics will be scored against the 11 weighted criteria in Appendix C.

Each criterion is scored from 0 to 5 and multiplied by its weighting. The weighted total is converted to a score out of 100 to provide a transparent basis for comparison.

The score informs, but does not solely determine, inclusion. The Corporate Clinical Audit Team will also assess:

- Whether Clinical Audit is the appropriate method;

- Availability of explicit standards and reliable data;
- Duplication with existing Local, Divisional, National or independent review activity;
- Corporate Clinical Audit Team and service capacity;
- Feasibility, dependencies and timing;
- Existing re-audit commitments; and
- The need to respond to urgent or emerging risk.

Scores will be moderated through a multidisciplinary process. Any decision to include a lower-scoring topic, defer a higher-scoring topic or depart from ranked order will have a documented rationale and approval through the agreed governance route.

6.3 Determining Programme Coverage and Size

The size of the Annual Corporate Clinical Audit Plan will be informed by the prioritised Audit Universe, rather than being determined solely by a fixed annual target.

Following scoring and moderation, topics will be grouped according to their relative priority. Consideration will then be given to the appropriate review cycle for each topic, taking account of:

- the significance and immediacy of the risk;
- the strength, scope and age of existing assurance;
- previous Clinical Audit findings and evidence of sustained improvement;
- statutory, regulatory or national requirements;
- emerging quality and patient-safety concerns;
- whether Corporate Clinical Audit is the most appropriate methodology; and
- the availability and reliability of standards and data.

This assessment will be used to estimate the level of annual audit coverage required across the Universe. It will be considered alongside existing re-audit commitments, urgent or emerging priorities, work carried forward from the previous year and the capacity of the Corporate Clinical Audit Team and participating services.

The proposed Annual Plan will state:

- the number of new corporate audits proposed;

- the number of re-audits and follow-up reviews required;
- the priority profile of the selected topics;
- the proportion of the eligible Audit Universe receiving coverage;
- any higher-priority topics not included and the reason for deferral; and
- any gap between the assessed level of audit need and available capacity.

The 2026/27 Corporate Clinical Audit Plan is set out in Appendix E.

6.4 Rolling Forward Programme

The Health Board will move towards a rolling three-year approach to Corporate Clinical Audit planning. This will support broader and more systematic coverage of the Corporate Clinical Audit Universe, enable re-audits and follow-up activity to be planned, and help identify future capacity and resource requirements.

The rolling programme will be developed following completion of the prioritisation, moderation and capacity assessment processes set out in this Framework. Potential topics will be reviewed annually against current risks, national requirements, previous audit findings, available assurance and emerging organisational priorities.

Future-year priorities will be developed through the agreed methodology and presented through the relevant governance arrangements. Reference to potential future audits will not constitute approval or a commitment to delivery.

7. CORPORATE CLINICAL AUDIT DELIVERY LIFECYCLE

The steps within the corporate clinical lifecycle are set out below and described under in more details under sections 7.1, 7.2 and 7.3.

1. **Proposal and initial assessment.**
2. Classification, screening and prioritisation.
3. Approval and appointment of Executive and clinical leads.
4. Scoping, protocol, standards, methods and data sources.
5. Information-governance, patient, equality and Welsh-language considerations.
6. **Fieldwork and data collection.**

7. Validation and quality assurance.
8. Analysis against each standard and assessment of variation.
9. Stakeholder factual validation.
10. **Final report and SMART improvement plan.**
11. Action monitoring and escalation.
12. Evidence-based closure.
13. Re-audit or agreed alternative follow-up.
14. Impact, sustainability, learning and programme review.

7.1 Scoping and Protocol

Before fieldwork, each audit will have an Executive sponsor, clinical/service lead, Corporate Clinical Audit Team coordinator and agreed stakeholders. The protocol will define the objective, scope, inclusion and exclusion criteria, standards, target compliance, sample rationale, methodology, data sources, timetable, governance route, information-governance controls and follow-up expectations.

Services will contribute operational expertise. The Corporate Clinical Audit Team will retain responsibility for agreeing a consistent and proportionate methodology in collaboration with the clinical lead.

7.2 Fieldwork, Analysis and Validation

Data will be collected using the approved tool and protocol. Proportionate quality checks will address completeness, consistency, duplicates, source verification and exclusions. Quantitative findings will normally report the numerator, denominator, percentage compliance, required standard and whether it was met.

Qualitative evidence may be used where professional judgement or narrative evidence is necessary.

Draft findings will be validated with relevant clinical and operational stakeholders. Factual corrections, additional evidence, limitations and disputed interpretations will be documented. Evidenced non-compliance will not be removed because it is unwelcome.

7.3 Implementation and Completion

An audit is not complete when the report is issued. Completion requires proportionate actions, monitoring of implementation, evidence-based closure and re-audit or another agreed follow-up method where required.

8. FINDINGS, IMPROVEMENT ACTIONS AND FOLLOW-UP

8.1 Findings and Reports

Findings will be reported against each agreed standard and will identify material variation, good practice, limitations and the clinical significance of gaps. Reports will not use Internal Audit-style assurance ratings unless separately approved for a defined purpose.

Finding type	Definition	Required response
Significant finding	Failure against a critical standard; actual or potential serious harm; statutory or regulatory non-compliance; systemic failure; or repeated failure despite previous action.	Prompt Executive and governance notification; immediate safety measures where required; SMART action plan; escalation to PQSOC where material.
Other non-compliance	Gap against an agreed standard that does not meet the significant-finding threshold.	Proportionate SMART action, named owner, timescale, evidence and monitoring route.
Good practice	Practice that meets or exceeds expected standards and may support wider learning.	Share through appropriate local and organisational routes.

8.2 Actions and Closure

Each action will be specific, measurable, achievable, relevant and time-bound, with a named owner, accountable service, due date, expected evidence, intended measure of improvement and escalation route.

The audited service owns implementation; the Corporate Clinical Audit Team coordinates monitoring and escalation.

Status	Definition
Open	Agreed action not yet evidenced as complete.
In progress	Implementation has begun and remains within the agreed date.
Overdue	The agreed date has passed without approved completion evidence.
Reprofiled	A revised date has been authorised with a recorded rationale and risk assessment; the original date remains visible.
Awaiting evidence	Completion is reported, but sufficient evidence has not been validated.
Closed: implemented	Proportionate evidence confirms implementation.
Closed: impact demonstrated	Follow-up or re-audit demonstrates the intended improvement.
Closed: alternative decision	The action is no longer appropriate, with documented clinical and governance approval.

An action will not be closed solely on an owner's statement. Where the intended effect must be demonstrated, implementation evidence alone is insufficient.

8.3 Re-Audit and Sustained Improvement

Each report will state whether re-audit is required and identify the scope, timing and owner. Re-audit may focus on the standards and risks requiring follow-up. Where re-audit is not appropriate, an alternative measure and rationale will be recorded. Sustainability will be tested over a clinically meaningful period where proportionate.

9. REPORTING, ESCALATION AND LEARNING

9.1 Individual Audit Report

Each report should include the following information as a minimum:

- purpose, scope and governance route;
- standards, target compliance and methodology;
- sample, data sources, exclusions and limitations;
- quantified findings against each standard and relevant qualitative evidence;
- variation, good practice, clinical significance and risk links;
- SMART improvement plan; and
- re-audit or alternative follow-up requirement.

9.2 Programme Reporting

Routine programme reports will show core and reserve audits, milestones, delays, dependencies, findings, action status and ageing, re-audit, impact and risks to delivery. Historic open actions will remain visible until closed through the evidence standard in this Framework.

9.3 Escalation and Learning

Immediate safety concerns, material findings, repeated non-compliance, inadequate action plans, overdue significant actions, disputed ownership and programme delivery risks will be escalated through the agreed route. Immediate concerns must also be managed through existing patient-safety and risk processes and must not wait for the audit report.

Learning and good practice will be shared proportionately through governance forums, briefings, dashboards, bulletins, professional networks and improvement routes, with consideration of applicability to other services and protection of confidential information.

10. PROGRAMME MANAGEMENT, CAPACITY AND CHANGE CONTROL

The programme will be supported by an annual capacity assessment covering Corporate Clinical Audit Team availability, clinical and service input, analytical support, specialist advice, data access, digital readiness and follow-up commitments.

No fixed workforce establishment is specified because operational staffing may change.

A programme plan will identify milestones, dependencies and pressure points.

Urgent work may be added only through an explicit priority and capacity decision.

Significant changes, including addition or removal of an audit, material scope change, substitution or delay affecting agreed coverage, will be reported through QMG and PQSOC, with ARAC informed through programme assurance reporting where relevant.

11. DIGITAL SYSTEMS, DATA QUALITY AND INFORMATION GOVERNANCE

11.1 Definitive Record

AMaT will be used as the definitive record for Corporate Clinical Audit activity, subject to confirmation that it supports all required programme controls. Until full implementation is confirmed, any parallel records will be reconciled and the definitive source identified in each programme report.

The minimum record will include approval, status, leads, scope, standards, findings, actions, owners, due dates, evidence, escalation, re-audit, closure and impact.

11.2 Data Quality and Information Governance

Reports will describe data completeness, reliability, validation, exclusions and limitations. Audit activity will use the minimum necessary information, apply Health Board confidentiality and information-security requirements, ensure authorised access and secure storage, and escalate information-security incidents through existing procedures.

12. KEY PERFORMANCE INDICATORS AND MEASURES OF IMPACT

Performance measures will balance programme control with evidence of benefit. Targets will be approved with the Annual Plan and will not be carried forward without review.

Measure	Purpose
Delivery against milestones	Demonstrates programme control.
Reports scrutinised through the agreed route	Demonstrates completion of reporting obligations.
Action status, ageing and significance	Shows follow-through and visibility of residual risk.
Re-audit completed by agreed date	Shows completion of the audit cycle.
Change in compliance against standards	Shows whether measured practice improved.
Outcome and balancing measures	Shows whether intended benefit occurred without unacceptable effects.
Sustained improvement	Shows whether change was embedded.
Learning disseminated and adopted	Supports organisational learning.
Relevant variation reviewed	Tests whether aggregate improvement masks inequality.

Each completed audit will state the baseline, expected improvement, actions, post-implementation measure, remaining gaps and further follow-up. Where patient outcomes cannot reasonably be measured within the period, justified process and balancing measures may be used.

13. RISKS TO DELIVERY AND MITIGATING ACTIONS

Risk	Potential effect	Control
Insufficient capacity	Delay, reduced scope or incomplete follow-up.	Annual capacity assessment, core and reserve programme, explicit reprioritisation.

Poor data access or quality	Unreliable findings or delay.	Early testing, validation, analytical support and clear limitation reporting.
Unclear ownership	Actions not implemented.	Named Executive, clinical and action owners and escalation of disputed ownership.
Competing urgent requests	Approved programme displaced.	Controlled out-of-cycle process and recorded decision.
Weak completion evidence	Premature closure.	Evidence-based closure and validation.
Failure to re-audit	No evidence of improvement.	Follow-up decision in every report and programme monitoring.
Duplication	Waste and stakeholder burden.	Screen against local, national and independent review programmes.
Information-governance failure	Confidentiality or security risk.	Minimum necessary data, controlled access and existing incident procedures.
Unclear governance route	Delayed or duplicated scrutiny.	Confirm route in the protocol and reflect it in programme reporting.

14. ANNUAL REVIEW

At year end, the Assistant Director for Quality and Patient Safety will provide an assessment of programme delivery and impact. It will cover audits delivered, deferred or cancelled; findings; action status and ageing; re-audit; demonstrated and sustained improvement; learning; capacity; data limitations; changes to the Universe; and recommendations for the next programme.

The annual review will inform programme development, risk review, quality priorities and relevant governance reporting. It will not provide an independent overall opinion on the adequacy or effectiveness of the Health Board's governance, risk management or control environment.

15.CONCLUSION

This Framework establishes a proportionate, clinically owned and improvement-focused approach to Corporate Clinical Audit. Its effectiveness depends on transparent selection, reliable standards and data, clear action ownership, disciplined follow-up and evidence that change has improved care.

The Annual Plan at Appendix C applies these requirements to 2026/27 and will be refreshed and approved annually.

16. REFERENCES

- Duty of Quality and Health and Care Quality Standards materials applicable to NHS Wales.
- Health Board Quality Strategy, Quality Management Framework and Integrated Medium-Term Plan.
- Relevant National Clinical Audit, professional, regulatory and clinical standards identified in each audit protocol.
- Aneurin Bevan University Health Board Clinical Audit Policy.
- Aneurin Bevan University Health Board Clinical Audit Strategy 2023–2026 and subsequent approved Strategic Aims for Clinical Audit 2026-2029.

17. APPENDICES

Appendix A: Roles and Responsibilities Matrix

Appendix B: Corporate Clinical Audit Universe

Appendix C: Prioritisation and Scoring Methodology

Appendix D: Glossary

Appendix E: Annual Corporate Clinical Audit Plan 2026/27

Appendix A: Roles and Responsibilities Matrix

Role	Accountable / responsible for	Not responsible for
Board	Overall quality governance and consideration of material assurance and risk through committee arrangements.	Operational delivery of individual audit actions.
Executive Medical Director	Ensuring appropriate clinical-audit arrangements and executive accountability for the programme.	Independent audit opinion.
Assistant Director for Quality and Patient Safety	Senior operational leadership, programme development, and escalation.	Owning service actions.
Corporate Clinical Audit Team	Programme coordination, methods, fieldwork support, records, reporting, action monitoring, and escalation.	Implementing operational actions belonging to audited services.
Executive sponsor for an audit	Senior sponsorship, removal of barriers and escalation.	Substituting for the clinical/service owner.
Clinical/service lead	Clinical scope, standards, stakeholder engagement, interpretation, and response.	Transferring clinical accountability to the audit team.
Division / Directorate / service	Resources, access, factual validation, action implementation, evidence, and local governance.	Treating registration as transfer of ownership.
Action owner	Delivering the assigned SMART action and evidence by the agreed date.	Self-authorising closure without validation.

Role	Accountable / responsible for	Not responsible for
CSEG / QMG	Functions described in Appendix F, subject to final approved route.	Independent audit opinion.
PQSOC	Scrutiny of quality, safety, outcomes, learning and improvement.	Routine operational action management.
ARAC	Oversight of the audit system, risk alignment, delivery and open-action visibility.	Clinical ownership or independent rating by the Corporate Clinical Audit Team.

Appendix B: Corporate Clinical Audit Universe

The Universe contains 100 distinct topic areas, each assigned to one primary domain for planning and counting purposes. Secondary domain links may be recorded when an audit is scoped.

Domain & Objective	Topic Areas
Safe Care (30) Measuring practice against explicit standards to identify and reduce avoidable harm.	Deteriorating Patient (NEWS2)
	Sepsis
	Falls Prevention
	Pressure Ulcers
	Venous Thromboembolism (VTE)
	Patient Identification
	Safeguarding Adults
	Safeguarding Children
	Mental Capacity Act
	Deprivation of Liberty Safeguards
	Resuscitation
	Infection Prevention & Control
	Healthcare Associated Infections
	Never Events
	Serious Incident Learning
	Harm Reviews
	Mortality Reviews
	Controlled Drugs
	High Risk Medicines
	Prescribing Safety
	Medicines Storage
	Blood Transfusion
	CTG Interpretation

Domain & Objective	Topic Areas
	Maternity Safety Standards
	Obstetric Emergencies
	Risk Assessment (Mental Health)
	Observation Standards
	Rapid Tranquillisation
	Professional Registration
	Clinical Competency Assessment
Effective Care (29) Measuring whether care is evidence-based and clinically effective, and identifying improvements needed to optimise outcomes.	NICE Compliance
	National Guidelines
	Clinical Pathways
	Care Bundles
	National Clinical Standards
	Royal College Standards
	Welsh Government Guidance
	Medicines Reconciliation
	Antimicrobial Stewardship
	Oxygen Prescribing
	Stroke Pathways
	STEMI Pathways
	Trauma Pathways
	Enhanced Recovery
	Diagnostic Quality
	Radiology Reporting Quality
	Endoscopy Standards
	Neonatal Care
	Perinatal Mortality Reviews

Domain & Objective	Topic Areas
	Paediatric Early Warning Score
	Immunisation
	Physical Health Monitoring in Mental Health Settings
	Community Rehabilitation
	Community Therapies
	Tissue Viability
	MDT Compliance (Cancer)
	SACT
	Radiotherapy
	Clinical Decision Support Systems
Equitable Care (10) Measuring whether patients receive fair access to services and consistent standards of care regardless of location, background or circumstances.	Cancer Pathways
	Non-reportable Waiting Lists
	Mental Health Crisis Access
	Paediatric Emergency Care
	Community IV Therapy
	District Nursing Services
	Community Falls Assessment
	Access to Diagnostics
	Compliance with National Standards Across Services
	Data Quality (supporting equity monitoring)
Person-Centred Care (11) Measuring whether care is respectful, compassionate and responsive to individual needs, preferences and values.	Consent
	Care Planning (Mental Health)
	Duty of Candour
	Complaints Learning
	Shared Decision Making

Domain & Objective	Topic Areas
	Communication Standards
	PROMs (Patient Reported Outcome Measures)
	PREMs (Patient Reported Experience Measures)
	Child Protection Documentation
	Breastfeeding Standards
	Surgical Documentation
Timely Care (12) Measuring whether patients receive the right care at the right time and identifying changes needed to minimise delay.	RTT Pathways
	Diagnostic Waiting Times
	Cancer Waiting Times
	Emergency Department Standards
	Ambulance Handover Performance
	Time Critical Pathways
	Radiology Reporting Times
	Pathology Turnaround Times
	Follow-up Waiting Lists
	Waiting List Validation
	Clinical Prioritisation of Referrals and Waiting Lists
	Deteriorating Patient Response Times
Efficient Care (8) Measuring whether resources are used effectively and services operate productively while maintaining quality and safety.	Theatre Productivity
	Day Surgery
	EPMA Utilisation
	Point of Care Testing
	Workforce Mandatory Training Compliance
	Clinical Supervision
	Appraisal

Domain & Objective	Topic Areas
	Surgical Pathway Efficiency

Appendix C: Prioritisation and Scoring Methodology

Each proposed audit topic will be scored from 0 to 5 against the criteria set out below. The raw score for each criterion will be multiplied by its agreed weighting, reflecting the relative significance of that criterion

The weighted scores will be totalled to produce an overall priority score out of 100. The overall score is divided by the combined weighting of 20. This will provide a consistent and transparent basis for comparing potential audit topics across the Corporate Clinical Audit Universe.

Domain	Weighting and Max Score	Criterion					
		5	4	3	2	1	0
Patient Safety	**×3 = 15**	Potential catastrophic or widespread harm	Potential major or significant harm	Moderate harm or recurring safety concern	Minor harm or limited concern	Minimal safety impact	No identified safety impact
Serious Incidents / Complaints / Claims	**×2 = 10**	Recurrent severe events or systemic failure	Multiple serious events or increasing trend	Recurring events or emerging trend	Isolated event	Rare events with no evident trend	None
Statutory / Regulatory Requirement	**×3 = 15**	Statutory or mandatory requirement with current non-compliance	Explicit regulator or Welsh Government requirement	National professional or clinical standard	Local mandatory policy requirement	Good-practice expectation	No requirement

Performance Concerns	**×2 = 10**	Sustained and worsening material failure	Repeated material failure against standards	Variable performance or recurring concern	Isolated or minor failure	Standard consistently met; validation may add value	No concern
Executive / Committee Request	**×1 = 5**	Time-critical Board, Chief Executive, PQSOC or ARAC request	Executive Director request	Divisional Director request	Clinical governance group request	Local clinical team request	No request
Evidence / Measurement Gap	**×2 = 10**	No reliable evidence that standards are being achieved	Limited evidence or a material measurement gap	Partial, outdated or inconsistent evidence	Generally adequate evidence with a minor gap	Recent, reliable and comprehensive evidence	No material evidence or measurement gap
National Priority	**×1 = 5**	Time-critical ministerial or national priority	Mandatory national programme	National improvement initiative	Regional priority	Local priority	No identified priority
External Review Findings	**×1 = 5**	Significant external finding requiring prompt action and follow-up measurement	Repeated or material external finding	Open recommendation or concern	Minor external finding	Closed issue where follow-up measurement may add value	No external finding

Corporate / Strategic Risk	**×2 = 10**	Strategic or Corporate Risk outside appetite	Strategic or Corporate Risk within appetite or material strategic objective	Divisional risk or cross-Directorate concern	Local service risk with wider relevance	Low local significance	No identified link
Previous Clinical Audit Results	**×2 = 10**	Poor compliance; actions not delivered or no re-audit	Low compliance or material actions outstanding	Mixed compliance or re-audit due	Broad compliance with minor actions	Strong recent compliance and actions complete	Current audit or reliable current evidence
Time Since Previous Audit	**×1 = 5**	Never audited or more than 5 years	4–5 years	2–4 years	1–2 years	Within the previous year	Currently under audit

Weighted score	Priority classification	Proposed treatment
75 to 100	**Priority 1**	Strong case for inclusion in the core Corporate Clinical Audit Programme
55 to 74	**Priority 2**	Consider for the core or reserve programme, subject to capacity and feasibility
35 to 54	**Priority 3**	Retain within the Audit Universe and monitor, or consider Divisional audit
0 to 34	**Priority 4**	No current requirement for Corporate Clinical Audit

Appendix D: Glossary

Term	Meaning
AMaT	Audit Management and Tracking system.
ARAC	Audit, Risk and Assurance Committee.
Audit Universe	The full population of potential Corporate Clinical Audit topics; not the annual programme.
Clinical Audit	Systematic review of care against explicit criteria, followed by improvement and further monitoring where indicated.
Corporate Clinical Audit	Clinical Audit of corporate significance, often cross-organisational or linked to material quality and safety concern.
CSEG	Clinical Standards and Effectiveness Group.
Executive sponsor	Executive leader supporting an individual audit and escalation of barriers.
QMG	Quality Management Group.
PQSOC	Patient Quality, Safety and Outcomes Committee.
QMS	Quality Management System.
Re-audit	Repeat measurement after action to determine whether improvement occurred and was sustained.
SMART	Specific, measurable, achievable, relevant and time-bound.
Welsh Risk Pool	NHS Wales risk-sharing and learning arrangements associated with claims and relevant standards.

Appendix E: Clinical Audit Plan 2026/27

The proposed programme of ten corporate clinical audits represents the initial delivery programme while the Audit Universe is fully scored, moderated and assessed against existing sources of assurance.

The application of this methodology will determine whether ten audits remains an appropriate minimum for future years or whether the proposed level of coverage should be revised.

Status: Proposed programme awaiting formal approval. The audit list below reflects the latest reconciled direction available in the source material. It distinguishes planned and reserve audits. Any change following final clinical scoping or formal approval must be recorded in programme control documentation.

Audit ID	Audit	Objective	Selection Rationale	Quarter
CA001	Decision Making & Consent	To measure compliance with legislative requirements, professional standards and Health Board policies for decision-making and consent, and identify improvements needed to support informed decisions about care and treatment.	Person-Centred Care Mandatory requirement with legal, ethical and patient-safety significance.	Q1
CA002	DNACPR	To measure whether DNACPR decisions are made, documented, reviewed and communicated in accordance with national guidance, legislation and Health Board policy, and identify any required improvement.	Safe and Person-Centred Care Mandatory requirement affecting lawful, ethical and consistently communicated decisions.	Q1

Audit ID	Audit	Objective	Selection Rationale	Quarter
CA003	NG Tube	To measure compliance with national safety standards for nasogastric tube insertion, placement verification and ongoing management, and identify action needed to reduce avoidable harm.	Safe Care Mandatory national safety requirement with potential for serious avoidable harm.	Q2
CA004	Discharge Notifications	To measure whether required notifications to the coroner following a patient's discharge are completed accurately, consistently and within agreed timescales, in accordance with the relevant procedure	Effective Care Concerns regarding the consistency and timeliness of notifications to the coroner and the associated legal and governance risks.	Q2
CA005	Death Notifications	To measure whether deaths meeting the criteria for referral to the coroner are identified, documented and notified accurately and within the required timescales, in accordance with statutory requirements and Health Board procedures.	Effective Care Linked to statutory death-reporting requirements and the need to ensure eligible deaths are identified, notified and reviewed appropriately.	Q2

Audit ID	Audit	Objective	Selection Rationale	Quarter
CA006	7-day Rolling Re-admission Rate	To measure compliance with agreed standards for identifying, recording and reviewing unplanned readmissions within seven days of discharge, and to identify improvements required to reduce avoidable readmissions.	Effective and Timely Care Early unplanned readmissions may indicate gaps in clinical management, discharge planning or continuity of care and require further review and improvement.	Q2
CA007	Consent Blood Transfusion	To measure whether informed consent for blood transfusion is obtained, documented and managed in accordance with legal requirements, national guidance and Health Board policy, and identify any required improvement.	Safe and Person-Centred Care Mandatory legal and national requirement for informed consent.	Q3
CA008	Medicines Documentation & Storage Mental Health	To measure compliance with legislation, professional standards and Health Board procedures for medicines prescribing, documentation, storage and management in Mental Health services, and identify action needed to reduce medication-related harm.	Safe Care HIW findings identify a priority need for measurement and improvement within Mental Health services.	Q3

Audit ID	Audit	Objective	Selection Rationale	Quarter
CA009	Learning from Serious Incidents Neonates	To measure whether agreed learning from serious neonatal incidents has been implemented and embedded in clinical practice, and identify further action needed to reduce recurrence and improve patient safety.	Safe Care CRR 002 is outside appetite, with significant concerns and external scrutiny in neonatal services.	Q4
CA010	Deteriorating Patient	To measure compliance with agreed standards for recognition, escalation and management of deteriorating patients, including NEWS2, escalation protocols and treatment-escalation planning.	Safe and Timely Care CRR 036 is outside appetite and the topic has significant patient-safety relevance.	Q4

Additional Audits for consideration if capacity is identified within the 2026/27 Plan			
Audit ID	Audit	Objective	Selection Rationale
CA TBC	Waiting List Harm Review Ophthalmology	To measure whether ophthalmology waiting-list harm reviews are completed consistently against agreed standards and support timely identification, prioritisation and management of patients at risk of harm.	Equitable and Timely Care Linked to SRR 005, CRR 011 and Audit Wales findings, with potential waiting-list harm.

CA TBC	Healthcare Acquired Infections Area TBC	To measure compliance with national and Health Board infection prevention and control standards, identify variation or non-compliance, and agree actions to reduce healthcare-associated infection.	Safe Care CRR 005 is outside appetite and there is a known area of concern requiring prompt corporate measurement and improvement.

Annual Plan control notes

"Proposed" does not mean formally approved. Approval decisions and any amendments must be recorded.

Executive and clinical leads marked TBC must be agreed before fieldwork.

The applicable standards, sample, data sources, dependencies, information-governance requirements and re-audit timetable will be defined in each audit protocol.

Reserve audits are not part of the committed programme unless formally activated through the programme-change process.

Risk reference numbers and any description of an audit as mandated must be verified against the current source before approval.

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	24 November 2026
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	**Financial governance, reporting & control**
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	**Robert Holcombe, Director of Finance, Procurement and Value Based HealthCare**
SWYDDOG ADRODD: **REPORTING OFFICER:**	**Robert Jones, Assistant Finance Director – Financial Systems & Services**

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

Er Gwybodaeth/For Information

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

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

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

The Audit, Risk and Assurance Committee is requested to:

- Note the contents of this report.
- Approve the updated financial control policy and procedures.



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

The Financial Control Procedures presented were considered and approved by the Executive Committee at their meeting on the 29th October and are now being presented to the Audit, Risk and Assurance Committee for approval.

Cefndir / Background

Effective financial control and compliance are fundamental pillars of sound governance within the NHS and the wider public sector. Robust financial control procedures ensure that resources are managed efficiently, risks are mitigated, and the organization remains compliant with statutory and regulatory requirements. Regular review and updating of these procedures, as outlined in the committee's terms of reference, are essential to adapt to changes in legislation, policy, or operational processes.

Scrutiny of losses and special payments is a key aspect of financial governance. Losses—such as write-offs, fraud, or error—and special payments, which fall outside normal business transactions, require careful examination to ensure transparency, accountability, and value for money. Rigorous oversight helps to identify root causes, implement corrective actions, and prevent recurrence, thereby safeguarding public funds and maintaining stakeholder confidence.

Asesiad / Assessment

1. Financial Control Procedures (FCP)

Financial Control Procedures are reviewed, as a minimum, on a 3 yearly basis, or when a material change in process or legislation requires.

The FCPs to be reviewed at this Committee are:

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

Together with a summary of all FCP review dates.

1.1. Capital Procedures and Guidance Notes

Owner: Director of Finance, Procurement and Value
Review Date: November 2026



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

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

The document defines the Capital procedures and guidance notes in relation to successfully managing Capital expenditure.

The document has been circulated for comment as follows:

- Senior Capital Project Manager
- Head of Capital Finance
- Assistant Director of Strategic Capital
- Assistant Finance Director – Financial Strategy, Planning, Capital
- Capital Programme Board
- NWSSP – Audit and Assurance Services

Section	Name	Main Changes
1	Introduction	1.1. Overview – Links to NHS Wales Infrastructure Guidance, Standing Orders and Scheme of Delegation added
2	Capital Programme Development and Management	2.2 Capital App – Digital Management of Divisional Capital Requirements – availability of app for Divisions to record, update and monitor capital requests and risks 2.3 Pre-Investment Panel (PIP) – clarification of revenue implications, consequence, importance and review 2.4 Approval for Capital Projects to Proceed – table updated to reflect Scrutiny and Approval job titles and procurement guidance
6	Design, Tendering and Contracting	6.2 Initiating a Scheme – paragraph added to inform a range of contracts may be used depending on the nature, complexity and risk profile of the project, such as JCT and NEC4 forms 6.3 Design – Approved Scheme – paragraph added to highlight the requirements of the Building Safety Act (Wales)
7	Commissioning	7.2 Commissioning Plan – requirement for a Commissioning Plan for all capital schemes prior to operational readiness activities commencing. Technical commissioning to be undertaken by Works and Estates, operational commissioning by the Directorate 7.3 Operational Policies – clarification of operational objectives, targets and plans
11	Leasing	11.3 Decision to Lease – requirements for all documentation to be signed before the lease period starts and any revenue implications to be agreed prior to document signing.



14	Controls, Monitoring and Effectiveness	14.2 Summary of High-Level Controls – Person responsible job titles updated 14.5 Key Performance Indicators – paragraph added to highlight the requirement for KPIs to be set, agreed and monitored in relation to Contractor and Consultant performance
Annex 1	Roles & Responsibilities	Assistant Director of Strategic Capital – updated in relation to job title and responsibilities
Annex 3	Capital and Estates Group	Terms of Reference – updated

1.2. Cash and Bank

Owner: Director of Finance, Procurement and Value
Review Date: November 2026

The procedure documents cash and banking procedures.

It sets out the requirements to ensure adequate controls are in place, over the handling of cash and operation of bank accounts.
It clearly identifies the responsibilities of relevant staff.

The procedure highlights the objectives, to ensure that sufficient cash is available on a daily basis to enable the Health Board to meet it's commitments and that cash is held securely and appropriately.

The document has been circulated for comment as follows:

- Assistant Head of Financial Services
- General Office Staff
- Head of Financial Services and Accounting
- Assistant Finance Director – Financial Systems and Services
- NWSSP – Audit and Assurance Services

Section	Name	Main Changes
6	Roles & Responsibilities	6.1 Head of Financial Services and Accounting – Responsibilities added 6.2 Assistant Head of Financial Services – Responsibilities added
7	Cash and Bank Process	7.6.8 Reconciliation of Bank Accounts – limits of cash held amended to, should 'not go above £6m or into an overdraft position' as per WG guidelines 7.7.4 Income Tax and NI Payments to HMRC – date amended to 22nd of the month 7.10 Banking of Cash and Cheques Received – process updated to reflect move to Ty Gwent i.e. post received, receptionist communication, management via secure room



		7.11.3 Payment of Trade Creditors – Natwest Customer Service (PayGate) updated 7.15 GOV.UK Pay Links – section added to reflect availability and process of receiving payments via debit/credit card 7.18 Money Laundering – regulations updated from 2007 to 2017
8	Further Information	Contact details updated to reflect move to Ty Gwent

1.3. Patients' Travel Costs

Owner: Director of Finance, Procurement and Value
Review Date: November 2026

The procedure details the financial support available to patients, who do not have a medical need for ambulance transport, but cannot meet the cost of travel to hospital.

It aims to ensure there is a clear control framework governing the reimbursement of patients' travel costs.

The document has been circulated for comment as follows:

- Assistant Head of Financial Services
- General Office Staff
- Head of Financial Services and Accounting
- Assistant Finance Director – Financial Systems and Services
- NWSSP – Audit and Assurance Services

Section	Name	Main Changes
7	Patients' Travel Costs Process	7.2.1 Basis of Entitlement – update on the migration of legacy benefits to Universal Credit by the Department for Work and Pensions 7.3 Documentation - Addition of bank transfer included, as well as cash or payable order 7.3.1 Patients not Automatically Entitled to a Refund – Welsh Government Low Income Scheme guidance updated
Appendix 3	Claims in Advance Form	PO Box address updated
Appendix 5	Retrospective Claim Process	Flowchart added to reflect the process in Section 7.3

Summary Position on Financial Control Procedures

The table below provides an update of the status of all financial control procedures.



FCP	Year Due	Approved	Committee Approved	Review Date	Notes
Petty Cash	26/27	To be reviewed	Feb-24	08-Feb-27	Scheduled for February 2027
Petty Cash - Mental Health	26/27	To be reviewed	Feb-24	08-Feb-27	Scheduled for February 2027
Accounts Receivable	27/28	Y	Apr-24	16-Apr-27	
Contract Management	27/28	Y	Apr-24	16-Apr-27	
Capital Assets and Charges	27/28	Y	Jul-24	09-Jul-27	
Salary Sacrifice	27/28	Y	Sep-24	02-Oct-27	
Policy for Out of Area Referrals to Secondary Care	27/28	Y	Sep-24	02-Oct-27	
Recovery of Overpayments to Employees	27/28	Y	Nov-24	12-Nov-27	
Accounts Payable	27/28	Y	Nov-24	12-Nov-27	
Counter Fraud Bribery and Corruption Policy	27/28	Y	Feb-25	18-Feb-28	
Approval of Orders over £100K	27/28	Y	Apr-25	22-Apr-28	
Overseas Visitors	27/28	Y	Apr-25	22-Apr-28	
Digital Procurement	28/29	Y	Apr-25	22-Apr-28	
Charitable Funds	28/29	Y	Apr-25	22-Apr-28	
Budgetary Control Policy & Procedure	28/29	Y	Sep-25	18-Sep-28	
Losses and Special Payments	28/29	Y	Sep-25	18-Sep-28	
Stores & Stocks	28/29	Y	Sep-25	18-Sep-28	
Engaging Off Payroll Workers	28/29	Y	Feb-26	12-Feb-29	
Patients' Property	28/29	Y	Feb-26	12-Feb-29	
Purchasing Cards	28/29	Y	Feb-26	12-Feb-29	
Procurement Policy	28/29	Y	Feb-26	12-Feb-29	
Grant Funding	28/29	Y	Feb-26	12-Feb-29	
FMS General Ledger	29/30	Y	Apr-26	28-Apr-29	
Commissioning Non NHS Clinical Services	29/30	Y	Apr-23	18-Apr-26	
Capital Procedures and Guidance Notes	26/27	Y	Nov-26	24-Nov-29	
Patients' Travel Costs Policy	26/27	Y	Nov-26	24-Nov-29	
Cash and Bank	26/27	Y	Nov-26	24-Nov-29	

2. Technical Accounting Issues

Technical updates

Since the last committee meeting in June 2026, there has been one technical accounting update issued by Welsh Government.

Update Note 2 for 2026/27 covered the following areas:

- **NHS Wales Indices 2026-27 to 2029-31**

Update to the Land & Building Indices provided by the District Valuer, for the next five years, which are to be used by organisations for future forecasting. The rate changes will need to be reflected by the Health Board in the ledger and reported through the Annual Accounts.

- **Timetable for Month 6 Agreement of Balances exercise**

Detailed timetable provided for the Agreement of Balances exercise at the end of Month 6, which is between NHS Wales organisations and Welsh Government only.

The intra-NHS Wales organisation Agreement of Balances process will take place at the end of Month 9, for which we are still waiting for the final timetable.

- **Asset Transfers for 2026/27**

This provides confirmation of the submission deadlines for organisations if there has been a transfer of asset between NHS Organisations in 2026/27.

This process ensures that Welsh Government are aware of any equipment or asset transfer between NHS organisations, and ensures budgets are re-aligned correctly centrally, if necessary.

There have been no Asset Transfers between the Health Board and any of its counterparts in 2026/27.

3. Public Sector Payment Policy (PSPP)

The following table shows the Public Sector Payment Policy performance for the month of October 2026 and on a cumulative basis for the 2026/27 Financial Year.

Category	Invoices	In Mth %	YTD %
NHS	Value	99.9	99.7
	Number	96.5	96.2
Non-NHS	Value	98.6	97.1
	Number	97.4	97.1

The Health Board has achieved the target to pay 95% of the number of Non-NHS and NHS creditor invoices within 30 days of delivery of goods/services in October and cumulatively for the 2026/27 financial year.

Procurement Reporting Regulations

As part of the Procurement Act 2023, a number of additional reporting regulations were introduced, including:

- Contract Award Transparency
- Contract Performance Monitoring
- Spend and Pipeline Reporting

Within the Contract Performance Monitoring section, is a requirement for organisations to submit a **Payment Compliance Notice.** The notice requires contracting authorities to publish information demonstrating compliance with contractual payment terms, particularly for public contracts above specified thresholds.

The first notice was due at the end of October 2026, to cover the period 01 April 2026 to 30 September 2026.

The following statistics were published by the Health Board:

Metric	Value
Average number of days taken to make payments	23.10
% of payments made within 30 days	88.33%
% of payments made within 31-60 days	10.18%
% of payments made within 61 days or more	1.49%
% of invoices paid within 30 days of due date during reporting period	87.92%
% of payments due during reporting period that were not made	12.08%



The Health Board's reported payment performance under the Procurement Payment Compliance Notice methodology is 88.33%, compared to the organisation's typical performance of over 95%, as detailed above.

The reduction arises from the exclusion of public sector invoices and credit notes, which historically achieve high compliance rates, reducing reported performance to approximately 93%.

A further reduction results from measuring compliance using the date payment is received by suppliers rather than the Oracle payment release date, identifying 5,855 invoices that fall outside the 30-day target and reducing compliance to 88.33%.

The principal cause is a known Oracle system configuration issue, whereby payments released on day 28 may be received after 30 days due to weekends and bank holidays. This issue is understood to affect organisations across NHS Wales. Work is underway to amend the payment release schedule to improve compliance with reporting requirements.

The reported position reflects a technical reporting and system timing issue rather than weaknesses in underlying payment processes, with corrective action being pursued at an NHS Wales level.

4. Payments in Excess of £100K

There were no exceptional issues to report.

5. Standing Financial Instructions

There is no further update with regard to the SFI's.

Argymhelliad / Recommendation

The Audit, Risk and Assurance Committee is requested to note the update in this report and approve the following FCPs included in this report.

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

The Committee is asked to note the reported compliance position, receive assurance that the underlying cause has been identified, and support continued engagement with NHS Wales Shared Services to implement the required Oracle system changes and improve future compliance performance.

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 AWCP – All-Wales Capital Programme PIP – Pre-Investment Panel ROU – Right of Use PSPP – Public Sector Payment Policy 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:	**Is EIA Required and included with this paper?**

• **Workforce** • **Service Activity & Performance** • **Financial**	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

Aneurin Bevan University Health Board

Capital Procedures

And

Guidance Notes

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ANEURIN BEVAN UNIVERSITY HEALTH BOARD
CAPITAL PROCEDURES
Annexes

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1 INTRODUCTION AND BACKGROUND INFORMATION

1.1 Overview

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

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

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

The Health Board manages it's Capital Programme according to the following guidance:

NHS Wales Infrastructure Guidance
Standing Orders
Scheme of Delegation

1.2 Aims and Scope

This guidance is designed to ensure that:

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

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

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

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

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

1.3 Definition

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

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the UHB;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has a cost of at least £5,000; or

- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or

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

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

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

1.4 Roles

To ensure successful Capital Programme management, individuals must have a clear role and responsibility as well as delegated authority. Each project must have a specific lead person identified.

- Annex 1 contains detailed role specifications for key individuals.

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

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

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

1.5 Sources of Capital

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

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

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

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

1.6 Capital Resource Limit (CRL)

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

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

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

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

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

2. CAPITAL PROGRAMME DEVELOPMENT AND MANAGEMENT

2.1 Overview

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

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

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

2.2 Capital App – Digital Management of Divisional Capital Requirements

To support improved visibility, consistency and governance of capital requirements across the Health Board, a **Capital App (Microsoft Power BI and Lists)** has been implemented. The App provides a standardised digital platform for Divisions to record, update, and monitor their capital requests and associated risks.
The Capital App replaces previous spreadsheet-based Divisional Capital Priorities and will be the **single source of information** for capital bids.

Purpose of the Capital App
The Capital App has been introduced to:

- Ensure **standard, consistent data capture** across all Divisions
- Improve **real-time visibility** of capital requirements for Divisions, Estates, Finance and Planning
- Support **transparent prioritisation** through embedded risk scoring fields
- Enable **auditability** of updates, decisions and mitigations
- Reduce duplication of effort and version control issues
- Streamline development of the **annual Discretionary Capital Programme**

Governance & Responsibilities
Divisions are responsible for:

- Maintaining accurate, up-to-date entries within the App
- Ensuring bids are complete, risk-scored, and include required justification
- Updating the App **monthly** in advance of the Divisional Capital Meeting
- Ensuring mitigation actions for high-risk entries (score 20+) are documented
- Archiving or closing items when risks are resolved or requirements no longer exist

Planning / Capital Team responsibilities may also be noted:

- Oversight of App structure, permissions and integrity
- Monitoring data completeness and quality
- Supporting Divisions with system use
- Running extracts for Capital Programme development and IMTP reporting
- All formal reporting will be generated directly from the App.

Support & Training

- Guidance on completing entries, risk scoring and required documentation will be provided through short user guides and ad-hoc training sessions coordinated by the Capital Planning Team.
- Any technical issues should be reported to the Capital Planning Team

2.3 Divisional Capital Priorities and Planning

Divisions are required to identify their capital requirements as part of their annual planning. This information must be captured and maintained through the **Capital App**, which is the Health Board's central system for recording and monitoring capital bids.

This should include:

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

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

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

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

The Divisional Capital Priorities within the Capital App must be reviewed and updated monthly and will be reviewed during monthly Divisional Capital meetings. It will form the basis of discussion at monthly Divisional Capital meetings. The Capital App will:

- Capture all capital requirements in one standardised platform
- Include risk rating and prioritisation of capital requirements
- Where appropriate, include detail of any revenue implications associated with the risk.
- Inform the development of the annual Discretionary Capital Programme
- Include benefits associated with bids
- Include details of how risk scores 20 and over are currently being mitigated
- Include detail of any revenue impacts, either costs or savings
- Include supporting documentation for each bid i.e PPD's, quotations

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

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

Urgent Capital Requirements

While all capital requirements must be recorded and updated within the Capital App, Divisions must ensure that **urgent capital needs** are clearly identified and escalated appropriately.

- The Capital App includes the ability to **flag bids as Urgent**, allowing the Capital Planning Team to identify high-priority items requiring immediate attention.
- Flagging an item as urgent **does not replace** the requirement for Divisions to **directly notify the Capital Planning Team** where urgent risks, failures or operational pressures arise.
- Divisions must contact the Capital Planning Team as soon as an urgent bid is added or updated within the App to ensure appropriate triage, assessment and response.
- Urgent items should be supported by clear justification, risk scoring and evidence of mitigation actions already in place.
- Urgent bids will also be reviewed and discussed at the monthly Capital and Estates Board, ensuring collective oversight, prioritisation and decision-making.

This process ensures urgent operational risks are managed promptly while maintaining the Capital App as the single source of information for capital requirements.

2.3 Pre-Investment Panel (PIP)

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

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

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

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

2.4 Approval for Capital Projects to Proceed

Value of proposal	Capital Documentation required	Responsibility	Scrutiny	Approval
Less than £25,000	Project Proposal Document (Annex 5)	User with sign off from Divisional General Manager or equivalent	Assistant Director of Strategic Capital /Head of Capital Finance.	Assistant Director of Strategic Capital

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

Project requiring All Wales Capital Funding

Requirements:

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

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

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

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

  Welsh Procurement Policy Note (WPPN) 011: Project Bank Accounts Policy – Advice for Welsh Contracting Authorities [HTML] | GOV.WALES

2.5 Programme Management

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

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

2.6 Capital Governance Hierarchy

The Capital Governance Hierarchy is detailed below:



2.6.1 Terms of Reference

- Please see Annex 2 for above terms of Reference

2.7 Capital Scrutiny

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

3 DELIVERING CAPITAL PROJECTS

3.1 Overview

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

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

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

3.2 Project Management

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

The Project is the responsibility of one named individual with clear duties and responsibilities.

- A clearly established project management structure is given responsibility for the project.
- The project structure will be established based on the size and complexity of the project and will be established from the development of the Strategic Case, through to project delivery.
- Key membership, roles and responsibilities will be determined in line with the five case model guidance and other relevant project guidance.
- Ownership of the project is retained by the Health Board and not delegated to external contractors.

The Project Team includes representatives of all interested departments.

- The Project Team has:
    - a clear brief
    - clear responsibilities;
    - a budget and cash-flow
    - a timetable for key events;
    - co-ordinated plans;
    - guidance notes;
    - monitoring information
- There is a clear scheme of delegation that supports each individual's levels of responsibility.
- Appropriate project files and documentation are kept in such a way that will allow auditors to examine the project.
- If indicated by the size and/or complexity of the project the requirement for a Project Initiation Document should be discussed with the Capital Team.
- Any change of key staff roles and responsibilities must be formally recorded, and the Capital Team notified.

3.3 Business Cases

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

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

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

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

3.4 Development of Scheme Costs

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

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

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

4 IMPLEMENTATION OF CAPITAL PROJECTS

4.1 Overview

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

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

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

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

4.2 Frozen Design Brief

For implementation to be successful and to meet audit requirements, the Project Director must finalise or "freeze" the brief. They must be satisfied that the investment that is proposed will meet the stated objectives of the project and deliver the agreed benefits.

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

4.3 Project Execution Plan

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

4.4 Implementation, Monitoring and Progress Reporting

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

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

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

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

Project Directors and Managers are required to work closely with Finance colleagues and key stakeholders.

It is essential that programme and progress information is presented clearly and concisely; appropriate Gantt charts and realistic programmes are to be developed and monitored regularly, and document version control clearly maintained.

5 FINANCIAL MONITORING

5.1 Overview

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

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

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

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

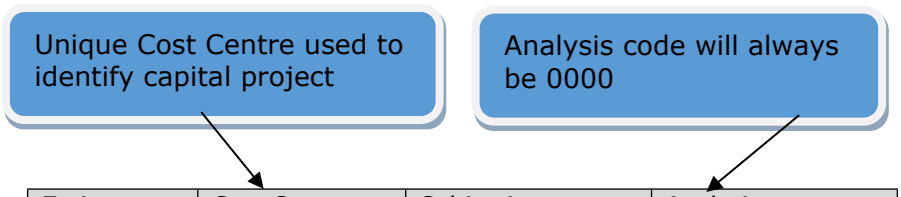
In addition to this, any underspend against an approved capital allocation cannot be assumed to be utilised within the project. It must be notified to the Capital Team.

5.2 Capital Cost Codes

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

A typical capital code will look like this:

Capital Code Structure



Entity	Cost Centre	Subjective	Analysis
040	P001	91100	0000

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

5.3 ABUHB Internal reporting

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

5.4 External Monitoring Returns

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

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

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

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

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

6 DESIGN, TENDERING AND CONTRACTING

6.1 Overview

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

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

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

In addition, the Standing Orders and Standing Financial Instruments should be consulted particularly when Welsh Government Consent or Noting is required for contract awards.

A summary is set out in the following paragraphs, but it should be noted that procurement frameworks are constantly being reviewed and advice should be sought from Works & Estate, Procurement or Capital Planning and Finance as appropriate.

6.2 Initiating a Scheme

Background

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

Procurement Strategy

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

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

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

A range of standard forms of contract may be used depending on the nature, complexity and risk profile of the project. These may include JCT and NEC4 forms of contract.

Where NEC4 contracts are used, project management processes will follow NEC principles including proactive risk management, early warning procedures, and compensation event management in place of traditional variation processes. Project teams must seek advice from Estates, Procurement and Capital Finance to confirm the most appropriate contract form.

Appointment of Professional Advisors (e.g. Cost Advisor), will also be subject to the relevant procurement protocols, ensuring compliance in line with procurement regulations.

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

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

6.3 Design – Approved Scheme

Design Phase
On completion of the feasibility stage and successful application of the PPD/BJC/OBC the preferred option can be worked up into a detailed design proposal.
Development of the Brief
The project team/design team will further develop the outline brief in association with the ABUHB stakeholders to ensure the brief translates into the project requirements.
Compliance/Standards/Derogations
At this stage internal/external designers will ensure full compliance with all current applicable statutory and NHS Standards.
Design Sign-off
The design and any derogation from standards must be signed off by service user and ABUHB PM/PD prior to tender. The existing position/'line in the sand' must be clearly identified and documented to ensure that it is available for future review.
Design Team
The design team is responsible for the technical content of the design and the project manager has authority over the design team in matters of design management.

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

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

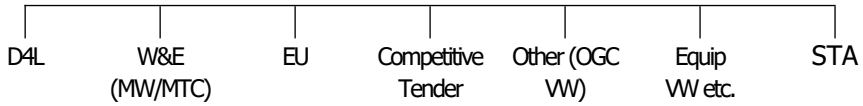
In addition, projects must consider the requirements of the Building Safety Act (Wales) and associated regulations where applicable.
For Higher-Risk Buildings (HRBs), defined in line with national legislation, additional requirements will apply including enhanced duty holder responsibilities, safety case preparation, and assurance mechanisms throughout the design, construction and occupation phases.

Project teams must engage with Estates, Health & Safety and specialist advisors at the inception of a project to determine whether a scheme falls within the scope of HRB requirements.

6.4 Tender

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

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



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

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

6.5 Construction Phase

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

The key requirement from a Capital perspective is that the Project Manager must continue to monitor and report on the key areas of cost, programme, risks and expected outcome using the process set out in Section5. (Subject to the relevant contract requirements, e.g. PM (NEC), Consultant/ Supervising Officer (JCT))

7 COMMISSIONING

7.1 Overview

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

7.2 Commissioning Plan

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

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

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

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

A **Commissioning Plan** must be developed for all capital schemes prior to operational readiness activities commencing. This plan forms the operational blueprint that ensures systems, processes, equipment, workforce arrangements, and compliance requirements are in place before a building or service becomes operational and will provide target dates where possible once operational readiness is confirmed.

The purpose of the Commissioning Plan is to:

- Provide a **structured, documented, and traceable** approach to all pre-commissioning activities.
- Ensure **milestones, dependencies, and resource requirements** are clearly identified and actively managed.
- Support safe and efficient opening of new capital assets.
- Provide assurance that all operational, clinical, digital, estates and logistical arrangements are completed prior to handover.

A robust Commissioning Plan should normally include, as appropriate:

A. Governance & Responsibilities

- Named Commissioning Lead and supporting roles
- Project reporting structure and frequency
- Version control and document management approach

B. Programme & Milestones

- Detailed activity schedule with
  - Pre-commissioning and commissioning phases
  - Clearly defined milestones
  - Critical path and interdependencies (e.g. Estates, Digital, Workforce, Contractors)
- Identification of high-risk dependencies that may affect service-readiness

C. Operational Readiness Requirements Including but not limited to:

- Workforce mobilisation and induction requirements
- Training, familiarisation and orientation plans
- Equipment verification, acceptance, tagging and placement
- IT systems installation and testing
- Medical devices commissioning
- SOPs and operational policies completed and approved
- Infection prevention requirements
- Clinical model readiness

D. Logistical Arrangements

- Key and access control arrangements
- ID badge processes
- Security, cleaning and FM arrangements
- Waste, linen, deliveries and postal systems
- Patient flow and internal signage validation
- Emergency routes and evacuation plans

E. Regulatory & Compliance Checks

- Statutory compliance (HTMs/WHTMs as applicable)
- H&S assessments
- Fire compliance
- Estates and contractor certification

F. Evidence & Readiness Assurance

- Checklists and commissioning evidence logs
- Go/No-Go criteria
- Defect reporting and resolution tracking
- Handover documentation requirements

G. Monitoring, Review and Update Requirements

The Commissioning Plan must:
Be reviewed regularly during the commissioning period (frequency may increase for complex schemes).Shared with the commissioning team
Provided as part of the **Post-Project Review** documentation

7.3 Operational Policies

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

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

A template for Operational Policies is given in Annex 9.

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

7.4 Staffing

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

7.5 Equipping Strategy

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

7.6 Hand-over to Operational Management

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

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

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

7.7 De-commissioning Redundant Facilities

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

7.8 Public Relations

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

7.9 Post – contract

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

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

Release of retention

The Project Director or his representative shall ensure that: -

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

7.10 Liquidated damages

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

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

8 POST CONTRACT REVIEW AND EVALUATION

8.1 Post contract review

The Project Director or his representative shall ensure that: -

- The success of the project is considered, and performance is objectively assessed.
- The post contract review considers whether the form of contract was appropriate for the project.
- Post contract review is carried out immediately on completion of the project.
- The review considers why amendments to the design or specification were required and whether they should have been identified in advance of the project starting.
- Users are asked to comment on whether the completed project achieves their design requirements / investment objectives.
- Performance of the project team is reviewed.
- Reports are made to the Board if there is any delay in the contract.
- Projects will be subject to (where applicable) capital audit reviews
- Final cost reports are prepared which explain any variances from budget.
- Differences between the contract price and the final cost are analysed and explained.
- The performance of the contractor is assessed in terms of: -
    - costs;
    - adequacy of supervision;
    - availability and suitability of plant and materials;
    - provision of labour;
    - relationship with employer;
    - relationship with sub-contractors;
    - industrial relations;
    - standards of work;
    - use of sub-contractors;
    - timely completion of work;
    - claims
- The report concludes with recommendations on the operation of future contracts.
- After the project has been in operation for a period the following issues are assessed:
    - the outcome compared to the plans;
    - are the revenue consequences of the project as budgeted?
- The following details of the finished asset are reported to the manager of the asset register for inclusion:
    - name;
    - place;
    - cost;
    - date first in use;
    - Asset valuation (if there is one)

8.2 Post Project Evaluation

The Project Director or his representative shall ensure that: -

- A post project evaluation is carried out six months after a project has been successfully commissioned i.e. in accordance with the guidance set out in the Capital Investment

Manual. The Full Post Project Evaluation evaluates the costs and benefits criteria described in the Business Case and used throughout for evaluation purposes.

- The evaluation is carried out by an evaluation team headed by operational and project managers not associated with the project.
- The evaluation is reported formally to the Capital Group / Strategic Capital and Estates Group.

9 MINOR WORKS

9.1 The Minor Works Service

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

The following principles apply for all schemes:

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

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

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

1. **Buildings**
2. **Electrical**
3. **Mechanical**
4. **Flooring/Decoration/Ceilings**

Amount	Rules
<£25k	Direct award to any MTC Contractors
>£25k – 50k	3 quotes off any 3 MTC Contractors
>£50k	All MTC Contractors invited to quote

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

10 EQUIPMENT

10.1 Overview

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

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

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

10.2 Procurement

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

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

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

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

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

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

C New Build or Refurbishment Capital Schemes:

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

- Group 2 (purchased by the Health Board) installed by the building contractor.
- Group 3 purchased and installed by the Health Board
- Group 4 low value items

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

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

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

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

10.3 The role of Procurement in CRL Management

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

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

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

11 LAND AND PROPERTY

11.1 OVERVIEW

Specific guidance is provided in Health Board Standing Orders and Estatecode Wales Edition 2018 (WHBN 00-08)

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

- The Health Board Land & Property Group is responsible for the management of acquisitions, disposals, leases, and other property matters even when such transactions are part of an approved scheme.

- The Health Board Land & Property Group is chaired by the Director for Estates and Facilities and should report to the Health Board and Welsh Government on a regular basis.

- This section provides a brief summary of the requirements of Estatecode. These transactions are carried out by officers from the Works and Estate department who will appoint any outside specialists and who work closely with NWSSP - FS - Property Management.

- In addition to any guidance contained within this section it should be emphasised that all acquisitions and disposals of land/property of any limit must receive the written approval of the Welsh Government before being entered into. Therefore for acquisitions, disposals and leases, Ministers Approval must be requested by a submission to the Capital Estates and Facilities Branch including the property name, acquisition/ disposal value and estimated timescale. This should be after internal ABUHB Board level approval.

11.2 ACQUISITION OF LAND AND PROPERTY

The Acquisition of Land and Property by NHS Health Boards in Wales is governed by **Estatecode**

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

The Business Case

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

Site Identification

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

General points when acquiring land and buildings.

- Check the availability and likely price.
- Check the accessibility of the site to the public.
- Check the relative business rates potential liability for each option.
- Ensure potential sites are capable of development i.e., services available, ground conditions suitable, density adequate or buildings suitable for conversion.
- Check the planning position and checks should also be made with the highway authority and utility companies.
- A structural survey should be carried out on existing buildings intended for reuse, including mechanical & electrical installations, drainage and other services, compliance with building regulations and planning permission, fire and health & safety issues, presence of asbestos or other contamination.

Valuations and Purchase Price

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

Planning Approval

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

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

Section 106 Agreements

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

Freehold Covenants

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

Heads of Terms

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

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

- the tenure.
- for leases – details of the proposed terms.
- any dilapidation requirements.

Solicitor's Role

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

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

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

Key Points

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

11.3 LEASING

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

Decision to Lease

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

Negotiating the Lease

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

11.4 DISPOSAL OF SURPLUS NHS PROPERTY

- The Disposal of Land and Property by NHS Health Boards in Wales is governed by **Estatecode**

12. PRIMARY CARE

12.1 Introduction

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

12.2 Guidance

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

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

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

There has been no other guidance issued in the meantime.

A. Interim Guidance

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

- WHC(2007) 064 - Primary Care Estate Development and the Bid Process
- WHC (2007) 007 - Guidance for Selection of 3rd Party Developers
- WHC (2008) 009 - Additional Requirements - 3PD Selection Process

- letter 19/11/2009 – IPD process
- WHC (2006) 032 – Improvement Grants - Revised Guidance

1. All references to WG approval or the Primary Care Estate Forum are deleted.
2. For 3PD Developments it is recommended that decision processes are developed via the IPD (initial proposal document) process but adopting a 2-phase approach. An initial service brief and outline case, which is an IPD, should be adopted for Health Boards' Board approval prior to the selection of a 3PD developer. Secondly, a more detailed document with the full proposal detail (following the content of the former Bid document) should be submitted for final Health Board approval prior to confirming full commitment to the scheme.
3. Any reference to the Premises Cost Directions of 2004 should read The National Health Service (General Medical Services-Premises Costs) (Wales) Directions 2015
4. Reference to design specification should refer to WHBN 36 General Medical Practice Premises in Wales, a guide to planning and design.
5. Welsh Government will require a copy of the final Health Board approved document for information purposes only. This document should confirm the specific funding requirements of any Welsh Government offer made by letter.
6. Welsh Government may also request timeline updates to ensure schemes are delivered within required timescales.
7. Improvement Grants should still be progressed with reference to WHC (2006) 032 for general principals, but referring to the current Directions, the National Health Service (General Medical Services-Premises Costs) (Wales) Directions 2015 and noting changes to abatement periods, eligible works and fees. Proposals should be developed in detail with practices, have justified service benefits and demonstrate commitment. Practices must agree revenue figures in advance and agree to claw back provisions should GMS services cease from the premises. Welsh Government will require the submission of a prioritised pipeline of proposed schemes for consideration in advance of each financial year.
8. Please refer to NWSSP - SES with any general queries or for scheme specific guidance.

13. LEASES

13.1 Overview

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

13.2 IFRS 16 Leases

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

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

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

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

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

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

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

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

13.3 Process for Entering Into a New Lease/Lease Renewal

13.3.1 Property Leases

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

13.3.2 Property Lease Approval Process

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



13.3.3 Equipment / Vehicle Leases

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

Equipment leases may be contained within:

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

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

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

14 CONTROLS, MONITORING AND EFFECTIVENESS

14.1 Overview

This section sets out the expected controls; the information required to evidence those controls and the person(s) who will have responsibility for ensuring those controls are in place and

monitored. The controls are considered to be the minimum necessary to demonstrate sound financial controls in relation to capital projects.
Managers should implement additional controls where projects are considered to involve a greater degree of risk and/or reporting than normal.

14.2 Summary of high-level controls

Phase/Area	Expected control	Evidence	Person responsible
Project planning and appraisal			
The planned project meets the requirements of the Health Board's IMTP/ Annual Plan and CF Strategy and is prioritised and evaluated on that basis.	Project Brief signed off prior to significant BJC/PPD and design development.	IMTP/ Annual Plan Capital Group Minute Executive Team Minute PIP minute/feedback Board Minute Project files Correspondence	**Action** Divisional General Manager/Project Director/ Lead User **Monitoring** Assistant Director of Strategic Capital
The benefits realised from the investment are clearly explained and described in such a way that they can be monitored and evaluated	Benefits have to be clearly stated in the Capital bid (PPD/BJC/SOC) Annexes 5 and 6	The Benefits/Impacts of Proposed Solution section of the relevant case has been completed and are subsequently taken forward to the Post Project Evaluation where applicable. Project monitoring reports	**Action** Divisional General Manager/Project Director/ Lead User **Monitoring Assistant Director of Strategic Capital**
All the financial implications of the project have been considered before the contract is let and are monitored throughout the implementation period	The PPD or BJC (Annexes 5 and 6) contains the following information 1. Capital budget 2. Revenue cost implications and a source of funding. 3. Profiled and realistic capital cash flow to be used for Project Monitoring purposes (Section 5)	The capital costs given in the bid document are full costs including works costs, equipment (inc. furniture), ICT, fees, contingency and VAT. Compare budget against tender Revenue section of PPD Project monitoring reports including AWCP where appropriate.	**Action** Divisional General Manager/Project Director/ Lead User /Business Partner Accountant **Monitoring** Assistant Director of Strategic Capital
Appropriate approvals for the scheme have been received.	Approval is required at: Project initiation Feasibility OBC FBC	Capital Group/Executive Team/Board minutes as required.	**Action** Divisional General Manager/Project Director/ Lead User **Monitoring** Assistant Director of Strategic Capital

Key risks are identified and a risk management approach set out	A risk assessment has been carried out and risks are allocated to those best placed to manage them.	The Project Risk Assessment section of the PPD is completed and if appropriate a Project Priorities (Annex 11) has been drawn up and is regularly reviewed and updated	**Action** Divisional General Manager/Project Director/ Lead User **Monitoring Assistant Director of Strategic Capital**
A clearly established management team, which includes representatives of all interested departments, has been given responsibility for the project.	A project team has been set up with a named individual responsible for the successful delivery of the project and reporting requirements are clear Only one named person can instruct contractors External advisers roles clearly defined and appointed competitively	Project Board and Team Minutes Project appointment letters Project Directory	**Action** Divisional General Manager/Project Director/ Lead User **Monitoring** Assistant Director of Strategic Capital
Pre Contract			
Contractors invited to tender are capable of undertaking the work - both financially and technically	Tendering for schemes is to be carried out in accordance with the ABUHB Standing Financial Instructions and the guidance set out in Annex 15. Most contractors will be pre-selected/vetted	Appropriate Frameworks etc.	**Action** Divisional Director facilities or Representative **Monitoring** Head of Procurement
The tendering process results in the most appropriate contractor being contracted to perform the contract for the best price.	Tendering for schemes is to be carried out in accordance with the ABUHB Standing Financial Instructions and the guidance set out in Section 6	Tender register and select list Tender, contract register Signed as reviewed Board minutes	**Action** Divisional Director facilities or Representative **Monitoring** Head of Procurement
The contract entered into is the most appropriate for the work in hand.	Standard terms and conditions are used. Legal confirmation is sought The suitability of guarantors is assessed. Under and poor performance is covered by liquidated damages. The basis of prices is specified.	Assess for suitability Correspondence Performance bond or similar Agreed by legal Contract clauses	**Action** Divisional Director facilities or Representative **Monitoring** Head of Procurement
Ensure best practice aimed at reducing the risk of bid rigging/ anti competitive	Measures are in place to reduce the risk of bid rigging and anti-competitive behaviour. Annex 15 section 4.12	Tender analysis etc. Annual Tender analysis and report to Capital Group	**Action:** Divisional Director facilities /Head of Procurement **Monitoring**

behaviour between contractors.			Audit
The design of the project meets the requirements of the Business Case.	The brief is sufficiently well developed to allow design. The design is sufficiently detailed for tender. The design is in line with the project approval. The design has been approved by the users.	Readiness to proceed to design Annex 17 Match design, specification, tender, as built Matching and signed. Check for inconsistencies. Proceed to Tender Annex 18	**Action** Directorate General Manager/Project Director/ Lead User **Monitoring** Divisional Director facilities or Representative

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

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

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

	Users should comment on the scheme. A final project report should be made to the Capital Group where applicable. The performance of the contractor should be assessed.	Project report Capital Group minutes Independent team	Director/ Lead User **Monitoring** Assistant Director of Strategic Capital

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

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

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

14.5 Key Performance Indicators
Contractor and consultant performance to be monitored through using a KPI Proforma. KPI targets are usually set based on the framework which the project has been appointed under. Where KPI's are not set or do not fulfil the Health Boards requirements from a performance perspective, these will be agreed prior to the commencement of the project.

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

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

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

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

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

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

14.8 WELSH GOVERNMENT and NWSSP–Specialist Estate Services **(SES) returns**

In line with the requirements set out within the NHS Wales Infrastructure Guidance, Project Progress Reports are required bi-monthly for WG selected AWCP projects. These need to be provided to the Welsh Government Capital Team electronically by the 12th working day of every other month.

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CAPITAL PROCEDURES
Annex 1

Key Capital Governance Roles and Responsibilities

The Chief Executive

- The Chief Executive has overall responsibility for delivery of the Health Board's Capital Programme.
- The Chief Executive may act as Project Owner/ Senior Responsible Owner and has overall responsibility for the management of capital schemes at all stages of the process, from inception to post project evaluation and for ensuring the recording of assets once acquired.

- The Chief Executive must ensure that the manager appointed to manage an approved capital scheme receives notification of delegated authority to commit expenditure, to proceed to tender or to accept a successful tender as required.
- The Chief Executive may delegate capital investment management in accordance with Welsh Government guidance, Estate code guidance and the Health Board's Standing Orders.
- The Chief Executive shall have the delegated authority to approve capital investment up to a value of £100,000.

The Executive Director of Strategy, Planning and Partnerships
Capital Programme

The Director of Strategy, Planning and Partnerships will:

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

The Assistant Director of Strategic Capital will:

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

- Provide effective management, co-ordination and development of the ABUHB capital annual or three year (as required) programme including the development, maintenance and implementation at a corporate level. These plans must balance with the organisation's Capital Resource Limit (CRL).
- Provide effective management, co-ordination and development of capital investment proposals and to encourage the use of good practice in the preparation of capital business cases.
- Lead and/or assist in the production of appropriate documentation and analysis, Business cases etc. and ensure that for each approved project a business case or business justification document is produced which contains a full appraisal of options against potential benefits and known costs for each investment proposal.
- Establish, or advise on the establishment of, appropriate Project Management structures including Project Teams, user groups and purchaser liaison arrangements.
- Produce, lead or assist in the production of, appropriate documentation and analysis, Business Cases and Capital Programmes and Reports for Health Board and Capital Group.
- Maintain links with external groups or bodies who have a key role in the allocation of capital resources. This includes Welsh Government.
- Provide practical support to Project Owners, Directors and Managers including the clarification of investment objectives, provision of a quality assurance role and implementation of Prince2.
- Provide as required, Capital and Project Papers for the Executive Team and the Health Board.
- Manage the business of the Capital and Estates Group
- Chair or delegate to Discretionary Capital Lead the Capital Monitoring and Divisional meetings as required.
- Apply NHS Wales Infrastructure Investment Guidance, Capital Investment Manual and Welsh Government 5 Case Model techniques including development of strategic and financial contexts, identification of benefits criteria, option appraisal and risk analysis to capital investment proposals.
- Support the ongoing improvement in Health Board Capital Investment protocols and practices to ensure that the maximum benefit is gained from limited capital resources.
- In co-operation with the Head of Capital Finance, develop annual or three year plans (as required) for discretionary capital expenditure and submit to the Health Board.
- Be responsible for the regular review and reporting of the Health Board Capital Programme.
- When property transactions form part of a capital project ensure that appropriate procedures are followed including Health Board Land and Property Group, Health Board scrutiny and approvals and Welsh Government approvals.
- Ensure alignment with the Welsh Government Capital Programme, the Health Board IMTP/Annual Plan and all current requirements of the strategic development of the Estate and if required provide strategic property briefings for the Health Board.
- Work with Shared Services to plan the audit programme and facilitate audit of Capital schemes.
- Review external opportunities to enhance funding through external/additional funding streams.

The Finance Director

The Finance Director will: -

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

Divisional Director of Facilities

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

Capital Programme

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

Technical/Professional Project Management

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

- Allocate design team resources.
- Support the development of user requirements.
- Provide technical advice on feasibility of user options.
- Undertake and support option appraisal for business case development.
- Provide outline costing, identifying the costing basis.
- Provide comprehensive cost information and estimates in line with the requirements of the CRL ensuring that cost variances are identified separately for the effects of programme and cost changes.
- Advice on statutory approval requirements.
- Advice on project timetable in the form of a project execution plan.
- Advising on the appointment of external project managers as appropriate.
- Support the appointment and management of external design teams.

- Compliance and Construction, Design and Management (CDM) regulation 2015.
- Provide appropriate support through membership of Capital Project teams.
- Ongoing management and control of capital schemes.
- Development of an agreed programme.
- Prioritise capital schemes.
- Advice on requirement of Capital Procedures compliance.
- Support the submission of Project start up documents with appropriate advice on status of any cost provided.
- Manage Design Teams ensuring appropriate and timely instructions/solutions are received through the Contract Administrator/Design Team

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

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

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1. Purpose

The Capital and Estates Group ('the Group') purpose is to oversee the Health Board's Capital Programme for both Strategic and Discretionary Capital; including:

- Oversee and monitor the ongoing progress and implementation of capital projects from all capital funding routes;
- Oversee the implementation of the Health Board Estates Strategy and the associated updated Estate Strategy Strategic Objectives.
- Take a strategic view of the Health Board's assets and estate to ensure that investment decisions are consistent and appropriate
- Approve proposals for funding within its financial delegated limits

2. Objectives

The objectives of the Group are to -

- Develop and ratify the Health Boards Capital Programme prior to Executive Team and Health Board approval.
- Monitor the Health Board Capital Programme, ensuring CRL compliance including proposing and implementing such measures required to achieve this.
- Receive capital reports from Regional Partnership Boards

<u>Discretionary and All Wales Capital</u>

- Escalate minor schemes that, through natural development increase by cost or technical intricacy, to the Capital and Estates Board for re-allocation to the All Wales Capital Major Projects Team. Typical escalation value to be over £1,000.000.
- Ensure compliance with the Health Boards
    - Capital Protocols and Procedures
    - Standing Financial Instructions and standing orders
    - Welsh Government Five Case model requirements
    - NHS Infrastructure Investment Guidance
    - Other guidance as issued or adopted by the Welsh Government or Health Board

- Manage the Capital Resource Limit including in-year measures and changes to funding and approved expenditure.

Strategic Estate

- Monitor delivery of the Strategic capital projects, acting as a point of escalation for issues and risks that cannot be resolved at Local or Divisional level.
- Assess wider regional and / or organisational plans and their implications for the Estate Strategy and the Strategic capital projects.

Evaluate new proposed capital developments to consider strategic fit, implications for quality & patient safety and the best use of resources to ensure value for money. General

- Liaise with NHS Wales-Shared Services Partnership, Audit and Assurance and Audit Wales and act upon their recommendations reporting within the Health Board as required.
- Support the preparation of Executive Team and Health Board submissions on both Programme and individual cases.
- Promote the use and development of the UHB's Capital Procedures.
- Provide overview of procurement including frameworks etc.
- Provide overview of contracting etc.

3. Financial Delegated Accountability

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

- Evaluation and approval of individual capital investment business cases with a cost of less than £75,000 prior to inclusion in the Health Board Capital Programme.
- Evaluation of individual capital investment business cases with a cost between £75,000 and £500,000 prior to Executive Team submission, approval by the Chair and Chief Executive and inclusion in the Health Board Capital Programme.
- Review of Project proposal documents and business cases for schemes costing from £500,000 to £1,000,000 prior

to Executive Team and Health Board submission. This should include any bids for funds from external funding sources that do not require Health Board capital resource.

Should decisions be required outside of the scheduled meetings, the Chair of the Group is able to take Chairs Action within their delegated finical limits.

4. Membership

The Group's membership is established to ensure representation across the key areas of the Health Board's response.

Name	Title / Role
Hannah Evans	Executive Director of Strategy, Planning and Partnerships
Hannah Capel	Assistant Director of Strategic Capital
Claire Nelson	Deputy Director, Planning, Partnership and Strategy
Steve Bonser	Operations
Jamie Marchant	Director of Estates and Facilities
Kelly Jones	Head of Capital Finance
Leigh-Anne Challenger	Senior Capital Programme Manager
Suzanne Jones	Assistant Finance Director – Financial Strategy, Planning, Capital & Commissioning
Paul Solloway	Director of Digital
Cathy Brooks	Assistant Director of Workforce
Lorraine Morgan	Programme Manager - Strategic Capital & Estates
Julie Gilbert	Clinical Support Services
Chris Heath	Medicine Division
Paul Rice	Mental Health and Learning Disabilities
Ali Gough	Primary Care and Community Division
Roxanna Williams	Urgent Care Division
Ashley Davies	Family and Therapies Division
Jonathan Thomas	Surgery Division
Joanne James	Surgery Division
Amy Dolben	Regional Partnership Board
Scott Taylor	Health And Safety
Moira Bevan	Head of Service, Infection Prevention and Control
Katy Jones	Procurement

Other attendees will be co-opted on an item specific basis and membership will be reviewed at each meeting to ensure it remains appropriate to the issues at hand. Audit and Assurance will attend in an advisory capacity.

The Group will be chaired by the Director of Strategy, Planning and Partnerships. In their absence, they will nominate a Deputy Chair from the membership to chair the meeting.

5. Declarations of Interest

All members and attendees of the Group must declare any relevant personal, non-personal, pecuniary, or potential interests at the commencement of any meeting. The Chair of the Group will determine whether there is a conflict of interest such that the member and/or attendee will be required to not participate in a discussion or otherwise limit their involvement in the meeting.
Any member at any time is entitled to ask the Chair whether an item of business should be discussed outside of a meeting in common for any reason.

6. Meetings

Frequency of Meetings

The Group will meet monthly. The agenda will be agreed by the Chair and agenda and papers to be circulated 2 working days before the meeting, unless by exception and agreed with Chair of meeting in advance. The meeting will be administered by the Capital Team Administrator.

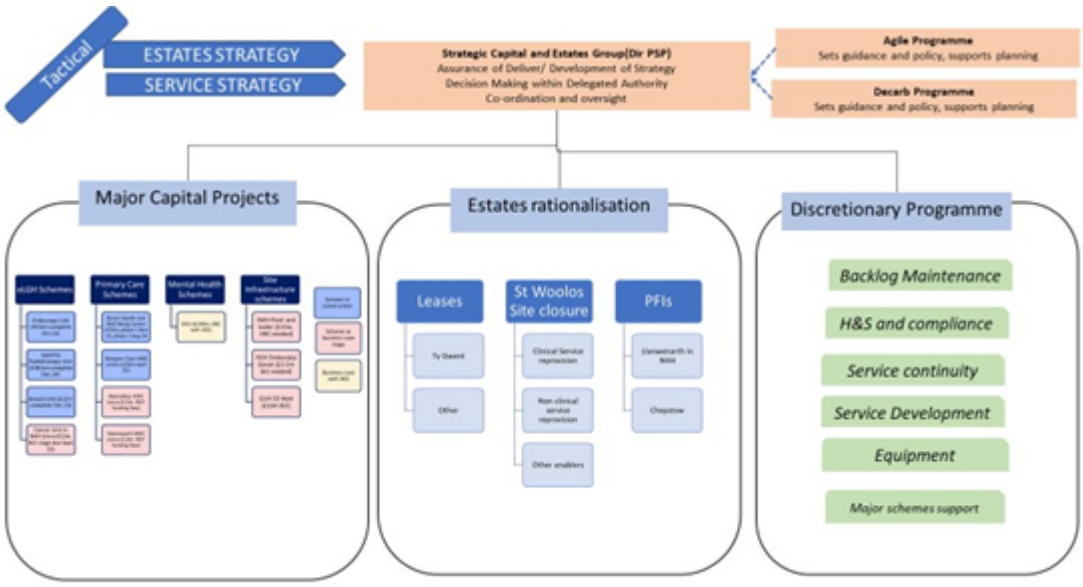
Quorum

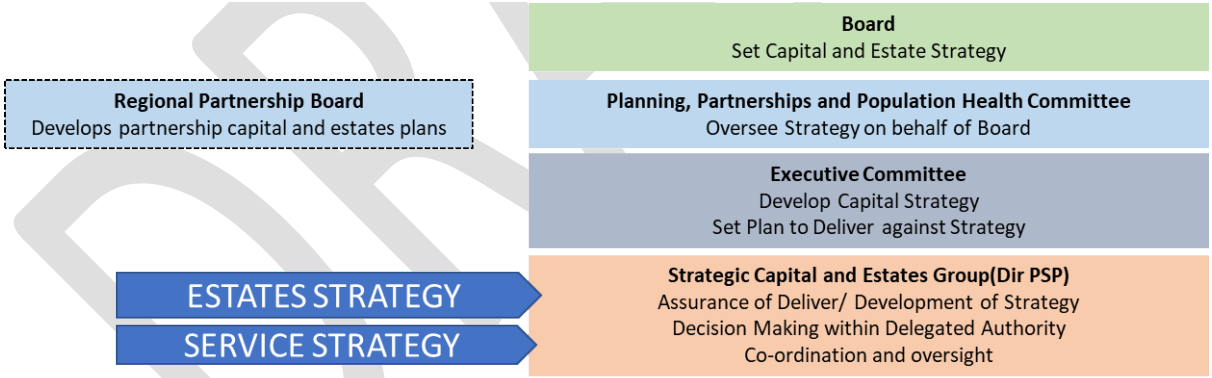
The quorum for meetings is at least 50% of all members. A duly convened meeting of the Group at which a quorum is present shall be competent to exercise all or any of the duties or powers vested in or exercisable by the Programme Board.

The Group's Chair may ask any or all of those who normally attend, but who are not members to withdraw to facilitate open and frank discussion of particular matters.

7. Reporting responsibilities

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





ANEURIN BEVAN UNIVERSITY HEALTH BOARD
CAPITAL PROCEDURES
Annex 4

CAPITAL APPOINTMENT LETTERS

Dear NAME

Appointment of Capital Project Director
Scheme Title: -
PART A

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

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

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

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

Signed on behalf of ABUHB

.....
[Insert Name]
Chief Executive

PART B

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

Signed

.....
[Insert Name]
Project Director

Capital Appointment Letter Annex 4 Attachment

The role and responsibilities of the Capital Project Director

The Project Director will: -

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

The Project Director shall ensure that: -

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

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

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

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Dear NAME

Appointment of Capital Project Manager
Scheme Title: -
PART A

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

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

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

Signed on behalf of ABUHB;

.....
[Insert Name]
Project Director

PART B

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

Signed;

.....
[Insert Name]
Project Manager

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Capital Appointment Letter Annex 4 Attachment

The Role and Responsibilities of the ABUHB Project Manager

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

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

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

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

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

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

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PROJECT PROPOSAL DOCUMENT (PPD)

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

This is to be submitted to the Capital App for scrutiny and processing to the Capital and Estates Board.



PPD%20TEMPLATE.docx

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Annex 6

Project Title:

Business Justification

Version no:
Issue date:

Purpose of this document

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

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

Please note that this template is for guidance purposes only.

VERSION HISTORY

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

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CONTENTS – BUSINESS JUSTIFICATION TEMPLATE

TEMPLATE AND SUPPORTING GUIDANCE

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

Appendix Investment appraisals
Cost Forms



Annex 6 Cost Forms attachment.docx

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BUSINESS JUSTIFICATION TEMPLATE AND SUPPORTING GUIDANCE

1. Purpose

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

2. Strategic Context

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

3. Case for Change

A. Business needs

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

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

B. Benefits

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

C. Risks

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

4. Available Options

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

Please bear in mind:

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

5. Preferred Option

On the basis of the above, please:

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

6. Procurement Route

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

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

7. Funding and Affordability

Please indicate:

- the capital and revenue costs of the proposed investment
- how the investment will be funded
- any affordability gap (as appropriate)
- Any savings/ efficiencies as a result of the investment

8. Management Arrangements

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

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

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INITIAL SCOPING DOCUMENT TEMPLATE

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

Title of Bid:

Project lead(s):

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

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

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

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

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

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

Revenue or Workforce implications:

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

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

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

Current stage of development:

ABUHB
Project Brief Template *Example*

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

The problem
- Define it objectively and provide evidence
- Objectives
- Can we give measurable deliverables? *"We must have 3 procedure rooms"*
- Is it "critical" to ABHB services?
- Can it release any current costs (revenue/ capital)?

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

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

Interfaces
Who and what does the project affect?

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

Performance
- What performance standards are relevant?

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

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

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

Project Management
- Who will be involved?

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

Risks
What are the **Risks** associated with doing the project?
What are the **Risks** associated with not doing the project?
What are the opportunities?

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CAPITAL PROJECTS

OPERATIONAL POLICY TEMPLATE

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

Name of service/department -

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Consumer Standards **– if applicable**

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

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

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

Author, File Name, Version Number and Date

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Signed off by:

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BENEFITS

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

A benefit may be described as:

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

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

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

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

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

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

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

RISKS

Risk Proforma:



Annex 11 - Risk Proforma Feb 2020.x

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

What constitutes a successful project?

A successful project is a project:

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

What tools are available?

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

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

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

What lessons have we learnt from previous projects?

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

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PROJECT INITIATION PLAN TEMPLATE

Project Initiation Document

1 Overview

1.1 Purpose

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

There are two primary uses for the document:

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

1.2 Key questions including

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

2 Background including Service Context

3 Project Definition/Scope

3.1 Objectives

3.2 Project scope

3.3 Project deliverables and desired outcomes

3.4 Constraints

3.5 Exclusions

3.6 Interfaces

3.7 Assumptions

4 Project Structure and Management Arrangements

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

5 Project Plan

6 Communication Plan

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

7 Quality Plan

8 Project Controls and Reporting

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

9 Initial Priorities

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

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PROJECT EXECUTION PLAN TEMPLATE

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

Project definition and Brief

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

Roles Responsibilities and Authority

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

Project Plan and Cost Management

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

Risk and Sensitivity Analysis
Programme management
i. Milestone events
ii. definitions and meaning
iii. detail required
iv. frequency of review
v. how progress is monitored against a Critical Path network diagram showing interdependencies, Critical Path and float and any GANTT charts.

Contracting and Procurement
Administrative Systems and Procedures
i. Document and computer filing systems
ii. Project reporting
iii. Meeting frequencies, objectives, attendances etc.

Safety and environmental issues
Quality assurance
Commissioning
Post Project Evaluation and Post Contract Review
Technical standards
i. drawing formats
ii. plant and equipment numbering consistent with Asset Register
iii. maintenance requirements (generally future)

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NOTES ON DESIGN, TENDERING AND CONTRACTING - WORKS SCHEMES

1 Overview

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

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

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

RIBA Plan of Work 2020.pdf

2 Initiating a Scheme

2.1 Background

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

2.2 Procurement Strategy

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

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

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

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

2.3 Accessing Works and Project Resources

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

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

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

WHBN 00-01 General Design Principles 2017

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

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

2.4 Feasibility Stage

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

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

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

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

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

Issues to be taken into account at feasibility stage are:

1. Existing Site Development control plans and other proposed changes
2. Site investigation to determine:
   - Site capacities MEP/infrastructure
   - Site ground contamination issues/constraints
   - ICT constraints/capacities
   - Fire precautionary issues
   - Safety Services issues
   - Operational Works Management specifications
   - Facilities Management specifications
   - Environmental issues:

i. Traffic impact studies
ii. Access statements
iii. Environmental impact studies

- CDM 2015 implications/access and maintenance or other relevant issues required in the Pre-construction information.
- Consultation with asbestos database
- Risk log identified/costed
- Equipment strategy to be considered
- Legionella issues
- Safety hazard notices/alerts
- Carry out a dimensional survey to confirm drawing accuracy of MICAD drawings
- Designer risk assessments
- Green issues
- Way finding issues
- Energy requirements
- Dementia Friendly Environment requirements.
- Project Manager via the Ops and Maintenance Manger to check requirements for degassing, residual oils, electric meter terminations etc.

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

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

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

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

For accurate equipping costs Procurement Services, NHS Wales Shared Services Partnership (Capital Equipping) are to be involved in the process from inception of scheme. See Section 10 of the main document.

There will also be a need to consider revenue implications to feed into the business case (PPD/BJC/OBC/FBC).

A cost plan projection and a guideline high level programme also need to be considered.

A Project Execution Plan or PEP (See Annex 14) should also be developed for major schemes (subject to discussion with the Capital Team this will be for projects with a capital value of £1m and above).

If consultants are invited to carry out a feasibility study it is important to:

- Ensure that there is a clear approval for capital funding and a fee estimate is provided leading to the release of a Capital Cost Code.

- Agree a procurement strategy (If necessary with NHS Wales Shared Services Partnership - Specialist Estates Services). The value of the project will determine if an All-Wales Construction Framework will be used.
- Have a signed appointment document to reflect the services required.
- If a Consultant is acting as Principal Designer under CDM 2015 ensure that a standard letter is issued to the principal designer at the outset of the commission.
- Have a costed resource plan and programme to undertaken the feasibility as per user/ technical brief developed by the internal team.
- Consider they have adequate PI and public liability (to be ratified annually for 6/12 years dependant on contract being underhand/under seal.
- They are on a recognised framework although if required competitive tendering is permitted.
- They are informed that we require copyright of their design drawings and specification
- They deliver on time and to budget as per brief.
- N.B. Design development may occur at this stage in the design which may necessitate additional fees. Any additional fee line rights to be proposed by the Project Manager agreed with Divisional Director Estates and the Capital Team.
- Consider drawing formats PDF/DWG AutoCAD 2008 or above.
- Ensure there is a break clause in the appointment process that permits ABUHB to proceed with their design by others if deemed necessary due to escalation of costs etc.
- Take advice from any patient panels/CHC/LA/specialist groups as deemed appropriate, consult/engage as necessary.
- Prepare and consider an equipment strategy.
- Prepare and consider life-cycle costings (if required by the scheme)
- Obtain outline planning permission if deemed a requirement.
- Obtain permissions to develop from statutory under-takers gas/water/electric/BT – carry out surveys as appropriate.
- Agree a cut-off date for design data standards.
- Welsh Government consents and approvals and OJEC thresholds need to be considered at this stage.

On completion of feasibility the Certificate of Readiness to Proceed to Design should be signed by the Divisional Director Estates /Capital Project Manager (See Annex 17).

3 Design – Approved Scheme

3.1 Design Phase

On completion of the feasibility stage and successful application of the PPD/BJC/OBC the preferred option can be worked up into a detailed design proposal.
An agreed fee line to take the project through this stage needs to have been approved by the Capital Group/Director of Planning to proceed through to design and a capital job number issued if not already done at feasibility stage.

3.2 Development of the Brief

The project team/design team will further develop the outline brief in association with the ABUHB Technical PM to ensure the brief translates into the project requirements.
The external/internal multidisciplinary design team will further develop the outline brief in association with the ABUHB representatives to ensure the brief translates into the project requirements. Work on the 1:200 sketch design/room relationship layouts along with the operational policies for whole site and departmental schedule of accommodation and will be enhanced further to create a detailed design to 1:50 and 1:5 drawings with accompanying detailed room data sheets.

Data sheets will be developed further to better inform the costing process and pre-tender estimate, specification, procurement of equipment strategy to take account of any abatements or purchase of new.

3.3 Compliance/Standards/Derogations
At this stage internal/external designers will ensure full compliance with all current applicable Standards in NHS Wales and ABUHB including:

1. Firecode
2. Health Building Notes (HBNs)
3. Health Technical Memoranda (HTM's)
4. Hazard Notices and Medical Source Alerts
5. Health Facilities Guidance
6. Equipment Rates
7. Activity Database/Data Sheets
8. BREEAM Health Care
9. Detailed Building Regulations (if deemed applicable)
10. Detailed Planning Application (if deemed applicable)
11. Health and Safety at Work Act
12. Workplace Regulations
13. Secured by Design for Health Care Premises
14. One Wales: One planet
15. Capital charges
16. Capital Investment Manual (Guidance only – now archived)
17. Concode (Guidance only – now archived)
18. CDM Regulations 2015
19. EU Directives Governing Public Procurement and Welsh Government Guidance
20. ABUHB Standing Orders/Standing Financial Instructions
21. ABUHB Works & Estates Technical Brief
22. ABUHB Code of Conduct for Contractors
23. Electricity Regulations
24. Dementia Friendly Environment requirements
25. Asbestos Regulations
26. Water management and Legionellae
27. Any requirement relating to Accommodation Utilisation (ASUG)
28. Any specific departmental or clinical guidance or standards that apply.
29. NHS Wales Infrastructure Investment Guidance.

3.4 Design Sign-off
An agreed date for design data cut off must be agreed by all relevant parties under the guidance of the PM. The design and any derogation from standards must be signed off by service user and ABUHB PM/PD prior to tender.

3.5 Design Team
The design team is responsible for the technical content of the design. The service and/or technical project manager has authority over the design team in matters of design management.
The design team will operate under a principal designer if appointed. If a principal designer is not appointed this role will be discharged by the Technical PM (ABUHB Estates).

The following factors must be considered and their impact on design and cost of the project evaluated:

- Integrity of brief is maintained throughout process i.e. freeze the brief as soon as is reasonably practicable.
- Design process is held to budget and programme. Advise ABUHB lead Project Manager/Project Director of any design development issues which will attract more fees
- For all PTEs exceeding £25k each firms should be contacted via a preliminary invitation to tender letter
- Ensure a fit for purpose design – taking into account patient needs/aesthetics/DDA/ longevity of products costs in use/life cycle costings.
- Review the requirement for art works to be incorporated into the project to enhance the patient experience and healing process (1% works cost).
- Consider any landscaping issues in depth/flood consequences with Environment Agency
- Consider an in depth traffic impact and environmental study if required.
- Revisit all issues as mentioned/listed in the feasibility section and further investigate their impact on design and cost of the project.
- Carry out a destructive pre-demolition asbestos survey if the building/site permits to further advise the business case. This may not be possible and in which case a contingency/P. sum needs to be considered to inform costs. Sometimes "hybrid" surveys are required in occupied areas.
- The selected contractor is required to present the proposed construction phase programme to the Principal Designer for approval prior to the award of tenders.
- The design should sufficiently detail the requirements of the ABUHB to enable a tender to be drawn up and costs to be apportioned to the works in question.
- The design and any derogation from standards are signed off by service user and ABUHB Project Manager/Project Director prior to tender.
- Prior to the construction phase a pre-construction H & S plan needs to be drawn up if the scheme attracts CDM compliance.
- The final design is to be subject to approval/design check by the ABUHB Divisional Director of Facilities or his delegated Estate representative.
- For major projects the design team will normally present the final design to the Divisional Director Facilities and/or his representatives prior to tender.
- All consultant/internal fees are to be monitored throughout the design process by the Project Manager (external/internal).
- Procurement strategy to be revisited and changed/checked as necessary.
- Room relationships to be checked for compliance with standards.
- Consider any cooling requirements in line with HTM's and ABUHB policy.
- Consultants to ensure update of data sheets during the construction phase to enable their use in the commissioning process.
- Prepare a more detailed outline programme of works with anticipated contract period.
- Prepare a detailed cost plan and update costed risk log.
- Hold regular project team and design team meetings to establish the scheme detail and minute matters arising. Enhanced membership may be required at this stage.
- Ensure consultation with and sign off from Infection Control.
- Ensure consultation with and sign off from Safety Services if deemed appropriate.
- Designer risk assessment to be fully developed within this stage.
- Formulation of a derogation register (if required) enhanced from feasibility stage.
- Full engagement required from procurement partners .
- Re-consult with statutory undertakers i.e. Environment agency, Highways LA, Planning, Building Regulations, Carbon Trust .
- Equipment strategy to be signed up by PD/PM on behalf of users and NWSSP – Procurement Services.
- Calculate any VAT reclaims/claw backs.

- Consider capital charges with Head of Capital Finance.
- Re-consider costs in use/revenue/service/contracts.
- Sign off Certificate to Proceed to Tender Divisional Director Estates /Capital Project Manager (Annex 18).
- Cost and progress reports are issued at suitable intervals with a minimum of one at mid stage and one at stage completion preference will be monthly.
- For Welsh Government funded projects BREEAM and AEDET assessments will be required.

3.6 Traditional Approach

The design team (internal or external) is responsible for the technical content of the design.

The Project Manager has authority over the design team in matters of design management.

The cost estimate produced by the QS must be regularly updated as the design is progressed, preference monthly.

The Principal Designer (normally Project Manager/Architect/Engineering Consultant) or ABUHB Technical PM (if no PD appointed) is to ensure all service requirements for the design are coordinated throughout the process and must ensure all large major equipment requirements are noted.

3.7 Fast Track Design Strategies i.e. Design & Build

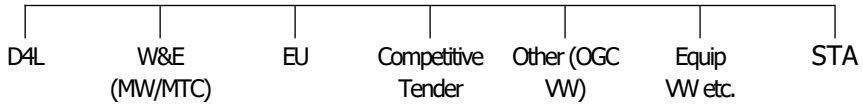
Consideration can be given to allow the contractor to design and build the whole project. The Project Manager and Project Director or professional adviser should assess the suitability of the contractor's design and scrutinise all clarifications as they are submitted.

4 Tender Stage – Katy to review whole of section 4

4.1 Tendering Capital Works Packages and Consultants

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

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



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

4.2 Building for Wales Framework) (see Annex 16)

The new National Framework went live on the 14th November 2024 and it is named the NHS Building for Wales 2 Construction and Consultant Frameworks (often abbreviated as NHSBfW2(see specialist Estates Notification 24/17).

4.3 Works & Estates Local Framework for Contractors (Minor/Major Works)

This covers the appointment of Contractors (Local specialist framework)

A new Framework is to be advertised via the Buy4Wales website via NWSSP–Procurement Services.

Contractors invited to tender shall be vetted financially and in relation to professional competence by Procurement via Buy4Wales.

Contractors not registered on Sell for Wales will not be considered for any invites to tender for Capital works under this procurement route.

Contract will operate for three years with Annual Evaluation to ensure Value for Money and Quality of Performance.

Individual Maximum Order Values to be a maximum of:

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

Running Schedule of MTC Schemes each financial year to be maintained for Building, Mechanical, Electrical, Decorating, Floor Coverings and Suspended Ceilings to ensure individual packages fall within financial limits and aggregated sum does not exceed the agreed threshold

MTC Quantity Surveyor to be appointed for the duration of the framework to monitor value for money and manage the MTC contracts. Monitoring of the contract and selection of the QS will be via Value Wales.

4.4 EU

This is covered by Designed for Life (D4L).

4.5 Traditional Competitive Tendering

4.5.1 Traditional Route via Approved Contractor List

Traditional tendering process remains an option for procurement of Works & Estates Capital Works, this to include a select list of contractors that have been previously vetted for competence and capability. Every effort will be made to maintain and update the approved list on a yearly basis.

Rotation of the list to be monitored by Divisional Director Estates or delegated representative. Head of Works & Estates to select 50% of tender invites remaining 50% to be selected by Project Manager/Technical Project Manager.

Note values contained in this section as follows:

- < £5,000 (Excluding VAT) - 1 **Written Quotation**

- £5,000-£25,000 (Excluding VAT) - Minimum 3 **Written Quotations** to be returned to the Corporate Service manager
- £25K to £1M Minimum - **4 Competitive Tenders** returned to the Chief Executive
- £1M to £4M Minimum - **6 Competitive Tenders** returned to the Chief Executive

Note 1
Consent for contracts exceeding £1 million is exercised directly by the Director General. However, contracts entered into under the All Wales Capital Programme are not covered by this requirement. The application and approval procedures for All Wales Capital Programme activity already embed arrangements for Welsh Ministers consent into the overall project approval process.
Additional monitoring arrangements are in place for contracts that fall below £1million. The following process and information requirement is as follows:
(I) For individual contracts with a value exceeding £500,000 and up to £1,000,000, a contract summary form should be provided for review prior to entering into the contract. It is not necessary to obtain consent to enter into such contracts, however adequate information and time should be given for the Director General to review the contract particulars.
(ii) For individual contracts with a value exceeding £250,000 and up to £500,000 a list of contracts let in the preceding 6 months is to be provided.

Note 2 Competitive Tendering Procedures will not be required when the Health Board has legitimate access to Framework Agreements. Mini Competition may still be required for any framework contractor appointment.

Note 3 For all contracts > £25000 The Health Board should take account of social, economic and environmental issues when making procurement decisions. (Local Labour)

4.5.2 Value Wales Competitive Route

The requirements to follow under this particular procurement route will be to advertise the project on Buy4Wales via Service Contract Manager Works & Estates. Invitations will then in turn be advertised for people on Sell4Wales. A prequalification questionnaire will then be sent out to the applicants requested to carry out the works, this questionnaire will then be used to select 4/6 for competitive tender via traditional specification and drawings.

4.5.3 Others (OGC Buying Agency Etc.)

Use of Pre-Tendered Contracts for the purchase of:

- Equipment
- Services
- Consultancies
- Legal Services
- Utilities
- Other Government Frameworks for Public Bodies applicable for works in question.

4.6 Equipment (See in addition Main Document Section 9)

European Public Contracts Directive 2004 to apply. Consult Head of Procurement/Capital Equipping.

4.7 All Wales Framework - Specialist Service Contracts

To be the responsibility of the Service User Department or Works & Estates Service Contract lead dependent on who holds the budget. Monitoring of service contracts to be done via Procurement/ Shared Services.

4.8 Single Tender Action

Single Tender action should be the exception and should only be called for when a single firm or contractor or proprietary item or service of a special character is required and set out in law. Single tender action should only be employed following Procurement Guidance on Single Tender and Quotation Approval Process.

Where an end user identifies a need for a Single Tender action, or single quotation action, the following process should be undertaken. This process ensures compliance with the following Policies, which are available on the Intranet: ***Organisation Policies: Standing Orders/Standing Financial Instructions***

End user identifies need for a Single tender/quotation action, in line with tender/quotation limits set out in above Organisation Policies

↓

End user prepares business case for goods/services in normal manner

↓

End user seeks approval for finances in normal manner, via Directorate Management or Finance Management Group (FMG)

↓

End user writes to Head of Procurement requesting formal approval to carry out a single tender/quotation action, in line with above Organisation Policies (draft example attached). This memo must state the reasons justifying need to go to one supplier only. A copy of the original business case and a copy of formal approval of finances should be attached

↓

Head of Procurement will forward to Chief Executive advising of Procurement issues, procurement law and Procurement rules and regulations surround the request

↓

Chief Executive will write back to end user authorising, or not authorising, a single tender/quotation action

↓

End user provides copy of final Chief Executive approval to Head of Procurement, who will arrange for single tender/quotation to be issued by relevant section with Procurement Services Department, if action has been agreed

4.9 Key considerations at tender stage:

Carry out a final review of Pre Tender Estimate (PTE), and update Proforma' Annex 17 & 18.

Drawings and specifications as appropriate should be prepared by the design team under direction of the Project Manager/Principal Designer

Concode should be used as a guide. The Project Manager/ Principal Designer to advise the Project Director of the contract type best suited to the works in question.

For traditional contracts the drawings and spec must be complete and comprehensive enough to reflect requirements.

For design and build, performance specifications can be prepared, where performance criteria, standards and quality issues and basic layout/room relationships/data sheets/ schedule of accommodation are included as basic criteria for issue to the contractor for tendering against.

Specification should ask for samples and maybe mock ups to ensure compliance with specification and workmanship requirements.

The Project Manager to ensure propriety is maintained at all stages and all contracts must comply with all Welsh Government Policies relating to the NHS.

A bona fide form/certificate of non-collusion is to be prepared at tender stage and sent out with the contract documents (see Annex 17)

ABUHB Code of Conduct for Contractors to be included with the document.

ABUHB technical design brief to be included in the specification build up for the scheme if deemed appropriate.

Day work sheets proforma to be included with the document.

Ensure a subcontractor selection proforma sheet is also included within the specification although it is recognised that this can be varied by the contractor.

If possible ensure that the pre-construction Destructive Asbestos Survey is included as part of the package if the main contractor is to be responsible for this aspect of the work. This is sometimes carried out by others prior to the contractor engagement.

Ensure there is a priced Summary Sheet attached to the specification to be completed by the contractor.

Ensure there is a Collection Sheet included in the documentation to be completed by the contractor.

Ensure the proforma for compliance issues are included within the document for:

- Water Management Issues
- Electrical Certificates
- Equipment Schedules
- Medical Gas Schedules
- Fire Strategy Updates
- Air Conditioning Schedules

Ensure a unique reference number is created for the scheme and is logged in a register for quotations or tender.

Ensure all return documentation is in return envelopes provided with the scheme appropriately reference by number and pre-addressed to:

- Corporate Service manager for quotations £5k - £25k +VAT
- Chief Executive for tenders above £25k +VAT
- Mini-comp to be returned to the Cost Consultant or PM engaged at the time of the commission for measured term

Designer risk assessments are produced for all aspects of the works.

A pre-construction phase H & S plan is prepared for inclusion with the package by the Project Manager/Principal Designer.

Ensure the Project Execution plan is updated in a timely manner if required.

Ensure all ICT issues are covered off and included with the package either as a Provisional Sum if tendered separately by ICT or as a complete package with a specification written by ABUHB ICT department.

Ensure selection of tenderers from ABUHB Approved Lists, appropriate frameworks, advertise on Value Wales Site etc. This may involve inviting firms to pre-qualify and draw up a tender list of these firms able to meet requirements of the Health Board. Equifax or equivalent checks on all contractors and consultants to be carried out prior to any appointment.

Should the requisite number of tenderers not be available due to market conditions or professional constraints the Chief Executive or designated deputy shall be authorised to accept a lower number of tenderers. Where the number of tenders received is insufficient to demonstrate adequate competition, a tender evaluation report will be prepared:

- Assessing the reasons why the full number of tenders were not received;
- Assessing the impact on project costs, compared with any pre-tender estimate (i.e. does the returned tender provide adequate value for money in line with prior expectations); and
- Requesting approval to accept the tender from the Chief Executive or designated deputy. In accordance with Capital Procedures.

Tenderers to be advised that costs are not recoverable from the Health Board unless substantial costs are incurred on some large design and build contracts. This would be by prior arrangement with the contractors.

Companies to be invited by letter to tender for works as per Health Board standard letter of invite for work costing £25k and above. (This excludes Measured Term Contractors)

Tender periods to be sufficient to enable contractors to tender the works, all dependent on type of contract and programme to complete the works. Design and build to be given an extended tender period to be confirmed by Project Manager. The normal tender period shall be 4 weeks.

Tender documents should specify criteria to be used in the assessment. If lowest tender is not recommended the reasons must be justified and carefully recorded.

See notes in Section 4.5.1 for contract approval requirements.

Notify Chief Executive of tender returns or EMT Admin Manager of quotation returns. Complete with reference number, date of return and pre-tender estimate of the works. (Annex 20)

The Tender Register is maintained by the ABUHB Board Secretary.

4.11 Return of Tenders

This does not include Mini-Comp or Measure Term Contracts.

Return of tenders/quotes to be logged in tender/quotation register with time deposited and amount.
Retain all return envelopes on file with tender/quotation returns.

Advise contractors that payment will be withheld if Health and Safety Files and O&M's are not supplied at handover. Contractors will be advised that the H & S Executive will be advised of any misdemeanours relating to the non-production of these documents.

All tenders must be returned in document envelope provided for on invite of the works.

Extensions of time are not normally granted but may be in exceptional circumstances and where the number of returned tenders may be reduced if not granted. All tenderers to be advised in writing if this is the case.

All tenders to be stored in safe custody prior to opening.

Carry out a tender evaluation exercise on return of tenders
Award of tender can be based on Evaluation Criteria rather than lowest price. This is to be supported by a 'Tender Report and Recommendation' by the Project Manager (PM) setting out the decision-making process and conclusion of the evaluation process.
Tender assessment should be sent to the Project Director to include issues of compliance technical content programme, prices and resources.

For complex projects tenderers can be asked to complete a method statement for the intended works.

The selected contractor is required to present the proposed construction phase programme to the Principal Designer for approval prior to the award of tenders.

Tender documents should specify criteria to be used in the assessment. If lowest tender is not recommended the reasons must be justified and carefully recorded in the form of a Tender Report and Recommendation.

'Results of tenders' and/or where appropriate, 'Tender Report and Recommendation' to be submitted to the Project Director whom will review and instruct to proceed to award contract

Post tender negotiations are permissible (usually with the two lowest tenderers)

Valve Engineering (VE) may be required at this stage to enable the scheme to proceed.

Ensure the construction phase plan is embraced by contractor at this stage. Assuming funding is in place and matched against the business case the Project Director will give an instruction to award the contract.
When all complete award contract and execute the contract.

- Under hand is less than £500k
- Under seal over £500k.

If smaller forms of contract are used the Project Director or Project Manager may sign on behalf of the Health Board i.e. JAC 90's JCT Minor Works forms of contract.

All unsuccessful and successful contractors are to be notified of contract award and sent the results of the tender in alphabetical and numerical order. This included Mini-comps.

Update the PEP – if required (Annex14) at this stage. (Projects over £1m)

Ensure contract/specification and drawings are stored in the Health Boards safe for safe keeping and for latent defect period usually 12 months unless the contract is executed as a deed.

Normally contracts above £25k should attract the need for a pre-contract meeting to be held.

Membership of the Pre-contract meeting should include:

- Principal Designer
- Project Manager
- Clerk of Works/Site Engineer
- Ops and Maintenance Representative
- User Department Representative
- Facilities Manager
- Principal Contractor and sub-contractors as required.
- Design Team
- Fire Officer - part only
- Infection Control - part only
- Health and Safety.

Pre-Contract Agenda – Notwithstanding the below requirements the contract agenda ANNEX 24 should be adopted.

Ensure a project directory is produced at this stage by Project Manager. Other relevant documentation at this stage to be completed/received:

1. Any parent/company guarantees (where appropriate)

2. Contractors current insurance details (to remain on agenda as standard item for duration of contract)
3. F10 notice issued (where appropriate to HSE)
4. Contractors H & S policy
5. Inland Revenue tax deduction certificate
6. Any risk assessments and method statements specific to the works

Nomination of contractors is not normally permitted under any contract. Naming is however permissible under the JCT Intermediate Form of Contract. An official order must be placed on the contractor for completion of the intended works via an Oracle order.
Normally no work is to be started until the order is set up and approved.

4.12 Tender analysis

A number of measures are in place to reduce the risk of bid rigging and anti-competitive behaviour. Following the OFT report into Collusion and Cover pricing Capital Audit reviewed the existing procedural framework against the best practice guidance issued as consequence of the report, aimed at reducing the risk of bid rigging/ anti-competitive behaviour between contractors.

The audit acknowledged the existing good practice in that the Health Board's procedures were generally in accordance with the best practice but recommended a number of specific actions. This table provides background information and sets out the actions required

Recommendation	**Action required**	**Responsibility**
Formal instructions on how to proceed if an insufficient number of tenders are returned within a tender exercise.	Section 4.11 of this annex	Responsible Estates Officer to submit request to Project Director/Chief Executive
Procedure for obtaining feedback from non-bidders and implement a log of feedback to inform future tender exercises.	The Divisional Director Estates or his representative will write to all – non-bidders to establish their reasons for not bidding	HWE Responsible Estates Officer/PM
Database of past and current bid results. Mechanism to analyse tender returns and identify any patterns or unusual behaviour that could show collusion.	Start data collection Agree analysis process and provide periodic reports.	Business Partner Accountant/Capital Finance BPA/Head of Capital Finance
Formal contractor rotation	To be implemented within the limits of existing frameworks with advice from Head of Procurement Annual Tender report	Divisional Director Estates Head of Capital Planning
Certificate on Non-Collusion for external consultants.	Annex 19	Divisional Director Estates
Guidance and Training in identification of bid-rigging.	Design and implement Request Audit assistance	Head of Capital Planning

Pre-Tender Estimate - V - Actual Tender Return Review:
Pre-Tender Estimates should be within 10% of the tender return. Any variance to this should be justified with narrative. This can be through the Tender Report and recommendation, or for minor schemes by means of a simple narrative beneath the tender/quotation Proforma.

5 Construction Phase

5.1 Contract Period

A capital cost code is to be issued by Head of Capital Finance to endorse the expenditure against the scheme.

The Project Manager to advise the Project Director of all issues as the contract proceeds.
Any material change to the intended works is to be advised to the Project Director by the Project Manager in accordance to the change control procedure (see Appendix 22). The proforma to indicate the reason for design change, cost implications and programme implications.

The Project Manager (with appropriate support from the Technical PM etc.) is responsible for contract cost control and is responsible to the Project Director.

The Project Manager must:

- Ensure regular monthly site meetings to take place chaired by Project Manager (meeting to have minutes taken). For complex projects a weekly meeting should be considered with mandatory attendance by contractor and design team.
- Ensure regular internal Project Team meetings are held monthly or fortnightly (subject to the complexity of the project) to inform the user department of any issues/ progress etc.
- Ensure works are executed within the approved contract sum.
- Ensure that the risk log is reviewed at each internal project team meeting.
- Report on a monthly basis of cost profile for the project
- Monitor programme and any delays to be reported through to the Project Director. (This needs to be escalated to the Capital Planning Team.)
- Ensure the liquidated damages amount is entered onto the contract documents prior to signature. This is to be calculated as to the expected loss incurred income for the Health Board for non-completion of the works.
- Issue Architects instructions/variations as appropriate to cover off:
  - Contingency variations (unforeseen)
  - Service side variations (charge control process)
  - Design variations (expenditure of any PS.Sums and PC.Sums etc.)
  - Contractor variations (cost saving proposals)

All variations must always be priced where possible. Approximate costs can be included and adjusted at a later date i.e. at final account. All variation orders to be retained on file for audit.

During the construction period the contractor is to advise on progress regarding the programme of works and must send valuation of works complete monthly to QS/Technical Project Manager. Monthly certificates for works completed and valued for all capital projects are to be prepared either by the consultant QS or the Project Manager (tech) for the scheme. Invoices are required to be paid in line with the contract provisions. All invoices to be sent to accounts payable. Monthly valuations/invoices to be recorded by the Project Manager and Technical Project

Manager and receipted to work certified on the monthly payment certificate certified by the external QS or Project Manager.

Where the individual order value is exceeded there will be a need to raise a new Oracle order/ submit a further requisition for approval to increase the original order.

Consultant fees are generally VAT reclaimable and payable on design work completed.

A schedule of payments made to each consultant and contractor shall be recorded and maintained by the PM within the project file.

Contractor and consultant performance to be monitored through using a KPI Proforma. KPI targets are usually set based on the framework which the project has been appointed under. Where KPI's are not set or do not fulfil the Health Boards requirements from a performance perspective, these will be agreed prior to the commencement of the project.

5.2 Insolvency

On hearing of impending insolvency, the Technical Project Manager should contact the Director of Finance or a designated deputy. The Director of Finance may elect to carry out a financial check or call in the Directors of the company concerned to explain their position. The issue must be kept confidential.

When it is evident that there is an issue the Architect and QS must be notified by Project Manager/Project Director. Sites should be secured so items on site can be valued by a third party.

Any payments due should be cancelled. The Technical Project Manager must ask the QS for a financial statement of works complete and materials stored on site in the ownership of the Health Board identified. The Project Manager to inform the liquidator/receiver that he will be filing a claim as an unsecured creditor of the company (in liquidation).

Replacement contractors shall be appointed as soon as possible to avoid unnecessary disruption and delay. Compensation from performance bonds is sought and the receivers are informed of any claim outstanding again the contractor.

5.3 Claims and Counter Claims

Working with the External Project Manager/Technical Project Manager/Project Manager will ensure:

- Any claims made are valid.
- All claims are in writing referencing the relevant contract clause.
- Claims are investigated to ensure that they are not covered by an insurance provision.
- Claims to be numbered in sequence for record keeping.
- The QS and Project Manager (external/tech) to examine the claims and make a judgement whether they are deemed valid or not.

5.4 Liquidated and Ascertained Damages (LAD)

It is important that the Technical Project Manager adheres to the relevant contractual requirements when considering whether or not to invoke LAD's against a contractor. In many cases it is questionable whether the UHB can demonstrate financial loss as a result of delay to a contract and this needs to be carefully considered when any action is proposed.

If applicable LADs will be recoverable from a contractor if that contractor fails to complete the contract works, or a section of the work, by the date set out in the contract (as amended by any extension of time awarded by the Project Manager) and the Project Manager certifies that completion has not been achieved by the due date. The Technical Project Manager must ensure that LAD calculations are calculated using the recommended formula within the contract or calculated on actual demonstrable proven loss.

This is outlined in the JCT Standard Form of Building Contract as an example. This may vary with other Forms of Contract as selected.

The procedure for recovery of LAD is at the discretion of the Health Board and damages should be recovered following receipt of a certificate issued by the Project Manager/Architect unless otherwise agreed. Once the decision to apply the LAD clause has been taken, the following points must be complied with before the Project Manager/Architect can legitimately seek recovery:

- A Certificate of Non-Completion has been issued stating that completion has not been achieved by the contract date.

- The Technical Project Manager /Architect has written to the contractor stating that LAD is payable under the terms of the contract. This notice should also inform the contractor of the date from which LAD will be recovered and the amount due at the date of notice. Before any subsequent recovery of LAD can be recovered under the contract, a new notice will need to be issued to the contractor.

The Technical Project Manager should carefully consider the effect of any revision to the completion date of the works following the recovery of LAD as this may require the Health Board to refund part or whole of the amount to the contractor.

5.6 Extension 0f Time

Most forms of contract selected will set out the detailed procedures for the claiming and granting of an extension of time for completion of the works and lists the grounds on which an extension of time may be granted.

The Technical Project Manager will be the responsible person for ensuring that all delays whether they are due to inclement weather or delays occasioned by the contractor, subcontractors or the Health Board are formally recorded. Such delays must have fully documented reasons for their occurrence before a decision can be taken whether or not to grant an extension of time. Cardiff Regional Weather Centre to be referenced as a baseline for weather related issues. This needs to be stated within the contract.

The Technical Project Manager shall seek the agreement of the Project Director before any extension of time is granted to the contractor. This shall be embodied in a Notification of Revision to Completion Date being issued to the contractor.

5.7 Practical Completion Handover Meeting

The Technical Project Manager should arrange handover meetings for individual capital projects to take place. The composition of the meetings will vary according to the size and complexity of the project.

At handover meetings inspections shall be made of the facilities and the Project Manager shall be responsible for ensuring that the project has been completed satisfactorily and in accordance with the design intent. The Technical Project Manager, on behalf of the Health Board, formally accepts the project as being practically complete.

Operation and Maintenance Manuals (O & M Manuals):
For larger and/or complex projects, a full and comprehensive O&M Manual is to be completed by the contractor.
Notwithstanding the requirements below, the contractor will supply 2 electronic and 1 hard copy document to the Health Board. This document is to be delivered as an integral part of the Handover meeting/process, subject to agreement of the Project Manager certain elements can be deferred to an agreed date. Failure of receipt of these documents may delay 'handover acceptance'. The (external when commissioned) Technical Project Manager will ensure that the contractor will include the following (albeit not exhaustive and subject to scheme specific requirements) in the O & M Manuals:

- final "as built" record drawings are provided as two "hard" copies, and two copies on disc, compatible with AutoCAD 2008 (later updates accepted subject to Project Manager agreement). One set of the documentation are to be deposited with the Estate Management Department. The second set of manuals deposited with the Technical Project Manager. The relevant commissioning certificates are to include at handover:

- Electrical Certificates inc. Emergency lighting and Fire alarms
- Lift Commissioning
- Water Chlorination Certificates
- Asbestos Clearance Certificates
- Air Conditioning Certificates
- Medical Gas Certificates
- Building Regulations Completion Certificate
- Nurse Call systems certificates
- Fire Door Certificates
- 3rd party Fire compartmentation accreditation Certificates

For New Builds include all of the above plus if applicable:

- Air tightness certificate
- Energy performance certificates
- Planning/Building Control certificate
- BREEAM
- AEDET
- Secure by Design

These must all be witnessed by an ABUHB representative and must be available at handover. The Contractor must also prepare a Health and Safety file for handing over to the Technical Project Manager.

The Technical Project Manager will then advise the Project Director and issue the contractor with a Certificate of Practical Completion (subject to any defects/incomplete items being corrected within a specified period of time - see Annex 21).

A copy of the Certificate of Practical Completion shall be retained with the contract documents in the project folder for audit purposes.

The penultimate interim Certificate shall be issued by the Technical Project Manager authorising payment to the contractor once the Certificate of Practical Completion is issued (less 50% retention sums held).

Defects/snagging: A schedule of defects is to be developed for snagging/defect items. This schedule should identify:

- Date of defect identification
- Date sent to Contractor
- Date contractor advised to complete
- Date of completion.

This schedule is to be integrated within the practical completion certificate.

5.8 Final Accounts

It is important that final accounts are agreed with the contractor and paid promptly within any time limit set by the particular conditions of contract.

Once the Certificate of Practical Completion has been issued there is no reason why the QS/ Technical Project Manager should not draw up and agree the content of the final account with the contractor. The Technical Project Manager will consult with the Head of Capital Finance on the timing of final accounts but will be bound by the terms of the contract.

As soon as the final account has been agreed and verified the documentation should be forwarded to the Project Director for action/sanctioning.

5.9 Defects Period

Any defects raised within the building with regards to plant, equipment or the building infrastructure from practical completion shall be reported through the Works & Estates Helpdesk for the attention of the relevant Technical Project Manager for the scheme.

A defects schedule shall be maintained for all schemes.

A Making Good of Defects Certificate to be completed at the end of 12 months with an accompanying list of outstanding defects to be issued two weeks prior to the defects period end date.

The Technical Project Manager shall call an end of defects period meeting no later than 12 months after the Certificate of Practical Completion has been issued.

It is the responsibility of the Technical Project Manager to co-ordinate any legitimate defects of workmanship for passing onto the contractor for correction under the terms of the contract.

Once the Technical Project Manager is satisfied that all the defects have been corrected he will advise the Project Director and issue the contractor with the End of Defects Certificate.

The Technical Project Manager will then issue the final valuation releasing any outstanding retention money.

A copy of the end of Defects Certificate shall be retained with the project/contract file.

5.10 Post Contract Review and Evaluation

This is covered in detail in section 8.2 of the main Procedure document.

5.10.1 Post Contract Contractor Evaluation

An evaluation of the Contractor's performance shall be undertaken on those projects over £500k and used to inform the future selection process.

A "Reporting of Contractor's Performance" form should be completed and submitted for examination by the Divisional Director Estates or his representative.

5.10.2 Post Contract Consultant Evaluation

The evaluation of consultant's performance shall be undertaken on all projects and used to inform the future selection process and the Divisional Director Estates informed.

For such projects the Technical Project Manager shall undertake the evaluation to establish how well the consultant performed against clinical and financial objectives.

5.10.3 Lessons Learnt

The UHB may require an informal Lessons learnt exercise examining elements of the whole project from the initial mandate to the delivery of Benefits. This would normally be facilitated by a third party not previously involved in the project.

5.10.4 Post Project Evaluation

The evaluation should include:

i. The extent to which the original objectives have been met and benefits delivered.
ii. The cost of the project and the extent to which it can demonstrate value for money.
iii. The Project outcome compared with the 'do nothing' or 'do minimum' scenarios.
iv. The economic viability of the project in comparison with the do-nothing option
v. Risk Allocation
vi. Timetable
vii. Functional suitability
viii. Functional relationships
ix. Recommended changes to the project and business case functions
x. User satisfaction
xi. Procurement route

ANEURIN BEVAN UNIVERSITY HEALTH BOARD
CAPITAL PROCEDURES
Annex 16

DESIGNED FOR LIFE 3

At present the 3rd generation NHS frameworks have been extended to run until April 2024 when the new Framework is expected to be introduced.
The New Framework will have 2 lots and thresholds have been revised as follows:

- Lot 1 Projects £20 million plus
- Lot 2 Projects between £7million – £10 million

Should you require to progress a project prior to April 2024, NWSSP-SES advise to use the current Framework below until notified.

Specialist Estates Services Notification 17/07 09 November 2017

For action by:
Chief Executives, NHS Health Boards and Trusts
Directors of Planning, NHS Health Boards and Trusts
For information only:
Copy to: Head of Capital, Estates and Facilities,

Dear Colleague
Please note that the Designed for Life Building for Wales construction and consultant frameworks for major capital projects in excess of £4 million ceased at the start of October 2017. The replacement for these frameworks is now programmed to be operational at the start of February 2018.
Should Health Boards/Trusts need to progress capital projects utilising construction and consultant frameworks until such time as the new frameworks are available, I would be grateful if you could contact Andrew Waddington, Head of Designed for Life Building for Wales onAndrew.Waddington@wales.nhs.uk.
It has been established that alternative frameworks may be utilised by Health Boards and Trusts , dependent upon the requirements, may include the National Procurement Service (Property) frameworks, SEWSCAP2 framework, SCAPE framework or Pagabo framework.
Yours sincerely,

NH Davies BSc (Hons), Dip Proj Man (RICS), MBA, MCIOB, FIHEEM
Director Specialist Estates Services
NWSSP Specialist Estates Services, 3rd Floor, Companies House, Crown Way, C

Framework Email Contacts:

- Andrew Waddington - *(Andrew.Waddington@wales.nhs.uk)*
- Jonathan Simcock - *(Jonathon.Symcock@wales.nhs.uk)*
- Jonathan Jones - *(Jonathon.Jones5@wales.nhs.uk)*
- Thomas Kuehn - *(Thomas.Kuehn @wales.nhs.uk)*

ANEURIN BEVAN UNIVERSITY HEALTH BOARD
CAPITAL PROCEDURES
WORKS AND ESTATE
ANNEX 17

CERTIFICATE OF DESIGN SIGN OFF AND READINESS TO PROCEED TO TENDER

SCHEME: _____

Aneurin Bevan Health Board is satisfied that this scheme has been prepared in accordance with the Health Boards capital schemes procedures and that all reasonable steps have been taken to ensure that once the contract is let the scheme should be able to proceed to completion without delay. In particular, the Health Board is satisfied that:

- The Design Brief was frozen at the appropriate stage and will not be altered during the course of the contract other than in exceptional circumstances.
- The design reflects fully the aspirations of the Head of Dept/PM and meets user briefing all aspects.
- The scheme has been designed within budget.
- There are no causes of delay currently foreseeable.
- Tender documentation etc. is consistent with and fully reflects the general production information to be provided to the Contractor. There is a feasible programme for the supply of any production material not available at tender stage and the Health Board has taken account of these factors in its assessment of the degree of readiness for the scheme.
- The Health Board has been assured by the Design Team and is satisfied that to the best of its knowledge and belief the design complies generally with the Building Regulations and with Codes of Practice including Health Service Standards and British Standards Specifications and where appropriate Design Certificates have been obtained.
- Capital Resources will be available to build and commission the scheme according to programme and to operate the planned services.

- Pre-tender Estimate: £ …….. Inclusive of VAT

  Allocate to proceed to tender ☐

Signed for and on behalf of the Health Board

Lead Designer
Signature: _____ Name: _____

Designation: _____ Date: _____

Project Manager
Signature: _____ Name: _____

Designation: _____ Date: _____

Project Director
Signature: _____ Name: _____

Designation: _____ Date: _____

ANEURIN BEVAN UNIVERSITY HEALTH BOARD
CAPITAL PROCEDURES
WORKS AND ESTATE
ANNEX 18

CERTIFICATE OF READINESS TO PROCEED TO TENDER

SCHEME: _____

Aneurin Bevan Health Board is satisfied that this scheme has been prepared in accordance with the Health Boards capital schemes procedures and that all reasonable steps have been taken to ensure that once the contract is let the scheme should be able to proceed to completion without delay. In particular, the Health Board is satisfied that:

- The Design Brief was frozen at the appropriate stage and will not be altered during the course of the contract other than in exceptional circumstances.

- The scheme has been designed within budget
  AND
  There are no causes of delay currently foreseeable

- Tender documentation etc. is consistent with and fully reflects the general production information to be provided to the Contractor. There is a feasible programme for the supply of any production material not available at tender stage and the Health Board has taken account of these factors in its assessment of the degree of readiness for the scheme.

- The Health Board has been assured by the Design Team and is satisfied that to the best
  of its knowledge and belief the design complies generally with the Building Regulations and with Codes of Practice including Health Service Standards and British Standards Specifications and where appropriate Design Certificates have been obtained.

- Capital Resources will be available to build and commission the scheme according to programme and to operate the planned services.

- Pre-tender Estimate: £ ……..inclusive of VAT

Signed for and on behalf of the Health Board
Lead Designer
Signature: _____ Name: _____

Designation: _____ Date: _____

Project Manager
Signature: _____ Name: _____

Designation: _____ Date: _____

Project Director
Signature: _____ Name: _____

Designation: _____ Date: _____

ANEURIN BEVAN UNIVERSITY HEALTH BOARD
CAPITAL PROCEDURES
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ANNEX 19

CERTIFICATE OF NON-COLLUSION

PREMISES:

SCHEME:

TENDER RETURNABLE:

The essence of selective tendering is that the Employer shall receive bona fide competitive tenders from all those tendering. In recognition of this principle we certify that this is a bona fide tender, intended to be competitive, and that we have not fixed or adjusted the amount the amount of the tender by or under or in accordance with any agreement or arrangement with any other person. We also certify that we have not done and we undertake that we will not do at any time before the hour and date specified for the return of this tender any of the following acts:

A. communicating to a person other than the person calling for these tenders the amount or approximate amount of the proposed tender, except where the disclosure, in confidence, of the approximate amount of the tender was necessary to obtain insurance premium quotations required for the preparation of the tender;

B. entering into any agreement or arrangement with any other person that he shall refrain from tendering or as to the amount of any tender to be submitted;

C. offering or paying or giving or agreeing to pay or give any sum of money or valuable consideration directly or indirectly to any person for doing or having done or causing or having caused to be done in relation to other tender or proposed tender for the said work any act or thing of the sort described above.

In this certificate the word "person" includes any persons and anybody or association, corporate or unincorporated; and "any agreement or arrangement" includes any such transaction, formal or informal, and whether legally binding or not.

Signed:

_____

On behalf of:

_____

Date: _____

THIS FORM MUST BE SIGNED AND RETURNED WITH THE TENDER
ANEURIN BEVAN UNIVERSITY HEALTH BOARD
CAPITAL PROCEDURES
WORKS AND ESTATE
ANNEX 20

AUTHORISATION AND NOTIFICATION OF TENDER

TO: The Chief Executive **REF:**
CAPITAL JOB: **DATE:**

I have today forwarded to the under mentioned list of contractors, invitations to provide tenders for:

_____

Authorisation to proceed to tender stage was approved on ……..
The pre-tender sum for the works is £ ……. Plus VAT.

Signed: _____ Divisional Director Estates or EMT member

Completed tenders are due to be returned to you by NOON ……

Please open these, in accordance to Standing Financial Instructions.

Name of Contractor	Contract Sum	Opened By

Tenders Opened By: _____ Signature
_____

Tenders Opened In The Presence Of:

(1) _____ Date of Opening Tender
_____

_____ Time of Opening Tender
_____

(2) _____ Details of Late Tenders
_____

_____

Signature and Designation

ANEURIN BEVAN UNIVERSITY HEALTH BOARD
CAPITAL PROCEDURES
WORKS AND ESTATE
ANNEX 21

CERTIFICATE OF PRACTICAL COMPLETION OF WORKS

Issued By: Issue Date:

Divisional Director of Estates & Facilities
Management Centre Job Ref:
St. Cadoc's Hospital
Caerleon
NP18 3XQ

Contractor:

Address:

Works:

Situated at:

Contract Dated:

Under the terms of the above mentioned contract, I/we certify that Practical Completion of the Works was achieved on:

Signature: _____

Name (print): _____

Designation: _____ Date: _____

(To be signed by or for the issuer named above)

The Defects Liability Period will therefore end on: .....

ANEURIN BEVAN UNIVERSITY HEALTH BOARD
CAPITAL PROCEDURES
WORKS AND ESTATE
ANNEX 22

VARIATION CHANGE CONTROL

Change Management Procedure

1.0 Purpose

1.1 This Change Management Procedure establishes how 'Changes' and "Compensation Events" will be proposed, accepted, monitored and controlled by Aneurin Bevan University Health Board (ABUHB). The Change Management Procedure will govern Changes to the Final Project Brief after Client Approval at Full Business Case through to Completion – i.e., Changes to Project Scope, Programme and Cost.

2.0 Procedures for Change Identification

2.1 The Works Information contained in the Stage 4 Contract sets the Client Approved 'baseline'. The Works Information is based on the design submitted as part of the approved Full Business Case or Business Justification Case.

2.2 When a ***Client (Client is identified as an official of the Health Board Trust)*** initiated change to the Client Approved 'baseline' is identified, the Change will be clearly defined using the attached Change Request Form.

2.3 The Requester completes Section 1 of the Change Request Form and submits it to the Project Director / Capital Team for review.

3.0 Procedures for Change Analysis

3.1 The Project Director will need to identify in the Change Request Form if the proposed Change has a time and / or cost impact. The cost impact will need to differentiate between the following:

- Works costs
- Non-works costs
- Equipment
- IT

3.2 At this stage, it is not always possible to quantify the time and / or cost impact. A RAG rating will be applied to identify the potential level of impact for both time and cost.

3.3 On the basis of the Change Analysis, the Project Director will determine if the request is reasonable / viable and decide whether the Change Request merits further

consideration by the Project Manager, Cost Advisor, Project Team and /or the Project Board.

4.0 Change Request Approval Procedure

4.1 If the Change Request is considered to be reasonable / potentially viable and if the Change will impact upon the Contract between ABUHB and the Supply Chain Partner, the Project Director will instruct the External Project Manager to raise a Request for Quotation for the Change from the Supply Chain Partner to provide a formal quotation for the time and cost impact of the Change in line with the NEC3 Contract procedures.

4.2 If the Change has no impact on the Contract but does have a potential cost impact, the Change Requestor will need to identify the potential cost consequences.

4.3 Upon receipt of the cost impact the Project Director will assess what level of authority is required to approve the change request in the context of the likelihood that the Change will have to be funded from the approved Project Contingency. The following limits, as set out in ABUHB SFIs, will apply:

- Associate Capital Project Director 25k
- Project Director £50k
- Exec Director / SRO £75k
- CEO / Deputy CEO £100k
- CEO & Chair £500k

4.4 In all instances the Project Team and / or Project Board will be kept informed of the emergence of changes and changes that have been agreed. All changes between £5k and below £25k will be discussed at the Project Team prior to sign off. All changes above £25k will be discussed at the Project Board prior to sign off.

4.5 If the Change is approved, the Project Director, in conjunction with the Project Manager will put measures in place for the appropriate project documentation to be updated and issued.

4.6 The effect on the project contingency will be noted and recorded on the attached Project Control Form and the Change Control Register will be updated.

It should be noted that the above process also needs to be followed for changes that reduce cost and /or propose moving costs from one cost header to another.

5.0 Approval of Compensation Events initiated by the Supply Chain Partner

5.1 This will follow the process as set out in the contract with the SCP and will be managed by the Project Manager in conjunction with the Cost Advisor and Project Director.

5.2 If and when both the Project Manager and the Cost Advisor agree that a Compensation Event is warranted and if and when the cost impact has been agreed

with the SCP the Project Director will be required to sign off the attached Project Control Form.

5.3 The Project Director has delegated authority for sign off up to £50,000. For values above that the Health Board Scheme of Delegation, as outlined above, will need to be be followed.

5.4 In this context the Project Team and Project Board will need to be kept informed of the approved Compensation Events and the effect on the project contingency.

It should be noted that the above process also needs to be followed for CEs that reduce cost and /or propose moving costs from one cost header to another.

6.0 Change and Compensation Event Tracking

6.1 The Project Manager will maintain a Change Control Register of all Change Requests , Compensation Events and the resolution of each. This will be appended to the monthly PM reports and shared with the Project Team and Project Board at monthly meetings.

Change Control Forms:

Change%20Control%20Form%20v3.doc

Change%20Control%20PCF.xlsx

ANEURIN BEVAN UNIVERSITY HEALTH BOARD
CAPITAL PROCEDURES
WORKS AND ESTATE
ANNEX 23

POST TENDER REVIEW:

SCHEME Title: ……

……

SCHEME REFERENCE: PPD [……..] Financial Code: [……]

TENDER RETURN DATE: ……..

PRE-TENDER ESTIMATE: £ …… Inclusive of VAT

Tender Returns:

Name of Contractor	**Contract Sum** (including VAT)	**Comments**

Is the Tender Estimate within **10%** of the Tender return?
If, No, Provide narrative to reasons why this has exceeded the 10% margin.

Narrative:

Narrative Reviewed by:

……
Signature (Responsible Design Officer)

.....
Signature (Responsible Lead Design Officer)

AGENDA FOR PRE-CONTRACT MEETING

ANNEX 24

DATE	
TIME	
SCHEME	
VENUE	

1.0 INTRODUCTION
The Chairman will arrange introduction of all present.

2.0 SCOPE OF WORK – to be outlined by Contract Administrator

3.0 CONTRACT
3.1 Outstanding production information.
3.2 Insurances and tax certificates
3.3 Bond

4.0 CONTRACT MATTERS
4.1 Start date
4.2 Contract period
4.3 Programme of works
4.4 Health and safety (see Appendix A) / Asbestos survey

5.0 SITE WORKING ARRANGEMENTS
5.1 F 10/Construction phase plan/method statements/risk assessments
5.2 Traffic management plan/access to site/deliveries/car parking for contractors
5.3 Site security/Arrangements for keys/Protection of the public/ storage/identity badges/contractor checklists, if applicable (Appendix. A)
5.4 Waste – transit routes, positioning and protection of skips
5.5 Welfare facilities – Canteen, Toilets etc.
5.6 Noise/dust control – advise local departments & wards in advance of any work likely to cause undue noise or dust and programme accordingly.
5.7 Infection Control – report to ward/department manager before proceeding and **wash** hands on every occasion

5.8 Local liaison – arrangements to minimise disruption or inconvenience
5.9 Service Arrangements – Water/Gas/Electricity/Telephone
5.10 Disruption to essential services (normally 7 days' notice in writing to W & E), P-T-W
5.11 Fire precautions/Visit from Health Board fire officer/Emergency arrangements/First Aid

6.0 SUPERVISING OFFICER/COMMUNICATIONS (SEE APPENDIX B)

7.0 SPECIFICATIONS AND DRAWINGS INCLUDING WORKING DRAWINGS

8.0 VARIATIONS – VALUATIONS/INTERIM CERTIFICATES – (SEE APPENDIX C)

9.0 COMMISSIONING OF PROJECT (Contractor and User commissioning)

10.0 AS BUILT DRAWINGS/INFORMATION FOR THE HEALTH AND SAFETY FILE OR TO UPDATE HEALTH BOARD RECORDS, SUCH AS THE ASBESTOS REGISTER

11.0 FUTURE MEETINGS – (SEE APPENDIX D)

12.0 DISTRIBUTION OF MINUTES

13.0 ANY OTHER BUSINESS

ANEURIN BEVAN UNIVERSITY HEALTH BOARD
APPENDIX 'A'

1. HEALTH AND SAFETY

The Construction, Design and Management Regulations (CDM) 2015 (or current updated) apply to all construction projects. If part 3 of CDM applies (notifiable projects), the organisation and arrangements for managing health, safety and environmental issues on the site must be detailed in the construction phase health and safety plan and is the responsibility of the Principal Contractor. **Work must not begin until this plan has been scrutinised and you have been notified, in writing that work can commence.**

The following items should be included in the site health and safety management system, whether as part of the "plan" (in the case of notifiable projects), as a stand-alone system, or incorporated into method statements.

This will include but not be limited to:

- A clear organisational structure detailing responsibility for health, safety and environment.
- Adequate arrangements for the following aspects:
- Secure site boundaries.
- Controlling access and egress to and from site.
- Site rules and the provision of induction training for anyone attending site.
- A site traffic management plan, including effecting segregation of vehicles and pedestrians.
- Adequate emergency arrangements, particularly for the effects of fire and spills that could impact on the environment.
- Adequate arrangements for the provision of first aid.
- A procedure for reporting and investigating incidents (including reporting to the H.S.E. when required by RIDDOR).
- Adequate and suitable welfare facilities.
- An inspection regime to monitor health, safety and environmental performance.
- A framework to ensure consultation and communication with everyone involved with or affected by the work, with regard to health, safety and the environment.
- A system to ensure that any sub-contractors have adequate arrangements for health, safety and environmental management and are subjected to the same site rules and regimes as directly employed staff, including the vetting and testing of risk assessments.

The Contractor must also ensure that risk assessments are in place for the tasks to be undertaken on site and that they are effectively communicated to all

appropriate personnel. Risk Assessments and where appropriate Permits to Work (P-T-W), should include but not be limited to:
Exposure to:

- Noise, vibration and dust
- Hazardous substances
- Manual handling
- Working at height
- Excavations (P-T-W)
- Hot Work (P-T-W)
- Work in confined spaces (P-T-W)
- Slip and trip hazards

The Contractor must ensure that the impact the work has on the day to day function of the area, adjoining or neighbouring areas, has been considered in the risk assessment process and that effective channels of communication are established and maintained with these areas and other appropriate Health Board staff groups, such as:
Works and Estates, Fire Safety, Safety, Health and Environment, Clinical Risk Management, Infection Control, Hotel Services etc.

In summary, ensure: Operatives are competent, Materials are safe to use, Equipment is fit for purpose and properly maintained, the working Environment is kept clean, ventilated, well-lit and free from clutter, and effective communication and consultation is established and maintained.

Upon completion of the project, a Health and Safety file (in the case of notifiable projects) or in all other cases, any information that will be necessary to update Health Board plans, drawings or records; or necessary to allow any future maintenance, alterations or demolition to be done safely, must be submitted to the Health Board.

SAMPLE CONTRACTOR CHECKLIST (Not applicable to Capital projects where site access will be controlled by the Principal Contractor

Appendix 4 - Gwent Healthcare NHS Trust, Estates Department
CONTRACTORS CHECKLIST No.....

Contractor Name		W & E Officer	
Scope And Location Of Work			
Start date/time		Finish date/time	

EMPLOYEE NAME	CSCS Card or affiliated equivalent, e.g JIB, ECS ,CCDO, SKILL, CISRS,CPCS	CRB checked	INDUCTION DELIVERED AND UNDERSTOOD including site rules, emergency procedures, waste, parking, welfare and first aid Employees signature	Risk assessment & Method statement approved	Comments	Badge Issued	Badge returned

CONTRACTORS SIGNATURE		JOB TITLE	
Permit to work issued (Yes, No, N/A)	DATE	PRINT NAME	JOB COMPLETE – Signed off and dated by Supervising Officer

CSCS Affiliated Cards: CCDO (demolition), CISRS (scaffolders), ECS/JIB/PMES (electricians, plumbers), CPCS (plant operators), SKILL (refrigeration, ventilation, air conditioning, heating)

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

APPENDIX 'B'

COMMUNICATIONS (Agenda Item 6.0)

The communications between all parties concerned with this Project must follow the normal pattern of the Health Board Works Projects, as follows:

1. All instructions to the Contractor will be given in writing by the Contract Administrator. No instructions are to be accepted by the Contractor from any other source. Site Works Orders are expected to be confirmed by formal instructions within 72hours.

2. Instructions to Sub-Contractors will be given only by the Main Contractor on receipt of directions from the Contract Administrator, bearing in mind that all instructions intended for Sub-Contractors must be issued by the Contract Administrator through the Main Contractor.

3. A copy of all correspondence relevant to the Contract, between the Contract Administrator and the Main Contractor.

4. A copy of all relevant correspondence emanating from the above should be sent to the Health Boards Project Manager.

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

APPENDIX 'C'

CERTIFICATE PROCEDURE – (Agenda Item 8.0)

Interim Certificates will be issued in accordance with the period specified in the Articles of Agreement to take account of works executed and goods on site etc. The term 'month' shall be deemed to mean calendar month, and all valuations made will be calculated on this basis.

Certificates for payment should be forwarded direct to the Contract Administrator, to ensure prompt payment of the Certificate.

Mechanical and Electrical valuation to be with the Project Engineer for presentation with the Main Contractor's valuation by the end of the third week in each month.

Where a Quantity Surveyor is employed he shall provide a Financial Statement monthly to the Project Manager.

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

APPENDIX 'D'

FUTURE MEETINGS – (Agenda Item 11.0)

Future meetings will be in two different categories - these are:

1. Contractors Site Meetings

   Site meetings are the responsibility of the Main Contractor and will be called and chaired by him. It is suggested that these should be at monthly intervals. It is also suggested that the Main Contractor should invite representatives of the Contract Administrator and Project Manager to these meetings. Minutes of these meetings will be issued by the Contractor.

2. Routine Agenda Items

   To include ongoing development of the Health and Safety File and the Ops and Maintenance manual, including familiarisation for Operational staff.

3. Contractor Manager meeting (Site Meetings)

   These meetings may be called and chaired by the Project Manager at intervals to discuss the progress of the development with the Main Contractor. The following persons or their representatives would normally be present at these meetings.

   The Project Manager – in the Chair
   The Contract Administrator – in the Chair
   The Project Engineers
   Representatives of the Main Contractor

   And as considered necessary - by representatives of:

   The Health Board Estates Officer
   Clerk of Works
   Engineering Clerk of Works
   Health & Safety Advisors

Minutes of the meetings will be issued by the Contract Administrator.

ANEURIN BEVAN UNIVERSITY HEALTH BOARD
CAPITAL PROCEDURES
PPD SCRUTINY DOCUMENT
ANNEX 25

ALL SUBMITTED PPD Documents will be scrutinised using the embedded document below:



202501 PPD
Scrutiny Template Di

Aneurin Bevan University Health Board

Financial Control Procedure

Cash and Bank

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

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

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

DOs

✓ Keep cash, cheques, payable orders and controlled stationery secure, with access restricted to authorised staff.

✓ Record cash and cheques immediately, maintain a complete audit trail and pass receipts promptly to the Treasury/Cashier team.

✓ Use two staff when opening/recording posted cheques, cashing up tills or transporting money to the bank.

✓ Bank all income intact and promptly; use separate secure bags for cash and cheques and retain collection evidence.

✓ Complete C&D sheets in black pen, use serially controlled stationery and reconcile totals to cash, cheques and paying-in slips.

✓ Reconcile bank accounts monthly to the cashbook and financial ledger, with independent review, signature and supporting evidence.

✓ Maintain and validate the daily cash-flow forecast, promptly escalating unexplained differences or potential cash shortfalls.

✓ Check payment requests, coding, approvals, bank details and available funds before processing; follow authorised limits and signatory requirements.

✓ Keep BankLine credentials, smartcards and readers secure and return them to Treasury when no longer required.

DON'Ts

✗ Leave money, cheques, controlled stationery, BankLine devices or banking documents unsecured or accessible to unauthorised staff.

✗ Allow one person to transport money, count till takings alone or complete and verify the same control without independent evidence.

✗ Delay receipting or banking income, bank net amounts, or omit supporting details from paying-in records.

✗ Use correction fluid on C&D sheets, ignore stationery sequence gaps or issue uncontrolled forms.

✗ Process a payment without valid authorisation, verified bank details, correct coding and confirmation that sufficient funds are available.

✗ Share BankLine passwords, smartcards or readers, or allow access outside approved roles.

✗ Issue a replacement payable order until the original has been returned or the bank has confirmed the stop.

✗ Accept a cash payment of £10,000 or more, including linked or split payments, without following the Health Board's money-laundering requirements.

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1 Introduction

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

2 Statement

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

This procedure is compliant with the Standing Financial Instructions and should be read in conjunction with the Petty Cash and Petty Cash – Mental Health Financial Control Procedures.

3 Aims

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

4 Objectives

The overall objectives are to ensure that sufficient cash is available on a daily basis to enable the Health Board to meet its commitments and that cash is held securely and appropriately.

5 Scope

This document is relevant for the following staff:

- Treasury Management Team, within Corporate Finance.
- NHS Wales Shared Services Partnership (NWSSP) - Payroll
- NHS Wales Shared Services Partnership (NWSSP) – Accounts Payable.
- General Office staff
- Budget Holders
- Catering Staff

6 Roles and Responsibilities

6.1 Head of Financial Services and Accounting

Is responsible for:

- Providing assurance that the Health Board complies with the relevant Standing Financial Instructions, legislative requirements and Welsh Government guidance relating to Treasury Management
- Investigating any issues escalated by the Treasury Manager
- Ensure any corrective actions are identified and communicated to the Treasury Manager
- Ensure any corrective actions are followed up
- Discuss the cash forecast with the Assistant Head of Financial Services on a weekly basis

6.2 Assistant Head of Financial Services

Is responsible for:

- Agree with the Head of Capital Finance the amount of cash to be drawn down, from Welsh Government, on a monthly basis, including any emergency drawdowns
- Liaising with Accounts Payable Manager / Team Leader in relation to authorisation of payment runs.
- Discuss the cash forecast with the Head of Financial Services and Accounting on a weekly basis
- Ensuring the appropriate staff have access to the relevant cash & banking systems to carry out their roles

6.3 Treasury Manager

Is responsible for:

- Agreeing with the Assistant Head of Financial Services, and the Head of Capital Finance the amount of cash to be drawn down, from Welsh Government, on a monthly basis, ensuring that there is sufficient cash to cover payment commitments and that the balance left in the bank account, at the end of each month, is within Welsh Government best practice limits.
- Ensure the Bank mandate and the list of signatories are up to date and comply with the Health Board's Standing Financial Instructions.

- Ensure all Bank statements are obtained and reconciled to the Financial Management System (FMS) General Ledger Control Account on a monthly basis and urgently report to Head of Financial Services and Accounting unexplained entries.
- Maintain Daily Cash flows using actual and forecast amounts of cash required.
- Validating the Daily Cash flow to the ledger balance of the Natwest Bank Account.
- Pay over if required and reconcile all General Ledger Control Accounts relating to payments to Her Majesty's Revenue & Customs (HMRC).
- Ensuring the Financial Control Procedure is followed for Petty Cash.
- Assisting the Assistant Head of Financial Services with liaising with Accounts Payable Manager / Team Leader in relation to payment runs.
- Liaising with General Offices re banking and relevant documentations.

6.4 Higher Treasury Officer

Is responsible for:

- Receiving and recording of Income.
- Obtaining all Bank statements and reconcile to the Cash books and General Ledger Control Account.
- Prepare the month end bank reconciliation, for review and sign off by the Treasury Manager (or Assistant Head of Financial Services in their absence).

6.5 Cashier –Corporate Finance

Is responsible for:

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

6.6 Payroll Manager / Team Leader - NWSSP

Is responsible for:

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

6.7 Accounts Payable-NWSSP

Is responsible for:

- Liaising with Treasury Manager / Assistant Head of Financial Services for BACS and Payable Order payment runs.
- Liaising with Treasury Team for processing Faster Payment requests and Foreign Payments

6.8 General Office –Facilities Division

Is responsible for:

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

7 Cash and Bank Process

7.1 Drawdown of Cash Allocation from the Welsh Government

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

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

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

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

7.2 Physical Security

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7.3 Bank Account

7.3.1

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

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

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

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

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

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

7.4 Corporate Purchasing Card

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

7.5 Authorised Signatories

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

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

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

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

7.6 Reconciliation of Bank Accounts

7.6.1 During the working week, the cash flow balance will be verified and balanced to the bank account end of day ledger amount.

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

- The Cashbook; and
- The Financial ledger

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

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

7.6.4 The basic purpose of the reconciliations is to explain the causes of any differences e.g. unpresented payable orders or unpaid BACS payments, and to ensure that action is taken to clear the items where required. The majority of reconciling items are due to timing and generally resolved within the next week e.g. an unpresented payable order will normally be presented before the next monthly reconciliation is due. If the issue has not been resolved at the next reconciliation date, it should be investigated and escalated if a recurrent issue.

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

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

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

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

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

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

- On a daily basis, the Higher Treasury Officer will provide an up to date balance statement of the cash at bank balance of the Main Revenue Account, in the form of a screenshot, to the

Head of Financial Services & Accounting and the Assistant Head of Financial Services.

- This balance statement will show the previous day's cleared balance and that day's bank account opening balance.
- The Treasury Manager or Assistant Head of Financial Services must enter the "Last Night's Ledger" balance on the Cash-flow, and initial to confirm that the figure has been entered and validated against the cash flow balance.
- The Head of Financial Services will check that the balance has been entered correctly, and figures have not been transposed.
- Both the Treasury Manager and Assistant Head of Financial Services will log into Bank line at a minimum of twice a week to verify the cash at bank balance, against the balance statement provided.
- The Assistant Head of Financial Services will ensure that the cash held at the end of the month does not go above £6m or into an overdraft position.
- There will be weekly cash forecast reviews held between the Assistant Director of Finance – Financial Systems & Services, Head of Financial Services & Accounting and the Assistant Head of Financial Services.

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

7.7 Operation of the NatWest Account

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

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

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

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

A list of daily NatWest Account receipts should be recorded on the Receipt Register Spreadsheet, which forms part of the cashbook for the NatWest Account reconciliation. The receipts are applied, via the Oracle Accounts Receivable module to the relevant invoice at the time of receipting, thus simultaneously updating the debtors ledger.

7.7.4 Payments from the NatWest Account are of three types.

- Payroll and Accounts Payable payment runs.

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

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

- Income Tax and National Insurance payments to HMRC.

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

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

This Debit Note is then sent to the NWSSP Account Payable department for inclusion on the appropriate payment run, to ensure payment reaches HMRC by the 22nd of the month.

- Payments to the NHS Pension Scheme

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

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

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

7.8 BankLine

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

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

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

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

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

7.8.3 Each workday morning the Treasury Officer or the Treasury Manager will obtain from the BankLine system a printed / downloaded pdf statement showing the balance on the Health Board's bank account and details of the previous day's transactions. The Treasury Manager will enter this information on the daily cash-flow spreadsheet, updating forecast figures to actuals and making adjustments where necessary.

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

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

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

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

7.9 Bank Account Transactions

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

When the bank statements are downloaded the amounts of these runs are compared to the figures provided by the Accounts Payable

and Payroll departments, and any differences must be fully investigated.

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

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

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

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

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

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

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

7.10 Banking of Cash and Cheques Received

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

7.10.1 Cheques (and very occasionally, cash) are received through the post at the Ty Gwent offices and are sorted by the receptionist. All mail is passed to a member of the Corporate Finance team. Cheques received are to be entered in a post book (which is stored in the secure room) by one finance officer and signed for and countersigned by another officer. The post book and the cheques are then passed promptly to the Treasury Officer responsible for receipting.

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

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

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

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

Any documentation that arrives with the cheque, such as a remittance advice, is to be cross-referenced to the system receipt number and electronically stored if required.

The cheques receipted are to be listed on a paying in slip and totalled. The total of the listed cheques should be agreed to the amount processed in Oracle and agreed with the post book. The receipted cheques are then placed in the safe, until they are collected for banking by the Health Board's specialised cash handling contractors.

The contractors are required to collect these banking's once every 4 weeks on a Monday. Each paying in slip total is to be entered into a contractor log book and on a Wednesday the cheques plus the original copy of the paying in slip should be placed in a secure

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

The contractor's log book must be signed with each week's banking by the Cashier.

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

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

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

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

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

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

cheques, and the number of the bags recorded in a general account bank book. This is locked in a secure Safe in the General Office until Health Board's designated Security Company collect the money on a weekly basis.

- At the end of each month, the Z Readings spreadsheet and C&D receipts are sent to a Catering Administrator or Officer for their monthly account documentation and also sent to the cashier's department for reconciliation to the bank statements.

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

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

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

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

For the larger General Offices the banking's are collected by specialised cash handling contractors. Banking's are collected at an appropriate frequency for each hospital site. The General Offices should place the amounts to be banked in the secure bags provided by the contractors and seal them. Separate bags are to be used for cash and cheques. A note should be made of the banking totals placed in each bag. When the contractor's Agent collects the bags they are scanned and a receipt produced showing the unique bag number. This receipt should be attached to the record of banking's.

An audit trail is then produced of the banking's in each bag handed to the contractors.

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

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

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

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

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

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

7.11 Payment of Trade Creditors

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

7.11.1 Payments to Trade Creditors are made by the BACS or by pre-signed payable orders held in the Cashier's department. An

independent log of all payable orders issued and spoiled is to be kept by the Cashier to ensure that payable orders are issued sequentially. An independent review of this log must be carried out on a regular basis and any breaks in the sequence must be investigated and explained.

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

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

When the actual payment run clears the bank statement, it must be checked against the figure on the cash-flow spreadsheet to ensure there are no discrepancies. If there is a discrepancy it must be reported to the Accounts Payable Manager and investigated.

7.11.4 Only nominated staff are able to initiate the transmission of BACS. The number of signatures required on BACS schedules must be established along with the maximum value of any payment within the schedule and the total value of the schedule. These limits must be established with BACS. The BACS limits must be reviewed annually and may only be changed on the written instruction of the Director of Finance, as per GBS guidelines

An input report for live submission is available online. The Accounts Payable Team Leader prints this off, reviews the report and signs

it as evidence of review.. The Treasury Manager is responsible for checking the total of the BACS run and the Accounts Payable Team Leader is responsible for checking individual payments within the run against pre-set limits and reviewing and investigating any exception reports, such as advice of unapplied automated credits or advice of wrong account numbers for automated credits.

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

7.12 Payment of Salaries and Wages

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

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

The Payroll Manager follows a similar system of submission to BACS Limited and all reports and documentation are available online and reviewed, evidenced and filed in the Payroll Department in Companies House, Cardiff.

7.13 Cancelled Payable Orders

7.13.1 Occasionally, a payable order is returned to the Cashier's department, relating to a payment of trade creditors. The payable order details are to be passed to the Accounts Payable Manager who should void the payment on the Oracle Accounts Payable system. By voiding the payment, the system will allow a replacement payable order to be drawn (for instance, if the payable

order has been mislaid). If the payable order is to be cancelled altogether and not reissued, the payment must be both voided and cancelled on the system. A copy of the payable order and any supporting documentation is to be kept in the Accounts Payable department and the original is to be filed in the Cashier's department.

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

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

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

7.14 BACS Recalls

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

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

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

7.15 GOV.UK Pay Links

7.15.1 The Local Health Board has set up and can provide a payment link for payees to make payment via debit/credit card directly. Various links have been created to identify the type of income being received, and support departments to receive income via card payment.

Links are able to be generated for a variety of departments and uses, and include, but are not limited to:

- Invoice payment,
- Accommodation,
- Blood tests,
- Replacement medical aid products (such as contact lenses and hearing aids).
- Managed/ Hosted practices (to support the day-to-day management of the practices).

The Cashier will review the reports in the Gov.UK Pay site, to identify what payments have been made, with each of the link types. These are recorded on a spreadsheet log.

Payments are received into our bank account 3 working days after the payment has been made. On receipt of a total into our bank account, this is reconciled to the log and processed in the Oracle Financial System in the appropriate way, depending on the type of income.

Only once a payment has been received into our bank account, should an official receipt be issued, if requested.

7.15.2 Chip and Pin Machines in Restaurants and Shops

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

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

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

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

7.16 Foreign Currency

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

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

The Cashier's department should then enter the payment into the RBS Account foreign payments online service, print out the payment details and have this appropriately authorised online. The Higher Treasury Officer should then prepare a journal to upload the foreign currency payments into the Oracle general ledger.

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

7.17 Cash Flow

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

The cash-flow summary is reviewed on a daily basis by the Assistant Head of Financial Services, to ensure that the cash

balance remains at the best practice target set by Welsh Government during the financial year and achieves the year-end target.

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

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

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

7.18 Money Laundering

The Money Laundering, Terrorist Financing and Transfer of Funds (Information on the Payer) Regulations 2017 extend HM Revenue and Customs (HMRC) supervision of businesses vulnerable to money launderers to include High Value Dealers (HVD'S). HMRC considers a high value payment to be:

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

HVDs are businesses that:-

- Deal in goods; and

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

HVD's must register with HMRC for supervision under the Money Laundering, Terrorist Financing and Transfer of Funds (Information on the Payer) Regulations 2017 and implement specific anti-money laundering procedures. However, if an NHS body has a clear policy of not accepting cash payments over the £10,000 (or equivalent) limit for any single transaction (or linked transactions); it is not affected by the rules.

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

The Health Board has a strict policy not to accept cash payments over £10,000 and hence is not registered.

8 Further Information

Enquiries regarding this procedure should be directed to the Treasury Manager, Assistant Head of Financial Services, Head of Financial Services and Accounting or the Assistant Director of Finance – Financial Systems & Services.

The team form part of Corporate Finance and located on the First Floor, Ty Gwent, Lake View, Llantarnam Business Park, Cwmbran, Torfaen NP44 3HR..

9 Audit

The procedure will be subject to internal audit review from time to time. In addition, external audit may review compliance, as part of the financial accounts audit work.

10 Review

The procedure will be reviewed, at a minimum every 3 years. More often if significant changes require review.

Appendix A

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

<table>
<tr><td colspan="3">Catering Department/Shop, …….Hospital</td></tr>
<tr><td colspan="3">Catering/Shop Income</td></tr>
<tr><td>Today’s Date:</td><td colspan="2">Z Readings ref no.:</td></tr>
<tr><td>Till Reading breakfast:</td><td></td><td rowspan="4"></td></tr>
<tr><td>Till Reading lunch:</td><td></td></tr>
<tr><td>Till Reading Shop:</td><td></td></tr>
<tr><td>Readings Total:</td><td></td></tr>
<tr><td>Total money
in till drawers:

CASH TAKINGS:

To be entered on C & D Sheet:

C&D Receipt No.:</td><td colspan="2"><u>Less float £……..</u>

. . . . . .</td></tr>
<tr><td>Difference between total readings and cash taken + or –</td><td colspan="2"></td></tr>
<tr><td>First signature:</td><td colspan="2">Second signature:</td></tr>
</table>

Aneurin Bevan University Health Board

Financial Control Procedure Patients' Travel Costs

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

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

Issue date: DRAFT
Review by date: DRAFT
Policy Number: ABUHB/Finance/0247

DO's

✓ Confirm the patient is attending NHS hospital services following GP/dentist referral.

✓ Check qualifying benefit evidence or a valid HC2W/HC3W covering the patient and travel date.

✓ Obtain appointment/attendance evidence and tickets, receipts or travel details.
✓ For HC5W(T), confirm NHS Business Services Authority approval and hospital attendance.

✓ Use the cheapest reasonable transport available.

✓ Refund public transport against tickets.

✓ For private cars, apply the approved fuel-rate basis and compare with public transport cost where required.

✓ Refund unavoidable eligible parking charges.

✓ Obtain written clinical confirmation for medically necessary escorts or taxis

✓ Check approvals and route retrospective claims through Finance and Accounts Payable.

✓ For advance payments, retain records, confirm attendance and notify Income Recovery if recovery is needed.

✓ Escalate suspected fraudulent or irregular claims.

Don'ts

✗ Do not pay without proof of entitlement, appointment/attendance and travel cost.

✗ Do not accept expired certificates or missing approvals, signatures or supporting documents.

✗ Do not reimburse primary medical/dental visits, self-referrals, transfers between treatment centres, private patients, visitors, self-discharge journeys or cases requiring ambulance transport.

✗ Do not reimburse a higher-cost option where a cheaper reasonable option was available.

✗ Do not pay taxi fares without confirmed medical need or exceptional circumstances; otherwise apply the lower eligible amount.

✗ Do not pay separate per-person amounts for escorts sharing a private car or taxi.

✗ Do not refund parking penalties or illegal-parking costs.

✗ Do not accept retrospective HC5W(T) claims received more than three months after travel unless formally permitted.

✗ Do not process suspicious claims without further scrutiny.

✗ Do not leave an advance payment unchecked.

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1. Introduction

1.1. Procedure Details

This procedure details the financial support available to patients, who do not have a medical need for ambulance transport, but cannot meet the cost of travel to hospital.

1.2. Patients' Travel Claims

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

Clarification of the claims process can be found in Appendix 6 and 7 flowcharts.

2. Statement

Aneurin Bevan University Health Board (ABUHB) is committed to ensuring sound financial controls are in place to ensure that there is good control and probity. An integral part of this is the reimbursement of patient's travel costs.

3. Aims

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

4. Objectives

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

5. Scope

This document is relevant for the following staff:

- Treasury Management Team within Corporate Finance.

- General Office Staff
- Staff in other Divisions dealing with patients who would require financial help with travel costs

6. Roles and Responsibilities

6.1. Director of Finance, Procurement & Value

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

6.2. Assistant Director of Finance – Financial Systems and Services

The Assistant Director of Finance – Financial Systems and Services is responsible for the day to day management of the process and authorising all retrospective patient travel request.

6.3. Treasury Manager

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

6.4 Treasury Officer

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

6.5 General Office Staff

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

6.6 Hospital Staff

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

Welsh Government guidance can be found here

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

7. Patients' Travel Claims Process

7.1. Eligibility Criteria

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

7.1.1. Requirements

The patient must be:

- In receipt of one of the qualifying benefits or allowances specified in the Welsh Government's Healthcare Travel Costs Scheme (HTCS)regulations (or in certain cases be a member of the same family as a person receiving a qualifying benefit or allowance), or

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

- The journey undertaken must be made to receive services provided in an NHS hospital for which the patient has been referred by a GP or dentist.

7.2. Basis of Entitlement

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

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

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

*(**Note** - The Department for Work and Pensions has been moving claimants from legacy benefits, including Income Support, income-based Jobseeker's Allowance, income-related Employment and Support Allowance, Housing Benefit and tax credits, to Universal Credit under the managed migration programme.)*

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

7.3. Documentation

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

If approved, the form will be forwarded to the Finance Department for processing.

The Treasury Officer reviews the documentation received ensuring the HC5W(T) form has been stamped by the NHS Business Authority, and either that they have an appointment letter attached or have been approved by the relevant general office. All receipts must be verified, and the amounts submitted are checked to ensure they fully comply with this policy.

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

The Treasury Officer sends the authorisation for payment forms and signed batch header template to the Accounts Payable Department. This may be as a result of a retrospective claim or if the patient was unable to produce evidence of eligibility to the Hospital general office at the time of their visit.

The Accounts payable officer checks the forms have been authorised correctly and a payment will then be made to the patient within a reasonable timescale.

A flowchart of the process can be found in Appendix 5.

7.3.1. Patients not automatically entitled to a refund

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A person who is an asylum seeker for whom support is provided under part VI of the Immigration and Asylum Act 1999. The recipient and any dependents where a dependent is classified as

someone in the UK who is a spouse or a child who is under the age of 18. To qualify a letter from the Home Office confirming their status as an asylum seeker being supported under the 1999 Act as at the date the travel was undertaken,

Or

A valid HC2W or HC3W certificate.

7.3.6. People not eligible for HTCS help

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

7.4. Claiming for Others

7.4.1. Carers and Escorts

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

7.4.2. Children and Other Dependents

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

7.5. Reimbursement

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

7.5.1. Travel by public transport

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

7.5.2. Community Transport and Voluntary Car Schemes

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

7.5.3. Travel by private car

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

Information on the current HMRC rates can be found here

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

7.5.4. Taxis

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

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

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

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

7.5.5. Car parking charges

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

7.6. Paying the Patient

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

7.6.1. Verifying the Claims

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

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

7.6.2. Payment on Day of Travel

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

7.7. Retrospective Claims

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

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

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

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

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

7.8. Payments in Advance

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

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

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

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

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

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

7.9. Fraudulent Claims

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

8. Further Information

Frequently asked questions are contained in Appendix 4.

Further information can be found in the Welsh Government's Healthcare Travel Costs Scheme (HTCS).

9. Audit

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

10. Review

The procedure will be reviewed, at a minimum every 3 years. More often if significant changes require review.

11. Appendices

Appendix 1

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

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

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

Appendix 2

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

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

Appendix 3

PATIENT'S TRAVEL – CLAIMS IN ADVANCE FORM

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

Confirmation of Patient Attendance	Y/N
If N, copy of this form sent to Income Recovery , Finance Department Aneurin Bevan University Health Board, PO Box 163, Cwmbran NP44 9EJ.	Y/N

Appendix 4

Frequently asked Questions

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

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

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

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

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

A. Unfortunately the HTCS does not apply to visitors.

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

A. Unfortunately the HTCS does not apply to visitors.

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

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

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

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

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

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

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

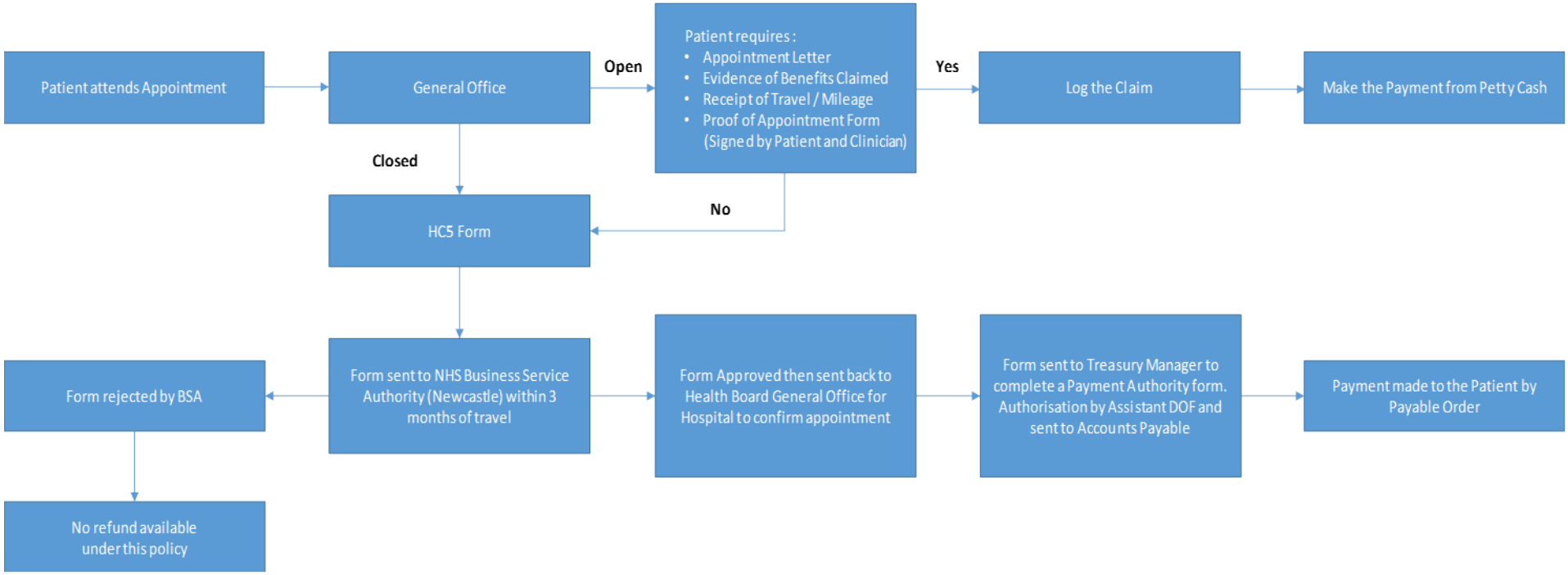
A. If hospital transport has been offered to you on the basis of your medical need, you are unable to claim under the HTCS, though previous dissatisfaction should be taken-up with the hospital concerned.

Retrospective Claim Flow Appendix 5

START
↓
Patient cannot provide the correct documents for reimbursement at the General Office
↓
Patient completes HC5W(T) and sends it to NHS Business Services Authority
↓
Is the claim approved?
├─ No → Claim cannot proceed → END
└─ Yes
↓
Form forwarded to Finance
↓
Treasury Officer checks:
• Approval stamp
• Appointment letter or General Office approval
• Receipts and amounts
↓
Are all checks satisfactory?
├─ No → Resolve issues before proceeding
└─ Yes
↓
Treasury Officer completes payment authorisation
↓
Treasury Manager checks and signs
↓
Treasury Manager completes batch template
↓
Assistant Head of Financial Services signs
↓
Assistant Director of Finance authorises payment
↓
Treasury Officer sends documents to Accounts Payable
↓
Accounts Payable checks authorisation
↓
Payment made to patient
↓
END

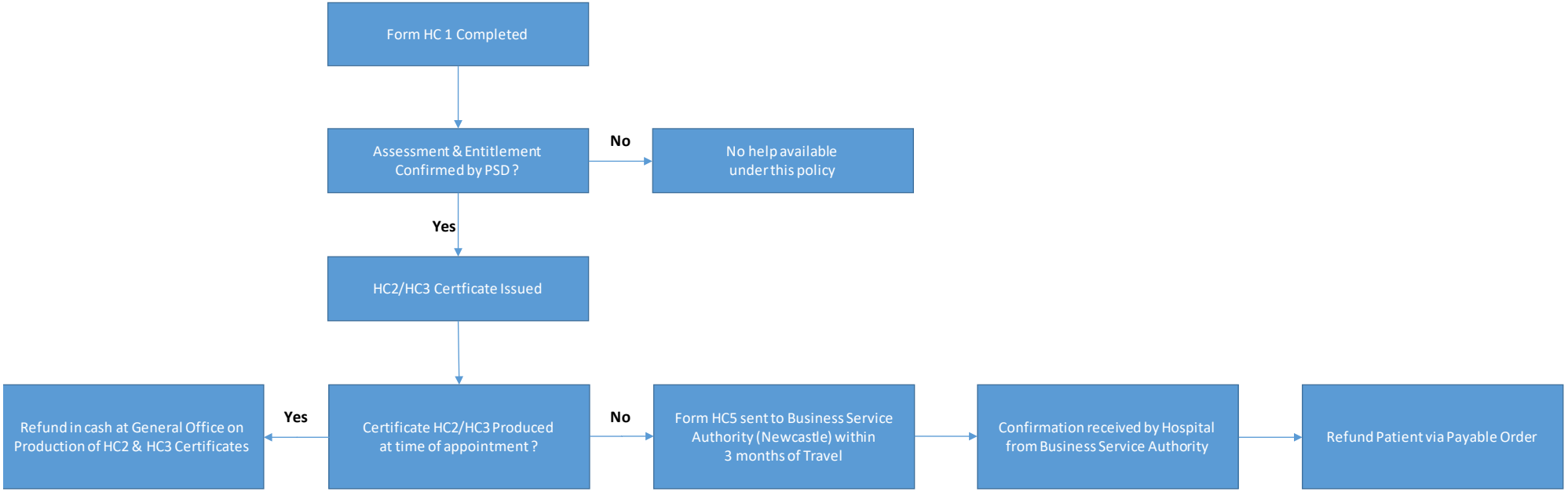
Appendix 6

Entitlement to Benefits



Appendix 7

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



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

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	24 November 2026
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Internal and External Audit Recommendation Tracker – Quarter 2 (June – September) Position
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Head of Corporate Risk and Assurance Risk and Assurance Officer

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report provides the Audit, Risk and Assurance Committee (the Committee) with an overview of the status of all internal and external audit recommendations as at the end of Quarter 2 2026/27 (01 July 2026 to 30 September 2026).

Updates were requested against 35 recommendations that had exceeded either their original or a revised implementation date.

The report outlines progress since the previous reporting period, recommendations completed and revised implementation deadlines requested.

Cefndir / Background

The previous report to the Committee (September 2026) covered the position to the end of Quarter 1 (April – June) 2026/27. At that meeting:

- **39** recommendations were confirmed as completed
- **27** recommendations were granted a deadline extension.

This resulted in the Tracker containing **74** Live recommendations.



Asesiad / Assessment

Internal and External Audit Recommendation Tracking

Since the report to the Committee in September, a further **23** recommendations have been added to the Tracker from Audit reports received at the September meeting.

The Tracker currently holds **97** live recommendations. Updates were requested for **35** recommendations:

- **16** that had reached their original implementation date by 30 September 2026
- **19** that had exceeded a previously revised implementation date

Appendix A contains full details of the 21 recommendations proposed as completed.
Appendix B contains full details of the 14 recommendations with revised implementation deadlines.

Table 1 below summarises the current position following these updates.

Table 1

Lead Director	Completed	Revised Deadline	Total Updates
Chief Operating Officer	**3**	**1**	**4**
Director of Digital	**6**	**6**	**12**
Director of Nursing	**0**	**1**	**1**
Director of Workforce and OD	**3**	**0**	**3**
Director of Allied Health Professions & Health Science	**1**	**0**	**1**
Director of Corporate Governance	**3**	**1**	**4**
Director of Strategy, Planning and Partnerships	**5**	**4**	**9**
Director of Public Health & Strategic Partners	**0**	**1**	**1**
Total updates this period	**21**	**14**	**35**

Table 2: Provides a summary of the **21** recommendations proposed as complete. Full details of these recommendations are set out in Appendix A.

Table 2

Completed Recommendations			
Audit Title	**Assurance Rating**	**Number by Priority Rating**	
2023 IT Infrastructure	Reasonable	**1**	**1**



2025 GMS Contract Challenges	Not Rated	**1**
2025 Digital Transformation	Not Rated	**2**
2025 Cancer Services	Not Rated	**1**
2025 Urgent and Emergency Care: Arrangements for Managing Demand	Not Rated	**1**
2025 Declarations of Interest	Substantial	**1**
2025 Records Management	Limited	**1**
2025 Strategic Risk and Assurance	Reasonable	**2**
2025 Falls Management	Reasonable	**1**
2025 Occupational Health	Reasonable	**2**
2025 Speaking up Safely	Limited	**1**
2025 Shadow IT	Reasonable	**1**
2025 GUH ED Extension	Limited	**2**
2025 Development of a Regional Radiotherapy Satellite Centre	Reasonable	**2** **1**
TOTAL		**5** **10** **1** **5** **21**

Table 3: Provides a summary of the **14** recommendations with revised deadlines are proposed. Full details of these recommendations are set out in Appendix B.

Table 3

Recommendations with Revised Deadlines		
Audit Year and Title	**Assurance Rating**	**Number by Priority Rating**
2025 End of Life Care	Reasonable	1
2025 Intelligence Led Organisation	Reasonable	1 1
2025 Technical Continuity	Reasonable	1
2025 Newport East Health and Wellbeing centre	Reasonable	1
2025 Standing Orders Compliance	Substantial	1
2025 Subject Access Requests	Limited	2 1



2025 Business Continuity Planning	Reasonable	3
2025 Cancer Referral Rates	Reasonable	1
2025 Development of a Regional Radiotherapy Satellite Centre	Reasonable	1
TOTAL	**2**	**12**
	14	

Closing Position

Subject to approval of the completion of 21 recommendations, 74 recommendations will remain live on the tracker. Of these, 53 remain within their original implementation date and 23 will have an approved revised date.

Number of Extensions	Number of Recommendations
0	**53**
1	**17**
2	**6**

For additional assurance, all live recommendations recorded on the Tracker arise from reports issued from 2024/25 onwards, with no outstanding recommendations relating to earlier audit years.

Argymhelliad / Recommendation

The Audit, Risk & Assurance Committee is asked to:

- **APPROVE** the closure of 21 recommendations;
- **APPROVE** revised implementation deadlines for 14 recommendations; and
- **NOTE** the current position of the 74 recommendations against their original implementation dates as set out in the audit reports.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Risks associated with overdue recommendations will be captured locally and escalated to the strategic risk register if necessary.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2.1 Managing Risk and Promoting Health and Safety Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Integral to the delivery of the IMTP



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

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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements** An EQIA (Equality Impact Assessment) is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well, Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs Integration - Considering how the public body's well-being objectives may impact upon each of the well-being goals, on their objectives, or on the objectives of other public bodies




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

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	Is this recommendation delayed by National requirements	Reporting Date	
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			Completed	Completed	5			Alerts have now been configured in our monitoring platform and this recommendation is completed	No	30/09/2026	
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			Completed	Completed	3			ABUHB has addressed the recommendation through the introduction and formalisation of documented service management procedures, operational controls and governance arrangements that support the management of infrastructure services and associated supplier-supported services. The Service Transition process now defines the documentation required before new or changed services are accepted into live operation. This includes support models, service agreements and contracts, operational procedures, user documentation, supplier information, and clearly defined process responsibilities. This ensures that key operational knowledge and support requirements are documented, maintained and transferred into business-as-usual service management. The process also provides formal controls around supplier dependency and support arrangements. New or revised contracts are required to be recorded within the contracts database, and new suppliers must be recorded within the supplier database. These arrangements are further supported by the Supplier Information Request Form (SIRF), which is classified as a Standard Procedure and controlled through SharePoint. The SIRF captures supplier, support and technical information, clarifies roles and responsibilities, and ensures that the Health Board maintains the information required to effectively manage services throughout the lifecycle of the relevant contract, product or solution. Collectively, these controls provide a structured approach to documentation to support arrangements, operational procedures, responsibilities	No	30/09/2026	
4009EA2025	External Audit	GMS Contract Challenges	Not Rated	Chief Operating Officer	N/A	4.1	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. 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	Head of Primary Care	31/07/2026			Completed	Completed	0	Clear escalation/de-escalation triggers, aligned with GMS contractual requirements, have been developed and included in the Enhanced Monitoring Framework that support exit from, or the continuation of, enhanced monitoring.		Enhanced Monitoring Framework: Clear GMS-aligned escalation and de-escalation triggers developed to support decisions on continuing or exiting enhanced monitoring.		30/09/2026	
4010EA2025	External Audit	Digital Transformation	Not Rated	Director of Digital	N/A	6.1	The Health Board should strengthen its approach to digital inclusion by; assigning a strategic lead for digital inclusion (Paragraph 43);	Following approval of the Digital Transformation Plan, a strategic lead for digital inclusion will be formally assigned to provide organisational oversight and accountability.	Director of Digital	31/07/2026			Completed	Completed	0			Our service discovery and programme management framework now includes digital inclusion principles. In addition Digital, Data & Technology representatives attend the Accessible Communication sterring group which ensures compliance with the Welsh Health Circular on Accessible Communication and Information Standards.		30/09/2026	
4010EA2025	External Audit	Digital Transformation	Not Rated	Director of Digital	N/A	6.3	The Health Board should strengthen its approach to digital inclusion by; assessing digital inclusion risks on new patient/public facing systems. Systems/care pathways should then be designed to enable accessibility and alternative access contact routes (Paragraph 43).	Digital inclusion principles will be applied to all new patient and public-facing digital developments. Digital governance arrangements will include explicit assessment of digital inclusion risks alongside existing assurance processes for cyber security, information governance and patient safety	Director of Digital	31/07/2026			Completed	Completed	0			Our service discovery and programme management framework now includes digital inclusion principles. In addition Digital, Data & Technology representatives attend the Accessible Communication sterring group which ensures compliance with the Welsh Health Circular on Accessible Communication and Information Standards.		30/09/2026	
4011EA2026	External Audit	Cancer Services	Not Rated	Chief Operating Officer	N/A	5.1	The Health Board should ensure reporting mechanisms are in place to operationally monitor the delivery of the cancer strategy and provide assurance to the Board and committees that delivery is on track.	Oversight of delivery will be provided through Cancer Board reporting to the Executive Committee, with periodic assurance reporting and annual deep dives to the Public Board. Re-established and strengthened the Health Board Cancer Board with clear terms of reference, executive leadership and multidisciplinary membership. Evidence of regular meetings and action tracking is in place. Cancer Programme formally designated as one of the Health Board's priority programmes with executive sponsorship from the COO. This will ensure regular updates into Public Board, and scrutiny via our annual plan / IMTP process.	Cancer Services Manager	31/07/2026			Completed	Completed	0	Governance and assurance arrangements for cancer services have been strengthened through the re-establishment of the Health Board Cancer Board, with clear Terms of Reference, Executive leadership and multidisciplinary membership. Regular meetings and action tracking are now embedded within the governance framework. Oversight is provided through routine reporting from the Cancer Board to the Executive Committee, supported by periodic assurance reporting and annual deep-dive reviews to the Public Board. In addition, the Cancer Programme has been designated as a Health Board priority programme with Executive sponsorship from the Chief Operating Officer, ensuring ongoing scrutiny through Public Board reporting and the Annual Plan/IMTP process. These arrangements are now established and operational.		Cancer Governance: Re-established the Health Board Cancer Board with Executive leadership, multidisciplinary oversight, action tracking and strengthened assurance reporting to Executive and Public Board.	No	30/09/2026	
4916A2025	External Audit	Urgent and Emergency Care: Arrangements for Managing Demand	Not Rated	Chief Operating Officer	N/A	5.1	Directory of services RS To ensure health and care staff can adequately signpost and refer people to the right urgent and emergency services, the Health Board should: • establish a mechanism to ensure the WAST Directory of Services remains up to date, which includes the identification of an officer with lead responsibility for this task	To strengthen the accessibility and accuracy of urgent and emergency care service information, the Health Board is taking the following actions: 5.1A named lead officer will be appointed to oversee all Health Board contributions to the WAST Directory of Services. This individual will act as the central point of contact for service updates, ensuring timely and coordinated entries across departments.	Chief Operating Officer 	30/11/2025		28/04/2026	Completed	Completed	1	Development of a Community Directory of Services will be progressed through the Single Point of Access (SPoA) programme. Progress is currently dependent on confirmation of the national feasibility study outcomes and the identification of funding opportunities to support		Community Directory of Services: Progressing through the SPoA programme, subject to the national feasibility study outcome and identification of funding.		30/09/2026	
ABUHB-2425-07	Internal Audit	Declaration of Interests	Substantial	Director of Corporate Governance	Medium	2.1	Mandatory Declarations Whilst it is the responsibility of individuals to declare interests, there is a requirement for some staff groups (e.g. Band 8A and above) to complete a mandatory declaration (either nil or otherwise). Currently, there is no central process (including reminders) for ensuring all staff required to do this complete the declaration process in a timely manner.	Agreed Action: As set out within the Standards of Business Conduct Policy (section 6), Line Managers are responsible for ensuring employees are aware of the requirement to follow and comply with the Policy and Standards of Behaviour Framework. The Standards of Business Conduct Policy is to be be discussed at Individual Performance Reviews, Consultant Appraisals and as part of the Consultant Job Plan Reviews as appropriate. In addition, the Corporate Governance Directorate will establish a centralised process to monitor and track the submission of declarations by all those staff required to submit a return in-line with the policy.	Director of Corporate Governance	31/03/2026		28/04/2026	Completed	Completed	1	Working with Woorkforce and OD colleagues to include list of 'high risk' groups in PADR documentation. Joint letter sent from DoCG and MD to all consultants reminding them if the requirement to declare interests. List of band 8a and above staff requested to target this cohort of 'high risk' staff. Meetings held with other Health Boards on the use of ESR to record DoIs in order to facilitate monitoring of compliance levels.		Updated Policy sets out the process for high risk groups. High risk groups are now listed in PADR documentation. Joint letter from DoCG and MD sent to all consultants to remind them of the requirements to complete DoIs. Work ongoing to target high risk groups. Allstaff at band 8a and above have been contacted to request DoI submissions. High risk deparments (R&D, informatics, pharmacy, W&E) have been contacted to request a list of eligible staff who will then be requested to complete DoIs		30/09/2026	
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 papers records left behind after the patient's DHR files were sent for	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 high-use case notes and support where required. A formal improvement plan to be created from these findings. The Information Governance Team	Head of Health Records – DHR	31/12/2025		28/04/2026	Completed	Completed	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 process 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 in		Significant activity has been undertaken to address this audit recommendation and whilst it is work in progress the ongoing activities are embedded into ways of working and will continue to evolve over time.		30/09/2026	
ABUHB-2526-03	Internal Audit	Strategic Risk and Assurance	Reasonable	Director of Corporate Governance	Medium	1.1	Executive Committee Oversight The Health Board's approach does not require regular, formal Executive Committee oversight of the SRR. Testing under objective 4 highlighted quality issues across the five SRR risks reviewed. Although multiple root causes are discussed under objective 4, the lack of formal Executive scrutiny heightens the risk of inaccurate or poor-quality SRR reports being submitted to the Board and sub-committees.	Agreed Action: The Health Board will formalise Executive Committee oversight of the Strategic Risk Register (SRR) by incorporating a standing agenda item for SRR review within the Executive Committee cycle of business. The Executive Committee will: • Receive the full SRR on a quarterly basis aligned to Board reporting cycles. • Undertake documented scrutiny, including review of risk scores, assurance gaps, and progress against mitigating actions. The Risk Management Framework will be to reflect this requirement and clarify roles and responsibilities. Expected Evidence of Implementation: • Updated Risk Management Framework including Executive Committee SRR oversight requirement • Executive Committee agendas showing SRR as a standing item • SRR reports presented to Executive Committee • Meeting minutes evidencing documented challenge and scrutiny of SRR risks	Head of Corporate Risk and Assurance	30/09/2026			Completed	Completed	0			The Executive Committee receives the Strategic Risk Register report in advance of each Board meeting, enabling Executive review and oversight before its submission to the Board. The Committee also receives the Corporate Risk Register on a quarterly basis. In addition, a Strategic Risk Register and Corporate Risk Register dashboard have been developed. This provides a clearer view of the relationship between the two registers, including the parent-child relationships between strategic and corporate risks		30/09/2026	
ABUHB-2526-03	Internal Audit	Strategic Risk and Assurance	Reasonable	Director of Corporate Governance	Medium	3.1	SRR Content – Completeness and Quality Testing identified that the SRR template and its completion do not consistently support clear, reliable or complete strategic risk reporting. While existing controls and assurance sources were generally well documented, and key above appetite risks receive robust Board and committee scrutiny, weaknesses in how several template sections are populated reduce the clarity of assurance. These include: • Poor linkage between controls, assurances, gaps and actions. • Non-SMART or miscategorised planned improvements. • Vague or inaccurate assurance gaps. • No reporting on action implementation. • Limited visibility of action impact due to minimal score movement. These issues – identified across all five SRR risks tested – stem from template limitations and applied use, undermining, as currently built, the assurance of operational risks in the SRR	Agreed Action: The Health Board will improve the completeness, clarity, and consistency of SRR content through template enhancement, targeted training, and strengthened Executive scrutiny. 1. Refresh the SRR template to: o Improve structure and clarity of required fields o Strengthen linkage between controls, assurances, gaps, and actions 2. Deliver targeted training and guidance to all SRR risk owners covering: o Completion standards o Definition of SMART actions o Identification of meaningful assurance gaps 3. Introduce structured deep dives into Committee agendas as a standing item, prioritised based on risk exposure, to enable focused review of assurance quality, progress of mitigating actions, and movement in risk trajectory. These actions will improve transparency and support more effective scrutiny, with a change to the way risk is managed from now on	Head of Corporate Risk and Assurance	30/09/2026			Completed	Completed	0			The update against recommendation 1.1 covers the improvements made to the template. In terms of action 3, Committee reporting is focused on risks that remain above the agreed appetite. Reports provide the underlying evidence and analysis necessary to explain why a risk remains outside appetite, the effectiveness of the controls in place and the actions being taken to reduce the risk. Where the information presented does not provide the Committee with sufficient assurance, a more detailed review or deep dive will be undertake, with the findings reported to a subsequent Committee meeting and where necessary reported to the Board through the Committee Assurance Reports.		30/09/2026	

ABUHB-2526-08	Internal Audit	Falls Management (Inpatient)	Reasonable	Director of Allied Health Professionals	Medium	1.1	Policies and Procedures Whilst the main Falls Policy for Hospital Adult Inpatients was in date, the following policies / procedural documents should be reviewed, updated and incorporated accordingly to ensure completeness: • Incident Reporting Policy • The Use of Bedrails and Bedrail Covers Policy – review date August 2025. • RIDDOR SOP – not referenced within the Inpatient Falls Policy. • The National Policy on Patient Safety Incident Reporting and Management in Wales – not referenced within the Inpatient Falls Policy The Falls Policy for Hospital Adult Inpatients could also benefit from a summary page or flow diagram outlining the falls reporting process, enabling staff to access key steps quickly within clinical settings - as detailed in Finding 5.	Agreed Action: 1.1 Review and update of associated Policies: Obtain final approval for and publish the revised Use of Bedrails and Bedrail Covers Policy on the intranet. The publication of the revised Incident Reporting and Management Policy on 12 February 2026 will be provided as evidence that this element has already been completed. 1.2 Make updates to the Falls Policy for Hospital Adult Inpatients Approve and publish the revised Falls Policy for Hospital Adult Inpatients, incorporating references to the RIDDOR SOP and the National Policy on Patient Safety Incident Reporting and Management in Wales, together with a concise falls-reporting flow diagram covering immediate post-fall actions, clinical review and escalation timescales, and RLDatix reporting. Expected Evidence of Implementation: Action 1.1 - Approved versions of the Incident Reporting and Management Policy and the Use of Bedrails and Bedrail Covers Policy published on the intranet, supported by the relevant approval records. Action 1.2 - Approved revised Falls Policy for Hospital Adult Inpatients published on the intranet, including references to the RIDDOR SOP and the National Policy on Patient Safety Incident Reporting and Management in Wales, together with the falls reporting flow diagram.	Director of Allied Health Professionals and Health Sciences	30/09/2026			Completed	Completed	0			The Use of Bedrails & Bedrails Covers Policy has been updated on the intranet, issue date 31/07/2026, review date 31/07/2029	No	30/09/2025	
ABUHB-2526-18	Internal Audit	Occupational Health	Reasonable	Director of Workforce and OD	Medium	4.1	KPI Reporting Although the full activity-based All-Wales KPI set is submitted to Welsh Government and received by the Director of Workforce and OD, only a small subset of management referral timeliness, same-day reporting, and pre-placement clearance, is regularly provided to the People & Culture Committee. The Committee does not currently receive wider qualitative indicators, service user feedback, or comparative analysis of performance between internal health board provision and externally delivered services under SLA arrangements. Given that the OH team delivers services to both internal and external bodies, disaggregating reporting to show internal versus external performance would provide greater insight and assurance.	Agreed Action: 1. The Occupational Health performance dashboard will be expanded to include MoHaWK benchmarking data and qualitative service user feedback, where available, to support broader performance oversight. 2. The service will continue to monitor referral waiting times across all referrals. As referrals are triaged strictly by date received, waiting times are consistent across internal and external referrals; therefore, additional disaggregation will be kept under review to ensure reporting remains meaningful and proportionate. Expected Evidence of Implementation: • Updated Occupational Health performance dashboard including MoHaWK data. • Dashboard included within Workforce performance reporting and reported to the People & Culture Committee.	Senior Occupational Health Nurse/ Manager	31/08/2026			Completed	Completed	0			Monitoring and operational oversight arrangements have been strengthened through the review and validation of Mohawk data, which will be incorporated into the organisation's performance dashboard to support ongoing performance management. In addition, waiting times are subject to weekly review, with workloads actively managed and reallocated where required to maintain service delivery and respond to changes in demand. These actions have improved the Health Board's ability to monitor performance, identify emerging pressures and take timely action to support service delivery.		30/09/2026	
ABUHB-2526-18	Internal Audit	Occupational Health	Reasonable	Director of Workforce and OD	Medium	5.1	Project Plan Tracker In August 2025 the OH Service senior team introduced a project plan tracker to strengthen oversight of performance and service-improvement actions. The addition of start and target completion dates would provide further structure in the delivery of the remaining 8 high and 19 medium priorities.	Agreed Action: 1. The Occupational Health project plan tracker will be updated to include start dates, target completion dates and responsible leads for all actions. 2. The tracker will be reviewed at each Occupational Health Senior Team meeting to monitor progress and prioritise actions according to risk. Expected Evidence of Implementation: • Updated project plan tracker including dates and responsible leads.12 • Senior Team meeting minutes demonstrating review and oversight.	Senior Occupational Health Nurse/ Manager	30/09/2026			Completed	Completed	0			A comprehensive action plan has been established, with defined start dates, target completion dates and responsible leads assigned to each action. Progress is monitored through a tracker that is reviewed monthly as a standing item within the Occupational Health Senior Team meeting, providing regular oversight and accountability. Embedding review arrangements within existing governance processes ensures actions remain up to date, progress is actively monitored, and duplication is avoided through separate reporting mechanisms.		30/09/2026	
ABUHB-2526-20	Internal Audit	Speaking Up Safely	Limited	Director of Workforce and OD	Medium	7.1	Training and awareness The audit identified an awareness and promotion of SUS across the Health Board. There is an opportunity to reflect upon the success of this and determine what communication / promotion plan would be the most appropriate to ensure staff access the correct route for their concern(s) in the future. In addition, training needs and compliance should be reviewed for each specific group, to determine if further enhancement is required: • General staff; • SUS champions; and • SUS Guardians. It would also be beneficial to monitor the impact of training on the number and origin of concerns raised. At the time of audit, 39 concerns had been raised which was significantly lower than observed at more mature arrangements within other health boards (others [illegible]	Agreed Action: Positively the results of the 2025 Staff Survey demonstrate an improvement in staff feeling safe to speak up and that the organisation will act on concerns. It is recognised that further work is required to support confidence in the SUS Framework. This will include: • Review current position and develop a SUS socialisation and response training plan which will be integrated into existing management and leadership training resources. Expected Evidence of Implementation: • SUS socialisation plan, • Training materials • Staff communication • Committee papers and reporting packs • Staff Survey results	Assistant Director of Workforce & OD and Head of Employee Wellbeing	30/09/2026			Completed	Completed	0			A dedicated Speaking Up Safely Guardian has been appointed to lead the implementation, promotion and oversight of the framework across the Health Board. Key actions completed include development and publication of a Speaking Up Safely Standard Operating Procedure, implementation of a communication and engagement plan, integration of Speaking Up Safely into existing leadership and safeguarding training programmes, and enhancement of support arrangements for staff, champions and guardians. In addition, strengthened monitoring arrangements have been established to track concerns raised, identify themes and areas for improvement, and measure impact alongside staff survey indicators relating to psychological safety and confidence to speak up. These actions have significantly strengthened the Health Board's Speaking Up Safely arrangements and provide a sustainable framework for ongoing improvement and organisational learning.		30/09/2026	
ABUHB-2526-23	Internal Audit	Shadow IT	Reasonable	Director of Digital	High	2.1	Board-level oversight is in place through the Finance and Performance Committee and the Partnership, Population Health and Planning Committee, with digital considered primarily in the context of performance and strategy. However, the central coordinating governance body, the DDaT Group, is not currently operational. As a result, while the governance framework is clearly defined, it is not fully functioning in practice. There is no dedicated forum to coordinate digital oversight, ensure compliance with established procedures, provide consolidated assurance on systems implemented outside formal approval processes, and oversee technology-related activities occurring within clinical and operational directorates.	Agreed action: The Health Board has established the DDAT Group which is the central forum responsible for coordinating Digital oversight. The ToR sets out the defined responsibilities for monitoring compliance with Digital procedures, reviewing risks (including Shadow IT), and providing regular, structured assurance reporting into Board-level Committees. Expected Evidence of Implementation: • Approved Terms of Reference and confirmed membership for the DDaT Group • Evidence of regular meetings (e.g., agendas and minutes) • Reporting outputs demonstrating oversight of digital risks and compliance (including Shadow IT) • Evidence of formal reporting and escalation to Boardlevel Committees (e.g., Finance & Performance Committee / PPHPC)	Director of Digital	30/09/2026			Completed	Completed	0			DDAT Group is now in place and first meeting has taken place. Meetings are in the diary every 6 weeks for the next 12 months.	No	30/09/2025	
ABUHB-2526-27	Internal Audit	GUH ED Extension	Limited	Director of Planning, Strategy and Partnerships	High	1.1	Lessons Learnt Review Recognising the extent of the issues impacting the project, the UHB has committed to undertaking a post-completion lessons learnt review, with the support of its key advisers, and already had a clear understanding of some contributing factors as demonstrated in discussions during the audit. Recognising the postponement of Phase 2, this exercise should be undertaken on completion of Phase 1. We suggest the review could include consideration of the following: • Impact of the applied procurement strategy; • Assessment of the chosen contract strategy (separately contracted design and build) and adequacy of risk provisions included; • Adequacy of the original scope, design brief and resultant design, considering the significant technical design changes made post-contract, and associated additional time and cost awarded to the Contractor;	Agreed Action: Lessons learnt will be undertaken following project closure in line with the NHS Wales Infrastructure Investment Guidance. Commitment gained from all parties to undertake the Lessons Learnt exercise. ABUHB remain in contract with Morgan Sindall for a year after completion of the project in line with the NEC contract. Whilst we will continue to gather evidence/ data, there are a number of Compensation Events outstanding which are yet to be agreed. Due to the nature and value of the claims, the lessons learnt will be undertaken following confirmation of an agreed way forward in order not to compromise any negotiations. Expected Evidence of Implementation: Completed Lessons Learnt Exercise Report	Project Manager	30/09/2026			Completed	Completed	0	Lessons learnt undertaken between all parties on 19/05/2026. Report attached. Compensation events are still outstanding.		Lessons Leant exercise completed for project and wider Lessons Learnt document developed		30/09/2026	
ABUHB-2526-27	Internal Audit	GUH ED Extension	Limited	Director of Planning, Strategy and Partnerships	High	8.1	Equipment Procurement From the audit sample testing of equipment procurements, the following was noted: • The Request for Approval (RFA) forms did not always capture sufficient detail to demonstrate procurement compliance and ensure the approver was appropriately informed. The UHB should ensure reports contain sufficient information to enable informed approvals to be granted. • One of our sample (valued at £11k) was non-compliant with SFIs, whereby a direct order had been placed without obtaining quotations/utilising an applicable framework. The required Single Quotation Action (SQA) form had not been completed. This was only identified by Procurement following audit enquiries. The Senior Procurement Business Manager has advised a checklist will be completed prior to placing orders from now on, to avoid this happening again. We were also advised the required File Note has been produced, to [illegible]	Agreed Action: Request for approval forms are Health Board documents, NWSSP have recently implemented updated procedures that require procurements to be supported with a Procurement Outcome Report. These reports contain more detail which will address the issues outlined in the audit report. There is an opportunity to merge the RFA and Procurement Outcome Report to reduce administrative burden and ensure the audit report issues are addressed. In regard to the SQA a request for approval form was completed and signed off but it was later identified that this should have been an SQA request. A file note has been logged on the contract folder highlighting this and additional support and guidance has been provided to the team to ensure that the correct process is followed. The non-compliance will be reported to the Audit & Risk Committee in the April 2026 report. Further to the above a checklist has been developed by NWSSP Procurement Services to ensure all correct steps have been taken and that checks and sign off have been completed before orders are placed. Expected Evidence of Implementation: Revised RFA/Procurement Outcome report developed and implemented (April 2026); Procurement checklist has been developed an implemented (October 2025), Non-Compliance reported to Audit & Risk Committee (April 2026)	Head of Sourcing	30/09/2026			Completed	Completed	0	Reported to ARAC - April as advised by Alex Curley		Actions within the recommendations have been implemented		30/09/2026	
ABUHB-2526-28	Internal Audit	Development of a Regional Radiotherapy Satellite Centre (RSC) at Nevill Hall Hospital	Reasonable	Director of Planning, Strategy and Partnerships	High	3.1	Service Level Agreement A Service Level Agreement (SLA) between the UHB and the Trust was developed over the preceding several months prior to Project handover but remained in draft and unsigned at the point of project completion. Operating a new healthcare facility without a signed SLA between the managing and service providers poses significant governance and safety risks. The lack of formal agreement on statutory compliance, maintenance, and clinical safety responsibilities increases the likelihood of operational failure, legal liability, and potential harm to patients or staff. The SLA should be considered a critical prerequisite for building occupation and service commencement.	Agreed Action: Final signed SLA document to be produced by Velindre, once received it will be signed by the Health Board. Expected Evidence of Implementation: • Completed Signed SL	Assistant Director of Strategic Capital, ABUHB	15/09/2026			Completed	Completed	0	SLA completed and signed		Signed SLA	No	30/09/2025	
ABUHB-2526-28	Internal Audit	Development of a Regional Radiotherapy Satellite Centre (RSC) at Nevill Hall Hospital	Reasonable	Director of Planning, Strategy and Partnerships	Medium	4.1	Promptness of identification and resolution of water quality issues Best practice guidance (i.e. HTM 04-01, BS 8680) emphasises that once a system is wetted, it must be either brought into full operational use promptly or maintained through rigorous flushing and monitoring regimes to prevent deterioration in water quality. The system was first wetted in January 2025, yet the first remedial measures were not initiated until May 2025 - a delay of approximately four months. This represents a significant gap in proactive control measures, particularly given the well-documented risks associated with stagnation and microbial proliferation in newly commissioned water systems. The four-month lag suggests either a breakdown in governance oversight or a lack of clarity over responsibility for maintaining the water system during the pre occupancy phase.	Agreed Action: Water issue resolved. The compliance team have an agreed testing plan in place. This issue will form part of the Post Project Evaluation within any lessons learnt to be incorporated within Management Procedures. Expected Evidence of Implementation: • Health Board Management Procedure to be implemented • Review at Post Project Evaluation/ Lessons Learnt	Divisional Director of Facilities and Estates/ Assistant Director of Strategic Capital	30/09/2026			Completed	Completed	0	Water testing now takes part as business as usual		Discussed within the PPE and evidence through Post Project Evaluation Document. Process embedded in BAU	No	30/09/2025	
ABUHB-2526-28	Internal Audit	Development of a Regional Radiotherapy Satellite Centre (RSC) at Nevill Hall Hospital	Reasonable	Director of Planning, Strategy and Partnerships	Medium	5.1	Root cause analysis – water issue During the review of the new health facility capital build project, it was noted that water quality issues delayed the commencement of patient treatment by several weeks. The UHB/Trust could not determine whether this issue was attributable to the main contractor's work or to external factorsIe.g., design, commissioning, utilities). Consequently, no compensation event or contractual remedy has been pursued. It was reported by ABUHB Management that the issue may have been the result of flux. In new builds, most pipe joints (especially copper) are soldered using flux — a chemical paste that helps metal bond properly. If commissioning and flushing aren't thorough, flux residue is left inside the pipes. That residue: • Is organic and nutrient-rich • Coats internal pipe surfaces • Acts as a starter food source for bacteria	Agreed Action: This issue will form part of the Post Project Evaluation within any lessons learnt to be incorporated within Management Procedures. Expected Evidence of Implementation: • Post-project evaluation report including lessons learned	Divisional Director for Estates and Facilities Assistant Director for Strategic Capital	30/09/2026			Completed	Completed	0	Flux residue is still an issue as reported by W&E. The flux residue is not impacting on the water testing results. Water testing is undertaken as part of the normal testing requime, no problems have been reported.		Discussed within the PPE and evidence through Post Project Evaluation Document	No	30/09/2025	

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	Is this recommendation delayed by National requirements	Reporting Date
ABUHB-2425-11	Internal Audit	End of Life Care	Reasonable	Director of Nursing	Medium	1.1	Framework for the capture and management of patient Future Care Planning documentation Whilst we appreciate that it is the responsibility of the individual to share FCP documents with the necessary health care providers (Health Board, GP, OOH GP, Ambulance Service, District Nursing service etc.) there is an absence of a policy within the Health Board and / or a supporting procedure to cover the: capture; coordination; and management of these key documents.	Agreed Action: The Health Board are working towards implementing a robust framework for capturing and managing patient Future Care Planning (FCP)documentation. This will include the following elements: Identification and Targeting: Implement a structured approach to identify patients who would benefit from FCP, such as those with chronic illnesses, frailty, or nearing end-of-life. Tools like the Elderly Risk Assessment score can be useful. Standardised Documentation: Use standardised forms and templates to ensure consistency in FCP documentation. This can include advance directives, anticipatory clinical management plans, and patient preferences for care. Multidisciplinary Collaboration: Encourage daily multidisciplinary huddles to discuss and document FCP for identified patients. This ensures that all relevant healthcare professionals are involved in the planning process. Electronic Health Records (EHR) Integration: Transition to digital ACP plans for better accessibility and efficiency. Integrate FCP documentation into the EHR system to ensure accessibility and continuity of care. This allows for easy sharing and updating of patient care plans across different care settings Education and Training: Provide ongoing education and training for healthcare professionals on the importance of FCP and how to conduct and document these conversations effectively. Establish and expand the role of ACP Practice Educators to provide specialised training and support. Increase the number of Advance Care Planning (ACP) facilitators to ensure better support in secondary care settings. Patient and Family Involvement: Ensure that patients and their families are central to the FCP process, with personalised conversations	Director of Nursing	31/12/2025	31/12/2026		Overdue	Overdue	1	This action has been delayed due to the lack of a national policy on Future Care Planning, in the absence of that policy ABUHB will develop an internal management policy which will be shared with partners by the end of December	The agreement at executive board was to not go live with WCP functionality until the flag was available in CWS due to the risk. The guideline is being developed in parallel and should be ready to go live at the same time. The proposed date for this is currently December 2026.		Yes	30/09/2026
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	30/11/2026	28/04/2026	Overdue	Overdue	2	October 2026: The Data & Analytical academy has been launched and a SBAR will be going to the Exeuctive Committee in November to approve the use of a kitemark to provide assurance on data standards				30/09/2026
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	31/12/2026	28/04/2026	Overdue	Overdue	2	October 2026: OCP is now completed and policy development will be completed by the end of the calender year				30/09/2026
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	31/01/2027		Overdue	Overdue	2	October 2026: Work continues to expand the scope beyond DDAT-managed products through Configuration Management Database updates and Service Transition activity. During this period, Pathology has been the focus, bringing its complex systems and products into the digital view. We are also tying in with the Networks and Cyber teams to document newly found configuration items that are being captured through our new firewalls."				30/09/2026
ABUHB-24-25-28	Internal Audit	Newport East Health and Wellbeing Centre	Reasonable	Director of Public Health	Medium	3.1	Disposals Four premises were identified for closure at the business case: • Ringland Surgery; • Park Surgery; • Always clinic; and • Clytha clinic & dental surgery. The sale of the Health Board premises of Alway and Clytha were estimated at £285k & £102k respectively (subject to revaluation confirmation), with an associated reduction in backlog maintenance (stated to be £174k for Park Surgery). Of these while Ringland was demolished on the Health & Wellbeing Centre site, the other three remained in-situ at the time of the review(Park surgery being GP owned). The Health Board have advised that this is due to a targeted reduction in the number of rented premises. They also advised that review remained ongoing and that this may not represent the final position.It is additionally recognised that excepting agreement to the contrary, sales proceeds would accrue to the Welsh Government.There was a need therefore to confirm the position in relation to these premises, associated costs and revenues, and any retention of sales proceeds as part of an end project evaluation.	Agreed Action: At the time of submission, the assumption in relation to the closure of identified buildings was correct. However, further work has progressed in relation to the Health Boards wider Estate rationalisation strategy, which has identified changes to the follows - • Ringland Surgery – demolished as part of new development. Complete • Park Surgery – as confirmed with audit, Park is not included within any financial benefit to the HB as it is privately owned • Alway Clinic – This has now become the base for the Newport Locality Team due to the Health Board relinquishing the lease for Victoria House as part of the wider estates, rationalisation for the HB. • Clytha Clinic – this still houses some Health Board services which weren't included within the 19 Hills development. There are plans owever for this to be disposed of as part of the wider St Woolos rationalisation work. Expected Evidence of Implementation: Disposal of Clytha to be included within the St Woolos Business Case.	Assistant Director of Strategic Capital Planning & Divisional Director Estates & Facilities	30/09/2026	31/03/2028		Overdue		1	October 2026: Clytha Clinic - work is underway under the Value and Sustainability Workstream of Estate Rationalisation to move staff who are currently there to alternative accommodation. The property will then be disposed of.				30/09/2026
ABUHB-2526-02	Internal Audit	Standing Orders Compliance	Substantial	Director of Corporate Governance	Medium	1.1	Inactive Advisory Groups - Within the Advisory Group structure, prescribed within the Welsh Government Model Standing Orders, the Stakeholder Reference Group and Healthcare Professionals Forum are not currently active in the Health Board and the posts of chair for each of these groups are vacant. Agreed Action: The Health Board acknowledges that the Stakeholder Reference Group and Healthcare Professionals' Forum are currently inactive and that Chair positions remain vacant. Since their original establishment in 2009, the Health Board has significantly evolved its approach to engaging clinical professionals and stakeholders. To address this, a comprehensive mapping exercise of existing engagement arrangements will be undertaken. This will inform an options appraisal for the Board to determine the most effective way to re-establish the required advisory fora, ensuring compliance with Standing Orders, avoiding duplication, and delivering maximum benefit. Expected Evidence of Implementation: • Completion of mapping exercise and options appraisal report. • Formal Board decision on future arrangements for the Stakeholder Reference Group and Healthcare Professionals' Forum. • Documented implementation of agreed actions, including appointment of Chairs and activation of the groups.		Head of Corporate Governance	30/09/2026	30/09/2027		Overdue		2	Committee reporting is focused on risks that remain above the agreed appetite. Reports provide the underlying evidence and analysis necessary to explain why a risk remains outside appetite, the effectiveness of the controls in place and the actions being taken to reduce the risk.				30/09/2026
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	30/11/2026		Overdue	Overdue	2	October 2026: SOPS awaiting to be revised and formally signed off to enable this recommendation to be completed, staff shortages have delayed the completion of this recommendation.				30/09/2026

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	30/11/2026		Overdue		1	October 2026: Processes have been changed and Civica has been amended to reflect these changes however, documents have to be reviewed and amended to reflect this. Further ID checks are now being undertaken in relation to identity of requestors and 3rd party representatives. All further actions will be completed by the revised date.				30/09/2026
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	30/11/2026		Overdue		1	October 2026: All subject access requests are acknowledged within 2 days this was communicated verbally to all team members. Unfortnately the past year has been challenging with resources and volume of work which has meant a focus on supporting the teams to maintain compliance with legislation deadlines. SOPs and guidance still to be updated				30/09/2026
ABUHB-2526-06	Internal Audit	Business Continuity Planning	Reasonable	Director of Planning, Strategy and Partnerships	High	1.1	BCP and action cards We noted none of the three sampled services had conducted nor scheduled any test exercises of their BCPs. Additionally, we noted the following weaknesses with BCP action cards: • action cards do not record triggers i.e. the event that would trigger their use; • action cards are not role specific; • not all action cards are critical function specific, but are more broad-based describing generic level actions; and • hard copy action cards are not stored in a safe place ready for use.	Agreed Action: The EPRR team will work with all service areas to ensure that local Business Continuity Plans (BCPs) are regularly tested and that action cards are updated to address identified weaknesses.Specifically: • Develop and roll out a train-the-trainer package and supporting test and exercise toolkit to enable divisions/directorates to conduct and record regular BCP exercises. • Support services to review and update all action cards to: o include clear activation triggers; o define role-specific responsibilities; and o align actions to critical functions. • Ensure that hard copies of BCPs and action cards are securely stored and readily accessible in key operational areas. Monitor completion and effectiveness through local BCP assurance audits and reporting to the EPRR Group. Expected Evidence of Implementation • Approved train-the-trainer and test/exercise toolkit. • Records of completed BCP exercises conducted by services. • Sample updated BCP action cards showing: o documented activation triggers, o named roles/responsibilities, and o linkage to critical functions. • Confirmation and/or photographs of securely stored hard copies in operational areas.	Head of Planning – Civil Contingencies	31/03/2026	31/03/2027	28/04/2026	Overdue	Overdue	2	Awareness and exercise sessions planned it for Divisions and shared across Health Board, also offer of bespoke sessions for areas. Due to service pressures there has been very little uptake for these. Further will be offered including work with individual areas All corporate plans, guidance, templates, examples, activation and command and control information are available on the EP site and shared with areas. All services are advised to hold a hard copy of their service plans and actions cards in a central location. Another organisational wide BC audit has taken place to heatmap to highlight gaps in service planning and exercising of plans. The audit findings will be escalated to divisional and service managers.				30/09/2026
ABUHB-2526-06	Internal Audit	Business Continuity Planning	Reasonable	Director of Planning, Strategy and Partnerships	Medium	2.1	Training for key staff in their role and responsibilities in respect of delivering business continuity We were advised that in the sample services that we examined, only a small number of senior staff are familiar with the BCP protocols. All three sample services examined acknowledged the need to extend business continuity plan training to further key staff, but had not yet scheduled any training events.	Agreed Action: The EPRR team will ensure that key operational and managerial staff across all divisions/directorates receive appropriate training in their roles and responsibilities for delivering business continuity. Specifically: • Identify and confirm Business Continuity (BC) leads within each division/directorate. • Develop and deliver a stand-alone, role-specific training package focused on staff responsibilities for activating, managing, and maintaining BCPs. • Ensure BC leads are equipped to cascade this training to other key staff within their areas. • Monitor completion and effectiveness through service level audits and regular reporting to the EPRR Group. These actions will ensure that all key staff understand their specific roles within the business continuity framework and can implement BCPs effectively during service disruption. List of appointed BC leads for all divisions / directorates • Approved and issued BC role-specific training package. • Training attendance records demonstrating that BC leads and key staff have completed training. • Evidence that training has been cascaded to relevant operational staff (e.g., attendance logs, training summaries). • Local BCP audit reports confirming that staff are aware of their responsibilities and can evidence training completion. Standing EPRR Group updates capturing divisional assurance on training delivery and coverage.	Head of Planning – Civil Contingencies	31/03/2026	31/03/2027	28/04/2026	Overdue	Overdue	2	The EPRR team planned and scheduled a series of BCP tests and table top exercises for service strategic, tactical & operational staff throughout 2026, only two TTX took place the remainder were cancelled due operational escalation and service pressures. 2.1 audit recommendation will require organisation prioritising the testing and exercising of BCP's. A stand-alone BC test & exercise facilitator table top exercise booklet has been produced for service use.				30/09/2026
ABUHB-2526-06	Internal Audit	Business Continuity Planning	Reasonable	Director of Planning, Strategy and Partnerships	Medium	3.1	BCP contact details protocols We noted an instance in the testing where BCP stakeholder contact details were recorded in the form of a SharePoint location that may not be operable in an interruption event and mean key resources cannot be mobilised.	Agreed Action: The EPRR team will ensure that current and accessible contact details for all key stakeholders is available and usable during any service interruption. Specifically: • Each service area will maintain hard copy BCP and action card folders containing up-to-date contact details for all critical staff, partner organisations, and stakeholders. • These folders will be stored securely and accessibly in designated operational areas to ensure they can be used if electronic systems (e.g., SharePoint) are unavailable. These actions will ensure that essential contact information remains accessible during an interruption, enabling timely and effective incident response. Expected Evidence of Implementation: • Confirmation showing hard copy BCP and action card folders are available in each service area.10 • Evidence of up-to-date contact lists included within those folders. • EPRR audit reports confirming that hard copy plans and contact details are in place, accurate, and accessible. Divisional assurance updates presented to the EPRR Group demonstrating ongoing compliance.	Head of Planning – Civil Contingencies	31/03/2026	31/03/2027	28/04/2026	Overdue	Overdue	2	Governance and assurance arrangements for cancer services have been strengthened through the re-establishment of the Health Board Cancer Board, with clear Terms of Reference, Executive leadership and multidisciplinary membership. Regular meetings and action tracking are now embedded within the governance framework. Oversight is provided through routine reporting from the Cancer Board to the Executive Committee, supported by periodic assurance reporting and annual deep-dive reviews to the Public Board. In addition, the Cancer Programme has been designated as a Health Board priority programme with Executive sponsorship from the Chief Operating Officer, ensuring ongoing scrutiny through Public Board reporting and the Annual Plan/IMTP process. These arrangements are now established and operational.				30/09/2026
ABUHB-2526-17	Internal Audit	Cancer Referral Rates	Reasonable	Chief Operating Officer	Medium	2.1	Analysis and reporting of rejected referrals We noted that there is no formalised consistent recording, analysis or reporting of the GP referred cases rejected through the screening/ vetting process operated by the Health Board and this may mean opportunities to make improvements to the related workflows are missed.	Agreed Action: 1. Establish current practices when rejecting referrals. 2. To identify an appropriate and robust method of recording rejected primary care referred cases. 3. Provide guidance to clinicians when rejecting referrals. 4. Aim to provide regular reporting of rejected referral rates/reasons Expected Evidence of Implementation: • Documented process / SOP showing how rejected referrals are handled (including identified current practice and agreed standard approach) • Clinician guidance (published document or templates) setting out clear rejection criteria and standard wording • Regular reports or dashboards showing: o number/percentage of rejected referrals o reasons for rejection o trends over time	Cancer Services Manager	30/09/2026	01/04/2027		Overdue		1	Update provided 05.10.26 1. The rejection, and reasons for rejection of USC referrals has been explored and concluded that no consistent approach is taken. 2. A Standard Operating Procedure has been developed in draft form for consideration. 3. The AMD for Cancer to obtain views of the Tumour Site lead and MDT members. 4. Final document for Cancer Board Sign off in December 2026. 5. Regular reports of rejection rate and reasons from Q4 2026/27			No	30/09/2026
ABUHB-2526-28	Internal Audit	Development of a Regional Radiotherapy Satellite Centre (RSC) at Nevill Hall Hospital	Reasonable	Director of Planning, Strategy and Partnerships	Medium	2.1	Unresolved Defects At the point of project completion and handover there were a number of defects which had been identified but not yet resolved. This was highlighted in July 2025 and again in an email dated 16th October 2025 when the UHB's advisers contacted the SCP commenting that they required a programme highlighting when these works will be completed and how they intend to close out with the Project Supervisor. A Defect status summary dated 16th October 2025 recorded 23 outstanding items.	Agreed Action: The Defects Tracker to continue to be managed by the Supervisor as per the NEC Contract. Progress monitored on a weekly basis. Escalation meetings to be held between Assistant Director for Health Board and Regional Director for Kier if actions are not being resolved. Expected Evidence of Implementation: • Updated defects tracker showing status and closure of items • Correspondence or escalation records with contractor • Supervisor confirmation at end of defects period that all issues are resolved (or evidence of retention use if applicable)	Assistant Director Strategic Capital	30/09/2026	31/03/2027		Overdue		1	Good progress has been made on defects. The solution to the generator harmonic system has been insalled/comissioned, awaiting sign off of data from Shared Services. Data has been received re power spikes in the building, no issues have been identifed. Some minor defects still outstanding, these are with the HB to provide information. Last email re defects received 2/10/26	Project Director escalation meeting 28th Oct 26 with Kier Regional Director		No	30/09/2025

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	24 November 2026
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	**Update on Single Quotation and Tender Actions from 1st September 2026 to 31st October 2026**
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	**Director of Finance, Procurement and Value Based HealthCare**
SWYDDOG ADRODD: **REPORTING OFFICER:**	**Alex Curley – Head of Procurement**

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

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

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

Appendix A provides specific detail regarding the Single Tender/Quotation Actions (STQ/STA) that have been submitted and approved for the period 1st September 2026 to 31st October 2026.

This report also includes information on SLA agreements which have been agreed by the Health Board to evidence greater grip and control on the organisation spend and input into wider review to ensure that SLA are agreed by the appropriate procurement route where required.

Key Headlines

☐ 3 STA/SQA requests approved.
☐ Total annual value: £142k.



☐ 1 STAs and 2 SQAs.
☐ No approvals identified as non-compliant with Standing Financial Instructions.
☐ 5 SLA agreements reviewed and agreed with annual value of £623k

Cefndir / Background

Whilst there can be valid reasons for only tendering with a single party, there is a risk that tenders involving only one party do not secure best value for money as a priority.

The monitoring of the use of STAs is also noted by NHS Performance and Improvement as an appropriate process to support robust grip and control.

Consequently, it is a requirement of Aneurin Bevan Health Board Standing Orders and Standing Financial Instructions that all requests for a Single Tender action (STA) or a Single Quotation action (SQA) are submitted to the Director of Finance and Chief Executive for consideration. The Head of Procurement provides a summary for each Audit, Risk and Assurance Committee detailing all actions submitted for consideration. The Audit, Risk and Assurance Committee's work plan includes a standing item for review of the following at each meeting.

Asesiad / Assessment

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

There have been 3 requests submitted which have been approved during the period with an annual value of £261,388 inc. VAT. Of the requests submitted 1 of these was an STAs with the remaining 2 lower value SQA's. The STA request was for the Maintenance of the Building Management System (BMS), a significant proportion of the Health Board's BMS estate is now integrated into one platform. The platform is a proprietary platform developed and licensed by supplier. As the software owner, supplier retains control of the licensing and provides manufacturer-level support for the system. These controllers can only be fully maintained, configured, programmed, and supported by supplier. 2 further SQA requests were received during the reporting period, One SQA for a Physio Exercise IT Platform, this SQA was agreed following a failed quotation exercise, the opportunity was advertised via multi-quote but not bids were received, in line with the regulations the process switched to a direct award. The total value of this agreement £20,0000. The 2nd SQA request was for Fire Alram testing and Maintenance at the Royal Gwent Hospital. The Fire alarm system at this site is a closed protocol system which can only be maintained by the original equipment manufacturer. The health board is in the process of replacing this system on a phased basis which will allow for a future competitive tender to be issued for this requirement.

Category under the SFI justifying the use of SQA/STA	Occurrences (no.)	Value (£/annum)
Follow-up work where a supplier has already undertaken initial work in the same area (and where the initial work was awarded from open competition);	**0**	**-**
A technical compatibility issue which needs to be met e.g. specific equipment required, or compliance with a warranty cover clause;	**2**	**132,725**
The need to retain a particular contractor for genuine business continuity issues (not just preferences)	**0**	**-**
An interim agreement prior to joining an all-Wales Collaborative Agreement.	**0**	**-**
Genuinely Only one Provider	**1**	**9,745**
In line with Policy and justified STA	**3**	**142,471**
Not in accordance with STA rationale	**0**	**-**

Trend Analysis

Period	Number of STAs/SQAs	Value £
Apr-Sep 2025	8	£305k
Nov-Mar 2025/26	11	£725k
Apr-Sep 2026	14	£1.0m

3 Year (Trend Analysis)

Financial Year	Number of STAs/SQAs	Value £
2024-25	29	£1.8m
2025-26	36	£2.9m
2026-27 (YTD)	14	£1.0m

Volumes remain reasonably static in terms of number of STA/SQA requests. It is anticipated that number will reduce as all SQA requests are now being issued via the multi-quote system. This is providing additional assurances that there are no alternative provider in the market and helping to reduce the overall number SQA's.

Service Level Agreement



In addition to the 23 SLA agreements reported in the last reporting period a further 5 have been approved in the latest reporting period. The total value of these 5 SLA's is circa £623k. Work continued between finance, procurement and divisional leads for the SLA to ensure that these are reviewed and progress towards the most appropriate procurement route for any future requirement.
Argymhelliad / Recommendation The Audit, Risk and Assurance Committee is asked to note the content of this report for assurance, including: 1. Assurance that the volume and value of STA/SQA remains low indicative with appropriate and not excessive use; 2. That the SFI process is being followed in most cases, with remedial actions for those specified where due process was not followed.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	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:	STA – Single Tender Action SQA – Single Quotation Action



	SFI – Standing Financial Instructions SLA- Service Level Agreement
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.

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	24 November 2026
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	**Update on Losses and Special payments – 1st April 2026 – 30th September 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 2026 and 30th September 2026.

Cefndir / Background

Losses and special payments are reported to the Committee 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 the Committee 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 £1.3m:

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	-	-	-	-
Fruitless payments, including abandoned capital schemes and constructive losses	-	-	-	-
Bad Debts and claims abandoned	-	-	-	-
Damage to buildings and loss of equipment or property	-	-	-	-
Theft of IT Equipment	-	-	-	-
TOTAL LOSSES	**-**	**-**	**-**	**-**
Special Payments per Annex 2				
Compensation payments made under legal obligation	-	-	-	-
Extra contractual payments to contractors	-	-	-	-
Ex gratia payments	-	-	-	-
Loss of personal effects	5	3	-	3
Personal Injury Settlements	81	383	8	375
Clinical Negligence Settlements	217	6,439	5,597	843
Other cases	5	80	-	80
Maladministration	-	-	-	-
Patient referrals outside the United Kingdom, the European Economic Area (EEA) and Switzerland	-	-	-	-
Extra statutory or extra regulatory payments	-	-	-	-
Voluntary Early Release Scheme	1	(4)	-	(4)
TOTAL SPECIAL PAYMENTS	**321**	**6,966**	**5,659**	**1,307**
Other - Penalties	5	13	-	13
TOTAL LOSSES AND SPECIAL PAYMENTS	**326**	**6,979**	**5,659**	**1,319**

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 £31.9m since 31st March 2026 to an overall provision of £268.5m. Of this, it is expected that £261.9m is recoverable from WRP leaving potential future losses to the Health Board of £6.6m.



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	-	-	-	-

There has been no recorded losses of cash during the first six months of 2026-27.

Loss Type	No. of Cases	Total £000	Met by the Welsh Risk Pool £000	Net cost to ABUHB £000
Bad Debts and claims abandoned	-	-	-	-

There has been no recorded bad debt write offs during the first six months of 2026-27.

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	-	-	-	-

There has been no recorded fruitless payments during the first six months of 2026-27.

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	5	3	-	3

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 5 total payments made, totalling £2.5k. The largest value payment made in this category was £1.6k in relation to the loss of hearing aids.

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	217	6,439	5,597	843

217 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 4 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 £1.66m.

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	81	383	8	375

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 £32k.

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	12	66	55	11

This relates to the amounts for cases classified as Redress (or "Listening to People") which are Clinical Negligence and Personal Injury cases, where the total value of the claim is expected to not exceed £50k 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 have increased the limit on the value of cases which are covered by this process to £50k, rather than the previous £25k. It should be noted that the Health Board has not had any cases exceeding £25k in 2026/27.

Other

Loss Type	No. of Cases	Total £000	Met by the Welsh Risk Pool £000	Net cost to ABUHB £000
Other	5	80	-	80

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 2026 to 30th September 2026.

Included within the above amounts are:
- 1 Employment Tribunal payment, totalling £30k
- 1 Late Payment, Compensation and Interest payment, totalling £50k
- 3 Ombudsman Investigation Cases, totalling £0.4k

Not included in the above totals are the amounts paid to staff in relation to the Band 2-3 recognition payment. The total anticipated recognition payment, of £4.895m was provided for at the end of March 2026.

The Health Board has made a significant volume of payments (1,345) in the period 1st April to 30th September 2026. The Health Board continues to work with the staff impacted, and the final payments are expected to be processed in November and December 2026.

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)	1	(4)	-	(4)

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 2026 and 30th September 2026, the Health Board has not agreed any VERS with staff members. The (£4k) relates to a payment processed in 2026/27, which was lower than the amount provided for as at 31st March 2026.

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	5	13	0	13

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 5 times.

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.

Organisation	2025/26 RSA %	2026/27 RSA %	Increase/ Decrease %	2025/26 Audit / Lessons Learned %	2026/27 Risk Weighting %	2025/26 Charges (£)	2026/27 Funding Requirement (£)
Aneurin Bevan	18.22%	17.74%	-0.48%	1.91%	2.45%	6,567,821	21,572,520
Swansea Bay	13.97%	14.53%	0.56%	1.30%	1.54%	5,036,926	17,675,827
Betsi Cadwaladr	21.00%	20.78%	-0.22%	3.40%	2.81%	7,572,155	25,274,843
Cardiff & Vale	16.76%	14.79%	-1.97%	1.23%	0.86%	6,044,591	17,985,230
Cwm Taf Morgannwg	14.60%	15.64%	1.04%	3.04%	3.25%	5,263,277	19,019,397
Hywel Dda	10.03%	10.45%	0.42%	1.21%	1.13%	3,617,124	12,708,240
Powys	2.12%	2.09%	-0.03%	0.60%	0.50%	763,322	2,544,946
Public Health Wales	0.64%	0.70%	0.06%	0.38%	0.31%	232,299	852,508
Velindre	0.79%	0.64%	-0.15%	0.69%	0.53%	284,387	776,627
Welsh Ambulance Service	1.87%	2.65%	0.78%	1.27%	1.61%	674,098	3,219,861
Total	**100.00%**	**100.00%**	**0.00%**	**15.00%**	**15.00%**	**36,056,000**	**121,630,000**

Despite a modest reduction in RSA share, over the last two years, the Health Board remains one of the largest contributors under the revised methodology and ranks third nationally on the risk-weighted element. This suggests that the Board continues to be materially affected by claims experience and audit/learning factors within the allocation model.

Clinical Negligence and Personal Injury Provisions

The table below shows the analysis of the estimated liability for losses as at 30th September 2026 compared to the position reported at 31st March 2026. 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 30th September is £6.6m.

Losses & Special Payments Provisions	31-Mar-26		30-Sep-26	
	No. of Cases	£'000	No. of Cases	£'000
Clinical Negligence	330	232,900	341	264,764
Personal Injury	76	527	71	685
Permanent Injury Benefit	21	3,075	20	3,016
Redress	8	80	7	59
Sub Total	**435**	**236,582**	**439**	**268,523**
Less WRP Recoverable: Clinical Negligence	-212	-230,188	-233	-261,607
Less WRP Recoverable: Personal Injury	-4	-100	-6	-280
Less WRP Recoverable: Redress	-7	-73	-6	-53
Net Liability	**213**	**6,222**	**194**	**6,583**

The percentage of recovery for Personal Injury cases is much lower than Medical Negligence cases as most Personal Injury cases are under £25K. Up to the end of September 2026, only 6 of the Personal Injury cases out of the 71 cases are over £25K whereas 233 of the 341 Medical Negligence cases are over £25K.



Argymhelliad / Recommendation

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

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

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

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

Resource Assessment: • **Workforce** • **Service Activity & Performance** • **Financial**	**Is EIA Required and included with this paper** A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following: Not Applicable Yes, outlined within the paper Yes, outlined within the paper
Asesiad Effaith Cydraddoldeb **Equality Impact Assessment** (EIA) completed	Choose an item. An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. Choose an item.



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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	24 November 2026
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Welsh Health Circular and Ministerial Directions Tracking
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Rani Dash, Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Bryony Codd, Head of Corporate Governance

Pwrpas yr Adroddiad
Purpose of the Report

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The paper presents the Audit, Risk and Assurance Committee with an overview of the current position relating to the implementation of Welsh Health Circulars (WHC) and Ministerial Directions (MDs) within Aneurin Bevan University Health Board.

Cefndir / Background

Welsh Health Circulars
A Welsh Health Circular (WHC) is health guidance, issued by Welsh Government to NHS Wales health bodies and professionals as a circular. Whilst issued as guidance, WHCs will often include expected actions to be implemented by respective organisations and individuals. The publication of WHCs can be seen at Health circulars | GOV.WALES.

For Aneurin Bevan University Health Board, WHCs are received from Welsh Government and issued via the Corporate Governance Team for action to the respective director leads/professional groups.

Ministerial Directions
Acts of Parliament, Assembly Measures and Assembly Acts enable Welsh Ministers to develop more detailed legislation, known as secondary or subordinate legislation, usually by means of Statutory Instruments (SI). Non-Statutory Instruments (NSI), otherwise known as Ministerial Directions (MD) are legislative in character; they alter legal rights and duties, however they are not SIs. NSIs, which are issued by Welsh Ministers, include codes of practice and guidance. The publication of MDs can be seen at Publications | GOV.WALES.

For Aneurin Bevan University Health Board, the website is regularly reviewed, by the Corporate Governance Team, for new Ministerial Directions and circulated to the lead Executive Director.

Asesiad / Assessment

Annual reporting of compliance with WHCs and MDs is included within the Annual Governance Statement. However, to ensure a more robust process to monitor the status of WHCs throughout the year, a WHC Tracker has been established, with progress against the tracker reported to the Audit, Risk and Assurance Committee twice a year.

To support the assessment of progress against implementation, the following definitions have been developed:

Completed:
Action/guidance embedded into day-to-day practice and continual (no end point)
Specific task required in the guidance completed.

In Progress:
Actions underway to embed into day-to-day practice
Actions being undertaken to achieve the task required

An overview of progress, as at the end of September 2026, is provided below:

	Welsh Health Circulars			
	2023	**2024**	**2025**	**2026**
No Progress	0	0	0	2
In Progress	0	2	10	12
Complete	43	44	32	10
Withdrawn	0	0	0	0
Total Number issued	**43**	**46**	**42**	**24**

The full tracker is provided as Appendix One, however, those WHCs not yet complete are highlighted below:

WHC No	Name of WHC
WHC/2024/002	**Standards for Competency Assurance of Non-Medical Prescribers in Wales**
WHC/2024/040	**Adopting a patient and family-initiated escalation approach**

WHC/2025/006	**Recording of Mental Health Outcome Measures**
WHC/2025/017	**Tranexamic acid use: Recommendation 7a of the Infected Blood Inquiry (IBI)**
WHC/2025/024	**NHS Wales hearing care: future approach to audiology services**
WHC/2025/027	**Changes to supply of Gluten Free foods in Wales; All Wales Gluten Free Subsidy Card scheme**
WHC/2025/034	**Implementation of the Planned Care Referrals DSCN (DSCN 2024/11)**
WHC/2025/037	**IBI Recommendation 7e: Implementing Shot Reports**
WHC/2025/038	**All Wales NHS Accessible Communication and Information Standards**
WHC/2025/039	**AMR & HCAI Improvement goals for 2025-2027**
WHC/2025/043	**New clinical pathway for treating and managing obesity**
WHC/2025/051	**Safety netting discharge leaflets for adults and children**
WHC/2026/001	**Timelines and responsibilities for implementing the patient and family-initiated escalation approach, Call4Concern**
WHC/2026/002	**Modernised Outpatient Dataset Phase 2: Planned Care**
WHC/2026/004	**Refreshed Intellectual Property guidance and template policy for NHS Wales Organisations**
WHC/2026/009	**The National COVID-19 Vaccination Programme Autumn 2026**
WHC/2026/010	**The National Influenza Programme 2026 to 2027**
WHC/2026/011	**Maternity Reporting Data Set (MR ds) - Data Requirements**
WHC/2026/013	**Publication of Quality Statements for Mental Health and Self-Harm**
WHC/2026/020	**Expansion of RSV Vaccine Eligibility to Adults Aged 65+**
WHC/2026/023	**Expansion of Pneumococcal Eligibility to People Experiencing Homelessness**
WHC/2026/024	**Regulation 28 Prevention of Future Deaths Report - Assurance on alarm 'latching' functionality in acute monitored environments**
WHC/2026/026	**An urgent time-limited Meningococcal B (Men B) vaccination programme in response to recent outbreaks**
WHC/2026/027	**Update to 'Safety netting discharge leaflets for adults and children'**
WHC/2026/029	**Introduction of Clesrovimab (Enflonsia) as an additional product for RSV passive immunisation in at-risk infants**
WHC/2026/031	**Delivery of the Welsh Emergency Care Data Set**

As Ministerial Directions are enforced, they are provided to the Committee for noting in Appendix Two, however actions against these are not tracked.

Following a review of the database, the Executive Committee and Audit, Risk and Assurance Committee requested that deadlines be added to the database. A review of WHCs issued confirmed that deadlines are not often provided however, where they are they are now included within the database. If a deadline for action

is not provided in the WHC, Executive leads are requested to determine an appropriate timescale for completion for inclusion in the database and are added when provided.
Argymhelliad / Recommendation The Audit, Risk and Assurance Committee is asked to note the current position in relation to the implementation of WHCs.

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

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	Included within the report

Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Executive Committee

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

WHC No	Date Issued	Review Date	Name of WHC	Summary	Status	Lead Executive (issued to)	Progress	Rating	Link
WHC/2024/002	05/03/2024	01/04/2026	**Standards for Competency Assurance of Non-Medical Prescribers in Wales**	Developed by HEIW following a review of the non-medical prescribing policies currently in place in NHS organisations.	Action	Director of Nursing (& Director of AHP's & Health Science)	Phased implementation approach. Electronic Register being updated by leads. Phased approach action plan developed for all disciplines with regular meetings and good representation from most professional groups. Next steps: determine maintenance of elctronic register, roll out compliance for DSP adn self-assessment, RPS framework - competency document has been agreed by the group for use - roll out in the next phase. Phased implementation continues with good progress since last WHC update. All Divisions have an IP lead who is responsible for updating the register for the Annual DSP.Electronic Register. Annual DSP embedded, working through solutions to compliance reporting to meet deadline for compliance report 1st May 2026. Next steps: - self assessment using the RPS competency framework, currently underway. Date set to achieve compliance. April 2026 - Pharmacy. July 2026 N&M, CPD events monthly - aim to increase attendnace, portfolio has been standardised for N&M and has been shared with Divisions, target date for all IP in N&M to have a portfolio July 2026. Divisions are in the process of updating the IP register, and ensuring all IPs have a portfolio. This is a piece of work being lead by the EAC Strategic group and progress is monitored by the Strategic Nursing & Midwifery Workkforce Group	In Progress	Standards for Competency Assurance of Non-Medical Prescribers in Wales (WHC/2024/02) | GOV.WALES
WHC/2024/040	03/10/2024		**Adopting a patient and family initiated escalation approach**	Person centred approach to (Call 4 Concern) allowing immediate help and advice in instances of deteriorating health	Action	Director of Nursing	Summary of the current progress: Live on A4, C4, B0, C0, and ICU discharges at GUH. Current model: CCOT/ANP handles the entire call once contacted by the switchboard. Calls to date: 5 (2 from recently discharged patients, 3 from current in-patients). Issues raised: Worsened back pain after being boarded on the ward, Impact on mental health due to boarding on the ward and MFFD but family required a second handrail for discharge. NEWS scores: Between 0 and 2, no Outreach review indicated by standard criteria. Time to manage calls: 90 minutes on average (compared to 60 minutes for usual CCOT deteriorating patient review). Driver diagram: Completed with ABCi support, awaiting publication and stakeholder review. Next steps: Expand working group: Include PALS, switch/flow coordinators, and managers of the pilot ward in future meetings. Continue GUH adult expansion: Focus on data gathering and refining the model. Modify switch flowchart. Collaborate with local HB leads: For learning and problem-solving, pending further NHS Executive input. Revise C4C call pathway: Ensure the right people are involved at the right stages. achieved findings from the phase 1 pilot. trends and data has been reviewed and outlined. these have been presented through Quality management group Expansion into Maternity, Neonatal, for RGH/NHH/YYF Peadiatrics and Mental health and learning disabilities. with Sight implementation groups at RGH/YYF/NHH. commencedf Patient wellness score Task and finish group supported by ABCi. Senior nurse team leadership to reinforce ward level ownership, senior oversight and to embed cultural and operational change	In Progress	Adopting a patient and family-initiated escalation approach (WHC/2024/040) | GOV.WALES

WHC No	Date Issued	Review Date	Name of WHC	Summary	Status	Lead Executive (issued to)	Progress	Rating	Link
WHC/2025/006	06/05/2025		Recording of Mental Health Outcome Measures	Guidance in relation to adopting the use of Patient Reported Outcome Measures (PROMs in mental health services.	Action	COO	MH - Complete. Guidance and expectations widely shared and embedded in inpatient wards. Delivery plan in place. Progress monitored via QPS forum. F&T - Phase 1 is nearing completion, with outcome data being embedded into performance meetings and a dashboard in development to strengthen reporting and analysis. Phase 2 has been delayed while focus remains on CTP compliance and data quality. Once addressed, work will focus on improving outcome measure response rates and exploring digital solutions used by services and other Health Boards.	In Progress	Recording of mental health outcome measures (WHC/2025/006) | GOV.WALES
WHC/2025/017	06/05/2025		Tranexamic acid use: Recommendation 7a of the Infected Blood Inquiry (IBI)	Implementation of the use of tranexamic acid in line with guidance and tranexamic acid should be included on surgical lists	Action	Medical	Clinical Director Pharmacy issued guidance. To be considered for Inclusion in Theatres Safety Briefing for June 2025 in order to formalise progression to the implementation stage on the theatre checklists	In Progress	Tranexamic acid use: recommendation 7a of the Infected Blood Inquiry (IBI) (WHC/2025/017) | GOV.WALES
WHC/2025/024	11/12/2025		NHS Wales hearing care: future approach to audiology services	A national approach for audiology services	Action	COO	We are still in progress, with actions underway to achieve the required tasks. As this WHC represents a long-term strategy for audiology in Wales, it is not expected to be completed or closed in the near future.	In Progress	NHS Wales hearing care: future approach to audiology services (WHC/2025/024) [HTML] | GOV.WALES
WHC/2025/027	16/07/2025		Changes to supply of Gluten Free foods in Wales; All Wales Gluten Free Subsidy Card scheme	The implementation of an All Wales Gluten Free Subsidy Card Scheme for patients with a dianosis of Coeliac disease or dermatitis herpetiformis in Wales	Action	AHP's & Healtl	We are preparing an SBAR report for the Executive Committee on progress, as this is far from straightforward and has a range of implications that will require Executive consideration. As I understand, all HBs in Wales are in the same position. I suggest that the safest description of our current position is 'in progress' but we mustn't assume from that statement, that the HB will be able implement the scheme fully as per the WHC, there is still a lot to be worked out and agreed.	In Progress	All-Wales gluten free subsidy card scheme (WHC/2025/027) | GOV.WALES
WHC/2025/034	25/09/2025		Implementation of the Planned Care Referrals DSCN (DSCN 2024/11)	Notice to comply with the published Data Standard Change Notifications (DSCNs): Planned Care Referrals	Compliance	Digital	WPAS has been updated to be compliant with the requirements of the DSCN. Whilst WPAS is now compliant, additional work is required by our Software Development team to develop CWS to become compliant and this is scheduled to complete within the next quarter/	In Progress	Data standards notice of change for planned care referrals (WHC/2025/034) | GOV.WALES

WHC/2025/037	25/09/2025		IBI Recommendation 7e: Implementing Shot Reports	Establish a mechanism for implementing recommendations of SHOT reports	Action	Medical	Governance Framework and Oversight •The Hospital Transfusion Committee (HTC) is responsible for overseeing the SHOT standards, and reporting of SHOT compliance and progress flows through the Committee. •Our governance framework for transfusion safety and SHOT standards is managed via the Quality Management Group (QMG), which provides board-level oversight of the review and implementation of the SHOT Safety Standards. This ensures that any concerns or risks identified are escalated appropriately. •The QMG is chaired by an Executive Director, providing senior leadership and oversight. Executive Leadership •In line with WHC requirements, the Executive Medical Director hold designated responsibility for the delivery and ongoing oversight of SHOT Safety Standards within the organisation. Baseline Assessment and Analysis •A comprehensive analysis of the SHOT Transfusion Safety Standards is underway using the SHOT baseline assessment tool. This process covers clinical, laboratory, and managerial domains to ensure accuracy and accountability. •The initial findings and proposed actions from this baseline assessment will be submitted to the BHNOG Transfusion Risk Group by 31st December 2025, as requested. Ongoing Improvement and Reporting •The Hospital Transfusion Team will lead improvement work, with any barriers to implementation escalated to the QMG. •Regular compliance reviews will be undertaken by the HTC every six months, with outcomes and process measures reported to the BHNOG Transfusion Risk Group to demonstrate improvements. •Representation at the BHNOG Transfusion Risk Group ensures alignment with national oversight and best practice. These arrangements ensure that governance, leadership, and accountability for SHOT standards are embedded within our organisational framework, with clear escalation routes and reporting mechanisms.	In Progress	Infected blood inquiry: implementing recommendation 7e, SHOT reports (WHC/2025/037) | GOV.WALES
WHC/2025/038	22/09/2025		All-Wales NHS Accessible Communication and Information Standards	Broadens and renews the All Wales Standards for Accessible Communication and Information for people with Sensory loss.	Compliance	Digital	The Accessible Communication and Information Standards (ACIS) work sits across a number of areas within the Health Board, including Digital, Patient Experience, Equality, Diversity and Inclusion, and Communications teams. We are supporting the implementation of the All-Wales standards through the development of an ACIS action plan aligned to the Strategic Equality Plan and Accessible Communication and Information Standards Indicators. To support this work, the Health Board has established an ACIS steering group, bringing together key stakeholders from Digital, EDI, Patient Experience and operational teams to oversee delivery and coordinate implementation across services. Current activity includes: •Ongoing work with Digital colleagues to explore how communication needs can be consistently captured and flagged within patient systems. •Promotion of accessible communication principles across services, including guidance on accessible formats and inclusive communication. •Engagement with teams supporting people with sensory loss and other communication needs to ensure the standards are reflected in service delivery. •Alignment with wider EDI and patient experience initiatives, including accessibility of information and inclusive service design. Implementation of the standards remains in progress, with actions underway to embed these requirements into routine practice across the organisation.	In Progress	Accessible communication and information standards in healthcare (WHC/2025/038) | GOV.WALES

WHC/2025/039	23/10/2025		AMR & HCAI Improvement goals for 2025-2027	Reaffirms the improvement goals previously set out in WHC/2024/038	Information/Action	Nursing	Regular updated provided to the Infection and Prention and Antimicrobial prevention group, referenced within term of reference for the group. Monthly progress reports developed and submitted to Divisions linked with targets for improvement. HAP audit planned for April as recommended in the directive . Refreshed action plan in development for 2026/27 to aline the quality statement. and monitored via exception reports within IPAS. Current position •ABUHB below Welsh average (per 100,000 population rates) for oC diff oE coli & Klebsiella bloodstream infections oRecognising that only C diff is indicating a reduction from last year, we are actively working toward improving •Aware of slightly above average MRSA & MSSA BSI rates and again actively working to ard improving via QI project, patient information leaflet developed. •Also aware of above average Pseudomonas BSI rates – again, clear focus on this currently and enhanced surveillance for hospital acquired infection•Primary care antimicrobial volume reduction target achieved. •Primary care 'access' use: target achieved, but anticipated to slip when volume reduces further. •Primary care antimicrobial course durations: achieved for amoxicillin & doxycycline, clarithromycin moving towards target. •Secondary care antimicrobial volume reduction: moving away from target, with increase in volume. Working with data analyst to check validity of PHW trajectory and identify areas for action. Medical Director tracking progress and has regular meetings with Consultant Antimicrobial Pharmacist. •Secondary care 'access' use: target not yet achieved, but slight move towards target in most recent data.	In Progress	Antimicrobial resistance and healthcare associated infection improvement goals: 2025 to 2027 (WHC/2025/039) | GOV.WALES
WHC/2025/043	23/10/2025		New clinical pathway for treating and managing obesity	An update for health boards, GPs and pharmacies	Action	Public Health	Update March 2026 Public Health Team has been working ABUHB Weight Management Service colleagues to develop a proposal to expand the tirzepatide prescribing to the primary care and other suitable prescribers. A SBAR will be presented at the Public Health ELT on 7th April 2026 and Medicine Management Programme Board on 8th April 2026. It will be presented at the Executive Committee meeting in May/June 2026. Update June 2026 A SBAR was presented at the Public Health ELT on 7th April 2026 and Medicine Management Programme Board on 27th May. It will be presented at the Executive Committee meeting on 17th July 2026. Update September 2026 A SBAR was presented at the Public Health ELT on 7th April 2026 and Medicine Management Programme Board on 27th May 2026. It will be presented at the Executive Committee meeting in October 2026.	In Progress	New clinical pathway for treating and managing obesity (WHC/2025/043) | GOV.WALES

WHC/2025/051	08/12/2025		Safety netting discharge leaflets for adults and children	Safety netting leaflets for the discharge of adults and children with a suspected or confirmed infection with immediate effect	Action	Medical	Vast progress has been made within paediatric services. The inpatient paediatric safety-netting leaflet has been signed off by the F&T Division, received Executive approval and is progressing through Welsh translation prior to publication. The communications team has incorporated a QR code linking directly to the UK Sepsis Assessment Tool in line with Welsh Health Circular requirements. Recommendations from the Equality, Diversity and Inclusion Team have also been incorporated to improve accessibility and inclusivity. The final version will be presented to the Deteriorating Patient Group prior to publication and distribution. Inpatient paediatric services have been routinely providing the "Taking Your Child Home" leaflet to patients and families since April 2025. Development of the Children's Emergency Assessment Unit (CEAU) safety-netting leaflet has also been completed. The document has been revised from the existing leaflet and standardised to ensure alignment with the approved inpatient paediatric version. The leaflet incorporates the UK Sepsis Assessment Tool QR code and Equality, Diversity and Inclusion recommendations and has been clinically reviewed to ensure that the advice provided is appropriate for inclusion within discharge information. The document is currently awaiting final Divisional approval. In the interim, the service continues to utilise a locally approved safety-netting leaflet to support safe discharge processes. Next Steps •Complete Welsh translation and printing of the approved inpatient paediatric leaflet. •Obtain Divisional approval for the revised CEAU leaflet and progress to Executive sign-off. •Commence a Health Board-wide review of specialty-specific safety-netting and discharge information resources. •Establish a standardised approach for the development, approval, implementation and review of safety-netting leaflets across all clinical areas. •Include implementation and monitoring of safety-netting and discharge information leaflets within the 2026/27 Deteriorating Patient Group workplan to support consistent adoption and ongoing assurance across the Health Board. Good progress has been achieved within paediatric services and the foundations are now in place to	In Progress	Safety netting discharge leaflets for adults and children (WHC/2025/051) | GOV.WALES

WHC No	Date Issued	Review Date	Name of WHC	Summary	Status	Lead Executive (issued to)	Progress	Rating	Link
WHC/2026/001	08/01/2026		Timelines and responsibilities for implementing the patient and family-initiated escalation approach, Call4Concern	Sets out the expectation to implement a system which enable patients and their families to call for immediate help and advice if they are worried about deteriorating health.	Action	Medical	The Health Board continues to progress implementation of Call for Concern through a phased and controlled approach overseen by the Deteriorating Patient Group. Following assessment of the operational, workforce and governance requirements associated with implementation, the Health Board formally advised NHS Performance and Improvement and Welsh Government that the July 2026 implementation deadline could not be safely achieved and set out a phased delivery trajectory to support sustainable implementation. A pilot has been completed across adult wards at the Grange University Hospital, providing valuable learning to inform wider deployment. Evaluation demonstrated positive patient engagement and identified opportunities to refine triage arrangements, responder models, governance processes and education packages prior to further rollout. A pilot of the Patient Wellness Score/Question (PWS/Q) undertaken within Ysbyty Ystrad Fawr concluded that the tool is suitable for wider implementation following minor amendments, with supporting education materials and communications resources currently being finalised. Progress has been made in developing specialty-specific pathways for paediatric, maternity and neonatal services. Tier 2 and Tier 3 responder arrangements, process maps and governance structures have been agreed through local implementation groups, with associated Standard Operating Procedures in development. The Health Board continues to participate in national implementation networks and Communities of Practice to support alignment with evolving national guidance. During 2026, a national communication confirmed that the term Call 4 Concern© is subject to copyright restrictions and should only be used where a 24-hour Critical Care Outreach model exists. As this model is not currently available across all acute sites, the Health Board has adopted the term Call for Concern, requiring review of previously developed patient-facing materials. Next Steps •Complete approval of specialty-specific Standard Operating Procedures. •Finalise education, communication and implementation resources. •Continue implementation of the Patient Wellness Score/Question across acute inpatient areas.	In Progress	Call4Concern: timelines and responsibilities (WHC/2026/001) | GOV.WALES
WHC/2026/002	04/03/2026		Modernised Outpatient Dataset Phase 2: Planned Care	This Welsh health circular is being published to provide all health boards and trusts with notice of the requirement to comply with the following published Data Standard Change Notice (DSCNs) Phase 2 of planned care/outpatients minimum dataset modernisation	Compliance	Digital	WPAS has been upgraded to comply with the DSCN requirements. DHCW are still developing the sign off and validation process and until this is complete, we will not be able to fully implement the requirements of the DSCN. It should also be noted that Welsh Government have suspended the publication of outpatient waiting lists statistics associated with this DSCN until the DHCW work has been completed.	In Progress	Data standards notice of change for planned care activity (WHC/2026/002) | GOV.WALES
WHC/2026/004	26/03/2026		Refreshed Intellectual Property guidance and template policy for NHS Wales Organisations.	Resource, develop, embed and implement a refreshed NHS Wales IP Structure, policy and processes.	Compliance/Action	Medical		No Update	Refreshed Intellectual Property guidance for NHS Wales organisations (WHC/2026/004) | GOV.WALES

WHC/2026/009	01/07/2026		The National COVID-19 Vaccination Programme Autumn 2026	Detailed guidance for the COVID-19 vaccination programme in autumn 2026	Compliance/Action	Public Health	Update 01.07.26 "In Progress" as we are currently developing the Winter respiratory vaccination plan which will be going the Vaccination Operation Group on 21st July 2026 and submitted to VPW on 28th July 2026 Update September 2026 Winter respiratory vaccination plan presented to VPW - Planning & Delivery group 13/08/26 and Strategic Immunisation Group 19/08/26	In Progress	https://www.gov.wales/national-covid-19-vaccination-programme-autumn-2026-whc2026009
WHC/2026/010	01/07/2026		The National Influenza Immunisation Programme 2026 to 2027	Detailed guidance for the influenza (flu) vaccination programme for the coming autumn and winter.	Compliance/Action	Public Health	Update 01.07.26 "In Progress" as we are currently developing the Winter respiratory vaccination plan which will be going the Vaccination Operation Group on 21st July 2026 and submitted to VPW on 28th July 2026 Update September 2026 Winter respiratory vaccination plan presented to VPW - Planning & Delivery group 13/0826 and Strategic Immunisation Group 19/08/26	In Progress	https://www.gov.wales/national-influenza-immunisation-programme-2026-2027-whc2026010
WHC/2026/011	01/04/2026		Maternity Reporting Data Set (MR ds) - Data Requirements	Sets out mandatory requirements for the collection, submission, processing and use of nationally defined maternity and neonatal data to support national maternity reporting, assurance and improvement functions in Wales	Compliance	Digital	This DSCN comprises 4 new datasets. ABUHB have written the scripts to extract and submit these data sets. The maternity service has completed the validation of 3 of the 4 data sets and it is anticipated that the remaining validation will be complete by the end of September.DHCW are still to develop the submission and sign-off mechanism and until this is complete these datasets will not be able to be submitted.	In Progress	Maternity Data Standards (WHC/2026/011) | GOV.WALES
WHC/2026/013	23/04/2026		Publication of Quality Statements for Mental Health and Self-Harm	Set out the outcomes and standards that define high-quality, person-centred care across health and social services in Wales	Action	COO	The Division has demonstrated delivery against the expectations of The Quality Statement for Mental Health through the implementation of person-centred safety planning, the Suicide and Self-Harm Prevention Strategy, Trauma-Informed Care training and collaborative care planning. These actions have strengthened compassionate and recovery-focused care. Progress is ongoing.	In Progress	
WHC/2026/020	30/06/2026		Expansion of RSV Vaccine Eligibility to Adults Aged 65+	Following consideration of additional data on the use of the RSV vaccine in older adults, JCVI issued further advice to extend the programme to those aged 80+ and all residents in a care home for older adults. Commencing 1 April 2026	Compliance/Action	Public Health	Update 01.07.26 "In Progress" as we are currently developing the Winter respiratory vaccination plan which will be going the Vaccination Operation Group on 21st July 2026 and submitted to VPW on 28th July 2026 Update September 2026 RSV expansion plan presented to Strategic Immunisation Group 19/08/26. Delivery started 01/09/26.	In Progress	https://www.gov.wales/update-rsv-vaccination-programme-2026-whc2026020
WHC/2026/023	27/07/2026		Expansion of Pneumococcal Eligibility to People Experiencing Homelessness	From 1 October 2026 the pneumococcal vaccination programme will be expanded to include people experiencing homelessness	Compliance/Action	Public Health	Update 27.07.26 In progress 28.07.26. Will be included in the 5-year plan for HP investment in the Vaccination Service. The Vaccination Service will lead on this as part of the Vaccination Equity Delivery Plan in conjunction with the Health Inclusion Service, Local Authority Housing and Homelessness teams and third sector partners. Update September 2026 Draft implementation plan to be presented to Vaccine Operational group 29/09/26 and to the Strategic Immunisation Group 14/10/26	In Progress	Expansion of Pneumococcal Vaccine Eligibility to People Experiencing Homelessness (WHC/2026/023) | GOV.WALES

WHC/2026/024	20/05/2026		Regulation 28 Prevention of Future Deaths Report - Assurance on alarm 'latching' functionality in acute monitored environments	The aim of this communication is to ensure that current practice does not introduce avoidable patient safety risks and to support a consistent, all-Wales approach to alarm management.	Action	AHP's & Health	UPDATE 25/09/26 The organisations Medical Devices Group (MDG) formed a small task and finish project to convey the assurance actions required for the Health Board to comply with the requirements of the Welsh Health Circular. These actions were aligned nationally through an All-Wales task and finish group, which was set up to coordinate activities across Welsh Health Boards and Trusts under the All Wales Medical Equipment Managers Group (AWMEMG). The Health Board's Quality and Patient Safety Risk Manager and EBME (Electro-Biomedical Engineering) Department supported this fact finding work locally. The review findings have been shared with the task and finish group for inclusion in a final all-Wales situation report. The output was for the AWMEMG to submit the All-Wales status report against the Welsh Health Circular requirements by 30th September 2026. This first phase is now considered complete. We will await the Welsh Government response to the National situation report to determine next steps.	In Progress	Regulation 28: prevention of future deaths report on alarm "latching" in acute monitored environments (WHC/2026/024) | GOV.WALES
WHC/2026/026	16/06/2026		An urgent time-limited Meningococcal B (Men B) vaccination programme in response to recent outbreaks	An urgent MenB vaccination response as a precautionary measure to help protect young people at highest immediate risk this year, in response an unprecendented outbreak in Kent and more recent smaller outbreaks in Weymouth and Reading.	Action	Public Health	MenB time-limited programme discussed at Strategic Immunisation Group (SIG) on 16/06/26 •Task & finish group has been stood up for the duration of the time-limited programme. •Liaising with VPW on WIS, PGD, vaccine supply, communication & engagement and information for healthcare professionals & eligible individuals •Funding will be reimbursed to health boards for vaccine supply and delivery costs associated with the programme. Update June 2026 Action being undertaken to achieve the task required. •MenB time-limited programme discussed at Strategic Immunisation Group (SIG) on 16/06/26 •Task & finish group has been stood up for the duration of the time-limited programme. •Liaising with VPW on WIS, PGD, vaccine supply, communication & engagement and information for healthcare professionals & eligible individuals •Funding will be reimbursed to health boards for vaccine supply and delivery costs associated with the programme. Update September 2026 All 7,755 cohort 1 patients have been appointed by letter, DNA text messages have continued to remind all patients to take up the offer. Social media comms has continued. @ 22/09/26 uptake of first dose for cohort 1 - 50% (highest uptake in Wales) uptake of dose 2 for cohort 1 - 39%. •7,457 eligible patients were identified for Cohort 1. •3,892 (52.2%) have received their first dose as of W/C 21/09/26, of which 3,027 (77.8%) have also received their second dose. Overall uptake for cohort 1 is 40.6% •For Cohort 2, patients are able to self-refer via a QR code or by contacting the vaccination service, to date 242 individuals have received dose 1, and 106 have also received dose 2. •First doses continue to be available until 31 December 2026 and second doses available until 31	In Progress	https://www.gov.wales/meningococcal-b-menb-vaccination-programme-urgent-time-limited-response-recent-outbreaks-whc2026026

WHC/2026/027	25/08/2026		Update to 'Safety netting discharge leaflets for adults and children'	Health Boards to formally adopt and integrate new safety netting leaflets into the discharge process for appropriate patients.	Action	Medical	Going to deteriorating patient group in September	In Progress	
WHC/2026/029	31/07/2026		Introduction of Clesrovimab (Enflonsia) as an additional product for RSV passive immunisation in at-risk infants	An additional product is now available for the RSV selective immunisation programme for at-risk infants, previously referenced in WHC/2025/029. The new product is Clesrovimab (Enflonsia) and the Joint Committee on Vaccination and Immunisation (JCVI) has advised this product is equivalent to Nirsevimab, which was introduced last year.	Action	Public Health	pdate 14.08.26 In progress 04.08.26 - WB looking at pathway for delivery as this may sit with Jenny as Neonatal Nurses decide who has the vaccine 14.08.26 Update September 2026 Update from Beck Graves (Neonatal Liaison Sister) - a system is in place for identification on NICU (there is an eligiblity criteria) and administration is recorded on CWS. 2.A local database is also used to record all babies who are eligible and those who have received the injection. The criteria- all babies born <32 weeks or high-risk infants as described in the Green Book.	In Progress	Introduction of Clesrovimab (Enflonsia) as an additional product for RSV passive immunisation in at-risk infants (WHC/2026/029) | GOV.WALES
WHC/2026/031	23/09/2026		Delivery of the Welsh Emergency Care data Set	Confirms the requirement for Local Health Boards to implement the Welsh Emergency data Set (WECDS), across all major emergency departments and minor injury units by 31 March 2027	Action	Digital		No Update	

Ministerial Direction	Date Issued	Summary	Lead Executive	Date sent to exec	Link
The Directions to Local Health Boards as to the General Dental Services Statement of Financial Entitlements (Amendment) Directions 2025	10/02/2025	These directions raise payments to dental foundation trainees and trainers for 2022 to 2023	Finance	19/02/2025	The Directions to Local Health Boards as to the General Dental Services Statement of Financial Entitlements (Amendment) Directions 2025 | GOV.WALES
The Directions to Local Health Boards as to the Personal Dental Services Statement of Financial Entitlements (Amendment) Directions 2025	10/02/2025	These directions raise payments to dental foundation trainees and trainers for 2022 to 2023	Finance	19/02/2025	The Directions to Local Health Boards as to the Personal Dental Services Statement of Financial Entitlements (Amendment) Directions 2025 | GOV.WALES
The Directions to Local Health Boards as to the General Dental Services Statement of Financial Entitlements (Amendment) (No.2) Directions 2025	10/02/2025	Rises in NHS dental contract payments and payments to dental foundation trainees and trainers for 2023 to 2024	Finance	19/02/2025	The Directions to Local Health Boards as to the General Dental Services Statement of Financial Entitlements (Amendment) (No.2) Directions 2025 | GOV.WALES
The Directions to Local Health Boards as to the Personal Dental Services Statement of Financial Entitlements (Amendment) (No.2) Directions 2025	10/02/2025	Rises in NHS dental contract payments and payments to dental foundation trainees and trainers for 2023 to 2024	Finance	19/02/2025	The Directions to Local Health Boards as to the Personal Dental Services Statement of Financial Entitlements (Amendment) (No.2) Directions 2025 | GOV.WALES
Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2025	11/02/2025	Directions to local health boards on amendments to the general medical services contract	Finance	19/02/2025	Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2025 | GOV.WALES
Statement of general ophthalmic services remuneration and fee directions: 2025	11/02/2025	The statement provides for the normal general ophthalmic services payments and claims process	Finance	19/02/2025	Statement of general ophthalmic services remuneration and fee directions: 2025 | GOV.WALES
The Directions to Local Health Boards as to the Personal Dental Services Statement of Financial Entitlements (Amendment) (No.3) Directions 2025	18/02/2025	Rises in NHS dental contract payments and payments to dental foundation trainees and trainers for 2024 to 2025	Finance	19/02/2025	The Directions to Local Health Boards as to the Personal Dental Services Statement of Financial Entitlements (Amendment) (No.3) Directions 2025 | GOV.WALES
The Directions to Local Health Boards as to the General Dental Services Statement of Financial Entitlements (Amendment) (No.3) Directions 2025	18/02/2025	Rises in NHS dental contract payments and payments to dental foundation trainees and trainers for 2024 to 2025	Finance	19/02/2025	The Directions to Local Health Boards as to the General Dental Services Statement of Financial Entitlements (Amendment) (No.3) Directions 2025 | GOV.WALES
Statement of general ophthalmic services remuneration and fee directions: 2025	21/02/2025	Update of entry no 7	Finance	03/03/2025	Statement of general ophthalmic services remuneration and fee directions: 2025 | GOV.WALES
The Directions to Local Health Boards as to the General Dental Services Statement of Financial Entitlements (Amendment) Directions 2025	21/02/2025	Update of entry no 2	Finance	03/03/2025	The Directions to Local Health Boards as to the General Dental Services Statement of Financial Entitlements (Amendment) Directions 2025 | GOV.WALES
The Wales Infected Blood Support Scheme (amendment) Directions 2025	28/03/2025	Amendment to the Infected Blood Support Scheme	Finance	08/04/2025	The Wales Infected Blood Support Scheme (amendment) Directions 2025 | GOV.WALES
Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment)(No 2) Directions 2025	22/04/2025	Relates to the payments being made by Local Health Boards to a GMS Contractor under a GMS contract	Finance	25/04/2025	Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 2) Directions 2025 | GOV.WALES
The Primary Medical Services)Intra-Periarticular Injections)(Directed Supplementary Services(Wales) Directions 2025	19/05/2025	Directed supplementary service (DSS) to manage specific musculoskeletal conditions	COO	21/05/2025	The Primary Medical Services (Intra-Periarticular Injections) (Directed Supplementary Services (Wales) Directions 2025 | GOV.WALES
The Primary Medical Services (Minor Surgery) (Directed Supplementary Services (Wales) Directions 2025	19/05/2025	Directed supplementary service (DSS) to manage dermatological lesions.	COO	21/05/2025	The Primary Medical Services (Minor Surgery) (Directed Supplementary Services (Wales) Directions 2025 | GOV.WALES
The Primary Care (Contracted Services: Immunisations)(Influenza) Directions 2025	30/05/2025	The underlying purpose of the Scheme is to enable the provision of services to administer nfluenza vaccinations and immunisations to persons aged 16 and above	Public Health	04/06/2025	The Primary Care (Contracted Services: Immunisations) (Influenza) Directions 2025 | GOV.WALES
Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No 3) Directions 2025	09/06/2025	Directions to local health boards on amendments to the general medical services contract	Finance	10/06/2025	Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 3) Directions 2025 | GOV.WALES
Amendments to Model Standing Orders and Model Standing Financial Instructions - NHS Wales (WHC/2023/032)	24/06/2025	Review of previously issued documents to ensure they remain accurate and current.	Finance	07/07/2025	Amendments to Model Standing Orders and Model Standing Financial Instructions – NHS Wales (WHC/2023/032) | GOV.WALES
Directions to Local Health Boards as to the statement of financial entitlements (Amendment)(No 4)Directions 2025	23/07/2025	Amendment to Statement of Financial Entitlements	Finance	04/08/2025	Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 4) Directions 2025

Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment)(No 5)Directions 2025	08/08/2025	Amendment to Statement of Financial Entitlements	Finance	12/08/2025	Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 5) Directions 2025
The Primary Medical Services (Type 2 Diabetes Mellitus Care Scheme for adults (Directed Supplementary Service)(Wales)(Amendment) Directions 2025	13/08/2025	Amendment of Primary Medical Services	COO	27/08/2025	The Primary Medical Services (Type 2 Diabetes Mellitus Care Scheme for Adults (Directed Supplementary Service) (Wales) (Amendment) Directions 2025 | GOV.WALES
The Primary Medical Services (Type 2 Diabetes Mellitus Care Scheme for adults (Directed Supplementary Service)(Wales) Directions 2024	13/08/2025	Local Health Board must establish, operate and revise a Type 2 Diabetes Mellitus Care Scheme for for adults for its area.	COO	27/08/2025	The Primary Medical Services (Type 2 Diabetes Mellitus Care Scheme for Adults) (Directed Supplementary Service) (Wales) Directions 2024 | GOV.WALES
The Directions to Local Health Boards as to the General Dental Services Statement of Financial Entitlements (Wales) (Amendment) (No 4) Directions 2025	04/09/2025	Amendments to the General Dental Services Statement of Financial Entitlements	Finance	26/09/2025	The Directions to Local Health Boards as to the General Dental Services Statement of Financial Entitlements (Wales) (Amendment) (No.4) Directions 2025
The Directions to Local Health Boards as to the Personal Dental Services Statement of Financial Entitlements (Wales) (Amendment) (No 4) Directions 2025	04/09/2025	Amendments to the Personal Dental Services Statement of Financial Entitlements	Finance	26/09/2025	https://www.gov.wales/directions-local-health-boards-personal-dental-services-statement-financial-entitlements-wales
The directed supplementary services directions and specification for people living with severe frailty in their own homes 2025	30/09/2025	Establish, operate and, as appropriate, revise a People living with severe frailty in their own homes scheme	COO	22/10/2025	The directed supplementary services directions and specification for people living with severe frailty in their own homes 2025 | GOV.WALES
The Primary Care (Contracted Services: Outpatients Waiting Lists First Appointment Scheme) Directions and Specification 2025	14/10/2025	Enable a review of outpatient first appointment waiting lists by dentists, general medical practitioners, POS contractor and NHS pharmacists	COO	22/10/2025	The Primary Care (Contracted Services: Outpatients Waiting Lists First Appointment Scheme) Directions and Specification 2025 | GOV.WALES
Statement of general opthalmic services remuneration and fee directions: 2025	11/11/2025	The remuneration to be paid to those providing general opthalmic services. Replaces the statement that came into force in February 2025.	Finance	18/11/2025	Statement of general ophthalmic services remuneration and fee directions: 2025 | GOV.WALES
The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment)(No6) Directions 2025	02/12/2025	Directions to the local health boards on amendments to the general medical services contract	Finance	09/12/2025	Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 6) Directions 2025 | GOV.WALES
Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment)Directions 2026	03/12/2025	Directions to local health boards on amendments to the general medical services contract	Finance	09/12/2025	Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2026 | GOV.WALES
Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment)(No. 7) Directions 2025	16/12/2025	These directions relate to the payments to be made by Local Health Boards to a GMS contractor under a GMS contract	Finance	07/01/2026	Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 7) Directions 2025 | GOV.WALES
The Primary Medical Services (Minor Surgery)(Directed Supplementary Services (Wales) Directions 2025	22/12/2025	Each Local Health Board must establish, operate and, as appropriate, revise a Minor Surgery Scheme for its area	COO	07/01/2026	The Primary Medical Services (Minor Surgery) (Directed Supplementary Services (Wales) Directions 2025 | GOV.WALES
The Directions to Local Health Boards as to the General Dental Services Statement of Financial Entitlements (Wales)(Amendment)(No 5) Directions 2025	23/12/2025	These Directions uplift NHS dectal contract payments for 2025 to 2026	Finance	07/01/2026	The Directions to Local Health Boards as to the General Dental Services Statement of Financial Entitlements (Wales) (Amendment) (No 5) Directions 2025 | GOV.WALES
Mental Health Review Tribunal for Wales (Membership) Bill	05/01/2026	If introduced, this bill would change the rules for medical membership of the Mental Health Review Tribunal for Wales	COO	07/01/2026	Mental Health Review Tribunal for Wales (Membership) Bill | GOV.WALES
The Nursery Milk Scheme (Wales) Directions 2026	14/01/2026	These revised Directions allow for the continued delivery of the Nursery Milk Scheme in Wales for a 4 year period.	Public Health	28/01/2026	The Nursery Milk Scheme (Wales) Directions 2026 | GOV.WALES
The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment)(No. 2) Directions 2026	16/01/2026	Directions to local health boards on amendments to the general medical services contract	Finance	Automatically implemented via shared services	The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 2) Directions 2026 | GOV.WALES

Code of Practice Quality Assurance and Performance Management, Escalating Concerns, and Closure of Regulated Care and Support Services 2026	04/02/2026	The Directions provide that Local Health Boards and NHS trusts must exercise their relevant functions in accordance with the provisions of the Code of Practice	Nursing	05/02/2026	Code of Practice Quality Assurance and Performance Management, Escalating Concerns, and Closure of Regulated Care and Support Services 2026 | GOV.WALES
Code of Practice Quality Assurance and Performance Management, Escalating Concerns, and Closure of Regulated Care and Support Services (WHC/2025/044)	04/02/2026	The Directions provide that Local Health Boards and NHS trusts must exercise their relevant functions in accordance with the provisions of the Code of Practice	Nursing	05/02/2026	Code of Practice Quality Assurance and Performance Management, Escalating Concerns, and Closure of Regulated Care and Support Services (WHC/2025/044) | GOV.WALES
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)	04/02/2026	Each Local Health Board and NHS Trust must exercise its functions in accordance with the relevant provisions of the Code of Practice on Quality Assurance and Performance management, Escalating Concerns and Closure of Regulated Care and Support Services	Nursing	05/02/2026	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
The Primary Care (Contracted Services: Immunisations) (RSV) Directions 2026 (NWSI 2026 No. 18)	05/02/2026	Each Local Health Board must establish, operate and, as appropriate, revise a Scheme to enable the provision of services to administer RSV vaccinations and immunisations	Public Health	05/02/2026	The Primary Care (Contracted Services: Immunisations) (RSV) Directions 2026 (NWSI 2026 No. 18) | GOV.WALES
The Primary Care (Contracted Services: Immunisations) (RSV) Directions 2024	23/02/2026	Each Local Health Board must enter into arrangements for the provision of services under the Scheme	COO	04/03/2026	The Primary Care (Contracted Services: Immunisations) (RSV) Directions 2024
The Wales Infected Blood Support Scheme (Amendment)Directions 2026	06/03/2026	Increased ex-gratia payments for 2026 to 2027 for beneficiaries on the Wales Infected Blood Support Scheme	Finance	10/03/2026	The Wales Infected Blood Support Scheme (Amendment) Directions 2026 | GOV.WALES
Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment)(No 3) Directions 2026	11/03/2026	Directions to local health boards on amendments to the general medical services contract	Finance	23/03/2026	Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 3) Directions 2026 | GOV.WALES
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)	13/03/2026	These directions to the new code of practice replace the 2009 stautory guidance	Nursing	23/03/2026	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
The Primary Medical Services (People Living with Severe Frailty in their own Homes) (Directed Supplementary Service) (Wales) (Amendment) Directions 2026	19/03/2026	GPs can continue to manage and monitor patients at high risk of admission or re-admission to hospital beyond 31 March 2026	COO	23/03/2026	The Primary Medical Services (People Living with Severe Frailty in their own Homes) (Directed Supplementary Service) (Wales) (Amendment) Directions 2026 | GOV.WALES
Mental Health Review Tribunal for Wales (Membership) Act 2026	24/03/2026	On 21 January 2026 a new Act became law changing the rules for medical membership of the Mental Health Review Tribunal for Wales	COO	27/03/2026	https://www.gov.wales/mental-health-review-tribunal-for-wales-membership-act-2026#description-block
The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment)(No4) Directions 2026	01/04/2026	Directions to local health boards on amendments to the general medical services contract	Finance	07/04/2026	The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 4) Directions 2026 | GOV.WALES
Directions to Local Health Boards as to the Personal Dental Services Statement of Financial Entitlements (Amendment No 2) Directions 2026	07/04/2026	These directions set out how NHS Dental contractors must be paid under a Personal Dental Services (PDS) Agreement from 7 April 2026 where they provide mandatory services only	Finance	10/04/2026	https://www.gov.wales/directions-local-health-boards-personal-dental-services-statement-financial-entitlements-16
Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 5) Directions 2026	23/04/2026	Directions to local health boards on amendments to the general medical services contract.	Finance	20/05/2026	Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 5) Directions 2026 | GOV.WALES
Primary Care Contracted Services: Immunisations (PCCS:I) Amending Directions (revoked)	24/06/2026	Amendment of the Primary Care (Contracted Services: Immunisations) Directions 2021	COO	30/06/2026	Primary Care Contracted Services: Immunisations (PCCS:I) Amending Directions (revoked) | GOV.WALES

The Primary Care (Contracted Services: Immunisations) (Influenza) Directions 2025	24/06/2026	Each Local Health Board must establish, operate and, as appropriate, revise a Scheme in accordance with these Directions and the relevant specification.	COO	30/06/2026	The Primary Care (Contracted Services: Immunisations) (Influenza) Directions 2025 | GOV.WALES
The Primary Care (Contracted Services: Immunisations) (COVID 19) (Wales) Directions 2026 (NWSI 2026 No. 116)	24/06/2026	Each Local Health Board must establish, operate and, as appropriate, revise a Scheme in accordance with these Directions and the relevant specification.	COO	30/06/2026	https://www.gov.wales/primary-care-contracted-services-immunisations-covid-19-wales-directions-2026-nwsi-2026-no-116
The Primary Care (Contracted Services: Immunisations) (Influenza) (Amendment) Directions 2026 (NWSI 2026 No. 117)	25/06/2026	Amendments to the Primary Care (Contracted Services: Immunisations) (Influenza) Directions 2025	COO	30/06/2026	The Primary Care (Contracted Services: Immunisations) (Influenza) (Amendment) Directions 2026 (NWSI 2026 No. 117) | GOV.WALES
The Primary Care (Contracted Services: Immunisations) (Amendment) Directions 2022 (revoked)	26/06/2026	Amendments to guidance for primary care contractors to administer COVID-19 vaccines from 5 February 2022.	COO	30/06/2026	https://www.gov.wales/primary-care-contracted-services-immunisations-amendment-directions-2022-revoked
The Primary Care (Contracted Services: Immunisations) Directions 2021 (amended version) (revoked)	26/06/2026	Amendments to guidance for primary care contractors to administer COVID-19 vaccines from August 2021	COO	30/06/2026	https://www.gov.wales/primary-care-contracted-services-immunisations-directions-2021-amended-version-revoked
The Primary Care (Contracted Services: Immunisations) Directions 2021 and Specification (revoked)	26/06/2026	Revoked - Detailed description and the legal requirements of how Health Boards can engage primary care contractors to administer COVID-19 vaccines	COO	30/06/2026	The Primary Care (Contracted Services: Immunisations) Directions 2021 and Specification (revoked) | GOV.WALES
The Primary Care (Contracted Services: Immunisations) (Amendment) Directions 2021 (as amended) (revoked)	26/06/2026	Revoked - Detailed description and the legal requirements of how health boards can engage primary care contractors to administer COVID-19 vaccines	COO	30/06/2026	The Primary Care (Contracted Services: Immunisations) (Amendment) Directions 2021 (as amended) (revoked) | GOV.WALES
The Primary Medical Services (Pneumococcal Immunisation Scheme) (Directed Supplementary Service) (Wales) Directions 2026	27/08/2026	Each Local Health Board must establish, operate and, as appropriate, revise a Pneumococcal Immunisation Scheme in accordance with these Directions.	COO	11/09/2026	The Primary Medical Services (Pneumococcal Immunisation Scheme) (Directed Supplementary Service) (Wales) Directions 2026 | GOV.WALES

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	24 November 2026
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	**Declarations of Interest and Register of Gifts and Hospitality**
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Rani Dash, Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Bryony Codd, Head of Corporate Governance

Pwrpas yr Adroddiad **Purpose of the Report**
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to provide assurance on the adequacy of arrangements for declaring, registering, and handling interests and offers of gifts and hospitality, including the current Register of Interests and Register of Gifts and Hospitality.

This report also provides an update on the Standards of Business Conduct Policy Implementation Plan and proposes minor amendments to the Policy to provide further clarity.

Cefndir / Background

It is a requirement within the Health Board's Standing Orders that all Board members and those employed by the Health Board declare any personal or business interests they may have, which may affect, or could be perceived to affect, the conduct of their role as a Board member or employee of Aneurin Bevan University Health Board.

In line with Standing Orders, the Audit, Risk and Assurance Committee is required to review and report to the Board upon the adequacy of the arrangements for declaring, registering and handling interests, and for gifts, hospitality and sponsorship.

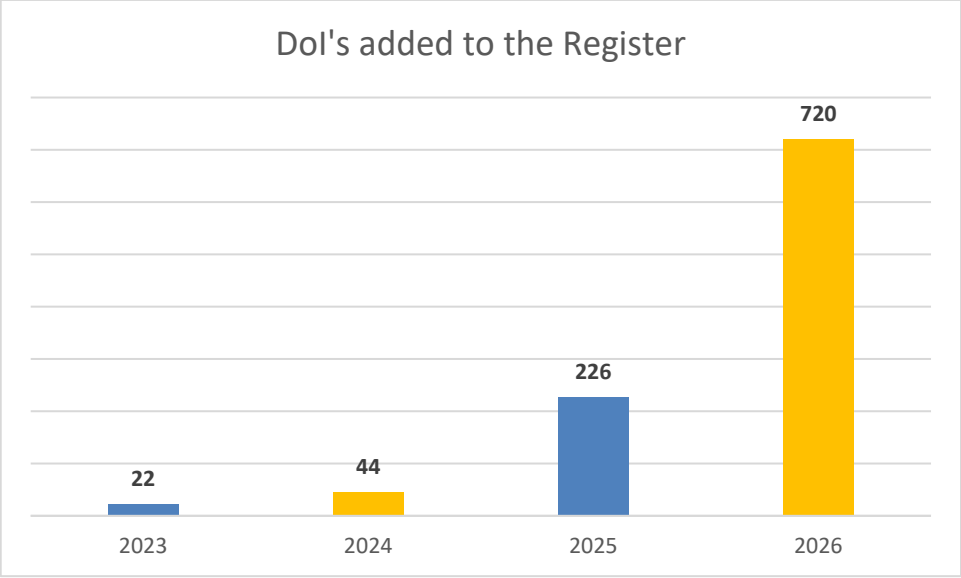
Asesiad / Assessment

The Board approved a revised Standards of Business Conduct Policy in September 2024. This Policy expanded on the previous policy and provides more explicit guidance on declaring interests, gifts and hospitality, and now includes honoraria and sponsorship.

Declarations of Interest
In support of the revised policy online Microsoft forms were introduced for completing declarations, which automatically populate the relevant register. A copy of the current Register of Interests, which includes declarations made since the introduction of the revised policy in October 2024, is provided as **Attachment One**.

Declarations of Interest are also a standard agenda item at each Board and Committee meeting to enable individual Board members to declare any interests in relation to any specific aspect of the agenda. Any declarations made are formally recorded within the minutes of the meeting. An annual review is also undertaken to ensure that all Board members review their Declarations of Interest. The DoI Register for Board Members is provided as **Attachment Two.**

The following graph shows the number of declarations submitted and added to the register on an annual basis (excluding Board members).



Targeting 'High Risk' Groups
The SOBC Policy requires that staff in 'high risk' groups complete a Declaration of Interest on an annual basis.

Staff are considered, for the purposes of this policy, to be in a 'high risk' post if their role necessarily brings them in to contact with external companies, contractors or suppliers, if they are able to initiate orders, are a budget holder, or strategic decision maker, in particular, those in the following areas:

- Staff at Band 8a and above
- Research and Development Staff
- Pharmacy Staff
- Informatics Staff

- Estates and Facilities Staff

In support of this, all staff at Band 8a and above have received an email from the Corporate Governance Team requesting that a DoI form is completed. These emails were sent on an incremental basis, starting with Band 9s in April 2026. Current compliance levels are outlined below:

	Compliance April	Compliance November	Total No.	Received April	Received November
Band 9	13%	47%	30	4	14
Band 8D	23%	58%	52	12	30
Band 8C	9%	48%	133	12	64
Band 8B	11%	50%	222	25	110
Band 8A	9%	46%	543	49	248
Overall	**10%**	**47.55%**	**980**	**102**	**466**

There have been queries from staff in these groups as to whether nil declarations are required. The Policy has therefore been updated to confirm that nil declarations are expected from these groups.

In relation to the areas specified in the 'high risk' definition above, Divisional Directors (or equivalent) have been contacted and requested to confirm those staff within their teams that would fall into this category. These lists are being compiled and will be reported on in future reports.

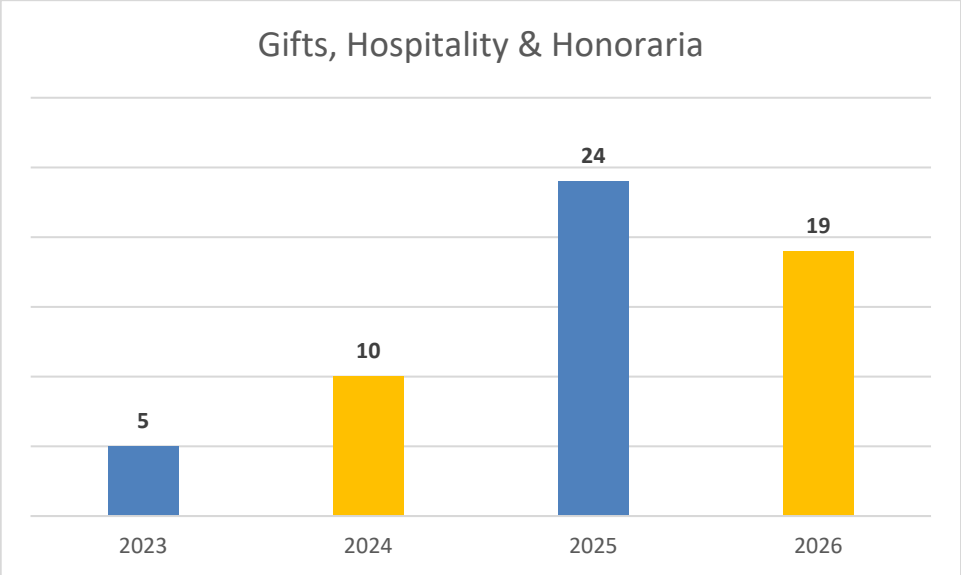
A joint letter from the Medical Director and Director of Corporate Governance has been sent to all Consultants within the Health Board reminding them of the requirement to declare interests. Current compliance levels are:

	Compliance April	Compliance November	Total No.	Received April	Received November
Consultants	4%	21%	607	25	126

Gifts, Hospitality and Sponsorship

In line with current policy, prior to accepting any gifts, the employee should consult with their line manager or Director of Corporate Governance for advice. If following advice the employee decides to accept the gift a declaration is made and the gift is retrospectively added on to the Health Board's Register of Gifts and Hospitality (Attachment 3).

The number of submissions made to the Gifts, Hospitality and Sponsorship register on an annual basis is provided below:



It can be seen from the graph above that there has been a reduction in submissions made in 2026, however, a separate Pharmaceutical Company Relationships Register for multiple gifts throughout the year as been established

Relationships with Pharmaceutical Companies

As a commitment to ethical ways of working, pharmaceutical companies disclose certain values made to UK healthcare organisations for collaborations related to developing and delivering new medicines. These payments are published via Disclosure UK which provides a public, searchable database. The record for 2025 was published on 30th June 2026 and there were a number of 'Event Sponsorship' payments that had been made to the Health Board but which had not been disclosed. A number of these related to the provision of lunches for Multi Disciplinary Team meetings. Following a review of the policy and the ABPI code of conduct, it was determined that a declaration was not required for MDT meetings at which lunch is provided, however, the policy will be updated to make it clear that, should there be an established relationship with a pharmaceutical company where hospitality of this nature is regularly provided, as long as the provision is in line with the ABPI code of conduct, the **relationship** needs to be declared to the Director of Corporate Governance. A pharmaceutical relationships register has now been established to capture this information. There are currently 11 companies on this register.

Standards of Conduct Policy Implementation Plan

In support of the revised policy, an Implementation Plan has been developed to support the roll out and increase awareness of the Policy across the organisation. This includes findings and recommendations identified by Internal Audit and Audit Wales.

A copy of the Standards of Business Conduct Policy Implementation Plan is provided as **Attachment Four.**

Standards of Business Conduct Policy – Amendments

The current Standards of Business Conduct Policy was approved by the Board in September 2024. As set out earlier in the report, the following amendments to the Policy are now proposed:

- Clarity that high risk groups are expected to submit a nil return where appropriate. (Page 7)

- **Relationships** with pharmaceutical companies providing regular hospitality to be declared for inclusion on the pharmaceutical relationships register (Page 23)

In line with Standing Orders, the Audit, Risk and Assurance Committee will continue to review and report to the Board upon the adequacy of the arrangements for declaring, registering and handling interests, and for gifts, hospitality and sponsorship. This will be undertaken bi-annually.

Argymhelliad / Recommendation

The Audit, Risk and Assurance Committee is asked to note the current arrangements in place, the Register of Interests and Register of Gifts and Hospitality as at November 2026, the progress made against the Standards of Business Conduct Policy Implementation Plan and amendments to the Standards of Business Conduct Policy.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate 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	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:	Set out within Policy
Rhestr Termau: Glossary of Terms:	Included within the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Executive Committee

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

Staff Name	Staffs Position	Staffs Department	Date of Submission	Declaration
Laura Leslie	B6 Physiotherapist	Children & ALD Physiotherapy	22/10/2024	Nil declaration
Natalie Stallard	NCN Pharmacist	Pharmacy	24/10/2024	Nil declaration
Laurence Vale Thornhill	Consultant Cardiologist	Unscheduled Care	25/10/2024	Nil declaration
Gareth Lavington	Head Counter Fraud	Corporate Finance	22/11/2024	Nil declaration
Mark Ross	Assistant Finance Director	Finance	22/11/2024	Nil declaration
Nicola Turner	Head Orthoptist	Scheduled Care	25/11/2024	Nil declaration
Dr Nidhika Berry	Consultant medical microbiologist	Clinical Services	27/11/2024	Director Sandeep and Nidhika Berry Pvt Limited - dividends as per rules/BAPIO Wales Executive Committee - sponsorship to attend conference
Nick Jones	Directorate Manager	Primary Care	03/12/2024	Nil declaration
Heidi Richardson	Administrator	CRT	11/12/2024	Nil declaration
Amelia Cobner	Speech and Language Therapist	Speech and Language Therapy	13/01/2025	Self employed Azira Aesthetics 1 year
Susan Kenneally	Obesity Medicine Physician	Nutrition and Dietetics	14/01/2025	Directorship S Kenneally Medical Ltd, 2017 to present & Ongoing Boots online Dr October 2024 Ongoing Sessional GP at the Independent GP Practice in Cardiff 2019-Ongoing
Elizabeth Andrew	Consultant Clinical Psychologist & Head of Adult Psychology	Mental Health & Learning Division	28/01/2025	I act as a tutor for the Association of Psychological Therapies (APT) delivering up to 3 courses a year for them on a paid basis. The Health Board also commission this organisation on occasion (though I would not teach for them within ABUHB). I am not a director in this company and do not own any shares in it, nor do I have a vested interest in it's functioning or success. I have provide consultation (one day per year) on mental well-being to Welsh Rugby Union (WRU). This is not paid in monetary terms but I may receive payment in kind on occasion (e.g. offers of match day tickets) Dr Liz Andrew, Psychological Services (currently operational). The provision of psychological therapy/psychological consultation to individuals who are not associated with ABUHB waiting lists or services at the point of contact. Financial details on form
Clare Fisher	Clinical Psychologist	MHLD	30/01/2025	South Wales CAT training Ltd (since about 2018) I am the course director for a course in Cognitive Analytic Therapy (CAT) run by South Wales CAT training Ltd. ABUHB has funded people to go on this course. I do this work outside my NHS hours (which are four days per week). I am paid for this work such as for teaching or course administration. South Wales CAT Training Ltd will be offering this training in the future. The company will also likely be bidding for HEIW funding to provide training in CAT.
Marcia Talarico	Nutrition support worker	Family and therapies	30/01/2025	Marcia Talarico Own Business is whole body approach, nutrition advice included as part of this, but not seeking any business with ABUHB or would not be in the future/ Volunteers but not in senior leadership role within Foodcycle
Helen Shannon	Lead dietitian oncology	family and therapies	03/02/2025	Nutricia ONS advisory board for 2025-2026. Providing monthly by email clinician perspective on types of ONS and how they may benefit certain patient groups.
Hannah Capel	Assistant Director for Strategic Capital	Planning	06/02/2025	Nil declaration
Dr Marufa Sultana	Specialty Doctor	Obstetrics and gynaecology	21/02/2025	Nil declaration
Nicola Collett	Principal Clinical Psychologist- Early Intervention in Psychosis	Adult Mental Health and Learning Disabilities	22/02/2025	I deliver clinical supervision at Oxford University/OCTC for the PGCert in CBT for Psychosis and Bipolar, as part of my role in Adult Mental Health Psychology. The trust receive payment for this work. However, I will be taking on an additional limited paid role from March 2025 to September 2025, marking therapy tapes. This will be undertaken outside of my role, in my own time. The reason for this is my one day role does not allow capacity for me to undertake this additional commitment within this time. I also run a small private psychological therapy practice online. None of my clients have been under the care of any service in Aneurin Bevan NHS University Trust.
Sophie-Ella Stark	Oncology dietitian	Family and Therapies	25/02/2025	I will be working with Nutricia on the oncology advisory board for 2025/26. As a result of this, I will be paid £700.
Rhiannon Bailey	Team Lead - CAMHS CMHT	Family and Therapies	19/03/2025	Director of Gateway Support & Care Ltd Responsible Individual Small private care home Eriskay Residential Care
Pippa Cotterill	Designated Education Clinical Lead Officer	Family and Therapies	01/04/2025	Secondment as Head of the Wales Office for the Royal College of Speech an Language Therapists
Sara Garland	general manager	F&T	10/04/2025	Nurse Advisor, WAST, bank work PRN
Emma Jones	Third Sector Contract Monitoring Officer	Mental Health & Learning Disability	14/04/2025	Nil declaration

Bryony Allen	Mental Health In Reach to School's Specialist Practitioner - Staff Manager	Families and Therapies	14/04/2025	Director - Rosemonte Holdings. Property Holding Company which part owns Eriskay Residential Care Ltd and has direct links with Gateway Support & Care Ltd. Set up in 2023 Partner part owns Gateway Support & Care Ltd
Alex Steptoe	Consultant in Emergency Medicine	Urgent Care	12/05/2025	Permamnent contract role as a HEMS doctor with East Anglian Air Ambulance. 2 shifts per month commitment Occasionally volunteer for this prganisation as a CPR trainer or at public events.
Marie-Claire Griffiths	Head of Strategic Planning	Planning	15/05/2025	Trustee with Newport Live
Philip Campbell	Divisional Director	Medicine	19/05/2025	Private Practice P Campbell Consultancy LTD Own <0.5% of shares of St Joseph's Hospital - no dividends ever paid Sponsorship to attend training events organised by Medtronic, Abbot & Biomed
Dr Adam Cann	Clinical Psychologist	Specialist Services	19/05/2025	Private Practice as a Clinical Psychologust/Cognitive Behavioural Therapist - advertised on line to self funding clients Provide therapy to Canopi (department of Cardiff University) providing mental health support to NHS Wales staff
Sarah Butt	Physiotherapy Administrator	Outpatient Therapies	22/05/2025	Staff Bank HCA with Cwm Taf Health Board October 2015 to present
Naomi Michele Lenina Jones	Senior Community Dentist	Community Dental Service	22/05/2025	Specialisty Dentist in Restorative Dentistry - part itme employment for 15 years
Wendy Munro	Consultant	Medicine	23/05/2025	Medical Examiner employed by NHS Shared Services since November 2022. 1 PA a week
Laura Owen	ED Consultant	Urgent Care	23/05/2025	Employed with West Midlands Ambulance Service since 2018. 2.5PA contract agreed and signed off by Urgent Care. Ad Hoc locum shifts
Jayas SIby	Senior Clinical Fellow	General Surgery	23/05/2025	Bank staff with Barts Health, occasional locum shifts in Barts Health on days off. Previously surgical clinical fellow in Whipps Cross Hospital before joining ABUHB
Haitham Barkouk	Consultant Psychiatrist	Mental Health (Addictions/Drugs and Alcohol)	23/05/2025	Out of hours locum work with Cardiff & Vale, Cwm Taff & Swansea Bay
Rhiannon Rogers	Clinical Specialist Paediatric Physiotherapist	Trauma and Orthopaedics - scheduled care	23/05/2025	Employed in Cwm Taf Morgannwg as clinical lead physiotherapist for 21 years
Lauren Carpenter-Barrett	Health Care Support Worker	Family and Therapies	23/05/2025	Social Care Wales - Newport City Council employed on 0 hour contract - bank staff
Belinda Cook	Lead educator NICU/ Senior sister	Families and rherapies	23/05/2025	Bank contract with Cardiff & Vale for a Welsh Risk Pool project - very infrequent shifts
Elizabeth Keddie-Gray	Clinical Trials Pharmacy Technician	Primary Care and Community	23/05/2025	Nil declaration
Rebekah Da Silva Teixeira	Research Midwife	R&D	23/05/2025	Bank NHS contract with Gloucester Royal Hospital and Newmedica Limited Band 6
Helen Francis	CAMHS Emergency Liaison Practitioner	CAMHS	24/05/2025	Bank Registered Mental Health Nurse with Cardiff & Vale since October 2019 Registered Mental Health Nurse with Richmond Nursing Agency since June 2023
Cilla Benge	Research Governance Administrator	Research and Development	27/05/2025	Nil declaration
Clair Balchin	Research Laboratory Co-ordinator	Research and Development	27/05/2025	Nil declaration
Hannah Louise smith	Sexual Health Outreach Worker	Gwent	27/05/2025	Employed with Caerphilly CBC as a Youth Worker since 2007
Shamira Ritigahawattage	Health Care Support Worker	Radiology	27/05/2025	Bank HCSW with Cwm Taff since 2024
Christopher edwards	consultant clinical scientist	scheduled care	28/05/2025	Directorship with The Private Phototherapy Clinic Ltd since 2005
Sue Kenneally	Physician in Obesity Medicine	Nutrition/dietetics	03/06/2025	
Louise Parfitt		Research Development	05/06/2025	Director with Mulberry Orthopaedics
Phil Lansdown	Rotational Band 5 Physiotherapist	Therapies	06/06/2025	Applying for a bank physiotherapy role with Bristol Childrens Hospital. Will be ad-hoc shifts.
Cheryl Chingosho	CAMHS Support Worker	SCAMHS and Ty Forrest BOOST	09/06/2025	Nil declaration
Sara Louise MORRIS	Fraud Investigator	Finance	10/06/2025	Community County Councillor Monmouthshire County Council
Helen Penny	Consultant Clinical Psychologist	Adult Psychology	12/06/2025	Private Practice. 1-3 clients at any given time and offer supervision to 0-3 supervisees/groups at a time. I only work with clients outside of ABUHB or clients commissioned by solicitors as part of a medico-legal claim who would not access support through the NHS. Supervision is provided to private practitioners or to support cohorts of the CT-PTSD Top up training programme in England. Very occasionally design and deliver training outside of ABUHB as part of this provate practice. Line manager fully aware of private work. This is paid work and a tax self assessment is completed each year
Sarah ilott	Community dentist	Community dental	24/06/2025	Nil Declaration
Dafydd Pritchard	Physiotherapist	Band 5	03/07/2025	Employment with St Jospeh's Hospital for the last 10 months Employment with Nuffield Vale Hospital fpr the last 8 months
JANE	MEDICAL SECRETARY	FAMILY AND THERAPIES	04/07/2025	Private Secretary to Dr M Olver

katie axe	Consultant Gastroenterologist, clinical director	Unscheduled care- gastroenterology	24/07/2025	Nil Declaration
Leigh Michael Roberts-Jones	GP with specialist interest cardiology	Cardiology	24/07/2025	GP Partner Forest View Medical Practice since 2021 & Medical Examiner's Service since February 2023
Louisa Fleetwood	Reporting Radiographer	Clinical support services	01/08/2025	Bank contract with Gloucestershire Hospitals NHS Foundation Trust
Amy Louise Miller	Team Lead Physiotherapist	Family and Therapies	11/08/2025	Shareholder FL Wangler Ltd since 2018
Tanya Scully	Rotational paediatric physiotherapist	Band 6	11/08/2025	Rumney RFC Head of Physio 2025-26 season. Welsh Gymnastics Physio for events since 2024. England Touch Rugby physio 2025-26 season
Julie Knight	Senior Physiotherapy Technician	Family & Therapies	11/08/2025	Nil Declaration
Suzanne Fincham	Administration Officer	Family and Therapies	11/08/2025	Nil Declaration
Jennifer Christie	Paediatric Physiotherapist	Child and family	11/08/2025	Query nil decalaration
Caragh Williams	B6 Physiotherapist ALD	Family & Therapies	11/08/2025	Nil Declaration
Mrs Sheona Louise Stubbs	Team Lead Paediatric Physiotherapist	Family & Therapies	11/08/2025	Nil Declaration
Debbie Paris	Band 7 Specialist Physiotherapist	Family & Therapies	12/08/2025	Nil Declaration
Cory Jenkins	Senior Finance Analyst	Finance - Surgery	12/08/2025	Nil Declaration
Rhys Lewis	Pharmacist	Primary care and networks	13/08/2025	Nil Declaration
Louise Leach	Operational manager Physiotherapy	Family & Therapies	14/08/2025	
Joanne Reid	Pharmacist	Primary Care and Networks	14/08/2025	Nil Declaration
Jenna Rudman	Pharmacy Technician	Primary care and networks	17/08/2025	Nil Declaration
Nadine Mayley	Physiotherapist Adult Learning Disabilities	Family & Therapies	18/08/2025	Nil Declaration
Hayley Randell	Physiotherapist	Family and Therapies	19/08/2025	St Joseph's Hospital - working as a bank physiotherapist since May 2022
Judith Harding	Pharmacist	Primary care and networks	19/08/2025	Nil Declaration
Gavin Rose	Pharmacist	Medicine	19/08/2025	Nil Declaration
Cameron Forde	Antimicrobial Pharmacist	Pharmacy	20/08/2025	Nil Declaration
Aimee Jones	Programme Divisional Pharmacist- Surgery	Pharmacy	21/08/2025	Nil Declaration
Joanna Peacock	Divisional Pharmacist Mental health and learning disability	Primary care and communites	21/08/2025	Nil Declaration
Saran Alis Wyburn	Band 6 Paediatric Physiotherapist	Families and Therapies	21/08/2025	Pontypool RFC 2 years. Pay monthly - self assessment
Jonathan Simms	Clinical Director of Pharmacy	Primary Care, Community, Complex Care	21/08/2025	Nil Declaration
Hana Thabrees	Principal Pharmacist Workforce Modernisation / Education and Training	Primary Care and Community	28/08/2025	Nil Declaration
Samantha Louise Shadbolt	Physiotherapist	Families and Therapies	28/08/2025	Nil Declaration
Tina Makzal	Mental Health Pharmacist	Mental Health	28/08/2025	Nil Declaration
Emma Knott	Programme Divisional Pharmacist	Primary Care and Community	30/08/2025	Nil Declaration
Bethan Jones	Principal Pharmacist for Procurement , Homecare and Clinical Informatics	Primary Care and Communities	01/09/2025	Nil Declaration
Lena Evans	Public Health Nursing Manger Torfaen	Family & Therapies	01/09/2025	Nil Declaration
Lowri Frances Benjamin	Physiotherapist	Family and Therapies - Physiotherapy	01/09/2025	Nil Declaration
Jill Davis	Band 7 Physiotherapist	Family and Therapies	01/09/2025	Voluntary leadership role in Vineyard Church Cardiff since 2019 (and spouse) Ambassador for Tropic Cosmetics since 2022. Consultant for Neals Yard Cosmetics since 2019. Sporadic & part time sales. Spouse - ambassador for Utility Warehouse since 2019
Mark Collard	Manager	Primary Care & Communities	01/09/2025	Nil Declaration
samantha street	Health Visitor	family Therapies	01/09/2025	Nil Declaration
Aimee Hawkins	Biomedical Scientist	Microbiology	03/09/2025	Aimeemayd Crochet Etsy Store (est 2023)

Sharon Lois Taylor	Personal Assistant - Children's & ALD Physiotherapy	Family & Therapies	04/09/2025	Nil Declaration
Emma Jenkins	Deputy Head of Dietetics & Weight Management Services	Family & Therapies	05/09/2025	Nil Declaration
Danielle Gunter	R&D Manager	Corporate	05/09/2025	Nil Declaration
Ffion Evans	Rotational Physiotherapist	Band 5	05/09/2025	Part time rugby pitchside/training physio for Cardiff Quinns since August 2025
Chris Phillips	Public Health Nursing Borough Manager	Family and Therapies	05/09/2025	Nil Declaration
Michelle Dando	Health Visitor	Families & Therapies	05/09/2025	Rejuvenate Aesthetics since April 2025
Kyriaki Sianou	HCSW	Families and therapies	05/09/2025	Nil Declaration
Laura Grady	Specialist Biomedical Scientist	Pathology	08/09/2025	Self-employed sole trader online retail business since June 2025
Katherine Joanne Holland	Health Visitor	Families & Therapies	09/09/2025	Run aesthetics business
Danielle Barrett-Wyatt	Health Visitor	family & therapies	09/09/2025	Self love life coach - self loves solves everything
merenna victoria williams	health visitor	families and therapies	09/09/2025	Tropic skincare limited since 2021
kerry hawkins	Health Visitor	Families and Therapies	09/09/2025	Cariad aesthetics
Ms Avril Jones	Specialist Health Visitor	Family and Therapies	09/09/2025	Licenced trainer of Solihull Approach, paid to deliver training modules since 2015
Katharine Susan Hobbs	Health Visitor	Health Visiting	09/09/2025	Cardiff Lymphatic Clinic since August 2025
Amelia Mason	Administrator	Health Visiting	09/09/2025	Nil Declaration
Rhian Wyn John	Administrative assistant	Family and therapies	09/09/2025	Nil Declaration
Lesley Ann Watkins	Assistant Practitioner	Ringland	10/09/2025	Nil Declaration
Lynne Margaret Herring	Pharmacist	Primary Care and Community	12/09/2025	Nil Declaration
caryl brown	ABUHB	Medicine	12/09/2025	10 hours paid work in a nursery September 2025 ongoing
Victoria Bodger	Senior Nurse	Family & Therapies	15/09/2025	Nil Declaration
Susan Bowry	Senior Admin	Families & Therapies	15/09/2025	Nil Declaration
Abigail. Plumb Ward	Specialist Nurse - Obesity	Family & Therapies	18/09/2025	Open University Part time lecturer since 2022
Joanne Bissex	Registered Nurse	Family and Therapies	26/09/2025	True Elegance Aesthetics Ltd Since July 2023 Aesthetics By Jo since April 2025
Belinda Lydon	Parent-Infant Mental Health Specialist	Child and Family Therapies	01/10/2025	USW Hourly paid lecturer ad hoc since 2019. Music Therapy Supervisor (hours fut around paid employment)
Jemma Chambers	Clinical Psychologist	Adult Psychology	02/10/2025	Dr Jemma Chambers Clinical Psychology Services Private Practice in Clinical Psychology in Cardiff City Centre Thursday & Friday from 07/11/2025
Susan Millar	Health Visitor	Families and Therapies	02/10/2025	Foster Carer
Katherine Freeman	Clinical Psychologist	Child & Family Psychology	06/10/2025	Nil Declaration
Lisa Hodge	Specialist Health Visitor	Families and Therapies	13/10/2025	Commissioned by Brazelton Centre UK to deliver NBO training
Lucy Windsor	Head of Corporate Risk and Assurance	Corporate	14/10/2025	Nil Declaration
Hannah Pennington	Advanced children's epilepsy nurse specialist and team leader for children's epilepsy team	families and therapies division	14/10/2025	Sienna Aesthetics and wellbeing Ltd 11 October 2025 to present. Taxable income
Charlotte Ford	Cancer Support Manager	Clinical Support Services	17/10/2025	PPSec to Simon Wood . Paid per letter no conflict of interest with the Health Board
georgia roberts	clinical psychologist	child and family psychology	20/10/2025	Nil Declaration
Marllah Hoskin	Associate audiologist	Audiology?	21/10/2025	Step dad part owns Minerva Hearing, who have a contract with the NHS
Natalie Skyrme	Divisional Nurse	Medicine	21/10/2025	Spouse - Red Electrical Cwmbran
keshav Jularam Swarnkar	Consultant Surgeon	General Surgery	22/10/2025	KJS Surgery & Endoscopy Limited since 2018
Lisa Jenkins	Health Visitor	Family and Therapies	22/10/2025	Total Care Services, Merthyr Tydfil Senior Care Assistant since 25/10/2025
Toni Baker	Assistant Psychologist	Child & Family Psychology and Therapies	23/10/2025	Nil Declaration
Emily Spencer	Junior Clinical Fellow	Acute/General medicine	27/10/2025	Nil Declaration
Baden Norwood Howell	Clerical Assistant	Surgery	27/10/2025	Nil Declaration
Ryan Hare	School Nurse	Families and Therapies	03/11/2025	Spouse holds a trustee role with Advanced Life Support Group since 02/12/2021 - listed incorrectly on Companies House as a Director (applied to have this updated). No financial transactions or benefits in kind

Hannah Loton-Jones	Health Visitor	Families & Therapies	04/11/2025	Personal Directorship - DAS Electrical Services Ltd
Jessica Faulkner	Registered Nurse	Health Visiting	07/11/2025	Nil Declaration
Jennie Evans	Speech and Language Therapist	Therapies	08/11/2025	Nil Declaration
April Valerie Nilssen	Mental Health Practitioner	Primary CAMHS	11/11/2025	Support worker/Family contact supervisor with Ymestyn Family Contact Services since 2023. Hourly wage, working 2-8 hours a month supervising family contact with Local Authorities
hayley ann Davenne	Dental nurse	accute	12/11/2025	Nil Declaration
Michelle Williams	Acute Liaison Nurse	Learning Disability	12/11/2025	Spouse/Partner Driector Cymru Healthcare - salaried
MISBAH GLADWYN-KHAN	CLINICAL PSYCHOLOGIST	AMHLD	12/11/2025	Private Practice income with Misbah Health LTD
Laura Jade Doheny	Deputy Sister	Clinical Support Services	13/11/2025	Sole trader with Nantwood Aesthetics since 2024
ARVIND KUMAR	Divisional Director (Interim)	Clinical Support Services	14/11/2025	Nil Declaration
CHRYSI KYRKYMTZI	BUSINESS SUPPORT ADMINISTRATOR	CSS	14/11/2025	Nil Declaration
Jodi Johansson	Business Support Officer	Clinical Support Services	14/11/2025	Nil Declaration
Sian Redwood	Transformation Manager	Clinical Support Services	14/11/2025	Nil Declaration
Helen Braithwaite	Senior Nurse 8a - Caerphilly Locality	Primary Care and Community	14/11/2025	Nil Declaration
Susanne Kelly	Pathology Business support officer	clinical support services	14/11/2025	Nil Declaration
Neil Maynard	Pathology Digital Operations Manager	Clinical Support Services	14/11/2025	Nil Declaration
Catherine Bailey	Consultant Clinical Scientist	Clinical Support Services	14/11/2025	Nil Declaration
Caroline Morgan-Henshaw	Biochemistry Operations Manager	CSS	14/11/2025	Nil Declaration
Rebekah White	Divisional Nurse	CSS	14/11/2025	Nil Declaration
Jessica Harris	Principal Clinical Scientist	Clinical Support Services	14/11/2025	Nil Declaration
Moises Hernandez Hernandez	Principal Clinical Scientist	Clinical Support Services	14/11/2025	Nil Declaration
Heather Jayne Hughes	Care After Death and Mortuary Services Directorate Support Manager	Pathology	15/11/2025	Husband undertakes casual funeral service operative duties for Phillip Tom & Sons Funeral Direcotrs - he is paid for this work.
anthony wilson	cellular pathology operations manager band 8a	clinical support services	17/11/2025	Nil Declaration
Caitlin Collacott	Trainee APT	Mortuary	17/11/2025	Nil Declaration
Andrea Boycott	Pathology Performance and Operations Manager	CSS	17/11/2025	Nil Declaration
Penelope Anne Knights-Holder	Specialist Biomedical Scientist	Clinical support services	17/11/2025	Nil Declaration
Natalie Sullivan	Band 4 Associate practitioner	Clinical support services	17/11/2025	Nil Declaration
Alison Elizabeth Gunter	Cellular Pathology Secretary	Clinical Support Services	17/11/2025	Nil Declaration
Laura Pollard	Healthcare Support Worker - Cellular Pathology	Clinical Support Services	17/11/2025	Nil Declaration
Tracy Lee Kilner	Medical Secretary, band 4	Cellular Pathology	17/11/2025	Nil Declaration
Lucy Bennett	Care After Death Manager	Clinical Support Services	17/11/2025	Nil Declaration
Nicole Carpenter	Care After Death Team	Pathology	17/11/2025	Nil Declaration
Helen Hopkins	Cross Sectional Imaging Manager	Clinical Support Services	17/11/2025	Nil Declaration
Elaine Lindley-Pilley	Business Manager Cellular Pathology and Chemical Pathology	Clinical Services	17/11/2025	Nil Declaration
Helen Hopcroft	Medical Secretary	Pathology	17/11/2025	Nil Declaration
Joanne Dunn	Human Tissue Act (HTA) Administrator	Mortuary	17/11/2025	Nil Declaration
Elizabeth Plenty	Administrative Support Officer	Physiotherapy Services for Children and Adults with Learning Disabilities	17/11/2025	Fitness franchise 'Rockfit' since June 2023. members pay to attend class
Lauren Jones	CAD Team	Pathology	17/11/2025	Partner works for funeral directors - Arthur Peake & Sons. Arthur Peake uses ABUHB mortuary stores.
Julie Tomlin	Biomedical Scientist	Clinical support services	17/11/2025	Nil Declaration
Kirsty Cooze	Med Sec	Clinical support services	18/11/2025	Nil Declaration
Alison Lowe	Medical secretary	Cellular Pathology	18/11/2025	Nil Declaration

AKASH EDACHIRA	BAND 3 PREANALYTICAL SUPERVISOR	CELLULAR PATHOLOGY	18/11/2025	Nil Declaration
Vida Joy Motamedi	Specialist Biomedical Scientist	Clinical Support Services	18/11/2025	Nil Declaration
Gwenan Angharad Jones	Senior Biomedical Scientist	Clinical Support Services	18/11/2025	Nil Declaration
Alex Warren	Associate Practitioner	Cellular Pathology	18/11/2025	Nil Declaration
Ceri Llewellyn	Head of Service, Clinical Photography & Medical Illustration	CSS	18/11/2025	Ceri Llewellyn Photography Ltd since June 2025
Julie Gilbert	AGM	CSS	18/11/2025	Nil Declaration
Ethan Horsell	Band 3 HCSW	Pathology	18/11/2025	Nil Declaration
Prajeeta Tumbapo	Band 3 HCSW	CELLULAR PATHOLOGY	18/11/2025	Nil Declaration
Pamela Margaret Latham	Trainee Biomedical Scientist	Clinical Support Services	18/11/2025	Nil Declaration
Siji Raphy	Pathology Laboratory Support Worker	Cellular Pathology	18/11/2025	Nil Declaration
Joanne Ivena Ware	Biomedical Scientist	Schedule Care	19/11/2025	Nil Declaration
Nicola Hannaway	Biomedical Scientist	Scheduled Care	19/11/2025	Nil Declaration
Nicole Blake	Laboratory Associate Practitioner	Pathology	19/11/2025	Nil Declaration
Carys Ffion Gauntlett	Healthcare Support Worker	Pathology	19/11/2025	Nil Declaration
Oliver Gall	Psychological Health Practitioner Supervisor and Psychotherapist	MH & LD	19/11/2025	Nil Declaration
Amy Dennis	Psychological Health Practitioner	PCMHSS	19/11/2025	Nil Declaration
Georgia Jenkins	Psychological Health Practitioner	PCMHSS	19/11/2025	Nil Declaration
Charlotte Holding	PHP	PCMHSS	19/11/2025	Nil Declaration
Amanda Goodwin	Medical Secretary	Cell path	19/11/2025	Nil Declaration
CLAIRE CHAPPELL	MEDICAL LABORATORY ASSISTANT	CELLULAR PATHOLOGY	19/11/2025	Nil Declaration
Helen Fleming	Secretary	Cellular Support Services	19/11/2025	Nil Declaration
claire griffiths	medical secretary	cell path	19/11/2025	Nil Declaration
Rachel Ayriss	PHP	PCMHSS	19/11/2025	Nil Declaration
Tim Walbyoff	Pathology Business Development and Project Support Manager	Clinical Support Services	19/11/2025	Nil Declaration
NATALIE STACEY	BAND 7 SENIOR BIOMEDICAL SCIENTIST	CLINICAL SERVICES	19/11/2025	Nil Declaration
Deborah Stephens	Care After Death Team	pathology	19/11/2025	Nil Declaration
Lisa Marie Lock	Laboratory Associate Practitioner	Clinical	19/11/2025	Nil Declaration
Maisie-Rae Morgan	Care After Teath	Pathology	19/11/2025	Nil Declaration
Behfar Khoshnevis	Biomedical Scientist	Cellular Pathology	19/11/2025	Nil Declaration
Janine Esteban	Pathology Support Worker	Cell Path	19/11/2025	Nil Declaration
Emma Elshaw	PACCT Operational Manager	CSS	20/11/2025	Nil Declaration
helder filipe de almeida santos duque	biomedical scientist	Clinical Support Services	20/11/2025	Nil Declaration
Ummi Nasiru	Biomedical scientist	Cellular Pathology	20/11/2025	Nil Declaration
Samantha Hallows	Pathology Support Worker	Cellular Pathology RGH	20/11/2025	Nil Declaration
Benjamin James Maryin	Psychological Health Board	PCMHSS	20/11/2025	Nil Declaration
Amy freenan	cellular pathology healthcare support worker	Aneurin Bevan	21/11/2025	Nil Declaration
Rachel Harding	Senior Biomedical Scientist (Band 7)	Clinical Support Services	21/11/2025	Nil Declaration
Marcus Silcocks	PACCT Service Manager	Support services	21/11/2025	Nil Declaration
Jamie Marron	Psychological Health Practitioner	Mental health	22/11/2025	Nil Declaration
Bethan Jones (Huffstickler)	Psychological Health Practitioner	Mental Health Learning Disabilities	24/11/2025	Nil Declaration
Llewellyn Phipps-Magill	Band 5 PHP	PHP SERVICE	24/11/2025	Nil Declaration
Rachel Ann Puw-Jones	Consultant Biomedical Scientist	Pathology	24/11/2025	Nil Declaration

Kelsey Jerrett	Trainee Clinical Psychologist	Adult Mental Health Services	24/11/2025	Nil Declaration
Tina Howard	Clinical Psychologist	Adult Mental Health and Learning Disabilities	24/11/2025	Paid therapy work with Talk in the Bay - 3 years
Amanda Lewis	Psychological Health Practitioner	MHLD	24/11/2025	Nil Declaration
Monique Beck	CAMHS Primary Mental Health Practitioner	mental health and LD services	24/11/2025	Nil Declaration
Dr Bethany O'Brien-Venus	Senior Practitioner Psychologist	Adult Mental Health	26/11/2025	Sole trader (private clinical psychologist) since November 2024 on my non working days. Referrals from Psychology Today, the Practice Rooms, PLE Health and own website. Paid at tandard hourly rate.
Laura-Beth McCarron	Clinical Psychologist	Child and Family Psychology	26/11/2025	Nil Declaration
Inderpal Singh	Consultant Physician	Medicine	27/11/2025	RS and KS Consultancy Ltd/ R Singh and K Singh Limited. Private Practice at St Joseph's Hospital. All work done outside contracted NHS hours. Partnership with spouse
Mike Larner	Clinical Psychologist	MH&LD	27/11/2025	Nil Declaration
Chloe Davies	Medical Laboratory Assistant/HCSW	Cellular Pathology	27/11/2025	Nil Declaration
Megan Small	HCSW	Cellular pathology	27/11/2025	Nil Declaration
Simon Hoad	Pathology Directorate Manager	CSS	02/12/2025	Partner is Pathology Manager for Spire Healthcare. Spire Healthcare have an SLA with ABUHB to perform pathology testing.
Julian Bendle	Microbiology Manager	Clinical Support Services	03/12/2025	Nil Declaration
Helen Cook	Physiotherapy Team Leader	Families and Therapies	05/12/2025	Nil Declaration
Sally Thorogood	Rotational Physiotherapist	Band 5	08/12/2025	Nil Declaration
KayCook	Administrator Physiotherapy	Family and Therapy Division	08/12/2025	Occasionally work for New Directions invigilating school or college exams
Seren Mae Dowell	Band 5 Rotational Physiotherapist	Nevill Hall hospital - MSK outpatients	10/12/2025	Nil Declaration
Bryony Codd	Head of Corporate Governance	Corporate Governance	16/12/2025	RJC Surgery LTD Dividends
Martina Tatarova	Administrive officer band 3	Family Therapies	16/12/2025	NHS Doreset (NHS Engldministrive) NHS Bursary scheme for AHPs
Bethan John	Care after death assistant	clinical support services	19/12/2025	Nil Declaration
Rebecca Pepper	Parent Infant Mental Health Therapist	Family & Therapies	19/12/2025	Nil Declaration
Lauren Elizabeth Procter	Health Visitor	Families and therapies	22/12/2025	Neonatal bank nurse with ABUHB
Charlotte Basnett	Band 5 Physiotherapist	Physiotherapy	29/12/2025	Nil Declaration
Angela Davies	Admin Team Lead	Family and Therapies	30/12/2025	Nil Declaration
Fareid Naseriyan	Rotational B5 Physiotherapist	Physiotherapy	02/01/2026	FN Sports Massage (Self employment)
Sarah Williams	CT/MRI Superintendent Radiographer GUH	Clinical Support Services	02/01/2026	Nil Declaration
Stalin Herzome Alphonse	MRI Radiographer	Radiology	02/01/2026	Personal - Stalin Herzome Alphonse starting soon
Erika Baker	Clinical Psychologist	Child and Family Psychology	05/01/2026	Nil Declaration
Dr Melanie Turpin	Clinical Psychologist	Child and Family Psychology	05/01/2026	Membership of Governance Board of National Adoption Service (NAS)
Gail James	Clinical Psychologist	Child and Family Psychology and Therapies Service	12/01/2026	Nil Declaration
Clare ELizabeth Gravell	Clinical Psychologist	Child and Family Psychology and Therapies	13/01/2026	Nil Declaration
Gill Cox	Operational service manager for medicine at GUH	Medicine	15/01/2026	GMC Independent Social Work Limited since August 2023
Charlotte Mazrae	Clinical	Child and Family Therapies	15/01/2026	The Autism Service since December 2025
Nova Aherne	Finance	Corporate Finance	22/01/2026	Cardiff & Vale Health Board - contracted as a Healthcare Support worker 12 hours a week on the weekend. Started 2021
Siobhan Cotty	Physiotherapy Technician	ABUHB	26/01/2026	Nil Declaration
Catherine Louise Harrigan	Biomedical scientist	Microbiology	26/01/2026	Snap Cymru 6 month contract, 10 hours per week on Mon/Tues from home
Emma Montgomery	Physiotherapy Band 5	Rotational	29/01/2026	Nil Declaration
Seren Evans	Band 5 Rotational Physiotherapist	CRT Caerphilly	29/01/2026	Nil Declaration
Louise Foley	Band 5 Physiotherapist	Family and therapies	30/01/2026	Nil Declaration
Jessica Whidborne	Band 5 Rotational Physiotherapist	Physiotherapy	02/02/2026	Nil Declaration

alice davies	consultant clinical psychologist	family and therapies	03/02/2026	Trustee - LEAF (Charity in Ledbury) Some independent work offering clinical supervision (not related to ABUHB) Previously been an expert witness (unrelated to this area)
Georgina Cratchley	Clinical Lead of the Gwent Parent Infant Mental Health Service (G-PIMHS)	Family and Therapies	03/02/2026	Nil Declaration
Madhu Kolli	Consultant	Family and Therapies	05/02/2026	Nil Declaration
Jennifer Ferry	Consultant Anaesthetist	PACCT	05/02/2026	Director of own Company - Greengrove Medical since 2022. Undertake occasional private lists as an anaesthetist in the private sector Elected Board Member of Regional Anaesthesia UK
Joseph Anderson	Consultant Neurologist	Medicine	05/02/2026	Nil Declaration
Andrew Rogers	Consultant Trauma and Orthopaedics	surgery	05/02/2026	Andrew Rogers Ltd 15 plus year - dividend income St Joseph's Independent Hospital - 6 years
Dr Louise Jennet Allman	Consultant Anaesthetist and ACCS TPD	Support Services	05/02/2026	Training Programme Director for ACCS Wales, HEIW since 2021 Provider of Procedural Sedation to Parkside Dental Practice (Private) since 2012 (average once a month) Director in Ltd company - Parkside Dental Practice since 2019
David JHepburn	Consultant ICM, Undergraduate lead (HSL)	CSS	05/02/2026	Glanwsyg Medical Services Ltd - Financial transactions for services - expert witness reports, public speaking engagements, private anaesthesia services Private anaesthetic services for London Womens clinic, St Joseph's Hospital, BUPA, AXA, PPP. 01/01/2026 onwards
Dr Leo P Pinto	Consultant Physician & AMD	Medicine	05/02/2026	Nil Declaration
Huw Pullen	Consultant Orthopaedic Surgeon	scheduled care	05/02/2026	South Wales Orthopaedics Ltd. Owners - company has a share holding in St Joseph's Independent Hospital Medartis - in person education (Paid) Zimmer - in person education (Paid) Stryker - in person education (Paid) Private practice business since 2011
Sanjit kumar singh	Consultant T&O	Scheduled care	06/02/2026	Nil Declaration
Dr Adele Babic	Consultant anaesthetist	PACCT	06/02/2026	Nil Declaration
Enya O'Neill	Band 5 Physiotherapist	Therapies	06/02/2026	Nil Declaration
Stephen Woolley	Consultant in Special Care Dentistry	primary care	06/02/2026	Advance Dental care 2022 ongoing private dental practice within a different Health Board
Lalit Bhalla	Consultant Cardiologist	Medicine	06/02/2026	LEEA Health Ltd - private cardiology wotk at St Joseph's Hospital
Jonathan Whelan	Consultant - Anaesthetics & Critical Care	CSS	06/02/2026	Medserve Wales - a medical emergency response charity affiliated to the British Association for Immediate care (BASICS) - no financial benefit Private practice - private anaesthesia, event medical cover, medico-legal work
Jake Hartford-Beynon	Consultant Anaesthetist	Clinical Support Services	06/02/2026	Teifi Medcial Ltd - Director for 4 years Private medical practice at St Joseph's Hospital for last 4 years via Teifi Medical
Rachel Squires	ABUHB	Family and Therapies	07/02/2026	O&G Private Practice St Joseph's Hospital since July 2025
Miss Ebube Obi	Consultant Ophthalmic Surgeon	Ophthalmology	09/02/2026	NaniChi Ltd - Trade names SosoChi, SosoChi Medical - Salary/dividends as Director Period of involvement and all details: Personal: 1. Research and provision of samples of digital adaptations for slit lamps and where necessary or where needed to enable digitisation of slit lamps to help further integrated eye care and referrals between primary and secondary care. 2. Research and provision of sample USB microscopes / mobile phone clip on magnifying lens accessory to enable remote acquisition of eye/ skin lesions or cancers by optometrists and GP's. 3. Research and or provision of skin and eyelid care information and or products. 4. Digitization / Digitalisation and Health care. 5. Various forms of provision of education, and education in healthcare and public health. Financial transaction or benefits in kind: Nil Currently 2022 - Following a successful grant, the provision of Slit lamp adaptors to optometrists. NaniChi LTD, 2017-Date. SIC Codes 86220 -Specialist medical Practice activities (2021-Date) 85590 - Other Education not elsewhere classified 47910 - Retail/Online sales
Khalid Ahmed Ramadan	Associate Specialist	Trauma and Orthopaedics	09/02/2026	Nil Declaration

Philip G Campbell	Divisional Director for Medicine	Medicine	09/02/2026	P Campbell Consultancy Ltd - Private practice income
Carys Knapper	CD and Consultant SRH ABUHB	F and T	10/02/2026	Nil Declaration
Clare Lipetz	Consultant	Family and Therapies	10/02/2026	Nil Declaration
Sian Warren	Consultant GU/HIV	Family and Therapies	10/02/2026	Occasional speaker fees for pharmaceutical companies
Chris Edwards	Consultant Clinical Scientist	scheduled care	11/02/2026	Salary from Newport phototherapy training
Rhodri Davies	Consultant Gastroenterologist	Medicine	12/02/2026	Nil Declaration
Dan Davies	Chief Business Officer	Corporate Governance	12/02/2026	Shareholder - Grumpy Productions Ltd since 28 January 2026
Robin Rice	Consultant Orthopaedic Surgeon / CCIO	Surgery	17/02/2026	Nil Declaration
Louise Massey	Consultant in Sexual and Reproductive Health	F and T	17/02/2026	Nil Declaration
Leah Briggs	Senior Physiotherapy Technician	Children's Centre	19/02/2026	Nil Declaration
Amy Roberts	Physiotherapist	Band 5	22/02/2026	Nil Declaration
Alexandra Thomas	MSK Clinical Specialist Physiotherapist - Children	Family and Therapies	23/02/2026	Match Day Physiotherapist for Swansea City FC Academy Since 2021
Lianne betts	Band 4 Physiotherapy technician	Family and therapy	23/02/2026	Nil Declaration
Karene Arete Lim	Consultant Radiologist	Surgery	24/02/2026	Lim Perkins Healthcare Ltd since 2019
Kate Waters	Band 7 Paediatric Physiotherapist	Families and Therapies	24/02/2026	Pilates Physiotherapist for PPP Physiotherapy and Pilates Course Presenter for APPI. Average 5-6 hours per week
Joanne Buchanan	Analytics & Modelling Capability Programme Manager	Corporate	26/02/2026	KAFO GUY Ltd - Orthotics private practice, consultancy and brokerage Nuffield Healthcare (Vale Hospital) Since September 2025
CHERIE LAMONT	SENIOR PAAEDIATRIC PHYSIOTHERAPY TECHNICIAN	FAMILIES AND THERAPIES	26/02/2026	Nil Declaration
Dr Nadia El-Farhan	Consultant in Chemical Pathology and Metabolic Medicine	Clinical Support Services	27/02/2026	Nil Declaration
Rachel Jones	Statutory Compliance Officer	Estates	04/03/2026	Paid for instances of advice totalling 8-12 hours. No conflict of disclosure, or relation to work with NHS
christina birkby	Medicines Governance Pharmacist- Primary Care	Primary Care- Pharmacy	12/03/2026	Nil Declaration
Zoe Hall	Band 5 Rotational Physiotherapist	Physiotherapy	12/03/2026	Private work with Seary Physiotherapy for 3 hours a week
Charlotte McMahon	Mental Health Practitioner	Families and Therapies	12/03/2026	Work for Compass Fostering Agency as a panel member on an ad hoc basis - starting April/May 2026. Zero hours contract £40 per hour
Paul Price	Systemic Psychotherapist	Child and Family Psychology and Therapies Service	17/03/2026	Nil Declaration
Benna Waites	Joint Head of Psychology, Counselling and Arts Therapies	Mental Health and LD	17/03/2026	FARA - a new charity being set up to support the voices of women and girls through facilitating dialogue. Trustee term likely to be 1-3 years. No anticipated conflict of interst between trustee role and NHS role.
Richard Howells	Executive Business Manager	Medical Director	26/03/2026	Justice of the Peace (JP) - Travel expenses
Dr Veronica Mary Hickson	Associate Specialist Community Paediatrics	Family & Therapies	08/04/2026	The Electrode Company Ltd since 1986 - previously sol a Lightman Pulse Oximeter Sensor accuracy tester to ABUHB & calibrated it in the past British Association of Paediatricians in Audiology (BAPA) - Honorary Executive Secretary National Deaf Childrens Society (NDCS) - invited member of Cymru Wales Advisory Committee Myself & Spouse are members of British Standards Institute (BSI) and members of ISO Joint working Group on ISO80601/2/61 the PulseOximeter Standard
Charlotte Christiansen	Family Therapist	Child and Family Psychology and Therapies Service	08/04/2026	Teaching at the Clinical Psychology Course and private supervision of family therapist
Nathan Haxton-Foley	Team Manager- Pontllanfraith District Nurses	Community and Primary Care	13/04/2026	Laserase Wales - 2 years - private business
Jennifer Pearce	Clinical Psychologist	Family and Therapies	13/04/2026	Private Psychological Therapy Provision - sole trader. Outside of ABUHB area
Matthew Yates	Clinical Psychologist	Child and Family Therapies	15/04/2026	Nil Declaration
Shannaya Reynolds	Physiotherapist	Band 5	17/04/2026	Nil Declaration
Sarah Carrington	Physiotherapy Head of Service	Family & Therapies	20/04/2026	Founder of The Good Leader Academy. Online leadership training and executive coaching for health care leaders. No financial transaction
Lloyd Hambridge	Divisional Director Primary Care, Community and CHC	Primary Care, Community and CHC	20/04/2026	Directly employed with a GP Practice (Blackwood Medical Group) working clinically 1 day a week

Namrata Singh Chauhan	clinical Specialist pelvic physiotherapist	Band 7 (St.woolo's Hospital)	20/04/2026	iPS Physiotherapy - Cardiff. Started 24/01/2026
Kathryn Walters	Joint Professional Head of Psychology, Counselling and Arts Therapies	MH&LD	21/04/2026	Small private practice (currently 2 long term clients). No new clients since 2022 and historically clients have been outside ABUHB.
Liza Methuen	Assistant Head of Capital, Estate & Property Management	Estate & Facilities	21/04/2026	Nil Declaration
Mark Arscott	Head of Operations	Works & Estates	21/04/2026	Newport Masonic Hall Directorship - zero financial transaction Skenfrith News management Company - zero financial transaction Monmouthshire Freemasons
Gareth Mannings	Senior Estates design officer	Estates	21/04/2026	Nil Declaration
Susan Bale	Research and Development Director	Corporate	22/04/2026	Nil Declaration
suzanne jones	Assistant finance director	finance	22/04/2026	Nil Declaration
William Batten	Formulary Pharmacist	Primary care	22/04/2026	Yeomans Property Development Limited from 17/04/2026 - Co-Director
Greg Bowen	Assistant Director of Finance	Finance	23/04/2026	Nil Declaration
Shelley Williams	Deputy Director of Workforce and Organisational Development	Workforce and OD	23/04/2026	Nil Declaration
Nigel Holt	Senior Estates Design Officer	Works and Estates	23/04/2026	Nil Declaration
Clifford Jones	Deputy Medical Director	PCCS	24/04/2026	Trustee - City Hospice 2022-Present Salaried GP at a GMS practice in ABUHB area
Simon Hodsdon	Head of Public Health	Public Health	24/04/2026	Nil Declaration
Scott Edwards	Senior Project Manager	Digital Data and Technology - Digital Programmes	27/04/2026	Nil Declaration
Carl Davies	DD&T Programme Manager	Digital Data & Technology	27/04/2026	Nil Declaration
Christine Price	Senior Project Manager	DDaT	27/04/2026	Nil Declaration
Angharad Brown	Consultant Orthodontist	Scheduled care	28/04/2026	Masonworth Ltd 10 years - financial transactions Newport Orthodontics Ltd 5 years - financial transactions
Kelly Jones	Head of Capital Finance	Corporate - Finance	28/04/2026	Spouse is Audit Manager for Audit Wales
Donna Challingsworth	Head of Nursing Surgery	Surgery	28/04/2026	Nil Declaration
Clare Sandford	Consultant Clinical Psychologist	Mental Health and Learning Disabilities	28/04/2026	Spouse/Partner - United Welsh - Bespoke Repatriation Service Contract 2020-2027
Kelly Griffiths	Digital Portfolio Benefits Manager	DDaT	28/04/2026	Nil Declaration
Leigh-Anne Challenger	Senior Capital Programme Manager	Planning	28/04/2026	Nil Declaration
Jeyanthi Ravi	Senior Surgical Care Practitioner Band 8B	Surgery	28/04/2026	An association with husband - run retail and Post Office Business - no income from this role With husband - own a residential property which is let and generates income
Hannah Evans	Programme Support Officer	DDaT	28/04/2026	Nil Declaration
Sian Bigmore	Head of Recruitment	WOD	28/04/2026	Nil Declaration
Joanne Walters	Senior Planning and Service Development Manager	Corporate Planning	28/04/2026	Involvement with YMCA Cardiff - No financial transactions or benefits
Rhys Knight	Directorate Manager	Surgery	28/04/2026	Nil Declaration
Victoria Richards-Green	Chief X Information Officer	Digital, Data and Technology	28/04/2026	Nil Declaration
Katie Williams	Senior Programme Manager, Place Based Care	Planning	28/04/2026	Nil Declaration
Elizabeth Hunt	Clinical Lead Optometry	Surgical	28/04/2026	Nil Declaration
Sam Crocker	Directorate Manager - Older Adult Mental Health Services	MH&LD	28/04/2026	Nil Declaration
Anne May	Strategic Lead Cancer Nurse	Clinical Support Services	28/04/2026	Nil Declaration
Caroline Hobbs	Head of CMA and Costing	Finance	28/04/2026	Nil Declaration
Mark Dickens	Lead Infrastructure Architect	DDAT	28/04/2026	Nil Declaration
Kolade Gamel	Service Group Manager	MH&LD Division	28/04/2026	Nil Declaration
Jonathan Thomas	Assistant General Manager	Division of Surgery	28/04/2026	Nil Declaration

Natalie Harrison	Consultant Dietitian	Family and Therapies	28/04/2026	Private work as educational advisor for Alliance Pharmaceuticals 2023-2025 and Abbot Clinical Nutrition Associate tutor at Cardiff Metropolitan University
Nikki Noble	Consultant Nurse	Family and therpaies	28/04/2026	Period of involvement and all details: I have received honorarium from several pharmaceutical companies. This is mainly for teaching webinars or occasionally teaching face to face or as a panellist at conferences. I have been involved in developing an online guide for Menopause for women living with HIV with Gilead for healthcare professional and I have also appeared in educational recordings for healthcare professionals for Consillient. I have provided educational webinars for Besins, Consillient and Gilead Sciences.
Tracy Bale	Nurse Consultant Dermatology	Surgical	28/04/2026	Able Calibration Services Ltd since 2006 - payment for services
Robert Jones	Assistant Director of Finance	Finance	29/04/2026	Spouse/Partner (Dr Cerian Jones) partner in Westfield Medical Practice - a GP Practice within ABUHB region
Tom Grace	MCA / DoLs Lead	Primary care / corporate	29/04/2026	Nil Declaration
Madhuparna Mitra	Consultant	Surgical	29/04/2026	Shareholder in Kausik Madhu Medical Services Personal involvement with Wales Puja Committee (Charity) Bayer pharmaceutical - educational grant for medical conference (periodic) Roche pharmaceutical educational grant for medical conference (periodic) Periodical Educational grant towards medical conference, travel and presentation
Claire Pramana	Head of PMO & Digital Engagement	Digital, Data & Technology	29/04/2026	Nil Declaration
Joanne Othen	PMO Support Officer	Digital, Data & Technology	29/04/2026	Nil Declaration
Christopher Martey	Physiotherapist - MSK Transformation Clinical Lead	Family and Therapies	30/04/2026	Arthritis and Musculoskeletal Alliance (ARMA) Charity, Charity number: 1108851 - position is as a Voluntary Trustee role. Reasonable expenses for Trustee business only. Not a leadership position, but a role with another Charity. As of 14 August 2023, I have begun sessional work with Arthritis UK, formerly Arthritis UK (Charity Number 207711) as a 'Musculoskeletal Core Skills Trainer'. I have an agreement to deliver at least 2x educational sessions within a 1-year period which usually take place across a half-day or full-day period. This involves delivering/teaching pre-set educational materials from Arthritis UK, either online (digital) or in-person as a 'workshop', to clinicians in primary care, most often GPs/Doctors and Physiotherapists. As a clinical lead Physiotherapist in Rheumatic and Musculoskeletal Diseases, I have worked (freelance) as an educator/instructor for Physiopedia UK (Charity number: 1173185) developing/delivering online content/webinars to support the education, training and continuous professional development (CPD) of Physiotherapists and Rehabilitation Professionals - This work is remunerated.
Joanne Jenkins	Head of Information Governance	DDaT	30/04/2026	Nil Declaration
Ian Haywood	Project Manager	Digital, Data & Technology (CSS Programmes)	30/04/2026	1st Sirhowy Valley Scout Group Group Lead Volunteer 20 years - Financial transactions received
Amy Buckley	Interim Divisional Nurse	MHLD	01/05/2026	Nil Declaration
Sian Lewis	Macmillan AHP Cancer Lead	Family & Therapies	01/05/2026	Regional ambassador for 5K Your Way (ABUHB region)
Lorraine Pietrzak	Divisional Pharmacist Urgent Care	Primary Care	01/05/2026	St John Ambulance Cymru, 1 year - volunteer role
Rhys Williams	Lead Pharmacist Medicine GUH	PCC	01/05/2026	Nil Declaration
Alison Williams	Head oF Speech and Language Therapy	Family and Therapies	01/05/2026	Royal College of Speech and Language. Professional Practice and Policy Committee - Wales representative
Rebecca Hammonds	Professional Lead for Children's Services	Families and Therapies	01/05/2026	Nil Declaration
Jenna Adams	Professional Lead Speech and Language Therapist	Family and Therapies	01/05/2026	Nil Declaration
Joanna White	Macmillan Principal Speech and Language Therapist	Family and Therapies	05/05/2026	Nil Declaration
Lauren Stead	Clinical Psychologist	Child &Family Psychology	05/05/2026	Nil Declaration
Emma Thomas	Consultant Clinical Psychologist	Families and Therapies	05/05/2026	Nil Declaration
Laura Banci	Professional lead SLT Adult Acute	Family & Therapies	05/05/2026	Nil Declaration
Emma Dunleavy	Perinatal Mental Health Pharmacist	Pharmacy	05/05/2026	Nil Declaration
David Challenger	Deputy Directorate Manager - Ophthalmology	Surgery	05/05/2026	Nil Declaration
Maxine Hiscock	Assistant Head of Patient Safety	Corporate	05/05/2026	Nil Declaration
Rachel Louise Hughes	Head of Information	DDAT	05/05/2026	Nil Declaration
Michelle Key	Senior Business Manager	Estates & Facilities	05/05/2026	Nil Declaration
Nicky Marsh	Senior Nurse	Medicine	05/05/2026	Nil Declaration

Geraint Scott	Head of the Welsh Language Unit	Workforce and Organisational Development	05/05/2026	Nil Declaration
Justine Jadie McCarthy	Assistant Head of Service	Primary Care & Community Division	05/05/2026	Nil Declaration
Daniel Dwyer-Westwood	Principal Business Analyst	DDaT	05/05/2026	Nil Declaration
Louise Driscoll	Workforce Manager	Workforce & OD	05/05/2026	Nil Declaration
Lisa Andrews	Finance Manager PLICS	Finance	05/05/2026	Nil Declaration
Adrian Perkins	Clinical Lead, Family and Systemic Psychotherapist	Families and Therapies Directorate	05/05/2026	Lim Perkins Healthcare Ltd; since October 2019 - fees from private clients
Debbie Thow	Senior Nurse, Monmouthshire	primary care	05/05/2026	Nil Declaration
Nathan Chidwick	Clinical lead physiotherapist	F&T	05/05/2026	self-employed physiotherapist 'Monmouth Physiotherapy' private practice. 15 years
Joseph Moss	Accountant	Financial Planning and Performance	05/05/2026	Nil Declaration
Michael Melhuish	Haematology Operational Manager	Clinical Support Services	05/05/2026	Nil Declaration
Victoria Crocker	Adults Programme Manager	Planning - Gwent Regional Partnership Board	05/05/2026	Nil Declaration
Anna Harding	Strategic Clinical Lead for the Community Admissions Avoidance Therapies Team	Family and Therapies	05/05/2026	Nil Declaration
Leanne Watkins	Assistant Head of Service Monmouthshire	Primary Care & Communities	05/05/2026	Nil Declaration
ELEANOR CLAIRE GARRETT	SENIOR NURSE YAB ANP/ BG CRT	PRIMARY CARE AND COMMUNITY	05/05/2026	Nil Declaration
Diana Turner	Professional lead OT Complex Care Directorate	Primary & Community Care	05/05/2026	Nil Declaration
Freda Lacey	MH/LD Partnership Manager (includes vol sector commissioning)	MH/LD Division	05/05/2026	Trustee for a charity called Credu - who do not provide services for ABUHB
karen fitzpatrick	senior nurse	primary and community	05/05/2026	Nil Declaration
Liz Rees	Deputy Head of Speech and Language Therapy	Family and Therapies	05/05/2026	Member of the Royal College of Speech and Language Therapists National Outcomes Steering group. Some involvement with the National Deaf Children's Society.
Matthew Williams	Operational Manager	Family and Therapies	05/05/2026	Nil Declaration
Steven Powell	Estates Manager	Works & Estates	05/05/2026	Nil Declaration
Jessica Moss	Older Adult Mental Health Head Occupational Therapist	Mental Health and LD	05/05/2026	Nil Declaration
Jane Louise Trumroer	Vascular Laboratory Manager	Clinical Support Services	05/05/2026	Nil Declaration
Kathryn Day	Service Improvement Manager	Public Health	05/05/2026	Nil Declaration
Dan Clayton	Principal Public Health Practitioner	Public Health	05/05/2026	Creigiau Recreation Charity Trading 2026 - Chair
Avril Lidstone	Senior Nurse	Division of Surgery	05/05/2026	Nil Declaration
Jo Wood	Clinical Lead Physiotherapist for Children & Adult learning disability	Family and therapies	05/05/2026	Somek &Associates
Angela Jones	Programme Manager (Digital Patient)	DDaT	05/05/2026	Nil Declaration
Maria Fryc	Project Manager	Digital, Data and Technology	05/05/2026	Nil Declaration
Claire Reilly	Operational Services Manager, Cardiology	Medicine	05/05/2026	Nil Declaration
Helen Louise Ronchetti	Deputy Head of Infection Prevention	Corporate Nursing	06/05/2026	Nil Declaration
Heidi Desmond	Senior Nurse HMP Usk and Prescoed	Primary and Community Care	06/05/2026	Nil Declaration
Michelle Hill``	Interim Deputy Head of Nursing	MHLD	06/05/2026	Nil Declaration
Lynette Kimberley	Professional Lead SLT Children's Centres and Early Years	Families and Therapies	06/05/2026	Nil Declaration
Lisa Trenchard	Senior Nurse Health Visiting	Family and Therapies	06/05/2026	Nil Declaration
Lauren Cliburn-Clark	Programme Support Officer	Digital, Data & Technology	06/05/2026	Nil Declaration
James Wills	Principal Finance Manager - Business Systems	Finance and Procurement	06/05/2026	Nil Declaration

Laura Melrose	Assistant Head of Business & Performance	Primary Care & Community Services	06/05/2026	Nil Declaration
Dr Jayne Williams	Lead of Older Adult Psychology	MHLD	06/05/2026	Michael Hall Photography Limited, since 2007. Occasional dividends
Mary Kivell	Advanced Clinical practitioner	Urgent Care	06/05/2026	Nil Declaration
Clare Williams	Professional Lead for SLT in LD	MHLD	06/05/2026	Nil Declaration
Gillian Cox	Operational service manager for medicine - GUH	Medicine	06/05/2026	GMC Independent Social Work Ltd Since August 2023 - dividend payments and benefits in kind
Matthew James Gosling	Interim Head of Financial Strategy	Finance	06/05/2026	Nil Declaration
Matthew Arathoon	Microbiology Operations Manager	Clinical Support Services	06/05/2026	Nil Declaration
Philip Jason Hill	Senior Nurse ANP UPC 24-7	Primary and Community Care	06/05/2026	Algorithm UK professional first aid training and consultancy (sole trader) since 1st April 2026 Clincial adviser/fundraiser for Jacks Appeal c/o ABUHB charitable funds circe 2015 to present day
Aarushi Shah	Physiotherapist (band 5)	Physiotherapist	06/05/2026	Nil Declaration
Sarah Louise h\umphries	Head of Digital Business Assurance	Digital	06/05/2026	Nil Declaration
Michelle Worwood	Senior Nurse	Surgery	06/05/2026	Nil Declaration
Kerri Lisa Emms	Deputy Head of Digital Business Unit	Informatics	06/05/2026	Nil Declaration
Jessica Ryan	Deputy Head of Public Health - Health Improvement	Public Health - Corporate	06/05/2026	Nil Declaration
Daniel Saunders	Senior Nurse	Medicine	06/05/2026	Nil Declaration
elleanor griffiths	senior lead informatics Specilaist midwife	Family and therapies	06/05/2026	System C - 12 months so far and a new contract signed to assist when Badgernet system goes live as an accredited badgernet midwife - payment for floor walking shifts
Victoria Dyer	Service Lead	Gwent Public Health Team	07/05/2026	Nil Declaration
Chloe Louise Phelps	Digital Senior Procurement Officer	Digital	07/05/2026	Nil Declaration
Craig Collins	Senior Estates Design Officer	Facilities & Estates	07/05/2026	Nil Declaration
Rhys Edwards	Workforce Business Partner	Workforce & OD	07/05/2026	Nil Declaration
Victoria Coghlan	Consultant Nurse Bladder & Bowel	Family & Therapies	07/05/2026	Occasionally asked to take part in advisory groups and national professional consensus work
Danielle Hannah Batty	Senior Nurse Older Adult Mental Health BG and Mon	Mental Health	07/05/2026	Derma Bare LTD - Company Director. Aesthetics and wellness business
Nicholas James	Band 6 CPN	Specialty services Mental Health	07/05/2026	Daughter works in same team
Ian Blakemore	Surgical Care Practitioner Gynaecology	GYnaecology	07/05/2026	I have a service agreement with Medtronic to provide training / lecture presentations / hands-on tips & tricks from a users perspective on Truclear hysteroscopic devices. Accommodation / expenses are sponsored. I have a signed declaration letter in conjunction with Medtronic confirming I have no influence in promoting / purchasing or recommending any Medtronic products.
Cara Tingle	Head of Statutory Compliance	Estates and Facilities	08/05/2026	Nil Declaration
James Broughton	Clinical Psychologist	Family & Therapies	08/05/2026	Nil Declaration
Louise Steed	Senior Compliance manager	Facilities and Estates	08/05/2026	Nil Declaration
Kirsty Holloway	Point of Care Testing Manager	CCS	08/05/2026	Nil Declaration
Dulcie Williams	Directorate Pharmacist for Palliative Care	Pharmacy/Primary Care	08/05/2026	Nil Declaration
Rebecca Goode	Head of Operational Transformation	Corporate	09/05/2026	Nil Declaration
Nicola Morgan	Consultant Community Paediatrician	Family & Therapies	11/05/2026	Safeguarding lead in Llanishen Evangelical Church, Cardiff
Rebecca Large	Clinical Psychologist	Family & Therapies	11/05/2026	Nil Declaration
Pauline Gething	band 7 case Manager commissioning	mental health and Learning disabilities	11/05/2026	Son works for home from home supported living, which in my role as case manager, I would commission with this provider - ongoing
Bethan Douglas	Digital Procurement Officer	Digital Business Unit	11/05/2026	Nil Declaration
Daniel Keyse	Estates Manager	Work and Estates	11/05/2026	Nil Declaration
Anna Morgan	Deputy Head of Public Health	Corporate (public health team)	11/05/2026	Nil Declaration
Heulwen Griffiths	Head of Business Systems and Governance	Corporate Finance	12/05/2026	Nil Declaration
Jessica Hamer	Lead Physiologist of Cardiac Rhythm Management	Medicine	12/05/2026	Nil Declaration
Gareth Jenkins	Programme Manager	Digital, Data and Technology	13/05/2026	Nil Declaration

Peter Brown	Asst Dir Workforce and OD	Workforce and Organisational Development	13/05/2026	Nil Declaration
Kelly McCreadie	Senior Project Manager	DDaT	13/05/2026	Nil Declaration
Ceri Phillips	Consultant Antimicrobial Pharmacist	Primary Care	13/05/2026	ThermoFisher Scientific Paid £1500 + expenses (one off) Father worked fpr Pfizer until 2005 - in receipt of Pfizer pension and holds shares
Callum Hague	Project Manager	DDAT	13/05/2026	Nil Declaration
Anna Roynon Reed	Research Delivery Senior Team Lead	Corporate	14/05/2026	I am involved in patient and public involvement activities with the National Cardiovascular Research Network (NCRN) in a personal capacity, as I am a gene carrier for a cardiac condition. This work is undertaken in my own time, and my manager is aware and supportive of this arrangement. If any involvement occurs during my normal working hours, I take annual leave and ensure this is clearly documented and agreed with my manager. The role requires any potential conflicts of interest to be declared, and I would do so appropriately where relevant. For example, I would not review any NCRN funding applications from ABUHB staff, nor would I support ABUHB staff in submitting applications to NCRN. At present, this has not presented any conflict, as I am not actively involved in research selection relating to cardiovascular areas.
Catrin Hnatiw	Clinical Lead for Paediatric Dysphagia	Paediatric Speech and Language Therapy	15/05/2026	Nil Declaration
Amanda Whent	Lead Nurse Dementia	Corporate nursing	15/05/2026	Tithe Barn community wellbeing cafe- community volunteer committee and chair of committee - unpaid
Sarah Elizabeth Argent	Consultant Psychiatrist	Mental Health and Learning Disabilities	15/05/2026	I hold an Honorary Research Fellow Contract with Cardiff University. I do not receive any benefits from this financially. I have been appointed Interim Medical Director for the Mental Health and Learning Disabilities Care Group in CTM UHB. This will run from 01.05.2026 for a period of 6 months. I continue to be employed in CTM for 10 sessions overall but have reduced my clinical commitment to take on this role for 6 sessions. I continue to hold the role of Clinical Lead for FACS for CAMHS within my employment with CTM UHB. My roles are clearly job planned to protect the time employed in each Health Board. I receive payment for this work as per the NHS Wales pay scale, with a leadership responsibility allowance for the MD sessions in CTM UHB.
Emma Noon	Community Staff Nurse	Prestatyn District Nurses	16/05/2026	Nil Declaration
Andrea Bower	Community Staff Nurse	Prestatyn District Nurses	16/05/2026	Nil Declaration
Emma Davies	Operational Lead Cardiac Rehabilitation	Medicine	18/05/2026	Nil Declaration
Emily Phillips	Advanced Critical Care Practitioner	Clinical Support Services	18/05/2026	Nil Declaration
Lauren Moulton	Band 5 RN	Gen Medicine	19/05/2026	Started training in aesthetics - no clients yet used models such as family
Nicole McGrath	Consultant Paediatrician	Family and Therapies	19/05/2026	Nil Declaration
Louise Jennet Allman	Consultant Anaesthetist	Clinical Support Services	19/05/2026	Parkside Dental Practice since 2020 - Occasional paid work <1 day per month
Michelle Olver	Consultant Sexual and Reproductive Health	Family and Therapies	19/05/2026	SRH Training Solutions - founder Medical education Company. No regular salary small profit for speaker fees Paid - sponsorship for industry stalls but no involvement in content of teaching. Paid to deliver teaching sessions and be part of an advisory board Founder of South Wales Menopause Clinic Consultant led outpatient menopause clinic delivering 3 sessions a week in the private sector - St Josephs and Spire Cardiff St Josephs private clinic 2 sessions a week Spire Cardiff 1 session a week. This is my 3rd year of practice
Inderpal Singh	Consultant Geriatrician and Physician	Medicine	19/05/2026	RS and KS Consultancy Limited - private practice 2 hours a week outside of NHS hours Unpaid clinical and academic advisor Royal Osteoporosis Society
mark robinson	Radiology consultant	Scheduled care	19/05/2026	Shareholder Rholben Radiology
Louise Webster	Consultant Anaesthetist	PACCT	19/05/2026	Nil Declaration
Ulfin Rethnam	Consultant Orthopaedic Surgeon	Trauma & Orthopaedics	19/05/2026	Director & Shareholder Zirzuri Ltd Private Practice St Joseph's Hospital since October 2018
Kavitha Pasunuru	Divisional Director	Family and Therapies	19/05/2026	A digital pilot tool that is being considered to improve children's neurodevelopmental pathway belongs to a company owned by a family member. I have not been involved in the decision making and have stayed away from this part of the work plan. I have no financial input or dealings with that company. I have submitted the potential conflict of interest to the RPB via the form that was requested. Private practice via online platform Psymplicity - paid Private practice Cyncoed Consulting Rooms - paid
Kenneth Dawson	Consultant Neurologist	Medicine	19/05/2026	Neurological private practice Dr Kenneth Dawson Neurological Services Ltd Shareholder Private practice from St Joseph's Hospital
Marion Schmidt	Consultant	Paediatrics	19/05/2026	Nil Declaration

Susan Carmichael	Public Health Principal	Corporate	19/05/2026	Unpaid - Gwent Sports Partnership - Active Gwent
Nimit Goyal	Consultant Radiologist	Clinical Services	19/05/2026	Shareholder NN Medical Services (6 years) Paid medical advisor for Mermaid Medical since January 2026
Lisa Forey	Head of Pharmacy, Operational Services	PCC	19/05/2026	Nil Declaration
Jemma Collins	Consultant Dermatologist	Surgery	19/05/2026	Jemma Collins Dermatology LTD-owner and director of company since September 2024. Own private company to do private dermatology work - no wage taken Chair of Welsh Skin Cancer Site Group
Andrew Hayward	8a Pharmacist	Primary Care and Network	19/05/2026	Nil Declaration
Anne-Marie Toms	Consultant Histopathologist	Cellular pathology	20/05/2026	Locum Consultant Histopathologist for CAVUHB
Dominique Murray	ICT Programme Manager	Digital Data and Technology	20/05/2026	Nil Declaration
Shaun Burgess	Senior Project Manager	Digital Data and Technology	20/05/2026	Nil Declaration
Prashanth D'sa	Consultant	Surgical, T&O	20/05/2026	Nil Declaration
Simon Wood	Consultant General Surgeon	Division of Surgery	20/05/2026	SW Surgery Ltd (since 2024) Personal Ltd company for private practice income, no other interests.Shareholder Private practice at St Joseph's Hospital since 2023, no conflict with NHS duties - paid/shareholder
Helen Davies	Professional Lead for Speech and Language Therapy in Neurodevelopmental service	CAMHS	20/05/2026	Nil Declaration
Makiya Ashraf	Consultant	Family & Therapies	21/05/2026	Nil Declaration
Rachel Cook	Senior Project Manager	DDAT	21/05/2026	Nil Declaration
Jarrod Vaughan Roberts	Directorate Pharmacist - ED	Primary care	21/05/2026	Nil Declaration
Rachel Harries	Pharmacist	Primary Care	21/05/2026	Nil Declaration
Cameron Rhys Forde	Advanced Pharmacist (8a)	Family + Therapies	21/05/2026	Nil Declaration
Meabh Cassidy	Pharmacist	PCC	21/05/2026	Nil Declaration
Shannon Cuthbertson	Principal of Intelligence	Public Health	21/05/2026	Nil Declaration
Rhiannon Bill	Clinical Psychologist	Unscheduled Care	22/05/2026	HenRhi Media Ltd, October 2025 - present - Shareholder
Dr Patrick Chance	Consultant Psychiatrist and Assistant Medical Director	MHLD	22/05/2026	Nil Declaration
Jane Hoidn	Principal Pharmacist Patient Services	Primary Care and Community	22/05/2026	Nil Declaration
Natalie Hazard	Principal Public Health Practitioner	Corporate	26/05/2026	Nil Declaration
Casey Keegans	Senior Nurse Band 8a	Mental Health	26/05/2026	Nil Declaration
Rachel Lewis	Seni9or Project Manager	Digital Data and Technology	27/05/2026	Nil Declaration
bill odonoghue	project manager	ICT Programme	27/05/2026	Nil Declaration
Thomas James Hughes	Clinical lead physiotherapist	Therapies	27/05/2026	Worked at St Joseph's Hospital as a hand therapist for around 10 years
Amanda Duggan	Pharmacy Manager YYF	Primary Care and Networks	27/05/2026	Nil Declaration
Christian Harris	Professional Lead Physician Associate	Medical Directors Office/Respiratory Medicine	28/05/2026	Nil Declaration
Alice Creasey	Occupational Therapist	Family and therapies	28/05/2026	Co-habiting partner is an employer for WHA Healthcare, ABUHB is one of their clients - I have no personal involvement
sian chard	Deputy General Manager Families and Therapies	Families and Therapies	29/05/2026	Nil Declaration
Tonia McGinty	Psychological Therapist	MHLD	01/06/2026	Work as a Pstchologist through a sub contracting employment for Health Harmonie Minds
Cerys Ridley	Lead Pharmacist Clinical Specialties	Primary Care	01/06/2026	Nil Declaration
David Richard Lewis	Consultant Vascular Surgeon	Scheduled Care	01/06/2026	D R Lewis Vascular Specialist Services Ltd Since 2017 - Director & Shareholder Paid private practice at St Joseph's Hospital and Veincentre Cardiff
richard Francis	Principle Public Health Practitioner	Corporate	01/06/2026	Nil Declaration
Gemma Burns	Joint Head of Child and Family Psychology and Therapies Service	Family and therapies	01/06/2026	Shareholder with Practice Solutions Ltd Paid private practice as a clinical psychologist since 2013
Cerys Rackham	Antimicrobial Pharmacist	Pharmacy	02/06/2026	Nil Declaration
Kirsty Thomas	Deputy Directorate Manager Specialist MH & LD Services	MHLD	03/06/2026	Nil Declaration
esther lowe	deputy directorate manager	mental health	03/06/2026	Nil Declaration

Emily Louisa Rea	Consultant in Palliative Medicine	Primary care	03/06/2026	Nil Declaration
Hayley Rose	Operational Lead Nurse in Heart Failure	Medicine	04/06/2026	Shareholder with ZRB Property Ltd Voluntary Nurse Forum Member with British Society of Heart Failure
Stacie Clarke	Programme Support Officer	Digital Data & Technology	04/06/2026	Nil Declaration
David Bosanquet	AMD for R&D, consultant vascular surgeon	Surgery	05/06/2026	Previous consultancy provided to Ennogen Ltd. Recent contact by compnay (non costed) to discuss recruitment to study - I directed them to R&D ABUHB. I will have no direct engagement with feasability assessment or decision as to if to engage with recruitemnt - previously paid, most recent meeting unpaid
Rebecca Carpenter	Head of Audiology	Surgery	08/06/2026	Private Earwax removal since April 2023 - paid
Caroline Mills	Consultant Dermatologist	Scheduled care	09/06/2026	Skin Clinic LTD >10 years - Shareholder Chair of the Medical Advisory Committee & Member of the Quality and Safety Committee St Joseph's Hospital
Uzayr Mahmood	Palliative Care Specialty Doctor	Primary and community care	09/06/2026	UN Mahmood Ltd since 06/06/2026 - shareholder & director. Conducting medicolegal work facilitating claims brought under RTA small claims
Kellie Turner	Lead clinical psychologist, CANDWR	Child and family psychology, family and therapies	09/06/2026	Rogue and Bard shareholder since 2019 - make and sell table top gaming merchandise Unpaid - Involved with Psychologists for social change - casually. In what's app group about topics of interest, and have in the past contributed to letters or consultations around key topics like mental health, psychosocial wellbeing, race, disability, trauma. Own a very small polymer clay jewellery hobby business and volunteer in the craft shop where they sell one day a month - on a non working day.
Suzanne Bryant	Head of Occupational Therapy Services	Family & Therapies	10/06/2026	Nil Declaration
elizabeth Jane Hallett	Lead pharmacist primary care	primary care	11/06/2026	Vice president Royal College of Pharmacy/Chair Welsh Pharmacy Advisory Council of the royal college of pharmacy . Elected Trustee of the Royal College Of Pharmacy - unpaid
Lisa Orford-Morgan	Senior Communications Officer	Communications	11/06/2026	Morf Designs Limited - Paid Director for 27 years
monika elzbieta beauchamp	consultant in cellular pathology	pathology	12/06/2026	Little Garth Management Compant Limited - unpaid
Rhys Thomas	Digital Logistics and Inventory Officer	DDAT - Digital Business Unit	12/06/2026	Nil Declaration
Mason Evans	Digital Procurement Officer	Digital Data and Technology	12/06/2026	Nil Declaration
Gareth Lewis	Head of Financial Services & Accounting	Corporate Finance	12/06/2026	Nil Declaration
Joanna Doyle	Head of Nursing	Family & Therapies	16/06/2026	Nil Declaration
Bronwen Elizabeth Lesley Davies	Consultant Clinical Psychologist	MH and LD	16/06/2026	Private therapy two evenings a week - paid
Roxanne Green	Head of Service Planning	Strategy, Planning & Partnerships	17/06/2026	Stori Housing Association - Non Exec Director (Voluntary Position for 2 years) Roxanne Green Management & Consultancy - provision of ad hoc consultancy support outside of South East Wales - Shareholder
Gemma Wyatt	Practitioner Psychologist	Adult Psychology	17/06/2026	Occasional work behind bar in festivals and provide welfare support - through Workers Beer Company & TLC Welfare - paid and voluntary depending on role
Jack Robinson	Commercial and Contract Manager	Estates and Facilities	18/06/2026	Nil Declaration
Leanne Miles	Contracts Manager - Estates & Facilities	Estates & Facilities	18/06/2026	Nil Declaration
Fern Rideout	Contract Manager	Estates & Facilities	18/06/2026	Nil Declaration
Rachel Munday	Senior Nurse Theatres	Clinical Support Services	19/06/2026	Private practice as Surgical assistant since 2008 to date - self employed to work with consultant surgeon, not an establishment - paid
Sarah Challenger	Older Adults Lead Arts Therapist	Mental Health and Learning Disabilities	22/06/2026	British Association of Art Therapy 2019-2020, 2022-present - Paid: honorarium Self employed as an Art Therapist 2018- present - paid University of South Wales lecturer 2018-present - paid
Carys Barnfield	Clinical Psychologist	Child and Family Psychology	25/06/2026	Nil Declaration
Thomas Owen	GMS Contract Manager	Primary Care	26/06/2026	Nil Declaration
Jan Sniatecki	Consultant Ophthalmologist	Ophthalmology	30/06/2026	Sponsored by Visufarma attendance at EuDEC conference in Milan 18-20/6/2026 conference fees, travel and accomodation paid by Visufarma Self employed - providing consultations and surgery for patients at Vale Eye Surgeons private eye clinic
Lauren Carson	Pharmacist	Primary Care an Community	30/06/2026	Nil Declaration
Huw Robert Griffiths	Clinical Lead Physiotherapist 8a	Families and Therapies, Physiotherapy	01/07/2026	Paid to talk at a conference on a single occasion by a private heathcare equipment provider.
Elena Smith	Band 5 physiotherapist	Rotational	01/07/2026	Cherry Tree estate agency 2022
Simon Green	Transport Officer	Estates and Facilities	03/07/2026	Nil Declaration

Sarah Albert	Frailty Pharmacist	Pharmacy	06/07/2026	Nil Declaration
Nirmal James	Consultant, Emergency Medicine	Urgent care	06/07/2026	Nil Declaration
Lucy Gwillim	Clinical and Operational Lead	Family and Therapies	06/07/2026	Nil Declaration
Sally Grimm	Dietetic assistant Practitioner	Dietetics	07/07/2026	Ty Melin Bakery November 2025-Present Paid Position
Lynne Robinson	Senior OT	Family and Therapies	08/07/2026	Director of JLR Legacy Properties - paid and shareholder Director of Pearl Heritage Properies - Paid and shareholder Self employed OT since May 2025 - no company name - paid Self-employed teacher for the Mini Movement and the Sunshine Movement since Feb 2023 - Paid
Deb Jackson	Divisional Nurse	Family and Therapies	08/07/2026	Nil Declaration
Rachel Raymond	Clinical Lead and service manager for Public Health Nursing	Family and Therapies	08/07/2026	Nil Declaration
Rhiannon Jenkins	Senior Nurse Community Children's Nursing Service	Family and Therapies	08/07/2026	CTMUHB - staff bank occasional bank work on a Saturday morning undertaking ND assessments
Clare Elizabeth Badger	band 8a Senior Nurse	Family and therapies	08/07/2026	Nil Declaration
Adam Brian Edwards	Operational and clinical Lead Forensic Camhs (8a)	Families and Therapies	08/07/2026	Nil Declaration
Hayley Jones	Senior Nurse - Health Visiting	Family and Therapies	09/07/2026	Nil Declaration
Tracey Redwood	Support Services Manager	Estates & Facilities	10/07/2026	Nil Declaration
Abigail Ceesay	Band 7 Clinical Specialist Physiotherapist in Acute Medical Inpatients	Families and Therapies	10/07/2026	Transport for Wales - 6 month contract
Andrew Hawarden	Lead Antimicrobial Pharmacist (Secondary Care) 8B	Primary Care and Community	10/07/2026	Sister works for Bristol Myer Squibb
Saneesh Chacko	Registered Mental Health Nurse-Psychiatric Liaison Team GUH	Adult Mental Health	13/07/2026	I am planning to undertake small amount of private Cognitive Behaviour Therapy(CBT) work during my days off. The private work is on self employed/freelance basis.
Jordan Royal	Service Development Lead	Public Health	13/07/2026	Torfaen Voluntary Alliance July 2026 - Ongoing. Unpaid trustee
Rachael Davies	Speech and Language Therapist	F+T	15/07/2026	Magistrate - Gwent bench since September 2022 - ongoing. Unpaid
Elizabeth Jenkins	Lead Pharmacist for Diabetes	Primary Care and Community	16/07/2026	Nil Declaration
Clare Payne	Senior Nurse	Family & Therapies	17/07/2026	Nil Declaration
David Pope	Operational Lead	CAMHS F and T	20/07/2026	Nil Declaration
Alice Reed	Interim Clinical Director for Therapies	Family & Therapies	23/07/2026	Hospital Caterers Association - Wales & Merseyside Branch. Treasurer from Sept 2025 to present - will be stepping down to member only. Unpaid/Volunteer
Caroline Vaughan	Head of Nursing	Urgent Care	23/07/2026	Nil Declaration
Catherine Elizabeth Mcnamara	Optometric Advisor	Primary Care	23/07/2026	C.Mac Optics Ltd company director 19 years - Share holder
Janice Jenkins	Assistant Director of Digital Transformation	DDaT	23/07/2026	Nil Declaration
Claire Delduca	Consultant Clinical Psychologist	Clinical Support Services	23/07/2026	Private Psychological Therapy and HEIW funded therapy to Doctors in Training as an Associate for Hammet Street Consultants - past 6 years
JAMIE RICHARD MARCHANT	DIVISIONAL DIRECTOR	ESTATES AND FACILITIES	23/07/2026	Nil Declaration
Steven William Bonser	Associate Director of Operations (Patient Transportation Services)	Corporate - COO Team	23/07/2026	Directorship with Newport Masonic Hall since 11/01/2026 - unpaid
Amy McNaughton	Consultant in Public Health	Public Health	23/07/2026	Fellow of the Faculty of Public Health and registered on the UK Public Health Register
Claire Rockliffe-Fidler	Consultant Clinical Psychologist & Service Lead	MHLD	23/07/2026	Nil Declaration
Caley Hill	Consultant Clinical Psychologist	Mental Health & Learning Disability	23/07/2026	Nil Declaration
Lizzie Wilkinson	Education and practice development lead for OT	Family and therapies	23/07/2026	Nil Declaration
Gemma Mainwaring	Business Partner Accountant MH&LD	Corporate	23/07/2026	Nil Declaration

Dr Sarah Collett	Clinical Psychologist	Older Adult Psychology	23/07/2026	Name and Period of Involvement: Self employed as a psychologist in private practice since 2022 providing psychological assessment and therapy to people who are self funding or funded through health insurance (Bupa and WPA). I currently see a small number of clients outside my working hours at R&R consulting rooms in Cardiff or online by Teams - Paid (Self employed)
Jacqueline Reynolds	Medicines Management Pharmacist	Pharmacy	23/07/2026	I have in the past and may do so in the future accept sponsorship to attend educational conferences e.g Primary Care Respiratory Society UK Conference - costs covered for travel, hotel & conference Occasionally I am asked to chair or speak at Pharma company educational events . Companies include GSK, Astra Zeneca, Chiesi, Napp - Paid
Laura Dovey	Consultant Clinical Psychologist	Older Adult Mental Health	23/07/2026	Nil Declaration
Katie Jones	Band 5 rotational physiotherapist	Physiotherapy	23/07/2026	Paid employment with St Josephs Hospital from now onwards
Clare Conaty	Principal Optometrist	Surgical	24/07/2026	Robert E Lloyd Opticians Cardiff and Cowbridge 14 years - paid and shareholder Committee member for South East Wales Regional Optometric Committee
Siana Fflur	Band 8a Clinical Psychologist, Gwent Attachment Service	Child and Family Psychology and Therapies Service	24/07/2026	Nil Declaration
Stephanie Evans	Lead Midwife for Complaints and Concerns	Family and Therapies	26/07/2026	Little Roots Antenatal Education Myself and a colleague have entered into a partnership together teaching antenatal education. Paid - to commence immediately
Victoria Andrews	Research Midwife	Research & Development	26/07/2026	Little Roots Antenatal Education Myself and a colleague have entered into a partnership together teaching antenatal education. Paid - to commence immediately
Simon Line	Digital POrtfolio Manager	Digital Data and Technology	27/07/2026	Nil Declaration
Michael Pugh	Digital Programme Manager	Digital, Data & Technology	27/07/2026	Nil Declaration
Daniel Hern	Finance Business Partner	Finance	28/07/2026	Nil Declaration
Kye Smith	Deputy Head of QPS	Corporate Nursing	28/07/2026	Nil Declaration
Celia Satherley	Service Manager - Paediatrics & Neonates	Family & Therapies	28/07/2026	Nil Declaration
Helen Mitchell	Clinical Psychologist	Diabetes & Endocrinology / Clinical Health Psychology	28/07/2026	Nil Declaration
David Davies	Divisional Head OT MH&LD	MH&LD	28/07/2026	Nil Declaration
Daniel Madge	Senior Organisational Development Manager	Workforce and OD	28/07/2026	Board Member and Trustee at Children's Chronic Arthritis Association (CCAA
Aimee Holden	Deputy Head of Nursing	Division of Surgery	28/07/2026	Nil Declaration
Gareth Moran	Head Of Digital Service Management	DDAT	28/07/2026	Nil Declaration
Naomi Lang	Clinical Lead Physiotherapist	Family and therapies	28/07/2026	Nil Declaration
Sam Haworth-Booth	Head of Community Pathways	Family & Therapies	28/07/2026	Nil Declaration
Margaret Parrott	Cancer Services Directorate Manager	CSS	28/07/2026	Nil Declaration
Lynne Herring	Pharmacist	PRIMARY CARE AND COMMUNITY	29/07/2026	Nil Declaration
Lisa Jones	Consultant Neuropsychologist, CNRS	Family & Therapies	29/07/2026	Nil Declaration
Charles Cowtan	Clinical Psychologist	Child & Family Psychology and Therapies Service	29/07/2026	Prvate Practice outside of area I work in
Karla Hobbs	Snr. Nurse Professional Practice	Corporate Nursing	29/07/2026	Nil Declaration
Michael Harber	Programme manager	Digital, Data, & Technology	29/07/2026	Nil Declaration
Zoe Thomas	Digital Portfolio Manager	DDaT	29/07/2026	Nil Declaration
James Stevens	Cardiology Clinical IT Manager	Medicine	29/07/2026	Nil Declaration
Alison Kirton	Senior Nurse Education (corporate Nursing Team)	Nursing Directorate	29/07/2026	Nil Declaration
Claire Louise Grace	Clinical Lead CAMHS ND Service	Family & Therapies	29/07/2026	Nil Declaration
Lindsey Sara Whitehouse	Assistant Head of Financial Reporting	Corporate Finance	29/07/2026	Nil Declaration
Justin Jones	Assistant Head of Estates, Capital and Property Management	Estates and Facilities	29/07/2026	Nil Declaration
Helen Roberts	Senior Nurse End of Life and Bereavement	Corporate	29/07/2026	Nil Declaration
clair amos	surgical care practitioner	scheduled care t &o	29/07/2026	Nil Declaration

Tanya Strange	Head of Nursing	Nursing	29/07/2026	Nil Declaration
Wayne Burrows	Pharmacist	Pharmacy	29/07/2026	Nil Declaration
Kate Pronger	Senior nurse alcohol team	medicine	29/07/2026	K8 Aesthetics - paid
Deborah Scott	Senior Midwifery Manager	family and therapies	29/07/2026	DK Facial aesthetics - paid
Richard Stubbs	Risk Manager, Quality and Patient Safety	Medical Director's Division	29/07/2026	Nil Declaration
Sam Fagan	Senior Nurse Undergraduate Nursing and Midwifery	Corporate Education Team	29/07/2026	Nil Declaration
Christina Martin	Head of Business Development VBHC	VBHC	29/07/2026	Nil Declaration
Rachel Prangley	Head of Primary Care	Primary Care, Community Services and Complex and Long Term Care	29/07/2026	Nil Declaration
Ceri-Anne Wilkins	Mental Health Practitioner	CAMHS	30/07/2026	National Activity Providers Association (NAPA). Involved since 2019, marking work for NVQ students working in dementia specialised care homes - paid
Emma Poyser	SCP Orthopaedics	T&O	30/07/2026	Nil Declaration
aoife hall	Senior EPMA pharmacist	pharmacy	30/07/2026	Nil Declaration
Ruth Badham	Head of OD	WOD	30/07/2026	Nil Declaration
Lucy Wilkinson	Educational Psychologist	Child and Family Therapies Division	30/07/2026	Nil Declaration
Mikaela Swindon	EDI Manager	WOD	30/07/2026	It's Better Ltd & Kami Property Ltd - Shareholder
Star Moyo	Head of Equality Diversity and Inclusion	Workforce & Organisational Development	30/07/2026	Co-Founder of WeNpower Community Interest Company - Paid
Samantha Howells	Radiology Manager	Radiology, clinical support services	31/07/2026	Nil Declaration
Halina Jane Moulton	Caerphilly East NCN Pharmacist	Phamracy	31/07/2026	Spouse/Partner Gibson STS Ltd since 2022 - Paid Personal - Vauxhall Surgery since 2021 - Paid
Victoria Dixon	NCN Pharmacist Monmouthshire North	Primary Care & Community Services Leads and Heads of Service	03/08/2026	Nil Declaration
Dr Simon James Donovan	Deputy Medical Director Primary Community and Complex care	Primary Care	04/08/2026	Nil Declaration
Dr David Ian Williams	Clinical Lead in NHS P&I MH Programme secondment	Family & Therapies	04/08/2026	Nil Declaration
natalie stone	dermatology consultant	surgery	04/08/2026	Nil Declaration
Sanjit kumar singh	Consultant T&O	Scheduled Care	04/08/2026	Nil Declaration
Dr Sarika Goel	Consultant Paediatrician	Women and Child Health	04/08/2026	Nil Declaration
Suzanne Davies	Head of Referral & Booking Services	Digital, Data and Technology	04/08/2026	Nil Declaration
Chuen Yeow Poon	Consultant Neonatologist	Family and Therapies	04/08/2026	Nil Declaration
Rowena Christmas	Clinical Director	Primary Care	05/08/2026	Wye Valley Practice - GP Partner - Paid (independent contractor) RCGP Welsh Council Member 2018-current unpaid Former Chair RCGP Wales 2021-2026 was paid Member of Gwent LMC unpaid GP Appraiser - since taking on CD role I only appraise Welsh GPs who do not work in ABUHB area. GP Appraiser since 2010 Paid monthly Safeguarding Peer Support Group Chair for North and South Monmouthshire Clusters Paid quarterly Chair of National Safeguarding Primary Care Peer Support Group, meetings through Y Ty Dysgu site hosted by HEIW Paid biannually Occasional public speaking appearances Often pro bono, occasionally paid
Ravi Manikonda	Paediatric consultant	Child health	05/08/2026	Nil Declaration
Richard Goodwin	consultant dermatologist	surgery	05/08/2026	Cutest Systems Cardiff - paid trustee in local Cardiff-based charity "Seeds for the future" for more than five years - unpaid/voluntary single sponsored teaching presentation for L'Oreal for Cardiff GP VTS training December 2025 payment to dermatology department. Single sponsored teaching presentation for L'Oreal for GP Pulse meeting London 2026 - payment to "Seeds for the future" charity Chair All Wales Dermatology Forum and regional representative for British Association of Dermatologists
Paula Leanne Edwards	Ultrasound Services manager	clinical support services	05/08/2026	PLE Scanning est April 2025 - paid Ultrasound scanning (ad hoc Weekends) since April 2026 - paid

Mr. Paul T. Hak	Consultant Trauma and Orthopaedics	Surgery	06/08/2026	Paid faculty member on course ran by Medartis UK - NHS implant supplier Private practice for Hand Surgery Trauma and Orthopaedics from April 2025 to present - paid
cerys sibley	Lead nurse primary & community care academy, Nurse manager Brynmawr wellbeing center	primary & community	07/08/2026	Nil Declaration
Jennifer Rankin	Consultant Psychiatrist	Mental Health	10/08/2026	Transition Point Coaching - I am beginning to develop a private coaching and mentoring company which I will lead - paid
jane gwilliam	consultant in EM	unscheduled care	10/08/2026	Husband is an area manager for novo nordisk - paid
Abby Waters	Senior Team Lead Nurse- R&D	Coorporate	10/08/2026	Nil Declaration
Craig westwater	Advanced critical care practitioner	Cssd	10/08/2026	Nil Declaration
Darielle Michaela Cox	Pharmacist Prescribing Advisor	Primary Care	10/08/2026	Nil Declaration
Kayleigh Poulsom	Care Home Pharmacist	Primary Care	10/08/2026	Nil Declaration
Katie Stradling	Pharmacy Technician	Aneurin Bevan Health Board	11/08/2026	Nil Declaration
Helen Hak	Strategic Clinical Lead Occupational Therapist for Stroke	Family and Therapies	11/08/2026	Nil Declaration
Helen Mayo	Pharmacy Technician Primary Care	Primary Care Pharmacy ABUHB	11/08/2026	Nil Declaration
Georgette Morrison	Clinical Psychologist	Continuing care	12/08/2026	Nil Declaration
Megan Jean Way	Care Home Pharmacy Technician	Primary Care	12/08/2026	Nil Declaration
Christopher Phillips	Service Manager	DDaT	12/08/2026	Admin bank position outside of AB in PTHB - paid
Henry Barnard	Physiotherapist	Rotational	13/08/2026	Weekend physiotherapy work with Spire Bristol - paid
Linda Collis	Professional Lead for Band 5 and Rotational Band 6 Physiotherapists	Family and Therapies	13/08/2026	Interior Design business started June 2026 outside of contracted hours - paid & unpaid
Ryan Davies	Consultant ophthalmologist	scheduled care	13/08/2026	Private practice at St Joseph's since 2022 - paid
Bethan Scoberg	clinical psychologist	child and family psychology	13/08/2026	Nil Declaration
Sally Fung Yee Lau	Advanced Clinical Pharmacist	Primary care	17/08/2026	Nil Declaration
Sarah Collett	Clinical Psychologist	Older Adult Mental Health	18/08/2026	Name and Period of Involvement: Self employment- I have carried out private work offering psychological assessment and therapy from 2022 and ongoing - paid
Zoe Haggerty	A Shift Lead in GPOOH	Urgent care	19/08/2026	Bequestme - owner/director in setting up stage, unpaid at present
Rhianon Reynolds	Consultant Ophthalmologist / ADD surgery	Surgery	19/08/2026	British & Eire Association of Medical Retina Specialists (BEAMS) founding member & Trustee - unpaid 2023-current - consultant for Roche Pharmaceutical - paid Travel sponsorship deom Roche to attend Ophthalmology Conferences Private Practice - St Joseph's and Nuffield Cardiff Bay - paid Withdrawal from Book an Eye Doctor
Joanne Butler	Deputy Finance Business Partner Accountant	Family & Therapies	20/08/2026	Nil Declaration
Angela Grivas	Clinical and Strategic Lead Occupational Therapist - CAMHS	F&T	20/08/2026	Nil Declaration
Lilia Delgado Vazquez	Deputy Head of Health, Safety & Fire	Allied Health Professionals and Health Science	21/08/2026	Nil Declaration
Stacey Harris	Advanced Neonatal Nurse Practitioner	Family and therapies	25/08/2026	Nil Declaration
Christopher Jones	Head of Nursing MHLD	MHLD	25/08/2026	Nil Declaration
tamsin jackson	antimicrobial and prison pharmacist	pharmacy	25/08/2026	Nil Declaration
Louisa Edwards-Brown	Research Radiographer	Clinical Support Services	26/08/2026	Paid work as a Bank Radiographer with Cwm Taf UHB January 2026-present
Guuleed Jama	Dietitian	Weight Management	27/08/2026	Self-employed private dietetic practice starting end of September 2026
Sharon Davies	Senior Business Support Manager	MHLD	01/09/2026	Works with clinical commissioning and has a family member that is funded by commissioned services - no professional contact
Anna Knapik	Counsellor Band 6	ABUHB PCMHSS Caerphilly Team	01/09/2026	Private counselling practice set up in 2022 but started accepting new clients July 2026
Laura Pardo	Clinical Psychologist	Mental Health and Learning Disabilities - Older Adult	02/09/2026	Nil Declaration
Rebecca Urrutia	ANNP	Family and Therapies	03/09/2026	Nil Declaration
Angharad Thomas-Edwards	Advanced Neonatal Nurse Practitioner	Family and Therapies	03/09/2026	Nil Declaration

Owen Thomas	Anaesthetic Consultant	PACCT	04/09/2026	Member of Birmingham Medical Research Expeditionary Society (BMRES). Charitable status - upaid voluntary work
Macauley Purchase	Rehab Coordinator	Community Pathways	09/09/2026	MPC Coaching 9 months - paid
Sharon Thomas	Rehab Coordinator	MSK	09/09/2026	Flow & Strength with Sharon - paid
Lois Farndale	Rehab Coordinator	Aneurin Bevan Health Board.	09/09/2026	Nil Declaration
Catrin Houston	Physiotherapy Senior Technician	Family and Therapies	10/09/2026	Shareholder Catnip company Catrin Houston Massage Therapy since 2018 - paid
Renee Edwards	Rotational physiotherapist	Band 5	11/09/2026	Nil Declaration
Elizabeth Taylor	Assistant Psychologist	Child and Family Therapies	14/09/2026	Nil Declaration
Dawn Marie Thomas	Counsellor	Primary care mental health team	14/09/2026	Private counselling service - paid Mind & Body Consultancy 10 years - paid
Leah Louise Wright	Advanced Neonatal Nurse Practitoner	Family therapies (NICU)	17/09/2026	Occasional voluntary support with Charity Ei SMART
Catherine Louise Harrigan	Specialist Biomedical Scientist	Pathology	18/09/2026	SNAP Cymru ALN advocate - paid employment due to end 30 November
Theresa Salkeld	PCMHSS Team Lead	Mental Health and LD	21/09/2026	Nil Declaration
Christopher Ian Jenkins	Consultant	Surgery	21/09/2026	Nil Declaration
Jonathan Paul Simms	Clinical Director of Pharmacy	PCC	21/09/2026	Nil Declaration
Rebecca Butler	NCN Pharmacist	Medicines management	22/09/2026	Nil Declaration
Ian Williamson	AMD Cancer Services	Clinical Support Services	22/09/2026	Nil Declaration
Darren Kempson	Band 6 Mental Health Practitioner (RMN)	Mental health	22/09/2026	Nil Declaration
sharon withers	HCSW	family and therapies	23/09/2026	Nil Declaration
Florica Serafina Musi	CD UPC24/7	Primary Care and Comunity	23/09/2026	Nil Declaration
Melissa Morgan	Practice-based Pharmacist	Caerphilly North NCN	23/09/2026	Nil Declaration
Clare Tibbatts	Consultant gastroenterologist	Medicine	23/09/2026	Foliaki Family Company - 10 years private practice BSG IBD Committee - Charity/Voluntary
Katie louise Axe	Consultant Gastroenterologist, Clinical Director Gastroenterology	Medicine	23/09/2026	Co-Chair of LGBTQIA+ ABUHB staff network Fellow panel member for National Royal College of Physicians ethics board
Amanda Head	Clinical Director Primary Care	Primary Care	23/09/2026	Nil Declaration
Jane Thomas	Aneurin Bevan University Health Board	Primary Care & Community	27/09/2026	Nil Declaration
Alun Walters	Clinical Director Primary Care	Primary care and community	28/09/2026	Nil Declaration
Amy Hayman	Practice Development Midwife	Maternity/ Families and therapies	28/09/2026	Freelance pilates instructor - paid Own business Onyx pilates and work for Flow House Studio
Emma Heron	Research Lead Nurse	Corporate	29/09/2026	Spouse/partner will be employed by NHS Wales Performance & Improvement as Head of Corporate Business
Rhys Hewett	Consultant Gastroenterologist	Medicine/Gastroenterology	02/10/2026	Energeia Medical Ltd since Oct 2023 - Shareholder Private Medical Practice at Spire Hospital Cardiff
Judith Johnson	Senior ANNP	Family and Therapies Division	02/10/2026	Nil Declaration
Sarah Harris	Clinical Psychologist	Family and therapies	02/10/2026	Nil Declaration
Marek Czajkowski	Consultant Hepatologist	Medicine	05/10/2026	Chiron Healthcare Ltd - private healthcare at St Joseph's Hospital - Shareholder Have undertaken paid consultancy work for COOK medical and CREO - endoscopy manufacturers, as part of an evaluation of new devices - paid Ad hoc teaching/training with COOK, max 10 hours contract since 2024 Private practice at St Joseph's Hospital since 2007, fees paid into Chiron Healthcare
Hayley McNamee	Senior Counselling Psychologist	Psychology	07/10/2026	Registered as Electro Design Lab Ltd, trading as MEDL. Employment as Talent and Develepmont Director from 1st September 2026 - Paid
Rachel Watkins	Advanced Neonatal Nurse Practitioner	Family and Therapies	13/10/2026	Nil Declaration
Lauren Blackstock	Senior Occupational Therapist	Family and Therapies	13/10/2026	Koum Therapies, working as a self-emplyed Occupational Therapist - Paid/Shareholder
Shannon Davis	Referral and Booking Team Leader	Digital, Data & Technology	14/10/2026	Nil Declaration
Ceri Stiles	Partial Booking Clerk	Data and Technology	14/10/2026	Nil Declaration
Justine Crockett	Business Support Manager	Digital Data & Technology	14/10/2026	Nil Declaration
Jodi Edwards	team Leader	digital data	14/10/2026	Nil Declaration
Tammy Jayne Cork	Booking Clerk	Health Records	14/10/2026	Nil Declaration
Beverley Ann Paginton	booking clerk	health records	14/10/2026	Nil Declaration
Emma Townsend	Booking clerk	Referral booking Centre	14/10/2026	Nil Declaration

LISA LEWIS	Validation Clerk	Digital Data & Technology	14/10/2026	Nil Declaration
Katie Harris	Business Support Manager	Digital Data and Technology	14/10/2026	Nil Declaration
Kate Fisher	Booking Clerk	Digital, Data and Technology	14/10/2026	Nil Declaration
Paige Andrews	Partial Booking Clerk	Digital Data and Technology	14/10/2026	Nil Declaration
Saira Ibrahim	Team Leader, and Booking Clerk	Digital, Data & Technology	14/10/2026	3 contracts with Aneurin Bevan - all paid
Jazzmin allen	booking clerk	Health records	14/10/2026	Nil Declaration
Chloe Scarfe	B6 Physiotherapist	YYF physiotherapy	15/10/2026	Brecon RFC 1 year involvement - paid
Bridie Stone	Clinical Practitioner Psychologist	Child and Family Psychology and Therapy Service	15/10/2026	Nil Declaration
Lee Jones	NCN Pharmacist	Newport West - Pharmacy	15/10/2026	Nil Declaration
Jillian Moore	NCN Clinical Pharmacist	Newport West NCN	15/10/2026	Nil Declaration
Sally Griffiths	Assistant Business Partner Accountant	Finance	15/10/2026	Nil Declaration
Lisa edwards	Senior Nurse	Surgery	15/10/2026	Nil Declaration
Louise Mellen	Service Manager	Specialist Mental Health support services and Learning disabilities	15/10/2026	Nil Declaration
alex simpson	pharmacist	primary care and communities	15/10/2026	Nil Declaration
Lorna Allcock	MHLD Head of Business and Performance	MHLD	15/10/2026	Nil Declaration
Emma Powell	Clinical & Operational Lead Primary CAMHS & CET	F&T	15/10/2026	Nil Declaration
Julia Schooley	Directorate Manager Acute Medicine	Medicine	15/10/2026	Nil Declaration
Sarah King	Head of Corporate Information	Corporate Governance	15/10/2026	Nil Declaration
Claire Fluck	Senior Nurse	CSS	15/10/2026	Nil Declaration
Laura Estelle Thomson	Deputy head of Nursing, Education, Development & Regulation	Corporate Nursing	15/10/2026	Nil Declaration
Rachel Challenger	Senior Nurse Surgery	DOS	15/10/2026	Nil Declaration
Shelley ann langmead	ANNP	Families and therapies	15/10/2026	Nil Declaration
Hannah Henson	Professional Clinical Lead	Family & Therapies	15/10/2026	Nil Declaration
Richard	Ellis	Adult Mental Health	15/10/2026	Nil Declaration
Sharon Lord	Team Leader	Digital, Data and Technology	15/10/2026	Nil Declaration
Olivia Colleypriest	Professional Manager Weight Management	F&T	15/10/2026	Nil Declaration
Ashley James Davies	Planning and Service Development Manager	Family & Therapies	15/10/2026	Nil Declaration
Amanda Biddle	Joint Professional Head of Occupational Therapy	Adult Mental Health	15/10/2026	Nil Declaration
Dijo Daniel	Clinical Endoscopist	Medicine	15/10/2026	Nil Declaration
Helen WIliams	Senior Nurse	Surgery	15/10/2026	Nil Declaration
Kylie Crook	QPS Manager	Corporate nursing	15/10/2026	Nil Declaration
Leanne Huish	Assistant Operational Manager	Urgent Care	15/10/2026	Nil Declaration
Steffan Wells	Senior Nurse	Primary and Community Care	15/10/2026	Nil Declaration
Alan Francis Sweeney	Physiotherapy Operational Manager	Family & Therapies	15/10/2026	Nil Declaration
Tracey Smith	Children's Centre Manager and Operational Lead for SPACE Wellbeing, NESH & ISCAN	Family & Therapies	15/10/2026	Nil Declaration
Amy Brunnock	Head of Engagement	Corporate Services	15/10/2026	Nil Declaration
Yvonne Copestake	Workforce Business Partner	Workforce & Organisational Development	15/10/2026	Nil Declaration
Carly Pollard	Clinical Mental Health Pharmacist	Pharmacy	15/10/2026	Nil Declaration
Haf Jones	Assistant Head of Legal Services	Corporate Nursing	15/10/2026	Nil Declaration
Rhiann Williams	Assistant Head of Financial Services	Financial Services	15/10/2026	Nil Declaration
Joel Amphlett	Senior Nurse	mhld	15/10/2026	Nil Declaration

Claire-Le-Anne Parkes	Senior Nurse	urgent care	15/10/2026	Nil Declaration
Karen Shapcott	Deputy Directorate Manager	Mental Health and Learning Disability	15/10/2026	Nil Declaration
ROBERT JOHN CALLEN-DAVIES	DIRECTORATE MANAGER	MENATL HEALTH & LEARNING DISABILITY	16/10/2026	Mindfulness Wales 6 years Trustee & Treasurer
Bethan Golding	Clinical Psychologist	MHLD	16/10/2026	Nil Declaration
Kwok Tung Tsang	Band 8a clinical pharmacist	NCN Newport	16/10/2026	Nil Declaration
Katie Watkins	Senior nurse	mental health and learning disabilities	16/10/2026	Nil Declaration
Rhiannon Griffiths	Clinical Lead Physiotherapist for Pelvic Health	family and therapies	16/10/2026	Nil Declaration
Clare Small	Senior Programme Manager	Corporate	16/10/2026	Nil Declaration
Paul Walding	Deputy Head of Nursing	Primary Care and Community	16/10/2026	Nil Declaration
Sarah Roberts	Pathology Governance Manager	Clinical Support Services	16/10/2026	Nil Declaration
Arian Howells	Directorate Manager in Emergency Medicine	Urgent Care	16/10/2026	Nil Declaration
Thomas Chinnick	Blood Science Manager	CSS	16/10/2026	Nil Declaration
Dawn Baker Lari	Directorate Manager - General Surgery	Surgery	16/10/2026	Nil Declaration
Bethan Williams	Consultant Radiographer	Breast Care	16/10/2026	Nil Declaration
Adele Griffiths	Allied Health Professions Consultant in stroke	Family and Therapies	16/10/2026	Nil Declaration
Bonita Overland	Directorate Manager	Surgical Division	16/10/2026	Nil Declaration
Hayley Griffiths	Consultant Clinical Psychologist	MH&LD	16/10/2026	Nil Declaration
James Dalton	Finance Business Partner	Finance	16/10/2026	Nil Declaration
Lucy Kings	Head of Nursing	Primary, Community and Complex care	16/10/2026	Nil Declaration
Sarah Flowers	Consultant Clinical Psychologist	Family and Therapies, Symptom Management	16/10/2026	Monmouth Christmas Lantern Parade Committee Member 2022-Current Unpaid Appointed to the Clinical Advisory Panel for the Infected Blood Compensation Authority - paid up to 15 days a year
Susan Palmer	Head of Research Delivery	Corporate	16/10/2026	Nil Declaration
Caroline Frances Rowlands	Deputy Head of Quality Safety and Learning	Corporate Nursing Directorate	16/10/2026	Nil Declaration
Stacey Wetherell	Pathology Performance & Operations Manager	CSS	16/10/2026	Nil Declaration
Kerian Buck	Deputy Head of Physiotherapy	F&T	16/10/2026	Nil Declaration
Lynsey Hook	Deputy Head of Nursing	Medicine	16/10/2026	Nil Declaration
Emma-Jayne Hagerty	Eating Disorders Clinical Lead	Mental health and learning disabilities	16/10/2026	The British Eating Disorders Society Charity - trustee since February 2025
Christopher Williams	ICT Operations Manager	Digital Data and Technology	16/10/2026	Nil Declaration
James Marinus van Gemeren	Divisional Pharmacist for Surgery	PC&C - however note I work in Secondary Care Pharmacy	16/10/2026	Nil Declaration
Bronwen Davies	Clinical Psychologist	MH and LD	16/10/2026	Active Psychological Solutions - Director/Own Business since 2020
Stacey Clarke	Programme Support Officer	DD&T	16/10/2026	Independent Travel Agent, paid - 2 months
Amy Davies	Band 8a Physiotherapy Clinical Lead for Medical Rehabilitation	Physiotherapy	16/10/2026	Nil Declaration
Laura Green	Assistant Psychologist	Adult Psychology - Homelessness	16/10/2026	Nil Declaration
Howard Stanley	Head of Safeguarding	Nursing	16/10/2026	Nil Declaration
Ian Thomas	Directorate Manager	Mental Health & LD	16/10/2026	Nil Declaration
Gordon Devoir	Business Partner Accountant - Family & Therapies	Finance	16/10/2026	Nil Declaration
Louise Michelle Harvey	Assistant General Manager	Division of Surgery	16/10/2026	Nil Declaration
Jodie Collins	Deputy Head of Primary Care	Primary and Community Care	16/10/2026	Nil Declaration
Sian Allen-Hitchen	Finance Manager	Finance	16/10/2026	Nil Declaration
Sophie Lewis	Deputy Finance Business Partner	Corporate - Finance	16/10/2026	Nil Declaration
Rachel Vaughan	Clinical Psychologist/Clinical Lead	WOD	16/10/2026	Nil Declaration
Jane Thornton	Site Lead for Medicine YYF	Medicine	16/10/2026	Nil Declaration

Amelia Ince	Senior Practitioner Psychologist	WOD - Employee Wellbeing	16/10/2026	Employment with UWE Bristol since 2023 - Paid
Brandon Kayat	Band 7 Practitioner Psychologist	ABUHB Homelessness Mental Health Hub	16/10/2026	Owner of Clarity Mind Therapy (Private Practice) since September 2025 - Paid
Owain Sweeting	Head of Business & Performance	Primary Care & Community	16/10/2026	Nil Declaration
Julie Morris	Interim Deputy Head of Service Dietetics	Therapies	16/10/2026	Nil Declaration
Rebecca Knight	Clinical Band 7 Critical Care Outreach Practitioner	Clinical Support Services	17/10/2026	Newport Rodney Parade Medic started 10/10/2026 - Agency part time work
Rhys Shorney	Head of Facilities	Estates & Facilities	17/10/2026	Prime Recovery & Movement - sports massage therapy - currently unpaid but will be paid from January 2027
Leeanne Lewis	Assistant Director for Quality and Patient Safety	Corporate Medical Director QPS	17/10/2026	Nil Declaration
Rhys Monk	Assistant General Manager	Division of Surgery	17/10/2026	Nil Declaration
Angela Whitaker	Clinical Lead Optometrist	Ophthalmology	18/10/2026	Currently employed by Moorfields Eye Hospital part time as Principal Optometrist - paid
Scott Taylor	Head of Health, Safety & Fire	Director of AHPs & Health Science	18/10/2026	Nil Declaration
Trisha Edwards	Head of Service, Monmouthshire Borough	Primary Care & Community Division	19/10/2026	Nil Declaration
Lucy Davies	Finance Business Partner - Urgent Care	Finance	19/10/2026	Nil Declaration
Olivia Bishop	Band 8a Pharmacist	Primary care	19/10/2026	Nil Declaration
Ruth Madine	Senior Workforce Business Partner	Workforce and OD	19/10/2026	Nil Declaration
Caroline Schanzer	Head of Application Development	DDaT	19/10/2026	Nil Declaration
Francine Ruckledge	Principal Clinical Psychologist	Mental Health and Learning Disabilities, Adult	19/10/2026	Nil Declaration
Adam Suter	Application Architect	Digital Data & Technology	19/10/2026	Nil Declaration
Christopher Guy Garner	Interim GM Urgent & Emergency Care	U&EC	19/10/2026	Nil Declaration
Amy Dolben	Assistant Director of Partnership & Integration	Planning	19/10/2026	Nil Declaration
Ellen Revell	Principal Clinical Psychologist, NC CMHT	Mental Health and LD	19/10/2026	Nil Declaration
Michael Thomas	Head of Business Delivery - Value Based Healthcare	Finance	19/10/2026	Nil Declaration
Sarah Griffiths	Deputy Finance Business Partner	Corporate	19/10/2026	Nil Declaration
Bethan Webster	Physiotherapy Operational Manager	Family and Therapies	19/10/2026	Nil Declaration
Moira Elizabeth Bevan	Head of Service - Infection Prevention	Corporate	19/10/2026	Nil Declaration
Samantha Jane Murray	Senior Nurse Infection Control	Nursing Corporate	19/10/2026	Nil Declaration
lyndsey Ward	Consultant Nurse	medicine	19/10/2026	Nil Declaration
Emma Lloyd	Principal Clinical Psychologist	Mental Health and Learning Difficulties	19/10/2026	Nil Declaration
Delun Davies	8a Pharmacist	Pharmacy	19/10/2026	Nil Declaration
Clare Greenhalgh	Principal Clinical Psychologist	MH & LD	19/10/2026	Nil Declaration
Natalie Simon	Clinical Psychologist	Psychology - Adult Mental Health	19/10/2026	Nil Declaration
Lisa Ingleson	Finance Business Partner Accountant	Finance	19/10/2026	Nil Declaration
Andy Warburton	Assistant Director of Digital Applications and Development	DDAT	19/10/2026	Nil Declaration
Megan Angharad Corns	Physiotherapy Education, Learning and Practice Development Lead (AFC Band 8a)	Family and Therapies	19/10/2026	Nil Declaration
Nicholas Price	Counsellor	PCMHSS	19/10/2026	Private Practice offering psychotherapy to clients since July 2022 - Paid
Craig Roberts	Assistant Director of Allied Health Professions & Health Science	Corporate	19/10/2026	Nil Declaration
Bethan Kate Lewis	Booking Clerk	RBC	19/10/2026	Nil Declaration
Claire Louise Kellaway	Clinical Lead Physiotherpist	Family and therapies	19/10/2026	Nil Declaration
Jacob Lovell	Contracts Officer	Research and Development	20/10/2026	Full time employed by Deel HR as a Sales Development Representative
Susan Jefferiss	Assistant Operations Manager	Urgent Care	20/10/2026	Nil Declaration
Melissa Blow	Deputy head of podiatry and orthotics	Family and therapies	20/10/2026	Nil Declaration
Naheed Ashraf	Unpaid Carers Lead	Planning	20/10/2026	Active Lives Community Group since July 2024 - unpaid
Lucy Wilkinson	Educational Psychologist	Child and Family Therapies	20/10/2026	Nil Declaration

Helenna Parfitt	Referral and Booking Centre Team Leader	Digital, Data and Technology	20/10/2026	Nil Declaration
Daniel Loder	Clinical Endoscopist (8a)	Unscheduled	20/10/2026	Nil Declaration
Heather Garrard	Physiotherapy Operational Manager	Family and Therapies	20/10/2026	Nil Declaration
Michael Charles	Assistant Psychologist	Child & Family Therapies	20/10/2026	Trustee for a CIO called Side by Side - unpaid Paid via invoice through a RIF funded service within the NHS to support groups of dads (Dads Group Gwent) and co facilitate a parent course called EPAtS - paid
Robert Brooks	Psychologist 8b	Child & Family Psychology	20/10/2026	Nil Declaration
Annie Lewis	Head of Nursing	PC&CD	20/10/2026	Nil Declaration
Stacey Mahoney	Senior Workforce Planning Manager	Workforce and OD	20/10/2026	Nil Declaration
Stephenie Hubbard	Joint Professional Manager Acute Dietetics	Family & Therapies	20/10/2026	Nil Declaration
Ryan Hobbs	Consultant in Emergency Medicine	Urgent Care	20/10/2026	Nil Declaration
Cheryl Hegarty	service deputy lead	ABUHB MHLD	20/10/2026	Nil Declaration
Mohan Babu Muthuswamy	Consultant in Anaesthetics and Intensive Care	CSS	20/10/2026	Nil Declaration
Joe Wah Loong	Pharmacist	Pharmacy	20/10/2026	Nil Declaration
Andrew Michael Phillips	Consultant Gastroenterologist	Medicine	20/10/2026	Nil Declaration
Kaushik Rajamani	Clinical director and Consultant in Rheumatology	Rheumatology	20/10/2026	Nil Declaration
Non Gibbon Morris	Consultant Anaesthetist	PACCT	20/10/2026	Nil Declaration
Paul Mizen	AMD clinical transformation and Consultant Acute Physician and Gastroenterologist	Medicine	20/10/2026	Nil Declaration
Helen Elizabeth Fowles	Respiratory Consultant	Medicine	20/10/2026	Llanfoisr Educators and Friends - Chair Trustee commenced September 2026 - Unpaid
Jessica Anderson	Consultant	Surgery	20/10/2026	Nil Declaration
MICHELLE BARBER	CONSULTANT PAEDIATRICIAN	WOMEN CHILD AND FAMILY	20/10/2026	Nil Declaration
MOUSUMI BISWAS	CONSULTANT PHYSICIAN	MEDICINE	20/10/2026	Nil Declaration
Sandya Nishanthi Abayanayake	Consultant Psychiatrist	Mental Health and Learning Disability	20/10/2026	Nil Declaration
Dr Stephen Edwards	Deputy Medical Director	CSS	20/10/2026	2 dormant companies Formal partial secondment to Powys Teaching Health Board as Assistant Medical Director of Planned Care
SUKHDEV SINGH	CLINICAL DIRECTOR RADIOLOGY & CONSULTANT RADIOLOGIST	CLINICAL SUPPORT SERVICES	20/10/2026	St Joseph's Hospital - Shareholder RSG Radiology limited - shareholder
Dr Lauren Gorman	consultant	Scheduled care	20/10/2026	Nil Declaration
Divya Sakhuja	Consultant Psychiatrist	Mental Health and LD	20/10/2026	Nil Declaration
george hill	urology consultant	surgery	20/10/2026	Nil Declaration
Dr Claire Powell	EM Consultant	Urgent Care	20/10/2026	Nil Declaration
Nakul Gupta	Consultant Paediatrician	Families and Therapies	20/10/2026	Nil Declaration
andrew david yeoman	consultant hepatologist	Unscheduled care	20/10/2026	Advisor to the PBC Foundation, PSC Support & Liver UK
Gareth Howe	Consultant psychiatrist and clinical director	Mental health and Learning Disabilities	20/10/2026	Nil Declaration
Furat Oweis	Consultant	family and therapies division	20/10/2026	Nil Declaration
Helen Watson	OPS LEAD	Families and Therapies	20/10/2026	Nil Declaration
Dr Eamon Mahdi	Consultant Haematologist	Haematology	20/10/2026	Nil Declaration
Paul Nichols	Consultant Anaesthetist	Clinical Support Services	20/10/2026	Nil Declaration
Javier	Vicini-Parra	34018432	20/10/2026	Nil Declaration
Nadia El-Farhan	Consultant Chemical Pathologist	Clinical Support Services	20/10/2026	Nil Declaration
Julia Claire Lewis	Consultant Addiction Psychiatrist	Mental Health and Learning Disabilities	20/10/2026	Nil Declaration
Ceri Richings	Consultant Psychiatrist	MH&LD	20/10/2026	Nil Declaration

Andrew Cooper	Head of Programmes (Employee Wellbeing)	Employee Wellbeing	20/10/2026	Nil Declaration
Kirsten Gibbins	Operational Lead Children's Continuing Care	Families and Therapies	20/10/2026	Chair of Governors for local Special School - unpaid
Dr Andreea Alina Ionescu	Consultant respiratory medicine	Medicine	20/10/2026	Aaionescu ltd - private practice work St Joseph's Private clinic since I became a consultant 17 years ago - not paid by the hospital
David Medhurst	Consultant Psychiatrist	MH&LD	20/10/2026	Nil Declaration
gareth edwards	consultant	F&T	20/10/2026	gjeconsulting ltd, private practice - shareholder
Harriet Slater	Consultant	Learning Disability	20/10/2026	Nil Declaration
Donna Wigmore	Senior Nurse Dementia Care	Corporate Nursing	20/10/2026	Nil Declaration
NIZAR MHANI	CONSULTANT	SCHEDULED CARE	20/10/2026	Nil Declaration
Miroslava Slavska	Consultant	Family and Therapies	20/10/2026	Nil Declaration
Mohamed Bader	Clinical Director Access, Urgent, and Primary Mental Health Services	Mental Health and Learning Disabilities	21/10/2026	Nil Declaration
Dr Rahim Safeer	Consultant Psychiatrist	Mental Health and Learning Disability	21/10/2026	Mindmed Limited - shareholder
Haris Saleem	Consultant	Acute Medicine	21/10/2026	Nil Declaration
Bapuji rao velagapudi	Consultant psychiatrist	MH&LD	21/10/2026	Nil Declaration
Lucy Emmett	Consultant Anaesthetist	PACCT	21/10/2026	Nil Declaration
Maryam AFzal	Consultant Psychiatrist	mental health & LD	21/10/2026	Nil Declaration
Sally Western	Prescribing Advisor	Pharmacy	21/10/2026	Nil Declaration
Ramya Venkataramakrishnan	Consultant Paediatrician	Family and Therapies	21/10/2026	Nil Declaration
Leena Gokhale	Consultant Gynaecologist and Obstetrician	Family and therapies	21/10/2026	Nil Declaration
banwen davies	consultant	families and therpaies	21/10/2026	Nil Declaration
Robert Stacey	EM Consultant	Urgent Care	21/10/2026	Nil Declaration
Pauline Mary Ruth	Consultant	Mental Healh	21/10/2026	Nil Declaration
Youssef Abourahma	Consultant Paediatrician	Family and Therapy	21/10/2026	Nil Declaration
katie perry	Clinical Psychologist	Family & Therapies	21/10/2026	Nil Declaration
Jessica Reid	Pharmacist	Secondary Care	21/10/2026	Nil Declaration
Victoria STacey	Consultant in Emergency Medicine	Urgent Care	21/10/2026	Nil Declaration
Anthony Hanks	Consultant EM	Urgent Care	21/10/2026	Nil Declaration
Vasudev Shanbhag	Consultant T and O	Surgical	21/10/2026	Abergavenny Hand Surgery Ltd - Director and shareholder VOSS Investments and Lettings - Director & Shareholder Shareholder - St Joseph's Hospital
Andrew Paul Cockeram	estates officer	works and estates	21/10/2026	Nil Declaration
ROBERT JOHN EVANS	SENIOR COMPLIANCE MANAGER	FACILITIES	21/10/2026	Nil Declaration
Peter D'Lima	Clinical Practitioner Psychologist	Child and Family Psychology and Therapies	21/10/2026	Broaden & Build Psychology Ltd - paid Private practice since December 2020 - Director paid & sareholer
Hilary Lewis	Consultant Community Paediatrician	Family and Therapies	21/10/2026	Nil Declaration
Tristan Ross Harris	Clinical Futures Finance Manager	Finance	21/10/2026	Nil Declaration
Laura Knight	Clinical Psychologist	Child and Family Psychology and Therapies	21/10/2026	Nil Declaration
Maike Eylert	Urology consultant	surgery	21/10/2026	Nil Declaration
James Hrastelj	Consultant Neurologist	Medicine	21/10/2026	Nil Declaration
Danielle Bunyan	Charge Nurse	Urgent Care	21/10/2026	BBC Freelance ad-hoc work - paid
Adrian Neal	Head of Employee Wellbeing	Workforce and Organisational Development	21/10/2026	Welsh Street Management Company since August 2025 - unpaid
Mandar Joshi	Consultant	CSS	21/10/2026	Nil Declaration
Kate Jobbins	Clinical Psychologist	Child & Family Psychology	21/10/2026	Nil Declaration
Dr Lynne Sutton	Consultant in Emergency Medicine	Urgent care	22/10/2026	Nil Declaration

Jean-Marc Soukias	Consultant Radiologist	Surgery	22/10/2026	Nil Declaration
Lorraine Rowlands	Directorate Manager	PCCS	22/10/2026	Nil Declaration
John Northfield	Consultant	Medicine	22/10/2026	Nil Declaration
martin moffatt	estates officer electrical	works and estates royal gwent hospital	22/10/2026	Nil Declaration
Aled Phillip Williams	Validation Clerk	Digital Data and Technology	22/10/2026	Nil Declaration
Dr Rachel Bebb	Consultant Paediatrician	Family and Therapies	22/10/2026	Nil Declaration
Ffion Hiscox	Validation Clerk	Digital, Data & Technology	22/10/2026	Nil Declaration
Mayur Panchal	Consultant Radiologist	Radiology	22/10/2026	Nil Declaration
Alessandra Roberts	Clinical Psychologist	Child and Family Psychology	22/10/2026	Nil Declaration
Sari Robinson	Staff Counsellor	WOD	22/10/2026	Lecturer in Integrative Counselling
Nicholas Cadman	Minor works manager	Estates and facilities	22/10/2026	Nil Declaration
Richard Evans	Community Pharmacy Lead	Primary Care and Community	22/10/2026	Nil Declaration
Hayden Stephenson	Clinical director, Critical Care	Clinical support services	22/10/2026	Nil Declaration
Muthuraja Marimuthu	Consultant Anaesthetist	Clinical Support Services	22/10/2026	Nil Declaration
Samantha Bright	Aneurin Bevan University Health Board	Primary Care	22/10/2026	Nil Declaration
Alanna Watkins	ED Consultant	Urgent Care	23/10/2026	Nil Declaration
Andrew Woods	Service Development Manager	Primary Care	23/10/2026	Nil Declaration
Michelle Llewellyn	Senior Primary Care Manager	Primary Care & Communities	23/10/2026	Nil Declaration
Bethan Merriman	Contract Manager	Primary Care	23/10/2026	Nil Declaration
Tom Owen	GMS Contract Manager	Primary Care	23/10/2026	Nil Declaration
Kelly Roberts	Primary Care Contracts Manager	Primary Care and Community	23/10/2026	Nil Declaration
Trish Chalk	Chalk	corperate	23/10/2026	Nil Declaration
Lynsie Howfield	Contracts Manager	Primary Care	23/10/2026	Nil Declaration
Andrew Dale	Staff Counsellor	Workforce and OD	23/10/2026	Private practice as a psychologist/psychotherapist since 2013 University of outh Walessince 2021 - paid
ABIN JO KOTTANCHERIL	HCSW	D3W	24/10/2026	HCSW with Hallmark care home - scheduled shifts outside contracted NHS hours 2022-2027 - paid
Kristina Robinson	Consultant	Scheduled Care	26/10/2026	Nil Declaration
Lauren Chapman	Service Development Manager	Primary Care	26/10/2026	Nil Declaration
Clare Walters	Head of Strategic Change	PCCS	26/10/2026	Nil Declaration
Andrew Bagwell	Consultant Anaesthetist	CSS	26/10/2026	Nil Declaration
Andreas Lappas	Consultant	MHLD	26/10/2026	Nil Declaration
Melanie John	Service Development Manager	Primary Care	26/10/2026	Nil Declaration
Joanna Norman	Service Development Manager	Primary Care	26/10/2026	Nil Declaration
Angharad Rees	Acute cardio respiratoery clinical lead	Family and therapies- physiotherapy	26/10/2026	Nil Declaration
Rebecca Prentice	Physiotherapy Assistant Band 3	Physiotherapy	26/10/2026	Nil Declaration
sian.taylor	Clinical Specialist Strategic Lead Dietitian CAMHS	Family and therapies	26/10/2026	Chair of British Dietetic Association ARFID sub group for 3 years - unpaid
Rebecca Kau	8a Pharmacist	Pharmacy	26/10/2026	Nil Declaration
Dr. Rajarajan Kannapiran	Consultant Neonatologist	Family and Therapies	27/10/2026	Nil Declaration
Kosta Morley	Consultant Emergency Medicine	Urgent care	27/10/2026	Nil Declaration
Michael Andrew Roberts	Consultant Ophthalmologist	Surgical	27/10/2026	Nil Declaration
Emma Pyatt	Referral Officer	Primary Care	27/10/2026	Nil Declaration
Emily Clark	Consultant in Public Health	Public Health	27/10/2026	Nil Declaration
Jessica Evans	RBC Team Leader	Digital Data & Technology - Referral & Booking	27/10/2026	Nil Declaration
Claire Swan	Primary Care Admin	Contracting	27/10/2026	Nil Declaration
Rachel Wainwright	Physiotherapy Clinical Lead for Inpatient Neurology	Family and Therapies	27/10/2026	Nil Declaration
Chineze Ivenso	Consultant Old Age Psychiatrist	Mental Health and Learning Disability Division	27/10/2026	query with bryonu

Rachel McWilliams	Senior Primary Care Manager	Primary Care	28/10/2026	Nil Declaration
Wendy Warren	Head of Planning Civil Contingencies	Planning	28/10/2026	Nil Declaration
Matthew Lloyd	Programme Manager	Planning and Performance	29/10/2026	Equine Assisted Learning Centre since 04/12/2024 - unpaid
Anwen Whitham	Consultant CLinical Psychologist	COmplex Care	29/10/2026	Stable Focus Psychology Ltd therapy in England to keep up core therapeutic skills - shareholder

Designation	Name	DoI 2026
Chief Executive	Nicola Prygodzicz	Nil
Medical Director	Seema Srivastava	Nil
Director of Strategy, Planning and Partnerships	Hannah Evans	Nil
Director of Finance and Procurement	Rob Holcombe	Nil
Director of Workforce and OD	Sarah Simmonds	Tydfil Training Consortium Ltd
Director of Nursing/Deputy Chief Executive	Jennifer Winslade	Nil
Director of Therapies and Health Sciences	Peter Carr	Digital Health & Care Wales, employed as Chair of the LIMS 2.0 Programme since July 2023
Director of Public Health	Tracy Daszkiewicz	Faculty of Public Health - President until July 2028 Board Finance responsibility President of the Faculty of Public Health, Therefore under Charitable Objects I am Chair of the Board of Trustees - This is a voluntary position for a three year term July 25- July 2028
Chief Operating Officer	Leanne Watkins	Nil
Director of Corporate Governance	Rani Dash	Nil
Director of Digital	Paul Solloway	Nil
Incoming Chair	Andrew Morgan	Director at both Darran Las Community Building and Fernhill Community centre - unpaid positions Chairman of Nos Galan Committee - unpaid Chairman of Darran Las Community Building Committee - unpaid Chair of Governors Darran Las and Glenboi School - unpaid
Incoming Vice Chair	Will Smart	CareTech Partners Limited (May 2024 to date) Alcidian Group Limited (October 2024 to date) Chair, Faculty of Health and Care, British Computer Society (May 2025 to date) Director, Federation of Informatiocs Professionals in Health and Care (October 2025 to date I provide strategic advisory services to T-Pro, a Dublin-based healthcare software company
Independent Member (Trade Union)	Vivek Goel	Kuber Services Limited, 50% share holder Tenovus Cancer Care, Trustee
Independent Member (Local Authority)	Helen Cunningham	Elected member Blaenau Gwent County Borough Council
Independent Member (University)	Professor Helen Sweetland	Nil
Independent Member (Community)	Paul Deneen	Nil
Independent Member (Finance)	Iwan Jones	North West Mutual Golf Union of Wales EHJ Associates The Aspect RTM Disused Tips Authority since 2026
Independent Member (Digital)	Dafydd Vaughan	Company Director, Cedyrn Ltd. Sep 2016-present. Consulting Chief Technology Officer, Public Digital (Oct 2023-present) Spouse: Senior Partner (Major Projects), TPX Impact (Jan 2024-Jun 2025) Spouse: Company Director, Mimulus HQ Ltd. Jul 2014-Jun 2024 and Jun 2025-present..
Independent Member (Third Sector)	Akmal Hanuk	Assadaqaat Community Finance (ACF) (Charity/Voluntary Body)
Independent Member (Community)	Penny Jones	The Palmer Centre - Trustee Daughter - Laura Anne Jones - MS 2007-2020 2023-present Day Paid County Councillor - Monmouthshire County Council since 2012
Independent Member (Community)	Neil Patrick	Neil Patrick Associates Ltd. July 2020 to present Pension the Pennies Ltd. November 2020 to present Vigorate Ltd August 2022 to present XXXX Holdings Ltd. Appt. December 2023 Resigned Feb 2026 I have held or hold directorships in all these businesses. All are now dissolved or in the process of being wound up except my personal consulting business Neil Patrick Associates Ltd. None have any involvement with public health.

Staff Name	Staffs Position	Staffs Department	Date of Submission	Nature of gift	Company	Value
Georgina Forbes	Specialist Dr	Sexual and Reproductive Healthcare	06/07/2026	Primary care study day in Sexual and reproductive healthcare - Payment for a stand at the primary care study day in SRH Companies sponsoring have no input into the content or speakers for the day	Organon Bayer Gedeon Richter Besins exeltis idorsia consilient Trion Theramex	Each pharmaceutical company will be paying £250
Bernadette Tenorio	Lead Macmillan Skin Cancer Nurse	Dermatology	18/08/2026	Dermatology Surgical Skills Day Wednesday 16th July 2025 Surgical training ALL Wales. Attended by GP , CNS with special interest on Skin Surgery	Gemma Hewitt MSD Merck Sharp & Dohme UK LTD	£420 paid in ABUHB charitable funds
Georgina Forbes	Specialist Dr	SRH	14/09/2026	Sponsorship for a stand at an SRH education event	Pfizer	£500 stand fee
Georgina Forbes	Specialist Dr	SRH	14/09/2026	Sponsorship and stand at meeting	Organon Pharma UK	300
Janardhan Navaratnam	Consultant Gastroenterologist and Hepatologist	Gastroenterologist	23/09/2026	All Wales Hepatology Day 14/05/2025 Sponsorship for venue	Advans Pharma UK & Ireland	£416.67
Claire Tibbatts	Consultant Gastroenterologist	Medicine	23/09/2026	Conference feed, charitable grants to P&II department for IBD projects DOI894		
Hannah Capel	Assistant Director Capital Planning	Planning	29/09/2026	Evening networking meal ahead of the IHEEM Conference in Manchester	Hannah Lewis-Jones Mott MacDonald	£50

Rebecca Coles	Acting Head of Dietetics and Weight Management	Dietetics and Weight Management Service	09/10/2026	Influencing & Leadership event including overnight stay. Company also paid £500 but this was paid into study leave charitable fund for the service	Nutricia	£250 for travel & accommodation plus £500 paid into dept study charitable fund
Ann Bentley	Head of Strategic Resourcing	WOD	09/10/2026	Company invitation to celebration event - costs for travel & hotel	Locum Tap Ltd	TBC - contact on AL
Karen Hazel	Consultant Nurse, Heart Failure and Cardiac Rehabiltation	Cardiology	18/10/2026	Hire of room and light lunch provided for a face to face All Wales Heart Failure Nurse working group. I was chair of the group	Pfizer	200.63
Natalie Brooks	Project Manager	Workforce Medical E-Systems	20/10/2026	Company invite to a celebration event - covered costs for travel & hotel	Locum Tap Ltd (Patchwork)	TBC - contact on AL
Chineze Ivenzo	Consultant Old Age Psychiatris	Mental Health and Learning Disability Division	27/10/2026	Sponsored conference attendance - travel and accomodation	Alzheimer's Society	

Staff Name	Staffs Position	Staffs Department	Date of Submission	Line Manager Returned Date	Declaration	Amount
James van Gemeren	Divisional Pharmacist for Surgery	Pharmacy	04/09/2025	04/09/2025	Attended a workshop/working group at Becton Dickinson HQ in Reading to review and comment on a theatres medicines system.	£800
Elizabeth Jenkins	Practice Pharmacist	Primary Care	23/10/2025	23/10/2025	Chair fees for Daiichi Sankyo	£375
Elizabeth Jenkins	Practice Pharmacist	Primary Care	23/10/2025	23/10/2025	Speaker fees for Boehringer Inhgelheim	£1,322
Rebecca Coles	Head of Dietetics and Weight Management Services	Dietetics and Weight Management Services	06/11/2025	07/11/2025	I have been asked to chair a session at a National Conference being held locally. The education session is to be sponsored by Nutricia Ltd. As payment is to be received, annual leave has been requested. The conference is a 2 day event. I will receive entry to the event for both days which has been provided by Nutricia, but payment will only be made for the second day, when I will be chairing the session	£600
Ceri Phillips	Consultant Antimicrobial Pharmacist	Pharmacy	13/11/2025	15/12/2025	Payment for podcast recording plus transport & hotel expenses	£1500 payment + £250 expenses
Chineze Ivenzo	Consultant Old Age Psychiatrist	Old age psychiatry	27/10/2026		Honoraria for participation in Eli Lilly over the last 10 months	

Standards of Business Conduct Policy: Implementation Plan: Update November 2026

Objective	Tasks	Timeline	Progress	Rating
Training and Awareness of the Standards of Business Conduct Policy	Develop AB Pulse site with advice and guidance on implementing the policy	November 2024	Included within the Corporate Governance pages Standards of Business Conduct - Declaring Interests, Gifts, Hospitality, Sponsorship and Honorarium	Complete
	Implement electronic forms to facilitate the submission of DoIs, Gifts, Hospitality and Sponsorship	November 2024	Electronic forms implemented	Complete
	Include SoBC Policy requirements in Corporate Induction and Employee Handbook	March 2027	Full review the Induction and Managers Handbook being undertaken by WoD. SoBC will be included in the new version when it is released	Not due
Implement Measures to target and monitor uptake, including Targeting 'High Risk' Groups identified in the Policy • Staff at Band 8a and above • Research and Development Staff* • Pharmacy Staff* • Informatics Staff* • Estates and Facilities Staff*	Request 'starters' list to identify key individuals at the start of their employment	January 2026	Starters list received weekly	Complete
	Request list of staff at band 8a and above in order to send targeted emails/communications	January 2026	Band 8a and above list received and targeted emails sent	Complete
	Contact Managers of high risk staff groups to identify staff who meet the criteria	October 2026	Emails sent requesting staff lists to target and monitor	Complete
	Monitor uptake against agreed 'high risk' lists, with updates to managers of non responders and escalation to Director of Corporate Governance	October 2026	In place for band 8a and above. To be established for other groups once lists are available (have been requested, see above)	In progress
	Add list of 'high risk' groups to DoI section in PADR paperwork to prompt submissions	March 2026	Included in PADR template	Complete

Objective	Tasks	Timeline	Progress	Rating
Whose role necessarily brings them in to contact with external companies, contractors or suppliers, if you are able to initiate orders, are a budget holder, or strategic decision maker				
Validation of the Declaration of Interests Register	Request 'leavers list' in order to remove staff from the register when leaving the Health Board	March 2025	Leavers list received on a weekly basis	Complete
	Contact 'High Risk' staff on an annual basis to confirm no changes	April 2027 onwards	First emails sent April 2026	Not yet due
	Introduce a 'removals log' to be held as a reference archive for leavers and changes to declarations	November 2025	Removals log established and updated on weekly basis on receipt of 'leavers list'	Complete
Board Member Validation to ensure register remains comprehensive and up to date throughout each financial year	Annual DoI request to be made in February of each year	February 2025	Annual declarations currently requested in support of the Annual Accounts reporting process	Complete
	Validation checks to be undertaken in September each year to confirm changes/no change to DoI submission	September 2025	Form reviewed to enable members to view previous submission and confirm no changes, or provide new declaration.	Complete
	Validate changes to DoIs, requesting confirmation in writing where previous declarations are removed	October 2025	Email confirmation requested when DOIs are removed	Complete
	Enhanced checks for Board members, including review of Companies House records	November 2025	Mid year validation and companies house checks undertaken	Complete

Objective	Tasks	Timeline	Progress	Rating
	Request that members leaving the Board confirm current DoI is correct on leaving		Board members are contacted and requested to confirm DOIs on leaving the Health Board	Complete

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Standards of Business Conduct

(incorporating Declarations of Interest, Gifts, Hospitality, Sponsorship and Honoraria)

Lead Author (S)	Head of Corporate Governance
Lead Executive	Director of Corporate Governance
Division/Department	Corporate Governance
Reference	ABUHB/Corporate/0258
Applies to	Health Board Wide
Approving Forum	Board
Date Approved	25/09/2024
Review Date	25/09/2027

Version Control		
Version No	Approved	Author
5	25/09/2024	Head of Corporate Governance

Policy on a Page: Key Messages

Aim

This policy outlines the arrangements in ABUHB to ensure that staff comply with the requirements for recording and declaring potential conflicts of interest and handling of gifts, hospitality, honoraria and sponsorship (even if these are declined).

Summary of key changes

This is a re-write and expansion of the former Standards of Business Conduct Policy, to provide more explicit guidance on declaring interests, gifts and hospitality, and now includes honoraria and sponsorship.

Key Requirements

How to declare and record potential conflicts of interest.

Ensure you are not in a position where you (or your close family's) private interests and NHS duties may conflict.

Seek your managers permission before taking any outside work, in accordance with employment terms and conditions.

Declare any offers of gifts, hospitality or sponsorship using the appropriate forms
Obtain permission before accepting any commercial sponsorship or hospitality.

If in doubt declare it!

Training:

No specific training requirements however, awareness raising sessions will be held with managers.

Target Audience

All employees and Board members



Click on this icon to return to the contents page



Click on this icon to access the sharepoint site and forms



Click on this icon for further guidance

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1. Introduction/Overview

The Standards of Business Conduct Policy enables Aneurin Bevan University Health Board (ABUHB) to ensure that its Employees and Independent Members practice the highest standards of conduct and behaviour.This policy sets out the expectations required and provides supporting guidance so that all Employees and Independent Members are supported in delivering that requirement.

2. Scope

This Policy is applicable across the whole of the Health Board. It applies to all Employees and Independent Board Members. The term "Employees" includes all those who have a contract of employment or honorary contract with the Health Board, or are workers within the Health Board.

3. Aim

The aim of this Policy is to ensure that arrangements are in place to support employees to act in a manner that upholds the Standards of Behaviour Framework as well as setting out specific arrangements for the appropriate declarations of interests and acceptance/refusal and record of offers of Gifts, Hospitality or Sponsorship. The Policy also aims to capture public acceptability of behaviours of those working in the public sector so that the Health Board can be seen to have exemplary practice in this regard.

ABUHB is committed to ensuring that its employees and Independent Members practice the highest standards of conduct and behaviour. This policy sets out those expectations and provides supporting guidance so that all employees and Independent Members are supported to deliver this requirement.

4. Background

The Welsh Government's Citizen-Centred Governance Principles apply to all public bodies in Wales. These principles integrate all aspects of governance and embody the values and standards of behaviour expected at all levels of public services in Wales.

"Public service values and associated behaviours are and must be at the heart of the NHS in Wales"

ABUHB is strongly committed to being value-driven, rooted in the Nolan principles and high standards of public life and behaviour, including openness, customer service standards, diversity and engaged leadership.

The Board expects all Independent Board Members and Employees to practice high standards of corporate and personal conduct, based on the recognition that the needs of patients must come first.

4. Background cont.

The "Seven Principles of Public Life", or the "Nolan Principles", form the basis of the Standards of Behaviour requirements for Health Board employees and Independent Board Members. These are:

- Selflessness – Individuals should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or friends.
- Integrity – Individuals should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.
- Objectivity – In carrying out public business, including making public appointments, awarding contracts, recommending individuals for rewards and benefits, choices should be made on merit.
- Accountability – Individuals are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate for their position.
- Openness – Individuals should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands it.
- Honesty – Individuals have a duty to declare any private interests relating to their duties and to take steps to resolve any conflicts arising in a way that protects the public interest.
- Leadership – Individuals should promote and support these principles by leadership and example.

n support of these principles, Independent Board Members and all employees must be impartial and honest in the way that they go about their day-to-day functions. They must remain beyond suspicion at all times. They can achieve the "Seven Principles" above by:

- Ensuring that the interests of patients remain paramount.
- Being impartial and honest in the conduct of their official business.
- Using public funds to the best advantage of the service and the patients, always seeking to ensure value for money.
- Not abusing their official position for personal gain or to benefit family or friends.
- Not seeking advantage or to further private business or other interests in the course of their official duties.
- Not seeking or knowingly accepting, preferential rates or benefits -in kind for private transactions carried out with companies, with which they have had, or may have, official dealings on behalf of the Health Board

This Policy re-states and builds on the provisions of Section 7, Values and Standards of Behaviour, of the Health Board's Standing Orders. It re-emphasises the commitment of the Health Board to ensure that it operates to the highest standards, the roles and responsibilities of those employed by the Health Board and the arrangements for ensuring that declarations of interests, gifts, hospitality, honoraria and sponsorship can be made.

The Policy is supported by a short guide on the Standards of Behaviour Framework that provides a summary of expected conduct. This Framework is intended to compliment the various Professional Codes of Conduct relevant to Employees of the Health Board.

The impact of other Health Board policies which should be considered by staff include:

- The Counter Fraud Bribery and Corruption policy
- Charitable Funds Financial Control Procedure
- Counter Fraud, Bribery and Corruption Policy
- Raising Concerns (Whistleblowing)
- Personal Relationships at Work Policy

5. The Bribery Act 2010

The Bribery Act 2010 came into force on 1st July 2011.

It reformed the criminal law of bribery, making it easier to tackle this offence proactively in both the public and private sectors. It is intended to respond to the extremely broad range of ways in which bribery can be committed by providing robust offences, enhanced sentencing powers, and wide jurisdictional powers.

Broadly, the Act defines bribery as:

“Giving or receiving a financial or other advantage in connection with the "improper performance" of a position of trust, or a function that is expected to be performed impartially or in good faith”

The Bribery Act 2010 abolished all existing UK Anti-Bribery Laws and replaced them with a suite of new offences markedly different to what has gone before.

The Bribery Act 2010 made it a criminal offence to “give, promise or offer a bribe and to request, agree to receive or accept a bribe either at home or abroad”. The maximum penalty for bribery is up to 10 years imprisonment, with an unlimited fine. In addition, the Act introduced a ‘corporate offence’of failing to prevent bribery by the organisation not having adequate preventative procedures in place. An organisation may avoid conviction if it can show that it had such procedures and protocols in place to prevent bribery.The ‘corporate offence’is not a standalone offence, but always follows from a bribery and/or corruption offence committed by an individual associated with the company or organisation in question.

Bribery does not have to involve cash or an actual payment exchanging hands and can take many forms such as a gift, lavish treatment during a business trip or tickets to an event.

Some simple examples follow:

- **Bribery in order to secure or keep a contract.**
- **Bribery to secure an order.**
- **Bribery to gain any advantage over a competitor.**
- **Bribery of a local, national or foreign official to secure a contract.**
- **Bribery to turn a blind eye to a health and safety issue or poor performance or substitution of materials or false labour charges.**
- **Bribery to falsify an inspection report or obtain a certificate.**

6. Roles and Responsibilities

Chief Executive

The Chief Executive is the "Accountable Officer" with overall responsibility for ensuring that the Health Board operates efficiently, economically and with probity. The Chief Executive will ensure a policy framework is set and that arrangements are in place to support the delivery of that framework.

Director of Corporate Governance

The Director of Corporate Governance has delegated responsibility for ensuring that the Health Board is provided with competent advice and support regarding the contents and application of this Policy and the Standards of Behaviour Framework. They will ensure that:-

(i) A Register of Interests is established and maintained as a formal record of interests declared by Employees and Independent Board Members. The Register will include details of Directorships, pecuniary (financial) and non-pecuniary interests in organisations that may have dealings with the NHS and membership of professional committees and third sector bodies. Where relevant it will also include details of interests of close family members or civil partners.

(ii) In addition, all staff employed in areas deemed specific 'high risk', as per Table 1, will be asked to complete a Declaration of Interest form, including confirmation of a Nil Declaration. For the purpose of defining high risk, the Health Board considers this to include those whose role necessarily brings them into contact with external companies, contractors or suppliers, those who are able to initiate orders or those who are budget holders and strategic decision makers.

This includes any interests that may influence, or be perceived to influence, the member of staff's judgement in the course of undertaking their duties whilst working for ABUHB.

Table One

Independent Members	Annually
Executive Directors	Annually
Associate Members	Annually
Staff in specified 'high risk' areas	
Staff at Band 8a and above	Annually
Research and Development Staff*	Annually
Procurement Staff*	Annually
Pharmacy Staff*	Annually
Informatics Staff*	Annually
Estates and Facilities Staff*	Annually

*whose role necessarily brings them into contact with external companies, contractors or suppliers, those who are able to initiate orders or those who are budget holders

Note: It is the individual employee's responsibility to make a declaration should their circumstances change within these timescales.

(iii)A Register of Gifts, Hospitality, Honoraria and Sponsorship, whether accepted or declined, is maintained.

(iv)Appropriate information from the Registers of Declarations of Interests and Gifts, Hospitality, Honoraria and Sponsorship is published on the Health Board Website in accordance with the requirements of the Freedom of Information Act.

6. Roles and Responsibilities cont.

(v)Reports detailing the content of the Registers of Declarations of Interests and Gifts, Hospitality, Honoraria and Sponsorship and the effectiveness and adequacy of the arrangements in place will be provided to the Audit, Risk and Assurance Committee on an annual basis.

(vi)The form that Employees should complete when making a Declaration of Interest or when advising if gifts, hospitality, sponsorship or honoraria have been accepted or declined are available on the following link.

Chair

The Chair should:

- -Ensure that Independent Board Members are aware of the requirements contained within this Policy and the Standards of Behaviour Framework.
- -Ensure that the Audit, Risk and Assurance Committee review the adequacy of arrangements for managing Declarations of Interest and Gifts and Hospitality.
- -Lead by example and ensure that they personally declare any relevantinterest or the offer of gifts, hospitality or sponsorship.
- -Approve (or not) the acceptance of gifts, hospitality and sponsorship that have been offered to Independent Board Members PRIOR to the event.

Executive, Assistant and Divisional Directors

Directors must ensure that:

- Employees are aware of the requirements contained within this Policy and the Standards of Behaviour Framework.
- Lead by example and ensure that they personally declare any relevant interest or the offer of gifts, hospitality or sponsorship.
- -They review the contents of the Registers of Declarations of Interest and Gifts,Hospitality and Sponsorship on an annual basis to assist with the verification of the accuracy of the information contained within it.
- During periods of annual leave and prolonged absence they will ensure that they delegate the responsibilities to their relevant deputy.

Line Managers / Departmental Managers

Line/Departmental Managers (with budget management responsibilities) will:

- Lead by example and ensure that they personally declare any relevant interest or the offer of gifts, hospitality or sponsorship.
- -Ensure that Employees are aware of the requirement to follow and comply with the Policy and Standards of Behaviour Framework. The Standards of Business Conduct Policy will be discussed at Individual Performance Reviews, Consultant Appraisals and as part of the Consultant Job Plan Reviews as appropriate.
- -Approve (or not) the acceptance of gifts, hospitality and sponsorship that have been offered within their Directorate PRIOR to the event.
- Support their Employees in the application of the Policy and the Standards of Behaviour Framework, seeking advice from the Director of Corporate Governance if required.

6. Roles and Responsibilities cont.

Employees and Independent Board Members

All Employees and Independent Members, including those on Honorary Contracts, will ensure that they:

- Understand this Policy and the Standards of Behaviour Framework, consulting their line manager if they require clarification.
- Declare to the Health Board for recording in the Register of Interests any relevant interests:
  - At the commencement of employment
  - Whenever a new interest arises, and
  - If asked to do so at periodic intervals by the Health Board.

- Inform patients and their relatives as appropriate, when referring them for treatment, investigation, or any aspect of their care if they have a material interest in an organisation to which they plan to refer a patient. The fact that the patient has been informed must be recorded appropriately.
- Verbally declare any relevant interest when a potential for conflict arises e.g. at Board and committee meetings, during procurement processes.
- Observe the Standing Orders,Standing Financial Instructions and procurement policies and procedures of the Health Board.
- Where employees or Independent Members wish to engage in any outside employment which may affect their contractual obligation to ABUHB, they must first discuss it with their Line Manager. This will ensure that their position in ABUHB is not compromised. Agreement to such outside employment will not be unreasonably refused.

It is the responsibility of all Employees and Independent Members to ensure they are not placed in a position that risks, or appears to risk, conflict between their private interest and their ABUHB duties. This responsibility applies to all ABUHB staff, including those who commit resources directly, by ordering goods or services, and those who do so indirectly.

6. Roles and Responsibilities cont.

Procurement Department

Where an Employee is requested to participate in an ABUHB procurement process and has not previously completed a Declaration of Interest Form, they will be asked to do so prior to participating, or asked to reaffirm their interests and to confirm that there are no other relevant interests that should be declared.

The procurement lead will scrutinise such individual Declarations of Interest to ensure that there is no opportunity for any conflicts of interest.

The NHS Wales Shared Services Partnership (NWSSP) will ensure that all procurement staff complete declaration of interest forms in line with their procedures. NWSSP will advise ABUHB,through the Director of Corporate Governance, of any such interests impacting on ABUHB services.

Whilst individual staff must not seek or accept preferential rates or benefits in kind for private transactions carried out with which they have, or may have, official dealings with on behalf of ABUHB, this does not apply to concessionary agreements negotiated with companies by NHS management, or by recognised staff interests on behalf of all staff,for example, NHS staff benefits schemes.

All staff in contact with suppliers and contractors, particularly if authorised to sign purchase orders or place contracts for goods, materials or services, shall adhere to accepted professional standards i.e. the NHS Wales Shared Services Partnership Procurement Policy and the Standing Orders and Standing Financial Instructions of ABUHB.

Directors and Senior Managers should ensure that no special favour is shown to current or former staff or their close relatives or associates in awarding contracts to private or other businesses operated by them or employing them in a senior or relevant managerial capacity.

Contracts may be awarded to such business where they are won in fair competition against other tenderers, but care must be taken to ensure that the selection process is conducted impartially, and that staff who are known to have a relevant interest play no part in the selection.

7. Register of Interests

The Director of Corporate Governance will maintain Registers of Declarations of Interests and Gifts, Hospitality, Honoraria and Sponsorship. Appropriate information from these Registers is available on the Health Board website.

The master copy of the Register, together with the forms which are used to inform its contents will be retained by the Corporate Governance Team.

The Register is available for public inspection. Enquiries should be made to the Director of Corporate Governance via the following email: ABB.BoardSecretary@wales.nhs.uk

8. Declarations of Interest at Meetings

It is a requirement that at the beginning of every Health Board, Committee or decision making / formal Health Board meeting that members and those in attendance be invited to declare their interests in relation to any items on the agenda. Where a potential conflict is material or the member has a financial / pecuniary interest in the matter under discussion, that person shall withdraw from discussions pertaining to that agenda item and shall not vote upon it. The potential conflict and the action will be recorded in the minutes of the meeting and the Register of Interests will be updated if required.

Where it becomes evident part way through a meeting that there may be a potential conflict the individual must declare their interest immediately. Under certain circumstances the Chair may choose to waive the need for the individual to leave the meeting. The advice of the Director of Corporate Governance should always be sought prior to such a decision being made. From time to time, employees may need to declare interests at other Health Board or Partnership meetings. Such declarations will be recorded as if it were a Board or committee meeting and the individual will be asked to withdraw from discussions pertaining to that agenda item.

9. Gifts, Hospitality, Honoraria and Sponsorship

Employees and Independent Members have a personal responsibility to volunteer information regarding offers and acceptance of gifts, hospitality, honoraria and sponsorship, including those offers that have been declined. Employees should seek approval from their line manager prior to accepting any gifts, hospitality, honoraria or sponsorship. These details must be recorded on the Gifts, Hospitality, Honoraria and Sponsorship Form and submitted to the Director of Corporate Governance for inclusion on the register.

In determining whether to accept gifts, hospitality, honoraria and sponsorship, it is not always possible to make explicit a situation in which these may be considered acceptable as each offer should be considered independently. In determining whether any offer of a gift, hospitality, honoraria or sponsorship should be accepted, the following principles should be considered:

- ·Openness: It has been openly offered and the offer will not be construed as any form of inducement and will not put the individual under any obligation to those offering it.

- Legitimate interest: Regard should be paid to the reason for the contact on both sides and whether it is a contact that is likely to benefit the Health Board i.e. further the aims of the organisation.

- Relationship: Consideration given as to Health Board is likely to enter into a contractual relationship with the organisation/ individual making the offer.

- Value: Gifts and benefits of a trivial or inexpensive seasonal nature, e.g. diaries/ calendars, are more likely to be acceptable and can be distinguished from more substantial offers. Similarly, hospitality in the form of a working lunch would not be treated in the same way as more expensive social functions, travel or accommodation

- Frequency: Acceptance of frequent or regular invitations particularly from the same source would breach the required standards of conduct.

- Reputation: If the body concerned is known to be under investigation by, or has been publicly criticised by, a public body, regulators or inspectors, acceptance of a gift or hospitality might be seen as supporting the body or affecting in some way the investigation or negotiations. As such it should always be declined.

Gifts

A gift is an item of personal value, given by a third party e.g. a patient or a supplier. The definition includes prizes in draws and raffles at sponsored events /conferences.

It is a criminal offence under the Bribery Act 2010 to accept any money, gift or consideration as an inducement or reward from a person or organisation holding or seeking to hold a contract with the Health Board. Such gifts should be refused and if they have already been received they should be returned clearly advising why they cannot be accepted. The appropriate Director, Director of Corporate Governance and Head of Counter Fraud should be advised immediately.

Click on the icon for further guidance on the types of gifts.

Gifts by way of inducement or reward

The Bribery Act 2010 prohibits staff from soliciting or receiving any gift or consideration of any kind from contractors or their agents, or from any organisations, firms or individuals with whom they are broughtinto contact by reason of their official duties, as an inducement or reward for:

a)Doing or refraining from doing anything in their official capacity; or
b)Showing favour or disfavour to any person in their official capacity.

It should be understood that a breach of the provisions of this Acts renders staff liable not only to dismissal but to prosecution under the Act, and it is expected that the Health Board would deal severely with any such breaches. Any instances would be referred to Counter Fraud for investigation, with a view to prosecution by the Crown Prosecution Service.

Staff should be aware that the Health Board is required in accordance with its Standing Orders to insert in every formal contract a clause entitling them to cancel the contract and recover any losses if any inducement or gifts are offered by the contractor or by his employees, whether with or without his knowledge. Any such offer of an inducement or gift should accordingly be reported by the person to whom it is made to the Director of Corporate Governance.

Any acceptance of a gift or hospitality needs to be justified. Think about the context in which the offer has been made, and the effect on your position. For example, is the gift or hospitality likely, or could it be seen as likely, to influence you? The onus is on you to make sure that the acceptance of hospitality or a gift will not be misconstrued.

9. Gifts, Hospitality, Honoraria and Sponsorship cont.

Hospitality

Hospitality is where there is an offer of food, drink, accommodation, entertainment or entry into an event or function by a third party, regardless of whether provided during or outside normal working hours. Employees in contact with contractors should be particularly mindful of accepting any hospitality that might later be misconstrued as impacting on strict independence and impartiality.

Click the icon for guidance on acceptable / unacceptable hospitality

Sponsorship

Sponsorship is sometimes provided by organisations to allow employees to attend conferences or working visits to view equipment. It may also include sponsorship of posts.

No sponsorship should be accepted without the prior agreement of the appropriate Line Manager. A Gifts, Hospitality, Sponsorship and Honoraria Form should also be completed prior to the acceptance of any sponsorship. If sponsorship is inappropriately offered and/or declined this should also be declared.

Click on the icon for further guidance on the many forms that sponsorship may take

Any acceptance of sponsorship needs to be justified. Think about the context in which the offer has been made, and the effect on your position. For example, is the sponsorship likely, or could it be seen as likely, to influence you? The onus is on you to make sure that the acceptance of any sponsorship will not be misconstrued.

Honoraria and Miscellaneous Payments

An honorarium is an ex gratia payment i.e. one which would not usually be expected to be provided.

Employees may be invited to give presentations at conferences, provide responses to surveys or attend professional meetings where a one-off payment or honorarium is offered. If this activity is to be undertaken during hours when the Employee is contracted to work for ABUHB, the payment should be made to ABUHB. Individuals may accept payment for activities that they undertake in their own time, subject to the provisions regarding outside employment contained within the various Employee Contracts and Terms of Service. The activity should be reported using a Gifts, Hospitality, Honoraria and Sponsorship Form.

Click the icon for further guidance on how to handle honoraria for work undertaken during Health Board hours and work undertaken in an individual's own time.

10. Secondary Employment and Private Practice

Secondary Employment (Paid,Unpaid or Self-Employed)

Throughout their employment with ABUHB employees should not engage in any outside employment which may adversely affect their ability to perform their work or which may involve the use of any confidential or commercially sensitive information obtained in the course of their employment with the Health Board.

Employees should inform their line manager of any secondary employment and ensure that this does not affect their ABUHB employment. Declarations should be made using the Staff Declaration of Interests Form. There should be no conflict with their normal contractual employment obligations to ABUHB,and such work should not involve the use of any confidential or commercial information obtained in the course of their employment with ABUHB.

Where Employees have or are contemplating other employment, they must ensure this does not compromise their availability or physical or mental fitness to perform their duties as an Employee of ABUHB. Employees must also ensure this does not place them in a position where their judgement or actions might be influenced by considerations arising from their other employment.

Employees have a responsibility to ensure that their line manager is made aware of any hours worked in order that the Health Board fulfils its statutory requirement of the Working Time Directive.

An Employee, absent because of sickness, is regarded as unfit to work and should not undertake any paid or unpaid work in any capacity during a period of sickness absence from the organisation, unless it is deemed jointly by their manager and the Occupational Health Department to be therapeutically beneficial to their recovery. Express written permission must be granted by the manager in advance in all such cases.

An employee found to be undertaking other work during sickness absence without the prior written consent of the manager, may be considered in breach of contract and will be subject to disciplinary action, which may result in the involvement of the Counter Fraud Department, the possibility of criminal investigation and/or dismissal. Such action will only be taken following advice from Workforce.

Private Practice

There are codes for good private patient practice which clearly include the fact that private practice should not adversely affect NHS duties.

The Health Board has a Private Practice Policy which provides medical staff with appropriate governance in understanding their contractual obligations and organisational expectations in relation to the undertaking of private practice.

Whilst the Policy is primarily directed at Consultants undertaking private patient activity, it equally applies to any other medical staff employed by the Health Board who may privately charge for their services whilst using NHS facilities, equipment or staff, or who may undertake such activities during NHS time, including private patients travelling from outside of the UK.Link to policy once approved

11. Research and Development

Before undertaking any research, the Health Board Research and Development Department must be contacted to ensure the appropriate approvals are in place. Research should always be fully costed and supported by either a Commercial or Non-Commercial Grant. This includes post marketing product evaluations. Research is governed by a number of frameworks and regulations including:

- The UK Policy Framework for Health and Social Care (UK Policy Framework)
- Medicines for Human Use (Clinical Trials) Regulations 2004 (as amended)

Anyone wishing to undertake or be part of research project will be required to hold a current ICH GCP certificate, registered with the Research and Development Department.

The Research and Development Department should always be contacted in these circumstances to offer advice and support in this area.

Rewards for Initiative

Potential intellectual property rights (IPR) should be identified, as and when they arise, in order to protect and ensure that the ABUHB receives any rewards or benefits (such as royalties) in respect of work commissioned from third parties, or work carried out by its Employees in the course of their duties.

Most intellectual property is protected by statute e.g. patents are protected under the Patents Act 1977, and copyright (which includes software programmes) under the Copyright Designs and Patents Act 1988. Appropriate specifications and provisions should be built into contractual arrangements before they are entered into or before work is commissioned or begins. Legal advice or advice provided via the Research & Development Department should be sought if in doubt in any specific cases.

With regard to patents and inventions, in certain defined circumstances the Patents Act 1977 gives Employees a right to obtain reward for their efforts, and the Health Board should agree a suitable reward for individual circumstances as appropriate. Other rewards may be given voluntarily to Employees who within the course of their employment have produced innovative work of outstanding benefit to the NHS. Similar rewards should be voluntarily applied to other activities such as giving lectures and publishing books and articles.

In the case of collaborative research and evaluative exercises with manufacturers, the Health Board should obtain a fair reward for the input its Employees provide. If such an exercise involves additional work for an Employee outside that paid for by the Health Board under their contract of employment, arrangements should be made for a share of any rewards or benefits to be passed on to the Employee(s) concerned from the collaborating parties.

Care should be taken that involvement in this type of arrangement with a manufacturer does not influence the purchase of other supplies from them.

Employees are reminded that all information generated during the course of their employment with ABUHB is the property of the Health Board and remains so, irrespective of origin or authorship.

Conflicts of interest can arise when a member of staff who hold patents and other intellectual property rights is involved in decision making and procurement. In addition, where product development involves use of time, equipment or resources from the organisation, this can also create risks of conflicts of interest, and it is important that the Health Board is aware of this in order to manage it appropriately.

11. Research and Development cont.

Employees are responsible for:

- Declaring patents and other intellectual property rights they hold (either·individually, or by virtue of their association with a commercial or other organisation), including where applications to protect have started or are ongoing, which are, or might reasonably be expected to be, related to items to be procured or used by the organisation.
- Seeking prior permission from ABUHB before entering into any agreement with bodies regarding product development, research, work on pathways, etc, where this impacts on the organisation's own time, or uses its equipment, resources or intellectual property.
- Where holding of patents and other intellectual property rights give rise to a conflict of interest, then the management actions outlined in this policy should be considered and applied to mitigate risks.
- Members of staff are also reminded of their responsibilities to ensure the correct use of copyrighted information.

12. Charitable Funds

There may be occasions when commercial organisations offer to make a donation into the ABUHB Charitable Funds. Monies paid into charitable funds from commercial companies must only be accepted as donations. Any offers where there is a benefit in return should be considered under the policy section relating to Sponsorship for Events Hosted Wholly or Partly by ABUHB. Where donations are received, they should only be used to fund expenditure which is in line with the terms of the charitable fund's use.

Expenditure from Charitable Funds and charitable fundraising within the workplace does not fall within the remit of this policy, however there may be a close association. Further guidance is available from the Charitable Funds Manager.

13. Failure to Adhere to Standards of Business Conduct Policy

If any Employee or Independent Member fails to declare an interest or gift, hospitality, honoraria or sponsorship as defined within this policy or the Standards of Behaviour Framework, and then:

- ·participates in a decision-making process where special favour is shown to unfairly award a contract; or
- ·abuses their official position or knowledge for the purpose of benefit to themselves, their family or friends

disciplinary action may follow. The action taken will depend on the individual circumstances and will be in accordance with the Health Board's Disciplinary Policy. Under some circumstances, failure to follow this policy could be considered gross misconduct.

In addition to any potential disciplinary action being taken, if there is any suspicion that fraud, corruption and/ or bribery has been or is being committed, then all such cases must be reported at the earliest possible opportunity to the Local Counter Fraud Specialist (LCFS) within ABUHB. This is also extended to include the inappropriate acceptance of any gifts, hospitality, honoraria or sponsorship.

Furthermore, if an employee breaches the Standards of Behaviour Policy or Framework, this could in certain circumstances result in notification/ reporting to the appropriate professional codes of conducts/ registration/ memberships i.e. Health Professions Council (HPC), General Medical Council (GMC), Nursing and Midwifery Council (NMC), etc. This could incur registrations being revoked and Employees no longer continuing to be employed in their current position within the Health Board.

13. Failure to Adhere to Standards of Business Conduct Policy cont.

Failure to declare a relevant interest by an Independent Member of the Board will be reported by the Chair to the Minister for Health and Social Services

14. Consultation, EQIA and Training Requirements

Consultation

The following groups were consulted with during the development of this policy:

- Workforce and OD Policy Group
- Audit, Risk and Assurance Committee
- Executive Committee

Equality Impact Assessment

An EQIA screening tool is currently in development to help staff to identify the relevance of each policy, project, function or major development/planning application to equality, and whether an EQIA should be undertaken.

In consideration of the EQIA guidance and the criteria outlined in the developing screening tool, the proposals are unlikely to have equality impacts and the Equality, Diversity and Inclusion Specialist is satisfied that a full EQIA is not required.

Training Requirements

There are no training implications arising from this Policy and the Standards of Behaviour Framework. However, awareness sessions will be held with managers.The importance of continued compliance will require reference in induction programmes, during Individual Performance Reviews, Consultant Appraisals, Consultant Job Plan Reviews and at times when Employees are invited to make declarations.

15. Audit and Review

The Director of Corporate Governance is responsible for the monitoring of this policy and its formal review every three years.

The Director of Corporate Governance will arrange for the Declarations of Interest Register and an overview of the gifts, hospitality, honoraria and sponsorship activities within ABUHB to be presented to the Audit, Risk and Assurance Committee at the end of each financial year.

The Audit, Risk and Assurance Committee will review and report to the Board upon the adequacy of the arrangements for declaring, registering and handling interests, gifts, hospitality, honoraria and sponsorship at least annually.

Audit Wales and the Health Board's Internal Audit Service may also review the arrangements from time to time and their findings are also reported to the Audit, Risk and Assurance Committee.

Staff should note that following implementation of the Freedom of Information Act 2000 the information contained within the Health Board Register will be subject to disclosure to any member of the public on request.

16. Legislative and NHS Requirements & Acknowledgements

Legislative and NHS Requirements

This policy aims to ensure that the Health Board complies with the requirements set out in: -

- (DGM(93)84) Standards of Business Conduct for NHS Staff
- WHC(2005)016 – The NHS and Sponsorship by the Pharmaceutical Industry
- WHC(2006)090 - The Codes of Conduct and Accountability for NHS Boards and the Code of Conduct for NHS Managers Directions 2006
- Director General, Health and Social Services, Chief Executive NHS Wales, Shared Values and Reinforcing Behaviour in NHS Wales (January 2011)
- Commercial Sponsorship - Ethical Standards for the NHS, Department of Health(November 2000)
- Code of Practice for NHS Wales Employers, Welsh Assembly Government (January 2011)
- Code of Conduct for Healthcare Support Workers in Wales,Welsh Assembly Government (January 2011)
- General Medical Council– Conflicts of Interest (September 2008)
- Health Board Standing Orders, Reservation and Delegation of Powers
- Nursing and Midwifery Council, The code - Standards of conduct, performance and ethics of nurses and midwives (May 2008)
- Royal College of Psychiatrists, Good Psychiatric Practice,Relationships with Pharmaceutical and Other Commercial Organisations (2008)
- Association of the Pharmaceutical Industry(ABPI), Code of Practice for the Pharmaceutical Industry (November 2011)
- The Institute of Chartered Secretaries and Administrators (ICSA), Model Conflicts of Interest Policy for NHS Trust Board Members (June 2010)
- The Bribery Act 2010
- NHS Counter Fraud Authority.
- Health Board Policy on Intellectual Property

Acknowledgements

This policy has been reviewed and developed against the following Health Board policies:

- Hywel Dda University Health Board Standards of Behaviour Policy (October 2022)
- Cwm Taf Morgannwg University Health Board Standards of Behaviour Policy (January 2023)
- Cardiff and Vale University Health Board Standards of Behaviour Policy (November 2022)

In this section you will find further guidance referenced throughout the policy



Examples of Relevant Interests

"Relevant interests" will include:-

(a) Directorships, including Non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.

(b) Ownership or part-ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with the Health Board. This includes shareholdings, debentures or rights where the total nominal value is £5,000 or one hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less.

(c) A personal or departmental interest in any part of the pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team.



(d) Sponsorship or funding from a known NHS supplier or associated company/subsidiary.

(e) A position of authority in a charity or voluntary body in the field of health and social care.

(f) Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.

(g) Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.

It is recommended that where there is doubt, a declaration of interest should be made.

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Types of Gifts

Gifts from Patients/Service Users or their Relatives

Employees may accept, subject to it not contravening their professional Codes of Conduct, gifts up to the value of £25 from patients /service users and relatives as a mark of their appreciation for the care that has been provided. This can include items such as chocolates, flowers, cards. There is no requirement to declare such gifts.

Where a gift is offered by patients or their relatives that is likely to be over £25 in value it should be politely declined. In some cases the gift may have been delivered and it may be difficult to return it or it may be felt that the bearer may be offended by the refusal. Under such circumstances the gift can be accepted, and the bearer advised that it will be utilised for the benefit of the Charitable Funds e.g. used as a prize in a raffle. A Gifts, Hospitality, Sponsorship and Honoraria Form declaring that the gift has been received must be completed. Employees should seek approval from their line manager prior to accepting any gifts.

Personal gifts of cash or gift vouchers/cards from patients or their relatives are not acceptable. It may only be accepted as a donation to an appropriate Charitable Fund and recorded as such.

Gifts from Suppliers/Commercial Organisations

No gifts, unless they are of low intrinsic value e.g. diaries,calendars, etc. are allowable from suppliers, contractors and other commercial organisations. All such offers of gifts should be politely declined.

Whilst it is not necessary to declare gifts of low intrinsic value, where other items are offered and declined a Gifts, Hospitality, Sponsorship and Honoraria Form should be completed. This will allow the Health Board to monitor when such organisations are inappropriately offering gifts or potential inducements.

Under some circumstances suppliers may send gifts to all of its clients as custom and practice e.g. hampers at Christmas. Whilst such practices should be discouraged and it is not acceptable for staff to personally accept these gifts, following discussion with the supplier/commercial organisation and line manager it may be considered appropriate to accept the gift and utilise it for the benefit of Charitable Funds.

Gifts of cash (including gift vouchers/cards) from suppliers/commercial organisations are not acceptable in any circumstances.



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Types of Gifts

Gifts from Dignitories / Overseas Organisations

There may be occasions when visits are made by dignitaries or overseas organisations who consider it "culturally custom and practice" to exchange gifts. In such cases Employees should seek guidance from their line manager initially and declare these gifts on a Gifts,Hospitality, Sponsorship and Honoraria Form. Further guidance may also be sought from the Director of Corporate Governance. A decision will then be jointly made as to the most appropriate way to manage the gift. This will depend on the nature of the "gift culture" and may include decisions to keep and display in public, donate to an internal user group, auction for charity etc.

Gifts to Groups of Staff, Service/Department or Organisation-Wide

Non-monetary gifts are sometimes made to show appreciation to the NHS from a patient/service user and/or their relatives, the general public, community groups, local business, suppliers, contractors or commercial organisations. Staff may accept non-monetary gifts that are voluntarily donated by a third party to a group of staff (e.g. whole ward or department), a service/department, or the whole organisation rather than to an individual, where there is no expectation of the donor receiving anything in return and where there are no conditions attached to the gift. Employees should seek approval from their line manager prior to accepting any gifts.

Where these gifts represent tangible items such as IT equipment, medical devices or electrical items, consideration should be given prior to accepting the gift to matters such as their compatibility with Health Board systems, their ongoing maintenance to comply with any warranties involved, storage, and any infection prevention issues with appropriate advice sought. Such gifts over the value of £25 should be declared on the Gifts, Hospitality, Honoraria and Sponsorship Form and registered to the group of staff or service/department receiving them. In addition, donated items over £5,000 must be recognised in the Health Board's Asset Register.

Bequests/Legacies/Wills

Employees are not permitted to accept bequests left to them by a deceased patient or service user who became known to them through providing care or treatment as part of their ABUHB employment. Accepting a gift of this nature, particularly where a patient is considered vulnerable, could leave the staff member open to accusations of financial abuse, fraud (by abuse of position) or misconduct. If an Employee is made aware that they may be a beneficiary in a patient's or service user's will e.g. by a deceased's legal representative, they must declare this to their line manager, with any complex cases escalated to the Director of Corporate Governance. In such a scenario, the Health Board will send a letter, endorsed by the employee, to those acting for the deceased's estate, advising that whilst the bequest cannot be accepted by the individual employee, the estate may, should they so wish, deposit the bequest in a designated charitable fund associated with the staff member involved, to benefit from a range of expenditure as per the charitable objectives of ABUHB's registered charity, Aneurin Bevan Health Charities, with the objective to "provide those additional amenities that will improve the conditions under which patients are cared for and treated or staff work".

Acceptable hospitality includes:

Offers of food and non-alcoholic drink, provided it is equivalent to that offered in similar circumstances by the NHS, can be accepted during working visits and does not need to be recorded in the Gifts, Hospitality and Sponsorship Register.

Other hospitality that may be accepted includes instances where:

- There is a genuine need to impart information, or represent the Organisation at Stakeholder Community Events e.g. Local Authority or Charitable organisations which have an association with the Health Board.
- An employee has been invited to receive an award or prize in connection with the work of the organisation or their role .
- An employee is invited to a Society or Institute Dinner or Function which is to be funded by a commercial organisation and where there is a genuine benefit to the professional standing of the individual or the Health Board.

These types of hospitality must be authorised prior to their acceptance by their line manager and a Gifts, Hospitality, Sponsorship and Honoraria Form must be completed. The hospitality should be proportionate i.e. it should not be of significant value and only the minimum number of Employees to achieve the purpose of representing the Health Board should attend.

Relationships with Pharmaceutical Industry

Should there be an established relationship with a pharmaceutical company where hospitality, such as lunches, is regularly provided, as long as the provision is in line with the ABPI code of conduct, the relationship needs to be declared to the Director of Corporate Governance (ABB.BoardSecretary@wales.nhs.uk) for inclusion on the pharmaceutical relationships register. A Gifts, Hospitality, Sponsorship and Honoraris form is not required.

Unacceptable hospitality includes the following examples as general guidance:

- A holiday or weekend/overnight break.
- Offers of hotel accommodation when this is not associated with a sponsored course or conference (see below).
- Use of a company flat or hotel suite.
- Attendance at a function or event restricted to Employees which is not for the purposes of training or organisational development.
- Lunch or dinner provided by a private company or their representative which does not form part of a training or development event.
- Entertainment and/or tickets/hospitality at sporting and other corporate entertainment events.

If employees are not clear whether an offer falls into one of these categories advice should be sought from their line manager in the first instance or if complex from the Director of Corporate Governance.

Employees should report any case where an offer of hospitality is pressed which might be open to objection. They should also declare on the appropriate form any offers of hospitality which are declined.

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Sponsorship for Research Projects

Sponsorship of a research project has specific legal responsibilities under the Clinical Trials Regulations. Before initiating a trial, the sponsor should define, establish and allocate all trial-related duties and functions. The NHS Research and Development (R&D) Forum Sponsorship Principles document provides a comprehensive summary of requirements, including various models of sponsorship and guidance on the allocation of responsibilities, duties or functions. If you wish the Health Board to Sponsor a research study you should contact the R&D Director prior to applying for a grant to ensure the Health Board is able to support the study or offer advice about alternative Sponsors.

Commercial Sponsorship for Attendance at Courses/ Conferences

Employees may accept commercial sponsorship for attendance at relevant conferences and courses, but only where the employee seeks permission in advance from their Line Manager. The sponsorship should only be extended to the number of Employees who would have normally attended if funded by the Health Board. The Line Manager must be satisfied that acceptance will not compromise purchasing decisions in any way.



Commercial Sponsorship to attend Demonstrations/Technical Evaluations

Employees may be invited to view products or equipment at another location. There may be occasions when it is appropriate as part of a procurement exercise to visit a suppliers' reference site to observe equipment in operation in a medical or laboratory setting. Such sponsorship is not usually considered appropriate and the Health Board will normally meet the costs of such a visit so as to protect the integrity of subsequent purchasing decisions.

Arrangements whereby the company meets all or part of the cost of such a visit must be approved by the appropriate Line Manager following consideration of the implications for the integrity of subsequent purchasing decisions.

Commercial Sponsorship for Sponsored Posts ('Linked Deals')

Pharmaceutical companies and other suppliers may offer to sponsor, wholly or partially, a post or equipment for ABUHB. The Health Board will not enter into such arrangements, unless it has been made clear to the company concerned that the sponsorship will have no effect on purchasing decisions within ABUHB.

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Types of Sponsorship

Sponsored posts must be approved and managed in order that appropriate monitoring arrangements are established to ensure that purchasing decisions are not being influenced by the sponsorship agreement. Under no circumstances may 'linked deals'be agreed, whereby sponsorship is linked to the purchase of particular products, or to supplies from particular sources.

Sponsored posts are posts that are funded,in whole or in part, by organisations external to the NHS. Sponsored posts can offer benefits to the delivery of care, providing expertise, extra capacity and capability that might not otherwise exist if funding was required to be used from the NHS budget. However, safeguards are required to ensure that the deployment of sponsored posts does not cause a conflict of interest between the aims of the sponsor and the aims of the organisation, particularly in relation to procurement and competition.

The following should be considered when sponsored posts are offered:

- External sponsorship of a post requires prior approval from the relevant Executive Director.
- Rolling sponsorship of posts should be avoided unless appropriate put in place to review and withdraw if appropriate.
- Sponsorship of a post should only happen where there is written confirmation that the arrangements will have no effect on purchasing decisions or prescribing and dispensing habits. This should be audited for the duration of the sponsorship. Written agreements should detail the circumstances under which organisations have the ability to exit sponsorship arrangements should conflicts of interest which cannot be managed arise.
- Sponsored post holders must not promote or favour the sponsor's products,and information about alternative products and suppliers should be provided.
- Sponsors should not have any undue influence over the duties of the post or have any preferential access to services, materials or intellectual property relating to or developed in connection with the sponsored posts.

The relevant Line Manager should declare any posts sponsored by external organisations on a Gifts,Hospitality, Sponsorship and Honoraria form and submit it to Director of Corporate Governance for recording on the register.

Sponsorship of Events in the Context of Partnership Arrangements with the Pharmaceutical Industry or other Commercial Organisations

The pharmaceutical industry and allied commercial sector representatives may organise meetings in support of specific functions or specialties within the healthcare sector. Under such arrangements they are permitted to fund the hiring of accommodation, meet any reasonable actual costs which may have been incurred and to provide appropriate hospitality. If no hospitality is required, there is no obligation or right to provide it, or indeed any benefit of equivalent value. An example of hospitality which would not be acceptable under these circumstances is where a company takes the attendees, on the conclusion of a course, for a meal in a restaurant.

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Types of Sponsorship

The Pharmaceutical Industry is expected to adhere to the ABPI Code of Practice for the Pharmaceutical Industry which clearly specifies what is and what is not acceptable; this is available via the following link:
2021 Interactive ABPI Code of Practice - Comes into operation 1 July 2021 (pmcpa.org.uk)

Sponsorship for Events Hosted Wholly or Partly by ABUHB

Where the ABUHB receives or invites offers of sponsorship for events which are hosted wholly or partly by the Health Board, the relevant Line Manager must consider whether it is appropriate to accept the offer. For all offers,whether accepted or declined, a Gifts, Hospitality, Sponsorship and Honoraria form must be completed and sent to the Director of Corporate Governance for recording on the register.

The following guiding principles should apply:

- Sponsorship of events by appropriate external bodies will only be approved if a reasonable person would conclude that the event will result in clear benefit for ABUHB and the NHS.
- During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection rules and legislation.
- No information should be supplied to the sponsor from which they could gain a commercial advantage, and information which is not in the public domain should not normally be supplied.
- ·the organisation's discretion, sponsors or their representatives may attend or take part in the event, but they should not have a dominant influence over the content or the main purpose of the event.
- ·The involvement of a sponsor in an event should always be clearly identified.
- Members of staff within the organisation involved in securing sponsorship of events should make it clear that sponsorship does not equate to endorsement of a company or its products and this should be made visibly clear on any promotional or other materials relating to the event.
- Members of staff arranging sponsored events must declare this to the organisation.

Whilst it is recognised that sponsorship can provide a useful source of funding for particular events or activities, it can also present risks and in considering whether to accept sponsorship, the following principles should be adhered to:

- Sponsorship should be sought in an open and even-handed manner with opportunities being offered as widely as possible.
- Benefits should be for the Health Board (not an individual) and should be proportionate.
- Arrangements must not compromise the standing or image of ABUHB i.e. they must be ethical.
- Sponsorship should be for a specific activity or event and not a general endorsement of the Health Board.
- The sponsorship must not imply that ABUHB endorses particular products, services or companies and organisations.
- Sponsorship should not be accepted from inappropriate sources, such as companies with dubious or doubtful backgrounds or who have poor financial or business practices.
- Arrangements must not bring adverse publicity to the event or the Health Board.

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Types of Sponsorship

Particular care should be taken when considering sponsorship from companies or organisations for which the Health Board has, or could have, contractual business arrangements. The above principles should be adhered to and a renewal or an award of a contract should not be influenced by any sponsorship arrangements.

A sponsor would normally expect to receive a reciprocal benefit which may be beyond a modest acknowledgement, and companies may seek sponsorship for a number of legitimate business reasons. These include:

- To raise the company's image and profile.
- To improve public/ community relations.
- To generate public exposure and media coverage.
- To differentiate the company from its competitors.
- To increase profit/market share.

Careful consideration should always be given to understanding what a sponsor might gain from the arrangement and these should be in keeping with the principles listed above.

Employees and Independent Members may, on occasion, be asked to provide an endorsement of an event, conference or training course that they have attended which was organised by a third party.

C

Caution should be exercised in these circumstances as it may not be appropriate to cite such an endorsement. It is also important to consider any potential future conflict, for example, where the third party may be in the process of re-tendering for the work or be seeking commercial gain from the endorsement.

ABUHB may also receive unsolicited proposals for sponsorship which is not in response to any action that the Health Board has taken. The Health Board should carefully consider such offers and ensure that the proposal meets the Health Board's requirements, standards and principles. ABUHB will need to ensure there are no conflicts of interest or that better value for money cannot be obtained by testing wider market interest.

All sponsorship arrangements should be approved by the appropriate Line Manager.



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Honoraria

Honoraria received for work undertaken during Health Board hours:

When appropriate authorisation has been granted to permit an employee to be involved in activity outside their normal contract during Health Board hours, any honoraria must be paid directly to the Health Board revenue budget to reimburse the Health Board for the Employee's time.

To ensure good governance, the honoraria must be paid into a revenue budget that is not managed by the Employee who has provided their services during Health Board time.



Honoraria received for work undertaken in an individual's own time (out of normal working hours or on authorised annual leave or union leave):

Individuals are personally liable for the paymentof both tax and NICs on any honoraria payments received for work undertaken in their own time.

Where an Employee wishes, a donation may be made to Aneurin Bevan University Health Board Charitable Funds in lieu of an honoraria. This must be received into the Charity's general fund and it is then for the Charity Trustees to determine how the donated funds should be used. The basic principle being that the employee giving their own time should have no influence over how the donation is then used and therefore lessens the risk of this being interpreted as being of any benefit to them as 'income' in any sense.

In cases of doubt, staff should seek advice from the Director of Corporate Governance and should report any case where an offer of sponsorship or honoraria is pressed which might be open to objection. Instances where honoraria has been offered and declined should still be declared on the Gifts, Hospitality, Honoraria and Sponsorship Declaration Form.

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	24 November 2026
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Post Payment Verification (PPV) Mid-Year Report 2026-2027
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Robert Holcombe – Director of Finance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Amanda Legge Post Payment Verification (PPV) Manager

Pwrpas yr Adroddiad
Purpose of the Report

Er Sicrwydd/For Assurance

The Audit and Risk Assurance Committee is asked to take assurance from the contents of this report. It highlights Post Payment Verification (PPV) progress and how practices have been performing over the April 1st – 30th September 2026 cycle. It compares the overall performance of the Health Board (HB) against the national PPV visits. There are no options included in this report. The report is for assurance and will only detail specific risks, if any, and provides the narrative for what PPV, Primary Care, Finance and Counter Fraud consider to be the best approach to support practices in improving.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

At mid-year and end of financial year, the PPV Manager will prepare a report for Health Board audit committees to outline how practices have been performing and highlighting PPV progress. The report is being produced for the Committee to review and seek assurance that the Post Payment Verification cycle is being managed appropriately. The purpose of the PPV process is to provide assurance to Health Boards that the claims for payment made by primary care contractors are appropriate and that the delivery of the service is as defined by NHS service specification and relevant legislation.

Cefndir / Background

PPV of claims from General Medical Services (GMS), General Ophthalmic Services (GOS) and General Pharmaceutical Services (GPS) are undertaken as a part of an annual plan by NHS Wales Shared Services Partnership (NWSSP).

Asesiad / Assessment

The following key points should be noted:

General Medical Services (GMS): Progress against the 2026/27 GMS visit programme is progressing well. During the first quarter, all PPV teams focused on undertaking routine GMS revisits alongside routine visits where required. As the backlog of work has now been addressed, the team is undertaking

practice revisits arising from previous findings, routine visits that have become due, and any ad hoc requests received from Health Boards.
A proportion of vaccination claims are now processed through the Welsh Immunisation System (WIS). Following issues identified by PPV during verification activities, new internal control processes have been implemented to prevent duplicate vaccination payments prior to payment being made, rather than relying on post-payment recovery processes.

General Ophthalmic Services (GOS): The GOS visit programme for 2026/27 is progressing more effectively than in recent years. This improvement is primarily due to the increased number of contractors who have adopted electronic patient records, enabling PPV to undertake a greater proportion of verification activities remotely. However, elements of physical visits remain necessary, as not all contractors currently operate electronic record systems.

General Pharmacy Services (GPS): During 2026/27, the PPV team continues to undertake verification of the Collaborative Working Scheme and the Quality and Safety Scheme. These reviews are conducted remotely, with data held by PPV being verified against supporting evidence requested from contractors.

In addition, PPV successfully conducted a pilot review of the Winter Incentive Scheme for one Health Board. The pilot produced positive outcomes, and the approach is now being rolled out nationally. The results will be incorporated into the year-end report.

Additional Services: Quarterly dispensing data checks continue to be undertaken, with ongoing enhancements being made to strengthen and streamline the process, ensuring a robust service moving forward. Results relating to the dispensing practices within Aneurin Bevan University Health Board have been incorporated into PPV reporting.

Training and Development: PPV training continues to be delivered to Health Boards and contractors as required. The team also provides tailored one-to-one support where requested, particularly for new practice staff working within primary care settings.

Data and Reporting**:** PPV data analysts are currently developing a suite of dashboards to enhance management information and reporting. These dashboards will provide additional insight and are intended to support future committee reporting requirements.

Clinical Waste Management: The PPV team also manages the Waste Management Audit programme on behalf of the Health Boards, offering advice and support to General Practitioners and Community Pharmacies in respect of Waste Management alongside the clinical waste self-assessments required to be completed by our contractors every three years. We will incorporate our WGOS contractors into our clinical waste process in the next financial year. The team is also continuing to investigate other avenues for savings from the provision of Clinical Waste services.

Stakeholder Engagement: Regular meetings are scheduled with all Health Boards and Counter Fraud teams to regularly review the progress report and to discuss themes, recommendations, and any risks.
In addition, the team facilitates quarterly national GMS and GOS Working Group meetings with Primary Care Managers and PPV representatives to support discussion and agreement on matters relating to the consistent national application of the programme. These meetings continue to provide valuable opportunities for collaboration and shared learning.

Argymhelliad / Recommendation

It is recommended that the Audit & Risk Assurance Committee Members note the contents of this report. There are no options included in this report and it is being produced for the Committee to review and seek assurance that the Post Payment Verification cycle is being managed appropriately.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Not Applicable 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.
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb	**No does not meet requirements**

Equality Impact Assessment (EIA) completed	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

Audit Report - 1st April to 30th Septem

General Medical Services (GMS) for 2025 - 2026

ABuHB = 35 visits c

GMS 2026-2027

Visit Type	HB Annual Visits Due
Routine	14
Revisit	21
TOTAL	**35**

General Ophthalmic Services (GOS) for 2025 - 2026

ABuHB = 23 visits wer

GOS 2026-2027

Visit Type	Annual Visits Planned
Routine	28
Revisit	9
TOTAL	**37**

General Pharmacy Services (GPS) 2025-2026

ABuHB = 31 visits wer

GPS 2026-2027

Visit Type	Annual Visits Planned
Routine	55
TOTAL	**55**

Due to commence in Quarter 3 of 2026/27

New Recovery process

DISPENSING 2025-2026

Quarter Period	Amount of Dispensing GP Practices
Quarter 1 & 2 2025/26 (Apr to Sep 2025)	12

Dispensing GP practices should not dispense to patients who live within 1.6 kms / 1 mile from a Local Community Pharmacy

ber 2026 = Aneurin Bevan University Health Board

ompleted with a total recovery of £54,246.91				ALL WALES = 156	
No. In progress	No. Recoveries	Value of recoveries	Value of Duplicate Recoveries	Total Recoveries	All Wales Visits Due
5	63	£2 365,26	£5 594,27	£7 959,53	95
5	594	£12 215,27	£0,00	£12 215,27	169
10	**657**	**£14 580,53**	**£5 594,27**	**£20 174,80**	**264**

re completed with a total recovery of £4,892.25				ALL WALES = 138 v	
No. In progress	No. Recoveries	Value of recoveries	All Wales visits due	All Wales No. in progress	All Wales Value of Recoveries
9	12	£546,33	145	63	£3 188,45
2	20	£703,60	64	14	£1 732,86
11	**32**	**£1 249,93**	**209**	**77**	**£4 921,31**

re completed with a total recovery of £9,759.62				ALL WALES = 232 v	
No. In progress	No. Recoveries	Value of recoveries	All Wales visits due	All Wales No. in progress	No. Recoveries
	0	£0,00	281	0	0

Value of Recoveries	All Wales Dispensing GP Practices	All Wales Value of Recoveries
£2 122,74	62	£42 478,77

6 visits completed with a recovery of £228,801.68			
All Wales No. in progress	All Wales Value of Recoveries	All Wales Value of Duplicate Recoveries	All Wales Total Recoveries
63	£15 071,29	£15 939,72	£31 011,01
65	£74 722,65	£683,20	£75 405,85
128	**£89 793,94**	**£16 622,92**	**£106 416,86**

visits were completed with a recovery of £20,003.35

visits were completed with a recovery of £46,088.70
All Wales Value of Recoveries
£0,00

GMS Summary

PRACTICE	Routine or Revisit	Overall Sample size	Claim errors	% Overall recovery	Value of recovery	Value of Duplicate recovery	Total recovery
Practice 1	Revisit	138	110	79,71 %	£2 911,65	£0,00	£2 911,65
Practice 2	Routine	325	12	3,69 %	£636,07	£2 071,59	£2 707,66
Practice 3	Revisit	1221	125	10,24 %	£3 424,21	£0,00	£3 424,21
Practice 4	Routine	281	25	8,90 %	£959,49	£357,99	£1 317,48
Practice 5	Revisit	1003	142	14,16 %	£3 327,93	£0,00	£3 327,93
Practice 6	Routine	173	7	4,05 %	£70,21	£110,33	£180,54
Practice 7	Revisit	259	215	83,01 %	£2 495,19	£0,00	£2 495,19
Practice 8	Routine	220	18	8,18 %	£670,70	£40,12	£710,82
Practice 9	Routine	341	1	0,29 %	£28,79	£3 014,24	£3 043,03
Practice 10	Revisit	51	2	3,92 %	£56,29	£0,00	£56,29

GOS Summary

PRACTICE	Routine or Revisit	Overall Sample size	Claim errors	% Overall recovery	Value of recovery
Practice 1	Routine	103	2	1,94 %	£55,19
Practice 2	Routine	103	0	0,00 %	£0,00

Practice 3	Revisit	300	16	5,33 %	643,37
Practice 4	Routine	103	0	0,00 %	£0,00
Practice 5	Routine	103	1	0,97 %	£68,04
Practice 6	Revisit	54	4	7,41 %	£60,23
Practice 7	Routine	103	3	2,91 %	£43,53
Practice 8	Routine	103	2	1,94 %	£71,63
Practice 9	Routine	96	3	3,13 %	£253,71
Practice 10	Routine	103	1	0,97 %	£54,23
Practice 11	Routine	103	0	0,00 %	£0,00

Breakdown of Recoveri	Advisory Notes
Immunisations and **DOAC/DOAR**.	• **The planned visits were sent to the HB for 2026/27 Visit Plan. These are subject to change due to ad hoc visits or closures/ mergers.** • **All closed visit files have been authorised by the Health Board GMS team with any concerns/ issues being addressed.** • **The duplicate amount**
Homes, Contraceptives,	
Surgery and **Near Patient**	
Homes, Contraceptives, **Denosumab**, Flu,	
Seekers, **Denosumations**. Duplicate recoverie	
Seekers and **Immunis**	
Care Homes, Flu,	
elins. Duplicate recoverie	
OAR, **Transgender** and	

Breakdown of Recoveries and	Advisory Notes
GOS 4W and	• **The planned visits**
All claims	

WGOS2	**were sent to the HB for 2026/27 Visit Plan. Numbers**
All claims	
WGOS 5	
GOS 4W	
GOS 4W	
WGOS 2	
GOS 6W	
WGOS 2	
All claims	

Internal Audit Progress Report

Audit, Risk and Assurance Committee

November 2026

Aneurin Bevan University Health Board

NWSSP Audit and Assurance Services

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Appendix A: Progress against 2026/27 Internal Audit Plan *6*

Appendix B: Audit Assurance Ratings *7*

Appendix C: Audit / Review Briefs Issued *8*

1. Introduction

The purpose of this report is to:

- confirm the status of the audit work for the 2026/27 Internal Audit Plan;
- seek approval for the delayed commencement of the Job Planning audit; and
- note briefs issued in the period for information.

2. Progress against the 2026/27 Internal Audit Plan

The current progress is summarised below, with further detail within Appendix B.

Audit Status	**Number**
Final reports	7
Draft reports	4
Work in progress	12
Planning	10
Request for deferral	1
Total number of audits planned	34

The following final reports have been issued since the meeting of the Audit, Risk and Assurance Committee on 15th September 2026:

AUDIT ASSIGNMENT	**ASSURANCE RATING**
Divisional Budgetary Control	Limited
Benefits Realisation (excluding digital)	Reasonable
Charitable Funds	Reasonable
Job Evaluation	Reasonable

Further information over the assurance rating detailed above is included within **Appendix C.**

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 15th September 2026.

Divisional Budgetary Control (limited)

Whilst appropriate policies, procedures and monitoring structures were in place, significant weaknesses were identified in budget setting, accountability and overspend management. Budgets were largely based on rolling forward historical allocations rather than activity, workforce and demand forecasts. Furthermore, budget holder accountability letters were not always issued or acknowledged, and overspends were not consistently supported by documented recovery plans or formal approvals.

Benefits Realisation (reasonable)

Benefits are generally identified during programme planning, linked to strategic objectives, and subject to governance and oversight, particularly for significant programmes and business cases. However, weaknesses were identified in the absence of a corporate-wide benefits realisation framework and a consistent approach to tracking, validating and reporting realised benefits across the non-digital portfolio. As a result, benefits monitoring is fragmented, limiting organisational visibility and assurance.

Charitable Funds (reasonable)

There is an effective governance and control framework for the management of charitable funds. We confirmed that donations were appropriately received, recorded, reconciled and allocated in line with donor intentions, with strong oversight from the Charitable Funds Committee. We raised, three medium priority findings. These related to strengthening Committee oversight of recurring charitable activities, reducing reliance on staff reimbursements by using formal procurement routes, and enhancing scrutiny of inactive and slow-moving funds. Overall, charitable funds are well managed.

Job Evaluation (reasonable)

We found a broad compliance with the NHS Job Evaluation Handbook, Agenda for Change requirements and local procedures, with job evaluation processes generally operating effectively and consistently. However, seven medium priority findings were identified. These included the need for a formal standard operating procedure, improvements to record keeping, data quality and reporting, stronger adherence to All-Wales referencing conventions, greater independence within consistency-checking arrangements, and better maintenance of training records.

4. Request for Deferral of Job Planning Audit

We have received a request to delay the commencement of the Job Planning audit until April / May 2027 onwards. Whilst there is regular management reporting over the completion of job plans, there will be delayed assurance against the audit scope objectives. However, a postponed audit start will allow us to expand the testing and to incorporate the job plan renewal process, alongside a larger sample size. In addition, we will be able to assess the impact of the actions underway, and the degree of progress made with the quality of job plans.

Therefore, to achieve the above position we are seeking **approval** from the Audit, Risk and Assurance Committee to postpone the Job Planning audit until April / May 2027.

5. Summary of Audit Briefs Recently issued

A summary of the briefs issued since the last Audit, Risk and Assurance Committee is provided within Appendix C, with copies of the final audit briefs included for information.

6. Recommendation

The Audit, Risk and Assurance Committee is invited to **note** the above points within the report and **approve** the request for the deferral of Job Planning until April / May 2027.

Appendix A: Progress against 2026/27 Internal Audit Plan

Reviews	Assurance Rating	Status
1. Divisional Budgetary Control	Limited	Final Report
2. Benefits Realisation (excluding digital)	Reasonable	Final Report
3. Falls Management	Reasonable	Final Report
4. Professional Staff Registration		Draft Report
5. Shadow IT	Reasonable	Final Report
6. NHH Regional Satellite Centre	Reasonable	Final Report
7. Policy Management		Work in progress
8. Governance of Escalation Level		Work in progress
9. Sustainable Funding		Planning
10. Charitable Funds	Reasonable	Final Report
11. Stakeholder Engagement		Planning
12. Duty of Quality		Planning
13. Value and Sustainability		Work in progress
14. Welsh Risk Pool Lessons		Work in progress
15. Hospital Sterilisation and Disinfection Unit (HSDU)		Draft Report
16. Patient Experience	Reasonable	Draft Report
17. Dementia Care		Planning
18. Mental Capacity Act - Deprivation of Liberty Safeguards		Planning
19. Cancer Referrals		Planning
20. Discharge Planning		Planning
21. Primary Care and Community Services Divisional Review		Planning
22. Clinical Audit		Planning
23. Job Planning		Request for deferral
24. Rostering & Operational Workforce Management		Work in progress
25. Vaccination Programme		Draft Report
26. Job Evaluation	Reasonable	Final Report
27. Follow-up of Agreed Actions		Planning
28. Electronic Prescribing and Medicines Administration		Work in progress
29. Project Management Office		Work in progress
30. Procurement of Digital Services		Work in progress
31. Networks		Work in progress
32. Capital Systems		Planning
33. Estates Assurance		Planning
34. Ophthalmology Review (2025/26)		Work in progress

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.

Appendix C: Audit / Review Briefs Issued

Audit Title	Status	Outline Scope
Hospital Sterilisation and Disinfection Unit (HSDU)	Brief issued	This audit will focus on the operational controls supporting HSDU services across the Health Board, including how these arrangements are governed, monitored and evidenced in practice.
Primary Care and Community Services Divisional Review	Brief issued	This review will assess a sample of divisional management arrangements, including delivery of IMTP / Annual Plan objectives and the management of key risks.
Procurement of Digital Services	Brief issued	The audit will seek to gain assurance that IT products purchased by the Digital, Data and Technology Directorate (on behalf of the Health Board) align with general procurement principles to ensure that best value is secured.
Welsh Risk Pool Lessons	Brief issued	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.
Governance of Escalation Level	Brief issued	This audit will review the arrangements in place for overseeing the Health Board's response to escalation, including how actions are managed, monitored and reported through the organisation.
Rostering & Operational Workforce Management	Draft brief issued	This audit will assess whether rostering arrangements are effective, compliant and optimised to support safe staffing and efficient workforce deployment. The review will also consider workforce planning arrangements within a sample of service areas and assess how workforce, demand and capacity plans are aligned to support operational and strategic objectives.
Sustainable Funding	Draft brief issued	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.
Stakeholder Engagement	Draft brief issued	The audit will seek assurance that stakeholder engagement arrangements within the Health Board are effective, inclusive, and embedded in decision making, supporting transparency and service improvement.
Mental Capacity Act	Draft brief issued	To provide assurance that 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.
Cancer Referrals	Draft brief issued	Building on the previous audit undertaken in 2025/26, this review will undertake a more detailed assessment of cancer pathway delivery, referral processes and demand forecasting, including how effectively these arrangements operate in practice and support achievement of cancer waiting-time targets.

Job Evaluation

Final Internal Audit Report

2026/27

Aneurin Bevan University Health Board



Reasonable Assurance

Contents

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Findings & Agreed Action Plan 3
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Review Reference	ABU-2627-20
Fieldwork	June - July 2026
Executive Sign Off	October 2026
Audit, Risk and Assurance Committee	November 2026
Executive Lead	Sarah Simmonds, Director of Workforce & OD
Audit Team	Stephen Chaney, Head of Internal Audit Eifion Jones, Deputy Head of Internal Audit

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

Executive Summary

Purpose

To ensure the requirements of the NHS Job Evaluation Handbook are being applied in a fair, consistent and equitable manner by the Health Board.

Overview

Job evaluation is a systematic process used to assess the relative value of roles within an organisation and support a fair and consistent pay structure. It forms a key part of the NHS Agenda for Change pay system, which aims to support workforce flexibility through the development and modernisation of roles. Aneurin Bevan University Health Board (the 'Health Board') is required to apply the NHS Job Evaluation Handbook in carrying out this process. Computer Aided Job Evaluation (CAJE) is the NHS electronic job evaluation system used to support job matching, local evaluation, consistency checking and the maintenance of audit trails in accordance with the Agenda for Change job evaluation Scheme.

In addition to the NHS Job Evaluation Handbook, the Health Board has developed local guidance and an intranet resource to support managers in understanding the job evaluation process and its implications for service redesign, role development, and organisational change.

We have concluded reasonable assurance on this area noting that the sample testing undertaken demonstrates compliance with national and local requirements. The matters requiring management attention include:

- Arrangements would benefit from a standard operating procedure to document the expected responsibilities/ activities of the job evaluation team – in preparing this document, management should be mindful that links within existing job evaluation guidance and intranet resources are broken or inaccessible.
- Testing found some inconsistencies in record-keeping across matched posts, re-evaluations and reviews.
- Number referencing conventions did not align with All-Wales guidance, potentially weakening the audit trail.
- Data quality issues were identified in the job evaluation database, including incorrect dates and reference numbers.
- Monthly activity reporting could be improved through improved presentation and trend analysis.
- The independence of consistency checking could be questioned without the introduction of further rotation of staff.
- Individuals training records should be retained, demonstrating sufficient refresher training.

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

Scope & Assurance Summary

	Objectives The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.	Related Findings	Assurance
1	The Health Board has appropriate policies and procedures in place, which set out the job evaluation process, roles and responsibilities, and promote fairness, consistency and equality for all members of staff.	1	**Reasonable**
2	Systems and processes for co-ordinating, monitoring and managing the evaluation of new posts, re-evaluations of changed posts and outcome review requests are compliant with policy.	2,3,4,5	**Reasonable**
3	Local consistency-checking arrangements are in place and align with the requirements of the NHS Job Evaluation Handbook.	6	**Reasonable**
4	Identified Job Matchers have received suitable training and support in relation to job matching, analysis, evaluation and outcome review requests	7	**Reasonable**

Management Actions

0	7
High Priority	Medium Priority

Themes



Risk Types

Quality or Safety Issues

Legal & Regulatory Non-Compliance

Public Perception & Reputational Risk

Findings & Agreed Action Plan

Objective 1: The Health Board has appropriate policies and procedures in place, which set out the job evaluation process, roles and responsibilities, and promote fairness, consistency and equality for all members of staff.	**Reasonable**

Overview / Summary of Observations

The NHS Wales Job Evaluation Handbook is the primary source of job evaluation guidance for NHS organisations and should be used alongside the NHS Terms and Conditions Handbook.

The ABUHB Job Evaluation Process Guidance is aligned with both the All-Wales Job Evaluation Policy and the NHS Job Evaluation Handbook, supporting the consistent application of the Agenda for Change framework. It provides clear and practical guidance on new post banding (matching), re-evaluation and review processes, while defining the roles and responsibilities of managers, job evaluation panels and staff-side representatives. The guidance promotes fairness, transparency and consistency and is more detailed and user-friendly than comparable guidance reviewed from other NHS organisations. Whilst the Job Evaluation Lead demonstrates strong knowledge of the process and manages it effectively, the development of standard operating procedures (SOPs) could strengthen resilience and support wider staff understanding of the process.

Testing identified several broken or inaccessible links within the guidance and related intranet pages, including links to the NHS Wales Job Description Template, the All-Wales Respect and Resolution Policy, and the Banding of Posts Policy. As managers and staff rely on these documents to support job evaluation decisions, inaccessible links may restrict access to key information, increasing the risk of inconsistent application of processes and non-compliance with national requirements.

	Key Findings	Risk & Impact	Agreed Management Action
1	**Policies and Procedures** Testing identified several broken or inaccessible links within the guidance and associated intranet pages: • NHS Wales Job Description Template (restricted access and not able to open) • All Wales Respect and Resolution Policy (link is broken and not able to open) • Banding of Posts Policy is not working on the JE intranet page (under the "Job Evaluation of Posts" page) As staff and managers rely on these documents when undertaking job evaluation activities, inaccessible links may restrict access to important information and increase the risk of inconsistent application of processes. In addition, the introduction of a standard operating procedure (SOP) would help strengthen staff understanding of the process and provide greater compliance.	Staff and managers may be unable to access key guidance, leading to inconsistent application of job evaluation processes. Increased risk of errors or non-compliance.	**Agreed Action:** The Health Board will undertake an immediate review of the Job Evaluation intranet pages and guidance. The broken, inaccessible or restricted links identified by Internal Audit will be corrected, replaced or removed as appropriate. Where access restrictions are necessary, clear instructions will be provided explaining how the relevant document can be obtained. A wider review of all Job Evaluation guidance and intranet content will confirm that links are active, documents are current and approved, obsolete content has been removed, and appropriate version control, ownership and review dates are recorded. Responsibility for maintaining published Job Evaluation information will be included within the Job Evaluation Officer's role, subject to appropriate management oversight. A documented annual review cycle and content-review log will be

			introduced, with updates made sooner where changes are identified between scheduled reviews. The Health Board will also develop and approve a Job Evaluation SOP or staff toolkit covering roles and responsibilities, panel arrangements, process requirements, timescales, independence and declarations of interest, case-file and record-retention requirements, consistency checking, escalation, exceptions, quality assurance and reporting. The approved SOP and revised guidance will be published and communicated to relevant staff, managers, panellists and staff-side representatives.
			Expected Evidence of Implementation: • Evidence that the links identified by Internal Audit have been corrected. • Completed review of all Job Evaluation intranet content and guidance. • Link and content-review log, including corrective actions. • Current controlled-document register. • Approved Job Evaluation SOP or staff toolkit. • Evidence of governance approval. • Evidence of publication and communication. • Confirmed responsibility for maintaining Job Evaluation content. • Approved annual review schedule. • Evidence of the first completed annual review.
		Medium Priority	**Officer:** Head of Workforce Planning supported by Business Support Team – Operational Manager
	Theme: Policies & Procedures	Control Design	**Target Implementation Date:** 31 December 2026

Objective 2: Systems and processes for co-ordinating, monitoring and managing the evaluation of new posts, re-evaluations of changed posts and outcome review requests are compliant with policy.	**Reasonable**

Overview / Summary of Observations

Job evaluation activity is undertaken through the national Computer Aided Job Evaluation (CAJE) system, which supports job matching, re-evaluation and review processes. Most posts are matched against established national profiles or previously evaluated linked roles, with the need for full Job Analysis Questionnaires now relatively rare due to the extensive range of national profiles available. Supporting documentation and records are maintained by the Job Evaluation Lead.

Audit testing found that the overall process is operating effectively; however, opportunities exist to strengthen process compliance, record management and reporting. Some inconsistencies were identified in the completion and documentation of job evaluation processes, and the Health Board has only recently adopted the All-Wales guidance numbering convention for recording amended and updated job descriptions. Consistent application of this guidance will help maintain a clear and comprehensive audit trail.

Testing also identified minor data quality issues within the job evaluation database, including duplicate records and date inaccuracies, which may affect the reliability of management information. Further enhancement could be achieved by recording service and divisional information to support trend analysis and reporting.

The recent introduction of monthly activity reporting is a positive development and provides valuable management information. Additional improvements to data reconciliation and outcome reporting would further strengthen oversight, performance monitoring and management assurance.

	Key Findings	Risk & Impact	Agreed Management Action
2	**Job Evaluation** As part of the audit, we tested the different processes involved in job evaluation (matched jobs, re-evaluation and reviews) and found slight discrepancies in the information held: **Matched Jobs:** Out of 146 posts (matched and linked) we tested 15 posts - 10 of which were matched and 5 were linked: • One post did not have an email from Line Manager requesting for the post to be considered for matching. • For one post tested, all three panellists were Workforce Directorate staff reviewing a nursing role (Head of Nursing Workforce Education & Professional Standards). In this instance, there is a risk that independence may be questioned. **Job Re-evaluation:** From the seven re-evaluated posts for 2026. the audit sampled 5 and found the following:	Inconsistent application of job evaluation processes may lead to incorrect or incomplete banding decisions	**Matched Jobs:** The Health Board will introduce a standard case-file template and checklist for matched, linked, re-evaluated and reviewed posts. The checklist will identify the documentation required and record any unavailable information or approved exception from the standard process. **Job Re-evaluation:** Where an original job description or Agenda for Change record cannot be located, the search undertaken, alternative evidence considered, limitations and rationale for proceeding will be documented. Historic job descriptions will continue to be assigned appropriate CAJE references. **Reviews:** Service standards will be established for acknowledging, validating, scheduling and completing review applications. Turnaround time will be measured from receipt of a complete application to the review panel. Delays and exceptions will be recorded and monitored through quarterly reporting.

	• 2 posts did not have the original AFC details as they could not be located (1 of which was a WOD role). **Reviews:** No reviews had been processed for 2026 recognising staff have up to 3 months to appeal if they are unhappy with the band outcome, so testing was focused on all five reviews undertaken in 2025: • 2 posts took a considerable time from the date of the application to the review panel (59 working days and 31 working days).		**Expected Evidence of Implementation:** • Standard case-file template and completion checklist. • Sample of completed job evaluation case files. • Approved records of any non-standard panel arrangements. • Procedure and sample evidence for cases where original records are unavailable. • Review service standards and quarterly turnaround-time reports. • Evidence of corrective action arising from identified gaps or delays.
		Medium Priority	**Officer:** Head of Workforce Planning supported by Business Support Team – Operational Manager **Target Implementation Date:** 31 December 2026
	Theme: Information, Data Quality & Data Accuracy	Control Operation	
3	**CAJE Referencing Convention** All-Wales guidance sets out the process for amending or updating job descriptions (JDs). Where an existing post has been amended, the original job match reference should be retained, with the suffix "A" added to indicate an amended job description (e.g. 2024/0012 A), together with a numerical identifier to record the number of amendments made to the original post. Audit testing identified instances where previously amended or updated posts had been assigned new unique reference numbers rather than retaining the original job match reference in line with All-Wales guidance. This approach can make it more difficult to track amendments and maintain a clear audit trail.	Non-compliance with All-Wales guidance may result in inconsistent record keeping and weakened audit trails.	**Agreed Action:** The Health Board has recently adopted the All-Wales guidance and has confirmed that the prescribed reference numbering convention will be applied consistently going forward.
			Expected Evidence of Implementation: • A copy of the adopted All-Wales process or local procedural guidance. • Examples of any legacy cases where a new reference has been issued, including the recorded rationale and link to the original record. • Results of a sample compliance review confirming that the convention is being applied consistently.
		Medium Priority	**Officer:** Head of Workforce Planning supported by Business Support Team – Operational Manager **Target Implementation Date:** Completed
	Theme: Information, Data Quality & Data Accuracy	Control Design	

4	**Data Accuracy** The Health Board maintains a separate database to record job-matched posts containing data quality issues, including inaccuracies in recorded dates and CAJE numbers: • Of the 4 records using the All-Wales reference numbering convention of "A", two of the references were recorded incorrectly. • Of 143 records for 2026, 10 errors were identified with the recorded dates. • Whilst no errors were identified with the cross-referencing within our sample of 10, further checking would be advisable given the errors identified at the first bullet. These errors increase the risk of incomplete or inaccurate reporting and monitoring. Management should review the dataset and implement appropriate controls to ensure information is recorded accurately, consistently, and maintained on an ongoing basis.	Risk of inaccurate and inconsistent reporting.	**Agreed Action:** The local database is for the internal team only, used as an easier tool to find and identify jobs in process. This database is not used for formal record keeping as CAJE is the primary system. Where there are any anomalies, CAJE will always be the primary source of accurate information, and the local-internal database is only used as a process-map (as CAJE does not have the functionality to do this). Quarterly data-quality audits will be completed using a defined sample and methodology. Identified errors will be corrected, recurring themes reviewed and further action taken where required. **Expected Evidence of Implementation:** • Baseline data-quality review and correction log. • Updated database-field guidance. • Evidence of communication to relevant staff. • Evidence of the validation control. • Quarterly data-quality audit reports, including findings, error rates and corrective actions.
		Medium Priority	**Officer:** Head of Workforce Planning supported by Business Support Team – Operational Manager
	Theme: Information, Data Quality & Data Accuracy	Control Operation	**Target Implementation Date:** 31 December 2026
5	**Activity Reports** Monthly activity reports are produced to summarise outcomes however these reports could be improved: • Monthly totals do not currently reconcile because they incorporate both activity undertaken within the month and activity carried forward from prior periods. • Reporting movements in post banding through data tables rather than narrative descriptions would facilitate enhanced data analysis and trend identification. This would improve the ability to analyse trends, support performance reporting, and provide greater insight into the impact and outcomes of the job evaluation process across the organisation.	Inadequate Job Evaluation reporting may result in poor oversight and unreliable management information on outcomes and trends.	**Agreed Action:** Following discussion with the Trade Union Partnership Forum, formal Job Evaluation activity reports will be presented on a six-monthly basis, with additional reports provided where requested. Activity will continue to be recorded and monitored throughout the year. The revised report will distinguish between cases brought forward, new submissions, completed or closed cases, cases awaiting information and the closing caseload. A reconciliation will demonstrate how the opening caseload, activity during the period and closing caseload relate to one another. The dashboard will include:

	A possible improvement to the reporting would be to include the service areas/ Divisions of the request, to facilitate trends analysis.		• number and type of matched and job evaluation requests; activity and outcomes by division; • turnaround times and performance against agreed service standards; • re-evaluations, reviews and outcomes – band increases, decreases and unchanged outcomes; • rolling 12-month trend analysis. Numerical outcomes will be presented through structured data tables, supported by narrative explanation where required. The underlying data and reconciliation will be subject to documented management review before each report is issued.
			Expected Evidence of Implementation: • Revised six-monthly activity report and dashboard • Documented reporting definitions. • Banding outcome and turnaround-time tables. • Rolling 12-month trend analysis. • Evidence of management review and approval. • Relevant committee or forum minutes confirming receipt and consideration of the report.
		Medium Priority	**Officer:** Head of Workforce Planning supported by Business Support Team – Operational Manager **Target Implementation Date:** 30 April 2027
	Theme: Performance Monitoring	Control Design	

Objective 3: Local consistency-checking arrangements are in place and align with the requirements of the NHS Job Evaluation Handbook.	**Reasonable**

Overview / Summary of Observations

In accordance with the NHS Job Evaluation Handbook (8th Edition, January 2024), all job evaluation outcomes should be subject to consistency checking by appropriately trained and experienced practitioners working in partnership between management and staff-side representatives. While the Handbook does not explicitly require consistency checkers to be independent of the matching or re-evaluation panel, this is recognised as good practice as it strengthens objectivity, segregation of duties and confidence in the integrity of the process.

Audit testing identified several cases where the same individuals participated in both the evaluation or re-evaluation panel and the subsequent consistency-checking process. The Health Board has a limited pool of consistency checkers, comprising five workforce representatives, which contributes to this practice. However, the involvement of the same individuals at multiple stages reduces the level of independent scrutiny and challenge that consistency checking is intended to provide.

This approach increases the risk that errors, inconsistencies or subjective judgements may not be identified or sufficiently challenged, potentially undermining the robustness, fairness and transparency of job evaluation outcomes. Discussions with the All-Wales Job Evaluation Lead confirmed that, where possible, consistency checking panels should comprise different members from those involved in the original evaluation or re-evaluation to maintain independence and strengthen assurance

	Key Findings	Risk & Impact	Agreed Management Action
6	**Consistency Checking** Of the 20 jobs sampled (10 matched, 5 linked and 5 re-evaluations), consistency checking was undertaken exclusively by the same staff-side representative and management representative, both from the Workforce Directorate. Whilst full training records were not retained (see **finding 7**), it was thought that only a handful were trained consistency checkers and all resided within the Workforce Directorate. Through our interviews, other individuals suggested they had also received the relevant training. To ensure that independence and objectivity is retained, the consistency checking should be rotated with staff from various parts of the organisation – this may be particularly important where an individual has already been involved in the evaluation panel.	Insufficient segregation of duties may result in incorrect or inconsistent job evaluation outcomes not being identified Reduced independence in the review process	**Agreed Action:** The Health Board recognises that the current pool of trained consistency checkers is limited and primarily based within the Workforce Directorate. The pool will be expanded to include appropriately trained management and staff-side representatives from a broader range of staff groups, working in partnership with the Job Evaluation Staff Side Lead to ensure consistency checking continues to be undertaken in accordance with the NHS Job Evaluation Handbook. Training has been offered to existing Job Evaluation panellists, with seven individuals currently scheduled to attend sessions in October and November 2026. Further training will be arranged in early 2027 to increase the pool of trained matchers. In line with All-Wales arrangements, separate consistency checking training will be offered to trained matchers once available, supporting the expansion and rotation of the consistency checking function.

			A central register will record training completion, organisational area, management or staff-side representation, job evaluation panel participation and consistency-checking activity. Individuals will not normally undertake consistency checks on cases in which they participated during the original evaluation process. Any exceptional departure from this requirement will be documented, risk-assessed and approved by the Job Evaluation Lead. All consistency checkers will confirm their independence and declare any actual, potential or perceived conflicts of interest. Compliance with training, rotation and segregation-of-duties requirements will be reviewed quarterly during implementation and reported annually once the arrangements are fully embedded.
			Expected Evidence of Implementation: • Register of trained consistency checkers. • Training attendance and completion records. • Evidence of representation from different organisational areas. • Updated segregation-of-duties and rotation guidance. • Sample cases showing that the consistency checker was independent of the original panel. • Approved records of any exceptions. • Quarterly compliance reports and an annual assurance report.
		Medium Priority	**Officer:** Head of Workforce Planning supported by Business Support Team – Operational Manager **Target Implementation Date:** 31 January 2027
	Theme: Resourcing	Control Operation	

Objective 4: Identified Job Matchers have received suitable training and support in relation to job matching, analysis, evaluation and outcome review requests.	**Reasonable**

Overview / Summary of Observations

Training for job matching, job analysis and consistency checking is delivered through annual training programmes. The Health Board currently maintains a pool of 32 active panel members, comprising 21 management representatives and 11 staff-side representatives.

From our sample of 15 posts, it was observed that all exercises to date had been completed by a core of 18 staff, with a significant proportion delivered by 13 key members of staff. It may be prudent to review the availability and capacity of the current cohort to meet future demands, to offer more choice, reduce the risk of bias and to ensure consistency.

Discussions with a sample of active members indicated that they feel appropriately trained, well supported and confident in undertaking their responsibilities within the job evaluation process. A record of trained job matchers is maintained; however, it does not distinguish whether they are trained to participate in matching, re-evaluation and/ or consistency panels. Training completion dates were also not consistently recorded, limiting the Health Board's ability to evidence that all panel members have completed the required training and continue to meet competency requirements. In addition, incomplete records reduce the ability to monitor compliance, identify refresher training needs and maintain a comprehensive audit trail.

To strengthen governance, assurance and operational oversight, the Health Board should ensure that attendance and completion of both initial and refresher training are systematically recorded, regularly reviewed and supported by a clear record of panel member authorisations and competencies. This would provide greater assurance that appropriately trained individuals are undertaking job evaluation activities and that training requirements are being effectively managed.

	Key Findings	Risk & Impact	Agreed Management Action
7	**Refresher Training** Whilst a register of panel members exists and included the date of initial training in some cases, comprehensive evidence of training completion is not consistently recorded or retained for all individuals. As a result, management is unable to readily demonstrate that all relevant staff have received the required training. A significant element of activity is delivered by 13 of the 32 active panel members. Ahead of determining training requirements, it would be opportune to assess the capacity/ availability of the current cohort to determine whether additional staff should be trained.	Incomplete training records may result in inconsistencies in the application of job evaluation processes and reduce assurance of compliance with Agenda for Change requirements.	**Agreed Action:** The Health Board will maintain a comprehensive training and competency matrix for all Job Evaluation panellists. The matrix will record initial and refresher training, evidence of completion, authorised competencies, management or staff-side status, organisational area, panel participation and current active status. Refresher courses should be repeated every three to five years in order for practitioners to feel up to date with any guidance released by the Job Evaluation Group (JEG) and NHS Employers. Inactive or infrequently used panellists will be contacted to identify barriers to participation. Individuals will be removed from the active list where appropriate. Those returning after an extended period of inactivity will have their training needs assessed before resuming panel activity. An annual capacity and succession-planning review will assess the number, availability, utilisation, representation and competencies of active panellists. The review will specifically consider the current reliance on 13 of the 32 active panellists and

			determine whether additional staff should be recruited and trained. Training compliance, panel participation, capacity and identified gaps will be reported six-monthly to the Job Evaluation Steering Group and Trade Union Partnership Forum.
			Expected Evidence of Implementation: • Completed training and competency matrix. • Initial and Refresher training completion record • Annual capacity and succession-planning review. • Approved refresher training standard and programme. • Current active panel-member register. • Evidence of engagement with inactive panellists. • Analysis of activity across the trained panel cohort. • Recruitment and training plan, where gaps are identified. • Six-monthly training compliance and capacity reports. • Relevant meeting minutes demonstrating oversight and follow-up.
		Medium Priority	**Officer:** Head of Workforce Planning supported by Business Support Team – Operational Manager
	Theme: Training & Development	Control Design	**Target Implementation Date:** 30 April 2027

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.

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 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 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]

Divisional Budgetary Control

Final Internal Audit Report

2025/26

Aneurin Bevan University Health Board



Limited Assurance

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Review Reference	ABU-2526-01
Fieldwork	February - June 2026
Executive Sign Off	November 2026
Audit Committee	November 2026
Executive Lead	Robert Holcombe, Executive Director of Finance, Procurement & Value
Audit Team	Stephen Chaney, Head of Internal Audit
	Eifion Jones, Deputy Head of Internal Audit

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

Executive Summary

Purpose

The overall scope of the audit was to ensure that the Budgetary Control Financial Control Procedure (the 'FCP') was adhered to within a sample of divisions, with the overall objective of determining if financial sustainability was being maintained.

Overview

The review of Divisional Budgetary Control was completed in line with Aneurin Bevan University Health Board's (the 'Health Board') 2025/26 Internal Audit Plan.

The Health Board is required to adopt Standing Financial Instructions (SFI), which govern the regularity of financial transactions. In particular, *SFI Section 5 – Financial Management and Budgetary Control* includes sub-sections addressing Budgetary Delegation; Financial Management, Reporting and Budgetary Control; Capital Financial Management, Reporting and Budgetary Control; and Reporting to Welsh Government with the Monthly Monitoring Returns.

The Health Board was expected to break-even by month 12 of 2025/26, achieving at least £40.4m of savings to do so. Whilst the Health Board ultimately achieved savings totalling £43.3m, additional cost pressures arising during the year led to a month 12 deficit of £18.3m.

The audit focussed on the principal expenditure control process of budgeting (up to and including month 10), the subsequent monitoring of spend and budget variance and application of the FCP in a sample of divisions.

We have concluded limited assurance on this area, as whilst budgetary control arrangements are in place, divisional budget holders did not always maintain a balanced budget or ensured overspends were addressed. The matters requiring management attention include:

- some budget holder accountability letters were not issued and / or returned/ signed within a sample of divisions tested;
- the budget setting model used by the divisions does not reflect actual activity levels and the same approach is applied each year without adjustment for prior outcomes;
- prior consent to overspend and overspend recovery plans were not documented, and opportunities pipelines were not implemented at sufficient pace; and
- there were instances of virement transaction values which exceeded the authorisation limits of approving officers.

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

Scope & Assurance Summary

Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	Policies and procedures are available to budget holders, are up-to-date and reflect current working practices	-	**Substantial**
2	Budget holder responsibilities are defined and observed	1,3	**Reasonable**
3	Deliverable service plans (e.g. workforce / capacity plans) are developed that are within delegated divisional budget allocations	2	**Limited**
4	Budget variances that arise in the year are monitored and overspends are addressed	3	**Limited**
5	Virements used to reallocate funds between divisions are controlled and monitored	4	**Reasonable**

Management Actions

2

High Priority

2

Medium Priority

Themes



Finance Management & Control

Risk Types

Financial Loss

Legal & Regulatory Non-Compliance

Public Perception & Reputational Risk

Findings & Agreed Action Plan

Objective 1: Policies and procedures are available to budget holders, are up-to-date and reflect current working practices — **Substantial**

Overview / Summary of Observations

Health Board Policies and Procedure documents that are associated with budgetary control were identified as follows:

Policy/ Procedure	Issue date	Expiry date
Reservation and Delegation of Powers	February 2025	February 2028[1]
Standing Financial Instructions (SFI)	May 2025	May 2028[1]
Budgetary Control Financial Control Procedure	18.09.2025	18.09.2028

Note 1. Expiry dates are derived by taking the issue date and adding three years, the conventional review period for these documents

Documents were examined and we noted that the Reservation and Delegation of Powers and SFI documents were based on all-Wales models in each case. We tested documents currency/ expiry by examining dates of preparation of existing versions/ statement of review date. We found no expired documents in this set and report no findings under this objective of the audit.

Objective 2: Budget holder responsibilities are defined and observed	**Reasonable**

Overview / Summary of Observations

Budget holder responsibilities are set out in some detail in the documents referenced under objective two above. In summary, these cover the following aspects:

1. Manage services within the delegated budget

Budget holders must deliver services within the financial limits assigned to them and use budgets only for their designated purposes.

2. Monitor financial performance and act early on variances

They must review monthly financial reports, track actuals vs budget, use the QlikSense dashboard, and take prompt action—such as recovery plans or seeking approval—whenever overspends or income shortfalls are likely.

3. Comply with governance, approvals, and financial controls

Budget holders must follow the Scheme of Delegation, Standing Financial Instructions, and procurement rules, ensuring staffing, spending decisions, and any changes (e.g., virements) meet required approvals

The FCP for Budgetary Control also provides the following proforma:

- Example of a Budget Delegation Letter (see **Objective 3**).
- Template for Line Manager/Budget Holder Recovery Meeting(s) (see **Objective 4**).
- Budgetary Control Policy Virement Form (see **Objective 5**).

The audit identified several non-compliances with the FCP within the divisions sampled.

Budget delegation letters are an additional governance tool used by the Health Board to delegate to budget holders, to ensure clarity, accountability, and compliance in the management of delegated budgets, as set out within Section 7.2 of the FCP. Budget holders receiving delegation letters are required to acknowledge their acceptance of the terms and the sums delegated by signing and returning these.

However, as identified within our sample testing, the absence of letters or delays in issuing the letters increase the risk that budget holders may not be complying with the content (**Finding 1**).

Key Findings		Risk & Impact	Agreed Management Action
1	**Budget holder accountability letters** As outlined within Section 7.2 of the FCP for Budgetary Control, delegation letters are used as an additional governance tool to detail responsibilities and expectations of budget holders. Sample testing identified: • two budget delegation letters to divisional directors were not issued until Q2 of 2025/ 26 (Medicine – August and DDAT – September), the third (Surgery – November) in Q3; • in two of the divisions (Medicine / Surgery), no delegation letters were issued to heads of directorates; and • only one (Medicine) of the three divisional directors' letters was acknowledged by the return to the Chief Operating Officer of a signed copy. Therefore, there is a risk that budget holders did not access them and may not be complying with their content.	Risk that budget holders do not operate the required budgetary disciplines that are required and that financial loss arises as a result.	**Agreed Action:** Executives will ensure letters will be issued and a record of acceptance will be progressed and pursued for all delegates. **Expected Evidence of Implementation:** Records available and responses followed up.
		Medium Priority	**Officer:** Chief Operating Officer & Director of Digital **Target Implementation Date:** 31st December 2027
	Theme: Finance Management & Control	Control Operation	

Objective 3: Deliverable service plans (e.g. workforce / capacity plans) are developed that are within delegated divisional budget allocations	**Limited**

Overview / Summary of Observations

We noted that budget setting for the Health Board in 2025/26 was conducted as a two-phase approach:

- phase 1 to establish baseline delegated budgets using a rollover method;
- phase 2 to distribute remaining allocation funding and expected income to align with Integrated Medium-Term Plan (IMTP) objectives, Welsh Government and Health Board planning priorities.

Phase 1 budgets were approved in March 2025 when budget allocations were delegated to divisions, and phase 2 was concluded in July 2025.

Divisions are required to undertake an annual budget-setting exercise with directorate managers and clinicians for each area. We noted that in this exercise, divisions are asked to complete a plan aligning the service needs/capacity, workforce and finance, but one that can be delivered within their delegated financial resources. While budgets for the sampled divisions were developed within delegated financial resources, they were not developed through the detailed assessment process outlined above. Instead, they were largely derived from prior year budgets with minor amendments and demonstrated limited evidence of fundamental change to support IMTP delivery.

There should be a greater consideration of cost pressures and operating within the financial envelope available and budgets should be set in accordance with Section 7.1 of the FCP, including 'in line with revenue, capital, commissioning, activity, service, quality, performance and workforce plans' (**Finding 2**).

	Key Findings	Risk & Impact	Agreed Management Action
2	**Budget setting methodology in the divisions** We noted that new year divisional budgets (all areas sampled) are set using a model where prior year recurrent budgets are rolled-over and adjusted for some incremental changes in line with the Welsh Government and Health Board planning priorities rather than one based on realistic expenditure, capacity and demand forecasts derived from activity, service, performance and workforce plans etc., reflecting expected activity levels. Noting that Welsh Government requires the Health Board to identify pipelines of opportunity as part of strategic planning, each division is required to identify their own opportunity pipelines for consideration during strategic and financial planning.	Budgets based on unrealistic figures, increases the likelihood of: • recurrent budget deficits, • inability to meet commitments, • reactive cuts later in the year.	**Agreed Action:** The IMTP process is a multi-disciplinary corporate approach to developing service workforce and financial plans. The DoF will provide clarity of financial implications of plans proposed and the CEO will set budgets within available funding limits for Board approval. The Board approved a deficit plan and some budget overspends will be expected. Budget holders are expected to live within those plans and adjust services to match available budgets. The ABUHB FCP for budgetary control provides guidance on this process. The Performance Framework reinforces this as well as V&SB reporting.

			Expected Evidence of Implementation: Detailed Budget Setting at Budget holder level.
		High Priority	**Officer:** Chief Operating Officer & Director of Digital **Target Implementation Date:** 31st March 2027 (to focus on 27/28 budget setting round)
	Theme: Finance Management & Control	Control Design	

Objective 4: Budget variances that arise in the year are monitored and overspends are addressed	**Limited**

Overview / Summary of Observations

We noted the following oversight activities are in place for budget variance monitoring:

- Budget holders can use QlikSense for self-service monitoring of spend against cost centres and available budgets. Whilst it does not include forecast data, forecasts are discussed at BPA team meetings, including mitigating actions for overspends. It was also observed that some budget holders are infrequent users and may not be familiar with all of the functions available.
- Finance business partners (FBP) conduct directorate level budget holder review meetings with directorate heads.
- Division level finance managers attend Division Management Team (DMT) meetings where their MI packs provide summary budget actual variance and comprehensive financial analysis and reporting.
- Health Board level monthly financial performance is reported to the Finance & Performance Committee and Board meetings.
- Health Board level Monthly Monitoring Returns (MMR) of IMTP progress/ financial data are made to Welsh Government.

Meeting cycles are generally monthly and typically documented. However, we found in our sample testing of the meetings held within the Medicine, Surgery and Digital, Data & Technology divisions that the format, content and level of detail varied.

As discussed under **Objective 2**, because of the budget setting approach adopted by the Health Board in the current climate of underfunding, overspends by the divisions often arise and this was the case with the three sample divisions examined in this audit. Analysis of the M10 Finance Performance Report content revealed that stand-out overspend drivers affecting the clinical divisions in 2025/26 were volume growth beyond plan funded levels and increased levels of enhanced care – full details are provided at **Appendix B**.

Regarding measures to control or constrain spend, documented budget holder responsibilities stipulate the following measures:

- any likely overspending, or reduction of income, that cannot be met by virement, is not incurred without the prior consent of the Chief Executive (Section 6.5 of the FCP); and
- remedial actions to recover a budget deficit (where this cannot be addressed by virement) should be agreed and recorded in a recovery plan (Section 7.5 of the FCP). Furthermore, where actions / virements do not recover a deficit position, the Audit, Risk and Assurance Committee and the Board should agree remedial actions, with a record maintained.

Other than the posting of virements to address budget overspends (see audit objective five that follows below) we saw no instances of these control measures operating across our three sample divisions, where we noted overspending against cost centre allocated budgets. (**Finding 3**)

Key Findings		Risk & Impact	Agreed Management Action
3	**Overspend consent and documented recovery plans** Whilst there was no lack of oversight monitoring (across all areas sampled) of budget overspends taking place in the divisions, we noted an absence of senior management prior consent to directorate overspending and documented recovery planning where this was occurring, as set out within Sections 6.5 and 7.5 within the Budgetary Control FCP. This may foster a culture in which budget overspends are seen as an acceptable consequence of day-to-day operations. In addition, budget holders often seek to reduce the specific cost driver, instead of exploring cost savings in wider areas, to support an overall reduction.	Unplanned or unauthorised overspending could put the Health Board in breach of its statutory financial duties.	**Agreed Action:** Budget holders have responsibilities, which they acknowledge within the signature of their delegation. The expectation is that they deliver to their allocated budget and if they overspend, that monies are re-allocated from a surplus to achieve a balanced position. This should be completed / considered before incurring the deficit. To ensure adherence to the FCP Budgetary Control Policy, they have a responsibility to clearly set out how a deficit will be recovered, if a virement can not ensure a balanced position. Section 7.5 of the Policy sets this out. Executive assurance meetings and the PADR process should be used to ensure a balanced position is retained, as it is part of the budget holder's responsibilities. V&SB workstreams are designed to facilitate cross organisation working and identify opportunities for local implementation. The ABUHB performance accountability framework also facilities driving improvement.
			Expected Evidence of Implementation: Budget holder meeting notes Assurance meetings notes Special Budget holder escalation meeting notes
		High Priority	**Officer:** Chief Operating Officer & Director of Digital **Target Implementation Date:** 31st December 2027
	Theme: Finance Management & Control	Control Operation	

Objective 5: Virements used to reallocate funds between divisions are controlled and monitored	**Reasonable**

Overview / Summary of Observations

Virements are a means of addressing a budget overspend but require an excess of funds available in another budget area. Where movements are between areas under the control of the same budget holder, no approval processes are adopted. Where virements are between different budget holders, these must be evidenced on the prescribed form (as outlined within Section 7.6 and Appendix 3 of the FCP for Budgetary Control), signed by the donor and receiver and entered onto a central 'budget journal' log before being posted to Oracle. A total of 792 virements had been logged in 2025/26.

We noted that the virement or allocation of central budget reserves should be formally notified to the Board as appropriate through the financial year, although we did not encounter any of this classification in our sample testing nor in our review of Finance & Performance Committee and Board papers in 2025/26.

Our sample testing of a total of 12 virement record forms across our three sample divisions, from the central log, revealed the following exceptions:

- virement values exceed the ASL authority limit of the signatories for 6 of the 12 sampled cases.
- donor details were absent from one of the virement record forms in the sample (**Finding 4**).

	Key Findings	Risk & Impact	Agreed Management Action
4	**Virement authorisation anomalies** We noted the following exceptions in the sample of virements we tested: • virement values exceed the authorised signatory list authority limit of the authorising signatories for 6 of the 12 sample cases. • donor details were absent from one of the virement record forms in the sample.	Risk that virement transfer of budget allocation is inappropriate and contrary to other planned allocations.	**Agreed Action:** The authorised signatory list is designed to manage spend controls. Budget holders are able to transfer budget within delegated limits. Compliance with virement forms process will be communicated out to budget holders. **Expected Evidence of Implementation:** Communication email.
		Medium Priority	**Officer:** Director of Finance **Target Implementation Date:** 30th November 2026
	Theme: Finance Management & Control	Control Operation	

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

Appendix B

Below is an analysis of the overspend drivers operating and corresponding mitigating actions from the 2025/26 M10 Finance Performance Report:

Division	Overspend Driver	Description of Driver	Mitigating Actions planned/ taken
Medicine	High patient acuity & demand	Increased enhanced care, winter surge activity, extended length of stay	Time limited winter wards; tighter enhanced care authorisation; "Our Next Patient" flow actions; discharge acceleration to reduce bed days
Medicine	Medical workforce & variable pay	Consultant sickness; reliance on locums and RN agency cover; ambulance handover delays	Substantive consultant recruitment; reduction in locum and RN agency usage; operational reviews targeting variable pay reduction; roster optimisation
Medicine	Drugs & medicines costs	High-cost acute and specialist drugs; volume growth beyond plan	Biologic and biosimilar switching; national generic switches; medicines optimisation schemes; prescribing delays/alternatives where clinically appropriate
Medicine	Delayed service/bed reconfiguration savings	Planned efficiency savings not realised in year due to timing	Revised delivery profiles; ongoing operational reviews; use of prior year purchased equipment to offset current year costs
Surgery	Additional planned care & cancer activity	104 week RTT clearance schemes; cancer growth beyond funded levels	Improved matching of activity to confirmed non-recurrent funding; tighter CTR monitoring; reduction of excess unfunded elective capacity
Surgery	Drugs & theatre consumables	High-cost surgical drugs; consumable price inflation	Biosimilar and formulation changes; standardisation of procedure packs; increased use of reusable instruments; procurement renegotiation
Surgery	Workforce & on call arrangements	Enhanced Care nursing costs; premium on call models	Skill mix and rota redesign; SAS cover replacing consultant on call where appropriate; substantiating posts to reduce temporary cover
Surgery	Equipment & maintenance costs	Leasing costs for surgical/robotic equipment; fragmented contracts	Lease buyout vs purchase decisions; consolidation of maintenance contracts; capital investment where whole life cost is lower
Digital / Data	End of non-recurrent programme funding	Digital systems and staff retained after project funding ended (£5m pressure)	Review of digital baseline costs; identification of costs to stop, re-scope, or recurrently fund through IMTP
Digital / Data	Contractual & licensing costs	Microsoft 365; hybrid mail; digital communications platforms	Contract review and cost control; costs recognised as unavoidable and built into underlying financial position

Division	Overspend Driver	Description of Driver	Mitigating Actions planned/ taken
Digital / Data	Delays to national programmes (RISP, LIMS)	Dual running of legacy systems; reliance on ageing infrastructure	Zero tolerance escalation of slippage; enhanced portfolio governance; escalation to WG/DHCW; strategic risk SRR 006B
Digital / Data	Digital resilience & cyber risk	Increased dependency on digital systems	Preventative investment in cyber resilience and infrastructure refresh to avoid unplanned failures and emergency costs
All divisions	Variable pay growth	Sustained operational pressures driving agency and bank usage	Variable Pay Reduction Programme; recruitment to vacancies; e-rostering and e-job planning to improve deployment
All divisions	Reliance on non-recurrent savings	46% of savings non-recurrent, increasing future risk	Work to make savings recurrent; Value & Sustainability Board oversight; divisional deep dives
All divisions	Winter and demand led pressures	Seasonal surge activity beyond baseline capacity	Time limited winter investments; use of reserves; escalation planning and recovery actions
All divisions	Historic overspending	Historic funding gaps and service cost base	IMTP refresh; 3-year recovery route map; strengthened financial governance and accountability

Benefits Realisation

Final Internal Audit Report

2025/26

Aneurin Bevan University Health Board/NHS Trust



Reasonable Assurance

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Findings & Agreed Action Plan 3
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Review Reference	ABU-2526-05
Fieldwork	February-April 2026
Executive Sign Off	November 2026
Audit Committee	November 2026
Executive Lead	Rob Holcombe, Executive Director of Finance, Procurement & Value
	Hannah Evans, Executive Director of Strategy, Planning and Partnerships
Audit Team	Stephen Chaney, Head of Internal Audit
	Eifion Jones, Deputy Head of Internal Audit

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

Executive Summary

Purpose

This audit forms part of the 2025/26 internal audit plan for Aneurin Bevan University Health Board (the 'Health Board') and focuses on the arrangements for benefits realisation within non-digital initiatives.

Benefits realisation is a critical component of programme and project management, ensuring that planned improvements such as enhanced patient outcomes, service efficiency, and financial sustainability are achieved.

The Health Board undertakes a range of transformation and service redesign programmes aligned to its strategic objectives. Effective benefits realisation supports accountability and demonstrates value for money in the use of public resources.

The purpose of this audit was to provide assurance on the adequacy and effectiveness of processes for identifying, monitoring, and reporting benefits regardless of the approval route taken.

Overview

We have concluded reasonable assurance on this area based on the control framework in place and good compliance at the more significant programmes/ projects sampled. The audit found that investment decisions are made through several mechanisms, and not all are documented through a formal business case process. As a result, our sample testing could only be drawn from investment decisions that had been subject to a business case (or similar) and approved by the Finance and Performance Committee, this considerably restricted the population by which a sample could be drawn.

The matters requiring management attention include:

- The Health Board has numerous governance routes through which benefits are considered. However, there is no corporate-wide framework for non-digital benefits realisation, resulting in variation in how benefits are identified, owned, monitored and reported.
- Benefits are generally defined during planning and are often linked to strategic objectives and measurable outcomes. However, tracking and reporting remain distributed across existing monitoring processes, limiting the Health Board's ability to obtain a consistent high-level view of realised benefits.

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

Scope & Assurance Summary

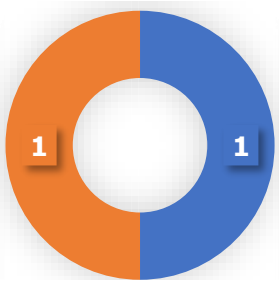
Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	Appropriate governance arrangements exist to co-ordinate and oversee the identification/monitoring of benefits at non-digital programmes and projects.	1	**Reasonable**
2	For all change/ investment programmes, regardless of the route taken for approval, anticipated benefits are clearly defined, measurable, and linked to organisational objectives at the planning stage of initiatives.	-	**Substantial**
3	Processes are in place to track, validate, and report all realised benefits against planned outcomes, including escalation of variances.	2	**Limited**

Management Actions

1 High Priority

1 Medium Priority

Themes



- Planning, Delivery & Deadline Management
- Performance Monitoring

Risk Types

Quality or Safety Issues

Financial Loss

Findings & Agreed Action Plan

Objective 1: Appropriate governance arrangements exist to co-ordinate and oversee the identification/monitoring of benefits at non-digital programmes and projects.	**Reasonable**

Governance arrangements are in place to oversee benefits realisation for non-digital programmes, particularly where initiatives are significant, Board-reported, or subject to formal programme management arrangements. Benefits-related oversight is exercised through existing Board, Executive, Committee, programme and service evaluation routes, with stronger evidence in major programmes and mature service changes.

However, the Health Board has not established a corporate-wide benefits realisation framework. Committee terms of reference reviewed do not identify benefits realisation as a distinct corporate control area, and no organisation-wide benefits register, standard methodology, minimum dataset or single reporting route was identified. As a result, roles, responsibilities and reporting arrangements are clearest where formal governance disciplines apply but are less consistently documented at individual benefit level in smaller or less formal initiatives.

Overall, governance routes are operating in practice, but greater standardisation would strengthen consistency, accountability, and Board / Committee level assurance.

	Key Findings	Risk & Impact	Agreed Management Action
1	**Benefits Framework** The Health Board has not established a corporate-wide benefits realisation framework for non-digital programmes. This results in inconsistent approaches to benefits planning, monitoring and reporting and limits the organisation's ability to obtain consistent, portfolio-level assurance. This would also ensure that benefits are monitored consistently regardless of source/ approval route.	Benefits for programmes and projects are not clearly articulated or linked to strategic objectives.	**Agreed Action:** The Health Board has several benefits reporting mechanisms, e.g. Digital, V&SB, Priority Programmes, PIP business cases, SBARs - but acknowledges a corporate approach would be useful. The Health Board will develop a set of benefits realisation principles as part of a Benefits Realisation Framework for all programmes to apply and develop an appropriate formal policy.
			Expected Evidence of Implementation: Benefits Realisation framework in place – programme reports demonstrating application.
		Medium Priority	**Officer:** Director of Finance & Director of Planning **Target Implementation Date:** 31 March 2027
	Theme: Planning, Delivery & Deadline Management	Control Design	

Objective 2: For all change/ investment programmes, regardless of the route taken for approval, anticipated benefits are clearly defined, measurable, and linked to organisational objectives at the planning stage of initiatives.	**Substantial**

Anticipated benefits are generally identified at the planning stage, particularly where initiatives are supported by formal business cases, internal/ external investment approval processes or structured service design. In stronger examples, benefits are clearly linked to the case for change, organisational priorities and measurable outcomes, including improvements in access, patient flow, quality, workforce sustainability, efficiency and financial sustainability.

Service transformation and evaluation documentation also demonstrates that intended benefits are often translated into performance indicators, outcome measures or structured evaluation questions. This provides a basis for an assessment of whether benefits have been realised. Strategic alignment is generally evident, with benefits supporting priorities such as Clinical Futures, pathway redesign, planned care recovery, quality improvement, financial sustainability and care closer to home.

The main limitation is consistency. In less formal or developmental initiatives, benefits are more likely to be expressed as broad outcomes or strategic aims, with fewer explicit baselines, targets, timescales or mapped links to organisational objectives.

Objective 3: Processes are in place to track, validate, and report all realised benefits against planned outcomes, including escalation of variances.	**Limited**

Benefits tracking and reporting processes are operating across several significant programmes, service changes and operational evaluations. In stronger examples, expected benefits are assessed against activity, outcome, workforce, financial, patient experience or flow measures, and reported through Board, Executive, Committee, programme or service governance routes.

Identified delivery risks and variances are generally escalated through established governance mechanisms, including programme boards, operational oversight meetings, assurance meetings, Committee reporting, quality governance and finance and performance routes. This provides senior visibility of benefits-related progress where programmes are significant, quality-critical, financially material or supported by formal evaluation arrangements.

However, tracking is not yet supported by a consistent corporate mechanism for comparing planned and realised benefits across the full non-digital portfolio. Additionally, some of the reporting tested focused on activity, milestones, risks or delivery status rather than explicit assessment of whether intended benefits have been achieved, partly achieved, delayed or not achieved.

Key Findings		Risk & Impact	Agreed Management Action
2	**Benefits Tracking and Reporting** Without a consistent tracking approach, the Health Board cannot form a comprehensive view of realised benefits across its entire programme portfolio – this is often linked to the route taken for approval. It was also noted from our testing that some programmes focus on reporting activity or milestones rather than progress against planned benefits. There may be an opportunity to link benefits realisation to the existing performance framework.	Benefits for programmes and projects are not clearly articulated or linked to strategic objectives. Monitoring of benefits is inconsistent, and reporting arrangements are inadequate.	**Agreed Action:** Arrangements exist for all significant programmes and workstreams and performance delivery, the scale & breadth of the portfolio of ABUHB does not easily fit into a one size fits all mechanism. Given the above we would not recognise this as a limited rating, and this is not considered a high priority in the context of other arrangements. Principles of good reporting practice will be considered and will be factored into the principles policy and framework referenced above.
			Expected Evidence of Implementation: As part of framework
		High Priority	**Officer:** Director of Finance & Director of Planning **Target Implementation Date:** 31 March 2027
	Theme: Performance Monitoring	Control Design	

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

Archwilio Cymru
Audit Wales

Aneurin Bevan University Health Board – Audit Committee Update

Date issued: November 2026



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Introduction

This document provides the Audit Committee with an update on our current and planned accounts and performance audit work at Aneurin Bevan University Health Board (the Health Board). We presented our most recent Audit Plan to the committee in April 2026.

We also provide additional information on:

- other relevant examinations and studies published by the Auditor General; and
- relevant corporate documents published by Audit Wales (e.g., fee schemes, annual plans, annual reports), as well as details of any consultations underway.

Accounts audit update

Audit of the 2025-26 Charitable Fund Accounts

- **Executive Lead: Director** of Finance and Procurement
- **Focus of the work:** To provide an audit opinion on the 2025-26 Charitable Fund Annual Report and Accounts
- **Status**: Audit underway
- **Expected Board date:** January 2027

Audit of the 2026-27 Health Board's Annual Report and Accounts

- **Executive Lead:** Director of Finance and Procurement
- **Focus of the work:** To provide an audit opinion on the Health Board's 2026-27 Annual Report and Accounts.
- **Status:** Planning starting in November.
- **Expected committee date:** 22 June 2027

Performance audit update

Deep dive review of the arrangements to manage estates

- **Executive Lead**: Chief Operating Officer
- **Focus of the work:** This work examined the effectiveness of corporate arrangements to manage the Health Board's estate. It had a particular focus on how NHS bodies are prioritising resources to meet strategic priorities whilst also ensuring the current estate remains fit for purpose.
- **Status:** Report Final
- **Expected committee date:** This committee (November 2026)

Structured Assessment 2026

- **Executive Lead:** Director of Corporate Governance
- **Focus of the work:** The 2026 structured assessment examines proper arrangements for the efficient, effective, and economical use of resources and tracks progress against previous audit recommendations.
- **Status:** Fieldwork
- **Expected committee date:** February 2027

Review of the management and prevention of diabetes

- **Executive Lead:** Executive Director of Public Health and Strategic Partnerships
- **Focus of the work:** This review will examine how well the Health Board cares for people living with Type 1 and Type 2 diabetes, to help stop their condition getting worse, reduce avoidable complications, and improve outcomes.
- **Status:** Set Up
- **Expected committee date:** April 2027

Local work – Operating Theatre efficiency and effectiveness

- **Executive Lead:** Chief Operating Officer
- **Focus of the work:** This work will focus on the management of operating theatres and the extent that arrangements support efficient, effective and good quality services.
- **Status:** Fieldwork
- **Expected committee date:** April 2027

Other relevant publications

Since the last committee update, the Auditor General has published the following outputs relevant to the NHS. These are set out below.

Zeroing in? Follow-up on public sector decarbonisation	November 2026
Diabetes in Wales – is the NHS ready for the future?	October 2026
Finding the right match: Latest results for Wales from the National Fraud Initiative	October 2026
Young people, opportunity and mental health in Wales: Understanding what's behind the rising numbers outside of Education, Employment and Training	October 2026
NHS digital: delivery not matching ambition	September 2026

Since the last committee update, Audit Wales has published its Welsh Language Report 2025-26 and its Interim Report 2026-27.

There are no relevant Audit Wales consultations currently underway.

Further information

Audit Wales has a range of other information to support the scrutiny of Welsh public bodies and to continue to improve the services provided to the people of Wales.

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Our publications which cover our audit work at public bodies.



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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Are NHS estates fit for purpose?

Aneurin Bevan University Health Board

July 2026

We have prepared and published this report under section 61(3)(b) of the Public Audit Wales Act 2004.

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Audit snapshot

What we looked at

1 Our review looked at how well the Aneurin Bevan University Health Board (Health Board) manages its estate.

Why this is important

2 The NHS estate in Wales provides the essential infrastructure to deliver healthcare services. It plays a key role in delivering safe, high-quality care and improving the patient experience. However, the NHS estate varies widely in age, condition, and location across Wales. A poorly maintained estate creates health and safety risks, including fire safety issues and potential harm to patients. An outdated estate can also affect service performance, be less energy efficient, and be a barrier to providing modern healthcare.

3 The NHS in Wales needs to modernise its estate, deliver environmental improvements, improve access, and adapt to meet the needs of modern healthcare. There are several NHS strategies and plans which are dependent on estate improvements. These range from immediate strategic priorities relating to infrastructure and capital investment, to the requirements to reduce carbon emissions and improve energy efficiency.

4 Welsh Government's 2018 long-term plan for health and social care – A Healthier Wales – highlighted the importance of the NHS estate as a key enabler for transforming health and social care. Including the need for modern facilities, supporting digital integration, and a focus on energy efficiency and environmentally friendly practices. This is all against a backdrop of significant financial pressures across the NHS in Wales.

What we have found

5 The Health Board has a clear vision for its estate and effective governance, with clear accountability, strong capital planning and good oversight. It performs well in estate condition, space utilisation, energy efficiency and statutory compliance. However, the estates strategy lacks clear milestones, links to key strategies and an affordable delivery plan. Reporting focuses more on operational matters than strategic outcomes.

6 The Health Board faces growing challenges from an ageing estate and rising maintenance pressures. While major risks such as RAAC (Reinforced Autoclaved Aerated Concrete) and backlog maintenance are understood, operational risks are increasing and governance arrangements, particularly around fire safety, are not working consistently. Estate information is generally good, but some condition data is outdated and incomplete records on surplus assets and restrictions limit long-term planning.

7 The Health Board has arrangements to manage risks to patients and staff, and compliance performance is generally strong. However, it cannot fully show that fire and water safety issues are resolved promptly, and estate-related incidents are not routinely analysed. Workforce pressures, including high vacancies, sickness absence, reliance on agency staff and an ageing workforce, reduce capacity and create risks to the long-term sustainability of estate services.

What we recommend

8 We made seven recommendations to the Health Board. These focus on:

- setting clear milestones and targets to track delivery of the strategy;
- strengthening operational risk management;
- developing an estates disposal strategy;
- strengthening the approach to estate-related safety incidents;
- strengthening reporting on fire safety
- address outstanding water safety issues; and

- developing and implementing a clear estates workforce plan.

Key facts and figures

122	Number of buildings managed by the Health Board in 2024-25.
£24.9 million	Capital monies used to improve estates in 2025-26 (excluding year-end funding).
£233.0 million	Cost to eradicate risk-adjusted backlog in 2024-25, an increase of 31% since 2022-23. High-risk backlog accounts for £88.4 million.
49%	Percentage of the 2,404 issues addressed following water safety assessments in 2024-25 at the end of March 2025.
40	Number of estates related clinical incidents in 2024-25.
14.3%	Vacancy rate in estates at the end of March 2025, compared to an all-Wales position of 11.6%.
12.4%	Sickness absence rate at the end of March 2025, compared to an all-Wales position of 6.6%.

Our findings

Strategic approach to estates

The estate strategy sets a clear vision, but future updates need milestones, clear alignment, and affordable delivery plans

9 The Health Board has a clear vision for its estate. Its estates strategy for 2018-2028 sets out this vision. The Board refreshed the strategy in 2022. The strategy aims to provide buildings that meet service needs, support patient care, and improve the experience of patients and staff.

10 We reviewed the estates strategy. It is well written and sets clear priorities to 2028. Positively, the strategy:

- covers all estates within the Health Board's responsibility, including acute hospitals, mental health services and community and primary care services;
- is supported by reliable data from a six-facet survey completed in 2017-18 and compares results with national key performance indicators;
- sets clear strategic objectives and identifies the enablers needed to deliver them;
- is aligned with the Health Board's long-term strategy;
- supports national priorities, including A Healthier Wales, the Well-being of Future Generations Act and national clinical frameworks;
- reflects commitments to environmental sustainability, energy efficiency, and biodiversity; and
- reflects opportunities to work with regional partners, including on Neighbourhood Care Networks and the Llantrisant Health Park.

11 However, the strategy:

- does not include clear milestones or targets;
- is not aligned with the Health Board's other key enabling strategies, including its clinical services plan, workforce strategy and digital strategy;
- does not clearly reflect the Health Board's duties under the Equality Act or the Socio-economic Duty; and
- is not supported by an affordable financial plan.

12 It is also not clear how the Health Board engaged with staff, patients, and partners in the development of the strategy.

13 At the time of our work, the Health Board had started work on its next estates strategy. As part of this work, it was considering a condition survey to help inform the strategy and provide a more up-to-date understanding of its estate. The Health Board also plans to use a three-lens approach, considering service need, estate condition and utilisation. This should help ensure future investment is evidence-based and aligned to service needs.

Governance arrangements for managing estates

Clear accountability supports effective estates management, but gaps in strategic oversight reduce assurance

Lines of accountability

14 The Health Board has clear lines of accountability for managing its estate.

15 The Chief Operating Officer is responsible for estates. The Divisional Director of Estates and Facilities leads day to day activities. Responsibility for capital planning sits with the Director of Strategy, Planning and Partnership.

16 Although these responsibilities sit in different parts of the organisation, the arrangements work well because of the close working relationship between the estates team and the Strategy, Planning and Partnership function. However, the effectiveness of this approach relies on strong personal relationships and could be affected by changes in key personnel.

Corporate oversight

17 There is reasonable oversight of estates at Board and committee level.

18 The Finance and Performance, and Partnerships, Population Health and Planning Committees have responsibility for estates at a corporate level. Both committees report to the Board.

19 The Finance and Performance Committee (FPC) oversees capital, estates, and related support services. It seeks assurance that arrangements are effective and robust. The committee also monitors progress against the estates-related objectives in the Integrated Medium-Term Plan and Annual Plan.

20 The Partnerships, Population Health and Planning Committee advises the Board on key enabling strategies, including workforce, capital, estates, and digital. This helps provide integrated strategic oversight.

21 The Board and FPC receive annual updates on estates compliance. These updates are mainly provided through slide-based briefings. Internal statutory compliance groups support this process and provide a clear structure for governance and oversight.

22 The Board receives detailed information on estate performance. This includes national benchmarking data and comparisons of backlog maintenance. Reports highlight key risks, such as asbestos and structural building deterioration. This shows a transparent approach to reporting estate risks. Including risk register entries scoring 15 also helps the Board oversee significant risks.

23 The Health Board's governance arrangements provide comprehensive oversight of operational estate performance, capital investment and statutory compliance. However, reporting focuses largely on operational activity and risk. There is limited reporting on the delivery of the estates strategy, its key outcomes and the benefits it aims to achieve. This may make it harder for the Board to assess whether the strategy stays on track and is delivering its intended objectives.

Operational management

24 The Health Board has a clear structure for managing estates.

25 Locality-based estates teams provide good operational coverage and help identify and resolve issues quickly. Estates managers meet regularly with the Head of Operations, who in turn reports to the Divisional Director for Estates and Facilities. This provides clear routes to raise concerns and take action.

26 There is a Divisional Management Team, chaired by the Divisional Director for Estates and Facilities, which meets monthly to provide strategic oversight of the division. Weekly operational meetings within Estates and Facilities, including a Monday operational catch-up and Friday meetings involving Estates Officers, support the timely identification and escalation of emerging issues. Regular assurance meetings between the Divisional Management Team and the Chief Operating Officer strengthen accountability and support effective risk and performance management. They also provide Executive and Board members with the information needed to make informed decisions.

27 A divisional dedicated Head of Compliance is responsible for coordinating and overseeing compliance within the Facilities Division.

28 The Health Board's Estates and Facilities Statutory Compliance Group provides oversight of statutory compliance across estates and facilities services. Meeting bi-monthly, it monitors compliance risks, performance, incidents, training, and asset management arrangements, reporting to the Health and Safety Committee and Divisional Senior Management Board.

29 The Health Boards Health and Safety Committee also provides assurance on estate issues through established reporting arrangements. The committee receives routine updates from the Health and Safety Operational Group, Fire Safety Management Group and Violence, Prevention and Reduction Group. The Health and Safety Committee reports to the Executive Committee.

30 In 2024-25 the Health Board found that some of these groups were not meeting as expected. The Health Board recognised this issue in its 2024-25 Annual Report and introduced a meeting schedule for 2025-26. While two of the three sub-groups had resumed meeting during 2025-26, the Fire Safety Management Group had not met at the time of our audit, although fire safety matters were incorporated onto the agenda of the Fire Safety Subgroup led by the Facilities Division.

31 Despite this, the introduction of infrastructure and estates groups has strengthened reporting and communication. Staff reported greater openness and shared accountability for estates issues, helping ensure risks are visible and reducing the likelihood that problems are managed in isolation.

Managing estate risks

32 Overall, the Health Board has reasonable processes for managing its estates risks. It has a framework for identifying, assessing, and monitoring estates risks at strategic, corporate and operational levels.

33 The Strategic Risk Register (Board Assurance Framework) identifies RAAC and backlog maintenance as the two most significant estates risks. Both are still outside the Board's risk appetite because of their potential impact and long-term nature.

34 The Board has clearly defined these risks, reviews them regularly, and has agreed mitigation plans in place. The Board also recognises that reducing these risks will take time because of their scale and complexity.

35 The Board receives assurance on the effectiveness of controls. This is particularly clear for RAAC, where monitoring and mitigation arrangements are well developed. The Board understands the residual risk position. It has chosen to tolerate these risks while longer-term remediation work progresses, and capital funding is secured.

36 The Board also receives an annual update on health, safety, and fire risks, including progress made to improve performance and reduce risk. While the Health Board has made improvements in these areas, risk levels are still above target. The Health Board needs to keep close oversight and continue reducing these risks further.

37 There are currently no estates risks on the corporate risk register. Management has provided assurance that divisional estates risks are being managed appropriately and do not meet the criteria for escalation.

38 At an operational level, the Estates Divisional Risk Register draws on DATIX data. It holds many risks. Many are scored as high or extreme. The number of recorded estate risks nearly doubled in five months. They increased from 44 in December 2025 to 84 in May 2026. This highlights the scale of the challenge and growing pressure on the estate.

39 However, review dates are not always consistent, and some entries record issues rather than risks. This makes it harder to use the register to support effective risk management and decision-making.

40 These issues are not limited to the estates function. They reflect wider organisational challenges in risk management. They highlight the need to review operational risk registers and related processes.

Using financial resources to improve estates

Processes to plan and oversee capital funding are strong, with clear governance and control of spending, but late funding still creates risks

Funding prioritisation process

41 The Health Board has a robust approach to how it prioritises the capital funds available to improve its estate.

42 In 2025-26, the Health Board had £10.93 million of discretionary funding and dedicated funds to invest in its estates. This investment has increased over the last three financial years (**Exhibit 1**).

Exhibit 1: use of discretionary and dedicated estates funds, 2023-24 to 2025-26 (£ million)

Fund	2023-24	2024-25	2025-26
Discretionary capital allocation	2.90	2.93	2.80
Estates and Facilities Advisory Board (EFAB) funding	1.31	2.67	0.22
Targeted Estates Fund (TEF)	-	-	7.91
TOTAL	**4.21**	**5.60**	**10.93**

Source: Audit Wales analysis of financial monthly monitoring returns

Note: A Welsh Government capital funding programme designed to address specific high-priority risks and deficiencies within the NHS Wales estate, particularly those affecting patient safety, statutory compliance, and service resilience. The Targeted Estates Fund (TEF) replaced the Estates and Facilities Advisory Board (EFAB) funding in 2025-26.

43 In 2025-26, the Health Board received £10.0 million of all-Wales capital funds. This was in addition to the TEF allocation. The funding supported work at the Grange University Hospital and Royal Gwent Hospital. It also supported mental health estate improvements and work to address RAAC.

44 The Health Board also received £3.97 million from the Welsh Government RE:FIT programme. This funded projects to reduce carbon emissions.

45 In total, the Health Board received £24.9 million for its estate. This is much lower than the estimated £233 million needed to address risk-adjusted maintenance backlog. It is also much lower than the £253 million needed to achieve Physical Condition B.

46 The Strategic Capital and Estate Board has a clear process for identifying and prioritising the Health Board's capital investment needs. It does this through a structured process to decide how available capital funding should be allocated. The Board approves the discretionary capital programme at the start of each financial year, ensuring it aligns with organisational priorities.

47 The Strategic Capital and Estate Board has clearly defined membership. It is chaired by the Director of Strategy, Planning and Partnerships. It meets monthly to plan, monitor, and oversee capital investment. It approves capital plans, business cases and in-year funding requests. It also monitors project delivery and spend. It oversees major projects and checks compliance with financial and planning requirements.

48 Divisions submit their capital priorities to the Strategic Capital and Estate Board using an electronic system introduced last year. Staff reported that the system has improved efficiency, oversight and reporting. Each division identifies its five highest-priority schemes, which are reviewed regularly throughout the year.

49 Proposed schemes are assessed against agreed criteria. These include deliverability, procurement readiness, scope, value, operational impact, strategic impact, revenue savings and capital cost. The Strategic Capital and Estate Board uses these assessments to develop the overall Capital Plan, which is then submitted to the Board for approval.

50 The Chief Operating Officer's team provides an additional level of scrutiny by reviewing and challenging divisional priorities before schemes are recommended for approval. This helps ensure that prioritisation criteria are applied consistently and that the Board receives a balanced and well-evidenced set of investment proposals.

Monitoring and managing capital funds

51 The Health Board has appropriate arrangements in place to monitor and manage how it spends the allocated capital funds.

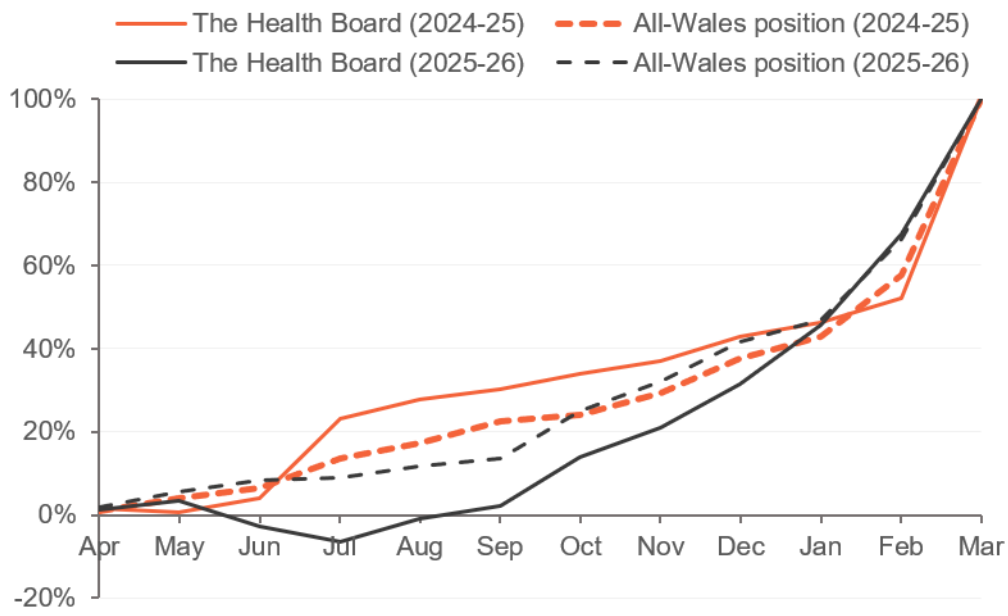
52 The Strategic Capital and Estate Board oversees capital expenditure. It regularly reviews financial performance, programme slippage, emerging risks, investment priorities, and the delivery of strategic capital schemes.

53 The Board and Finance and Performance Committee both receive regular capital programme reports. In addition, divisions review current and forecast spend at their operational meetings. A dedicated capital accountant supports financial management of the programme. Internal Audit and other controls provide additional assurance.

54 The Strategic Capital and Estate Board keeps a list of pre-approved schemes so it can respond quickly when additional capital funding becomes available. This helps the Health Board maximise funding opportunities and minimise delays in delivering its capital programme.

55 We reviewed the spend profile for the Health Board's discretionary allocation for 2024-25 and 2025-26. Our analysis shows that the Health Board used its discretionary allocation in full. We also found that most spending takes place towards the end of the financial year (**Exhibit 2**).

Exhibit 2: running total discretionary estate spend per month, compared with the all-Wales position, for 2024-25 and 2025-26 (percentage of total spend)



Source: Audit Wales analysis of financial monthly monitoring returns

56 In 2025-26, the Health Board received an additional £5.4 million of end-year funding from the Welsh Government for estates projects. The funding was used effectively. However, the late allocation led to an uneven spending profile during the year. It also restricted how the funding could be used, as projects needed to be completed within a short period before the end of the financial year.

57 There is clear reporting of capital investment beyond the estates function through the Partnerships, Population Health and Planning Committee. Regular updates on key programmes and regional initiatives provide clear visibility of investment decisions, progress and delivery.

58 The Health Board shows strong regional collaboration in estates and capital planning. This is reflected in the development and approval of major schemes, including the Bevan Health and Wellbeing Centre and programmes delivered through the Regional Joint Committee.

Ensuring an efficient and productive estate

Despite good condition and utilisation, rising maintenance costs, ageing assets, and information gaps create risks to the long-term sustainability of the estate

Condition of the estate

59 The Health Board has a high proportion of estate that meets physical condition standards despite having the oldest estate in Wales. However, the cost to remove high-risk backlog maintenance is the second highest in Wales. This is despite a slight improvement in overall estate condition over the last three years (**Exhibit 3**).

Exhibit 3: age and condition of the estate, compared to the all-Wales position, 2024-25

Indicator	The Health Board	All-Wales position
% of estate built before 1948	28.2	13.5
% of estate built before 1995	80.4	63.9
Cost to remove high risk backlog per m^2 occupied floor area (£)	264.23	164.60
Cost to remove high and significant risk per m^2 occupied floor area (£)	303.09	458.43
% of estate meeting physical condition standard	96	83
Cost to achieve physical condition B per m^2 occupied floor area (£)	754.52	538.54

Source: Estates and Facilities Performance Management System (EFPMS)

Note: The All-Wales position also includes Public Health Wales NHS Trust, Health Education and Improvement Wales, and NHS Wales Shared Services Partnership which were outside the scope of the audit.

60 Across the Health Board's sites, the cost to remove high-risk backlog is highest at St Cadoc Hospital, at £1,392.40 per m² of occupied floor area. The cost to achieve Physical Condition B is also highest at St Cadoc Hospital, at £2,118.67 per m² of occupied floor area. Overall, risk-adjusted backlog costs are increasing each year.

61 The Health Board reports that Nevill Hall Hospital is its only site with reinforced autoclaved aerated concrete (RAAC). A major RAAC survey was completed in 2023 and informed an ongoing six-monthly inspection programme to monitor and manage associated risks. The most recent inspections were completed in late 2025/early 2026 and summer 2026. The estimated cost of managing the associated risk is £602,228.

62 The Health Board was unable to provide a planned budget split between planned and reactive maintenance. It could only provide actual expenditure data.

63 The Health Board holds a range of estate condition surveys. Of the 34 entries in the EFPMS dataset, 13 are desktop assessments. One is a full six-facet survey and 20 are partial six-facet surveys. Reliance on internally completed surveys reduces independent assurance. It may also limit the consistency and robustness of the information used to support decision-making.

64 The Health Board reviewed its condition surveys across all sites in 2022. Since then, the estate has changed because of building deterioration, new compliance requirements, and evolving service needs. As a result, the accuracy and usefulness of the survey data have reduced.

65 Continued reliance on these surveys increases the risk that the Health Board bases investment and maintenance decisions on information that no longer reflects the estate's current condition.

Robust management information

66 The Health Board is making appropriate use of management information to manage its estate.

67 The Health Board uses two Computer Aided Facilities Management (CAFM) systems to manage estates services. These are supported by an up-to-date asset register. The systems provide automated alerts for planned maintenance and enable engineers to record, track and update maintenance tasks.

68 The existing CAFM systems support the effective management of estate information and maintenance records. Following a procurement exercise and contract award, the Health Board is migrating to a single replacement system. Completion is planned by the end of 2026-27. The investment aims to improve efficiency, make information easier to access and strengthen estate management and maintenance delivery.

69 The Health Board reports performance on a range of areas of estates compliance. It includes key performance indicators on safety, condition, repairs, energy, staffing and planned maintenance. However as mentioned in paragraph 64, this data currently relies on internal surveys.

Maximising productivity and efficiency

70 The Health Board has a high proportion of estate that is functionally suitable and well utilised. It performs strongly against key productivity and efficiency indicators. Performance in both functional suitability and space utilisation have been consistent over the past three years. Energy performance has improved and is now the lowest of all health boards (**Exhibit 4**).

Exhibit 4: productivity and efficiency performance of the estate, compared to the all-Wales position, 2024-25

Indicator	The Health Board	All-Wales position
% of estate functionally suitable	98	84
% of space utilisation	92	92
energy performance (kilowatts)	326	367

Source: Estates and Facilities Performance Management System

Note: The All-Wales position also includes Public Health Wales NHS Trust, Health Education and Improvement Wales, and NHS Wales Shared Services Partnership which were outside the scope of the audit.

71 The Health Board does not have an estates disposal strategy. This limits its ability to take a structured and proactive approach to managing surplus or underutilised assets.

72 In some cases, legal restrictions may limit opportunities to dispose of or repurpose sites. However, the Health Board does not hold a comprehensive record of these restrictions. Information is held across multiple sources, with no single consolidated register. As a result, the Health Board cannot easily assess the extent to which legal restrictions affect its estate or future disposal options.

73 To build a complete picture of its estate, the Health Board needs to review site records, land registry information and lease agreements, with support from NHS Wales Shared Estates Services. Until this work is complete, estate planning and investment decisions may be based on incomplete information. This could reduce the Health Board's ability to identify and realise opportunities to rationalise its estate.

74 The Health Board's Decarbonisation Framework sets out how it plans to achieve net zero carbon emissions by 2030. It focuses on reducing emissions, improving energy efficiency, and supporting more sustainable ways of working. The Health Board has made good progress. Carbon emissions from building energy use fell by 37% between 2010 and 2024. This shows that actions taken so far have helped reduce emissions.

75 However, further reductions may be harder to achieve. Reaching the 2030 target will require ongoing investment, strong oversight, and the successful delivery of additional carbon reduction projects.

76 The Health Board has continued to improve energy efficiency through the Welsh Government RE:FIT programme. It has upgraded ventilation systems, improved draught proofing, and replaced traditional lighting with LEDs. The Health Board performs better than the all-Wales average in this area. LED lighting covers 50% of its internal floor space, compared with 45.4% nationally. This shows that the Health Board has taken steps to reduce energy use and carbon emissions.

Supporting the quality of care

Compliance processes are strong, but gaps in reporting, fire safety oversight and remedial work reduce assurance that safety risks are effectively managed

Minimising risk to patient care

77 The Health Board has arrangements in place to manage risks to staff and patients arising from the condition of its estate. However, these arrangements need to be strengthened.

78 The Health Board recognises that the age, condition and complexity of its estate create ongoing risks to patient safety. It has systems and controls in place to manage these risks, including reporting incidents through DATIX. Estates and clinical teams also demonstrate a positive learning culture, using post-incident reviews, reflective “debrief” processes, and shared learning to help prevent similar incidents.

79 Current reporting arrangements rely on staff raising concerns. This may lead to some estate-related risks being reported inconsistently or not reported at all. Reported estate-related incidents increased from 20 in 2022-23 to 40 in 2024-25, with a further 42 incidents recorded part way through 2025-26.

80 However, the Health Board has not analysed the reasons for the increase. It may reflect a decline in estate condition, improved reporting, greater staff awareness or a combination of these factors. Without further analysis and assurance over the completeness of reporting, the Board cannot fully understand the causes of incidents or target improvement activity effectively.

81 Since 2022, the Health Board has reported eight personal injury claims linked to the estate, with a total cost of £70,298. These incidents occurred across a range of locations, including wards, corridors, stairwells, entrances, plant rooms, storage areas and external spaces. Contributing factors included poor lighting, maintenance issues, unsuitable design and environmental hazards.

82 The Health Board is improving its information systems. However, it does not yet have a fully integrated process for identifying, analysing and monitoring estate-related patient safety risks across the organisation.

83 The Health Board also does not routinely collect feedback from staff and patients on estate condition or their experience of using its buildings. As a result, it may miss opportunities to identify and address estate issues that affect care, the working environment and service delivery.

Ensuring compliance

84 The Health Board has robust processes to ensure its estate is compliant with relevant legislation.

85 Compared to the all-Wales position, the Health Board performs well on statutory health and safety and fire requirements. Performance has improved over the past two years **(Exhibit 5)**.

Exhibit 5: occupied floor space meeting statutory and safety requirements, compared to the all-Wales position, 2024-25 (percentage)

Indicator	The Health Board	All-Wales position
% of occupied floor space meeting statutory health and safety requirements	94	87
% of occupied floor space meeting statutory fire safety requirements	86	84

Source: Estates and Facilities Performance Management System

Note: The All-Wales position also includes Public Health Wales NHS Trust, Health Education and Improvement Wales, and NHS Wales Shared Services Partnership which were outside the scope of the audit.

86 However, performance varies across sites. Seven sites have no occupied floor area that meets statutory health and safety requirements. These locations provide community-based services, including primary care, outpatient clinics, dental services, specialist treatments and diagnostic support.

87 Fire safety compliance also varies across the estate. At Royal Gwent and Nevill Hall Hospitals, 28% to 30% of occupied floor area does not meet statutory fire safety requirements. This increases risk and highlights the need for further improvement at these sites.

88 The Health Board has completed all required fire risk assessments in 2024-25. These assessments found 1,090 issues. However, the Health Board could not report how many of these issues have been resolved. As a result, it cannot show that fire safety risks are managed effectively. The absence of a dedicated forum for overseeing fire safety risks further weakens assurance in this area.

89 The Health Board has received 12 informal fire notices from the National Fire Chiefs Council covering four sites. These notices highlighted issues with fire detection systems and emergency escape routes. Although they have not led to formal enforcement action, they identify fire safety concerns that require prompt action.

90 The Health Board has an up-to-date water maintenance schedule. It has completed all required water risk assessments. These assessments found 2,404 issues. By the end of March 2025, only 49% had been resolved. This increases the risk of legionella and indicates that a significant amount of remedial work is still outstanding.

91 At the time of our review, the Health Board had not received any enforcement notices from the Health and Safety Executive

92 The Health Board’s 2024-25 report identified health and safety risk assessments as an area of concern. It highlighted variation in quality and standards. While stronger controls have reduced the level of risk, performance is still outside the organisation’s target level. Continued improvement is therefore needed.

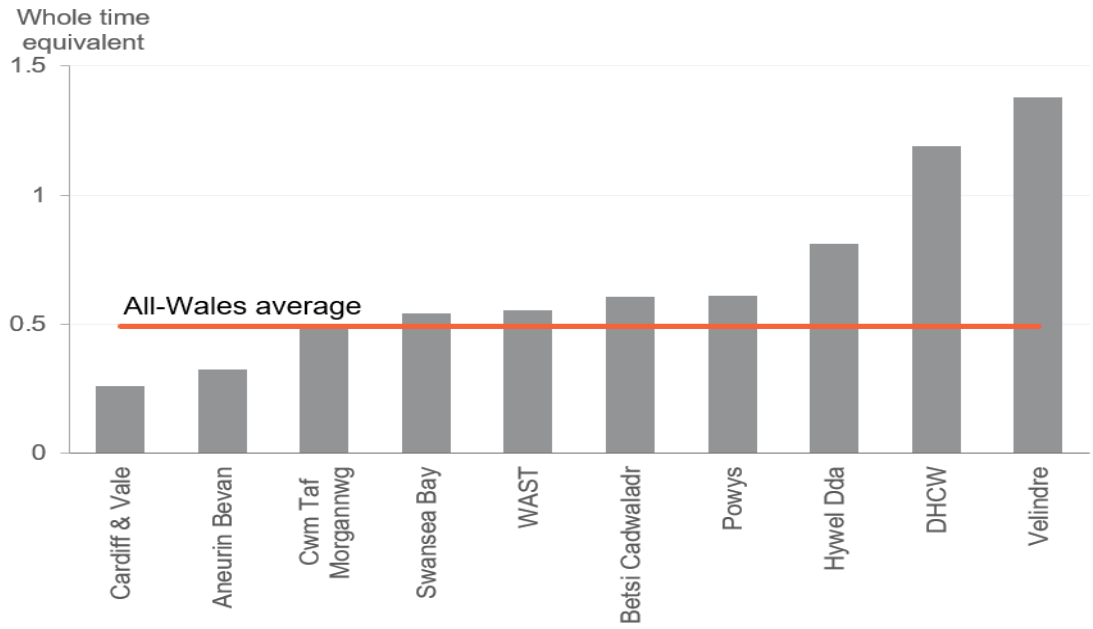
Managing the estate workforce

Staff shortages, vacancies and limited workforce planning reduce capacity and create risks to the long-term sustainability of estate services

93 The estates service is organised into four regions: Abergavenny, Llanfrechfa, Newport, and Rhymney Valley. Each region has a workforce based at its main hospital, serving sites across that area.

94 The Health Board has a relatively small estates workforce. At March 2025, it employed 0.32 whole-time equivalent staff per 1,000 m² of occupied floor space. This compares with 0.49 across Wales (**Exhibit 6**). The Health Board did not report data on the use of external contractors, and therefore we are unable to assess the full staffing resource available.

Exhibit 6: size of the estates function per 1,000 m² occupied floor area, by NHS body at 31 March 2025 (whole time equivalent)



Source: Audit Wales analysis of NHS data

95 The Health Board faces significant workforce challenges within its estates team. At March 2025, the vacancy rate was 14.3% (18 whole-time equivalent posts), compared with 11.6% across Wales. Vacancies remained at this level in September 2025, giving the Health Board the highest vacancy rate in Wales. While there are no local recruitment restrictions, shortages of skilled estates staff remain a national challenge.

96 In 2024-25, the Health Board spent £487,000 on agency staff to support its estates team. It also spent £2.883 million on variable pay, including bank staff and overtime. The Welsh Government required NHS bodies to stop using agency estates staff by 30 September 2025, but the Health Board did not meet this target. It spent £684,000 on agency staff in the last six months of 2025-26[1].

97 Sickness absence places additional pressure on the workforce. At March 2025, sickness rates were highest in the Abergavenny (19.28%) and Newport (17.19%) regions. High levels of sickness absence reduce capacity and increases the risk of service disruption.

98 The Health Board could not provide information on contractor use or spend. Without this information, it cannot fully understand workforce capacity, monitor costs, and plan its workforce effectively.

99 The age profile of the workforce also creates a risk to future capacity. At March 2025, 31.5% of estates staff were aged over 60, compare with 25.4% across Wales. This was the second highest proportion in Wales.

100 Operational pressures and staff absences create a risk that planned maintenance will not be completed on time. Delays could lead to asset deterioration, higher reactive maintenance costs, and service disruption. The Health Board can use external contractors to complete outstanding work. This provides an important mitigation and helps prevent maintenance backlogs. However, it may increase costs and does not resolve the workforce and capacity issues causing the delays.

[1] Based on data reported in the Health Board's financial monthly monitoring returns for 'estates and ancillary staff'.

101 The Health Board does not have a formal estates workforce plan. However, it has introduced an apprenticeship programme to help build future capacity. Two electrician apprentices were in post at March 2025, and the Health Board plans to recruit two more by September 2026. While this supports longer-term sustainability, there is limited evidence of short-term succession planning.

102 The Health Board has also not explored opportunities to work with other organisations to address workforce challenges.

103 The Health Board monitors training compliance for estates staff. In 2024-25, compliance with statutory and mandatory training was 82%, below the 85% target. The Health Board did not provide a breakdown of results, so it was not possible to identify specific gaps. However, compliance was 100% in several specialist areas, including asbestos management, working at height, water hygiene, lift release and confined space working.

104 The Health Board also did not provide evidence that estates staff receive training in the digital systems used to support estate management.

Recommendations

105 We have made seven recommendations because of our work.

R1 The Health Board should ensure its next estates strategy includes clear targets and milestones, aligns with key organisational plans, and is supported by a realistic and affordable financial plan **(paragraph 13)**.

R2 The Health Board should apply its agreed risk escalation and de-escalation criteria consistently to estates risks. When an operational estates risk meets those criteria, the Health Board should review it and escalate it to the corporate or strategic risk register **(paragraph 38)**.

R3 The Health Board should develop and implement an Estates Disposal Strategy to support the disposal or reuse of surplus and underutilised estate assets. It should also maintain a central record of legal and contractual restrictions affecting estate assets, using site records, Land Registry information, and lease agreements **(paragraphs 71 to 73)**.

R4 The Health Board should strengthen its approach to estate-related safety risks by using incident data, claims, staff and patient feedback to drive improvement and provide Board assurance **(paragraphs 79-83)**.

R5 The Health Board should strengthen its arrangements for managing issues identified through fire risk assessments to ensure actions are completed on time, risks are reduced, compliance requirements are met, and the Board receives clear assurance **(paragraph 88).**

R6 The Health Board should prioritise and track the completion of outstanding actions arising from water risk assessments to reduce water safety risks and provide assurance that remedial works are completed in a timely manner **(paragraph 90)**.

R7 The Health Board should develop and implement a comprehensive estates workforce plan to address workforce challenges, strengthen succession planning, and ensure the cost-effective use of contractors **(paragraph 103)**.

Appendices

1 About our work

Scope of the audit

We looked at the following areas, as they relate to estates, during the period February to July 2026:

- strategic planning;
- governance arrangements;
- utilisation of financial resources;
- estate productivity and efficiency;
- implications on quality and safety; and
- workforce management.

We did not look at:

- major estates projects funded (or potentially funded) through the All-Wales Capital Health Programme;
- operational management of estates, including the management of leased estate;
- 'soft facilities management' services such as cleaning or security services, which are also key to supporting fit-for-purpose estate; and
- primary care estates.

Audit questions and criteria

Questions

Our audit addressed the following questions:

- Does the NHS body have a clear planning approach for its estate in the medium to longer term?

- Does the NHS body have effective governance arrangements for estates management?
- Is the NHS body utilising its financial resources available for estates appropriately?
- Does the NHS body have an efficient and productive estate?
- Does the NHS estate support the quality of care and experience of patients and staff?
- Does the NHS body have effective arrangements for managing its estate workforce?

Criteria

We assessed the Health Board's approach against audit criteria shaped by:

- NHS Wales planning frameworks, and other relevant NHS Wales planning documents, including the NHS Wales Decarbonisation Strategic Delivery Plan 2021-30;
- Legislation, including the Wellbeing of Future Generations Act (2015), the Equality Act 2010 and the Public Sector Equality Duty (PSED);
- Relevant guidance from NHS Shared Services Partnership;
- Previous audit work on the management of NHS estates.

Methods

We reviewed a range of documents, including:

- Board and committee papers and minutes.
- Key governance documents, including Finance & Performance Committee, Partnerships, Population Health and Planning Committee, and Statutory Compliance Group papers.
- Key strategies and plans.
- Key risk management documents including the Strategic Risk Register and the Corporate Risk Register.

We interviewed the following key stakeholders:

- Chief Operating Officer
- Divisional Director for Estates and Facilities
- Director of Strategy, Planning and Partnerships
- Assistant Director of Strategic Capital
- Head of Capital Finance

We held a focus group with the Head of Health, Safety and Fire, Head of Operations and Head of Statutory Compliance.

We reviewed national data available from the Estates and Facilities Performance Management System (EFPMS), monthly financial monitoring returns submitted to the Welsh Government, and local data provided to us by the Health Board. We have not audited the data from these sources.

2 Size and location of the Health Board's backlog maintenance

The map below shows the size and location of the Health Board's risk adjusted backlog in 2024-25. It excludes sites with a backlog of £1 million or less.

Exhibit 7: size and location of the Health Board's risk adjusted backlog, 2024-25 (£ million)



Source: Estates and Facilities Management System (EFPMS)

3 Key terms in this report

Term	Description
2018 Estatecode Wales	Gives detailed advice on how to manage land and buildings used for healthcare services.
Backlog maintenance	A measure of the investment needed to restore a building to a set standard, based on assessed risk.
Computer Aided Facilities Management (CAFM)	A system used to manage estates and facilities work, including asset records, planned and reactive maintenance, compliance checks, and reporting.
DATIX	An electronic system used across NHS Wales to record, manage and analyse patient safety incidents, concerns, complaints, and risks.
Discretionary capital	Funds that an organisation can allocate at its own discretion.
Estates and Facilities Advisory Board (EFAB)	A Welsh Government capital funding programme that supported targeted estates improvements across NHS Wales, including infrastructure, decarbonisation, and fire safety. It was replaced by the Targeted Estate Fund (TEF) in 2025-26.
Estates and Facilities Performance Management System (EFPMS)	An all-Wales system used to collect and report data on NHS estates and facilities. It supports monitoring, benchmarking, and improving performance, and informs planning and decision-making.
Functionally suitable	The percentage of occupied floor area that meets the 2018 Estatecode Wales Condition B standard.

Term	Description
High-risk backlog	Issues that need urgent action to prevent serious failure, major service disruption, or safety risks that could cause harm or legal action.
Occupied floor area	The total floor area of buildings in use to deliver NHS services, including spaces owned, leased, or used under agreements.
Physical condition B	Defined in the 2018 Estatecode Wales as sound, operationally safe, and showing only minor deterioration.
Regional Joint Committee	A statutory body that brings health boards and local authorities together to plan and deliver integrated health and social care services at a regional level.
Risk-adjusted backlog	The estimated cost to fix maintenance issues, weighted by how serious the risk is to safety, services, or compliance.
Significant-risk backlog	Repairs or replacements that need urgent action to avoid compliance concerns or risks to safe healthcare delivery.
Six-Facet Survey	An NHS estates appraisal that assesses a building's condition, suitability, space use, quality, safety, and environmental performance to support estate planning.
Space utilisation	The percentage of occupied floor space that is empty or under-utilised as defined in the 2018 Estatecode Wales.

Term	Description
Targeted Estates Fund	A Welsh Government capital fund that targets high priority estate risks in the NHS, including safety, compliance, and resilience. It provides £80 million (2025–27), with NHS bodies contributing 30%.
Welsh Government RE:FIT framework	A Welsh Government–supported framework that helps public bodies improve energy efficiency in buildings, with projects delivered by approved providers and savings guaranteed through contracts.

4 Management Response Form

Recommendation	Commentary on planned actions	Completion date	Responsible officer
R1 The Health Board should ensure its next estates strategy includes clear targets and milestones, aligns with key organisational plans, and is supported by a realistic and affordable financial plan **(paragraph 13).**	**Accepted** The Health Board accepts the recommendation. It is refreshing its Estates Strategic Plan to align with Gwent 35 and the five enabling strategic plans for people, quality, finance, digital and green health. The refreshed plan will include clear and measurable targets, time-bound milestones and priorities for the development, maintenance and rationalisation of the estate. The strategy will be supported by an operational delivery plan setting out the activities, delivery schedules, accountable leads, dependencies and performance measures required to implement it. It will also be underpinned by a realistic and affordable financial plan, developed with the Finance Directorate, which will identify anticipated capital and revenue	31 July 2027	Executive Director of Strategy, Planning and Partnerships

Recommendation	Commentary on planned actions	Completion date	Responsible officer
	requirements, funding assumptions, costs, savings and financial risks. The strategic plan, delivery plan and supporting financial plan will be considered through the Health Board's established governance arrangements before approval.		
R2 The Health Board should apply its agreed risk escalation and de-escalation criteria consistently to estates risks. When an operational estates risk meets those criteria, the Health Board should review it and escalate it to the corporate or strategic risk register **(paragraph 38).**	**Accepted** The Health Board will build on the organisation-wide work already undertaken to strengthen its risk management arrangements. Estates risks are currently managed and monitored through the Estates and Facilities Division's established governance arrangements. Significant matters are escalated by the Divisional Director through the relevant operational, executive and committee meetings and supporting reports. The Health Board will undertake a focused review to ensure that these existing arrangements are consistently aligned with, and formally evidenced	31 December 2026	Chief Operating Officer Operational lead: Divisional Director of Estates and Facilities Supporting lead: Head of Corporate Risk and Assurance

Recommendation	Commentary on planned actions	Completion date	Responsible officer
	against, the agreed risk escalation and de-escalation criteria. The Estates and Facilities Division, supported by the Corporate Risk and Assurance Team, will review the operational risk register to confirm that significant or systemic estates risks are appropriately linked or escalated to the Corporate Risk Register or Strategic Risk Register where the relevant criteria are met.		
R3 The Health Board should develop and implement an Estates Disposal Strategy to support the disposal or reuse of surplus and underutilised estate assets. It should also maintain a central record of legal and contractual restrictions affecting estate assets, using site records, Land Registry information, and	**Partially Accepted** The Health Board does not agree that establishing and maintaining a separate central record of legal and contractual restrictions would provide proportionate additional value to the disposal process. Relevant restrictions are identified through established legal due diligence when an asset is considered for disposal or alternative use. The resource required to create, validate and maintain a separate record is therefore considered disproportionate to the anticipated benefits.	31 December 2027	Executive Director of Strategy, Planning and Partnerships

Recommendation	Commentary on planned actions	Completion date	Responsible officer
lease agreements **(Paragraphs 71 to 73).**	The Health Board through the Value and Sustainability Programme, an Executive-led estates rationalisation workstream is reviewing the existing estates baseline to identify surplus and underutilised assets and assess opportunities for their disposal, reuse or more efficient utilisation. This work will inform the development of an Estates Disposal Strategy, aligned with the refreshed Estates Strategic Plan and supporting operational delivery plan. The Disposal Strategy will establish the criteria, governance arrangements and decision-making process for identifying, prioritising and progressing assets for disposal, reuse or alternative use. The Health Board is assessing the most appropriate digital solution to support a transparent, accessible and routinely maintained record of estate utilisation, ownership and relevant restrictions.		
R4 The Health Board should strengthen its approach to	**Accepted**	31 March 2027	Chief Operating Officer

Recommendation	Commentary on planned actions	Completion date	Responsible officer
estate-related safety risks by using incident data, claims, staff and patient feedback to drive improvement and provide Board assurance **(paragraphs 82).**	The Health Board will build on its existing incident reporting and learning arrangements by strengthening the integration of estate-related safety intelligence through its Quality Management System (QMS). Through the QMS, intelligence from incidents, claims, concerns, complaints, staff and patient feedback, regulatory findings and operational performance information will be triangulated to support a more comprehensive assessment of estate-related safety risks. This will help identify recurring themes, contributory factors, variation between services and locations, emerging risks and areas of potential under-reporting. This intelligence will be used to inform improvement priorities, remedial actions, maintenance and capital investment decisions, risk register reviews and organisational learning. Estate-related safety intelligence will be reviewed through established governance arrangements and reported through the quality and safety governance framework.		Operational lead: Divisional Director of Estates and Facilities Supporting lead: Head of Corporate Risk and Assurance

Recommendation	Commentary on planned actions	Completion date	Responsible officer
	Monitoring will include trends in estate-related incidents, complaints, claims, regulatory findings, compliance with statutory requirements and progress against agreed improvement actions. The effectiveness of these arrangements will be assessed through evidence of completed actions, reductions in overdue high-risk actions where applicable. Assurance on key themes, actions, outcomes and any significant residual risks will be provided to the appropriate Committee and the Board through routine reporting arrangements.		
R5 The Health Board should strengthen its arrangements for managing issues identified through fire risk assessments to ensure actions are completed on time, risks are reduced, compliance requirements are	**Accepted** The Health Board will strengthen its arrangements for managing actions arising from fire risk assessments through enhanced monitoring, accountability and governance. All actions will be recorded on a central action tracker, with a named responsible officer, risk rating and agreed completion date. Progress will be reviewed routinely by	31 December 2026	Executive Director of Allied Health Professions and Health Science Operational lead: Head of

Recommendation	Commentary on planned actions	Completion date	Responsible officer
met, and the Board receives clear assurance **(paragraph 88).**	the Fire Safety Management Group, with particular focus on: • the number and proportion of actions completed within agreed timescales; • the number of overdue actions, including those assessed as high risk; • the age and risk profile of outstanding actions; • compliance with relevant statutory and regulatory requirements; and • evidence that completed actions have reduced or controlled the identified risk. The Fire Safety Management Group will challenge delays, agree revised timescales only where these are supported by a clear rationale and appropriate interim controls, and escalate overdue high-risk actions through the Health Board's risk and governance arrangements. Regular assurance reports will be provided to the Health and Safety Committee, setting out performance trends, areas of non-compliance, overdue high-risk actions, mitigating controls and progress against agreed		Health and Safety

Recommendation	Commentary on planned actions	Completion date	Responsible officer
	improvement milestones. Significant concerns or exceptions will be escalated to the appropriate Executive and Board Committee. Improvement will be evidenced through a sustained reduction in overdue actions, timely completion of high-risk actions, improved compliance with agreed timescales and confirmation that actions have been completed and their effectiveness verified. This will provide clearer assurance that fire safety risks are being actively managed and that the Health Board is meeting its statutory obligations.		
R6 The Health Board should prioritise and track the completion of outstanding actions arising from water risk assessments to reduce water safety risks and provide assurance that remedial works	**Accepted** The Health Board has made progress in strengthening water safety management, with an ongoing focus on reducing risk, improving governance and embedding a consistent, risk-based approach across all sites. During 2026/27, the Health Board will complete the second cycle of water risk assessments across all sites. Previously identified actions will be reviewed to confirm	31 March 2027	Chief Operating Officer Operational lead: Divisional Director of Estates and Facilities

Recommendation	Commentary on planned actions	Completion date	Responsible officer
are completed in a timely manner **(paragraph 90).**	their status and effectiveness, and any new or outstanding risks will be recorded, risk-rated and allocated to a named responsible officer with an agreed completion date. Where actions cannot be completed within the agreed timescale, the rationale, interim mitigating controls and revised completion date will be documented and subject to appropriate escalation. The Water Safety Module within the new Computer Aided Facilities Management (CAFM) system is scheduled for implementation during quarters three and four of 2026/27. This will provide a single, centralised record of water risk assessments, remedial actions, responsible owners, target dates and supporting evidence, strengthening accountability and the reliability of assurance reporting. Progress will be monitored through the Water Safety Group, with oversight including: • completion of the second cycle of water risk assessments;		

Recommendation	Commentary on planned actions	Completion date	Responsible officer
	• the number and risk profile of outstanding and overdue actions; • the timely completion of high-risk actions; • compliance with required water sampling and monitoring arrangements; • the adequacy of interim controls where remedial works remain outstanding; and • verification that completed actions have reduced or controlled the identified risk. Performance trends, exceptions and overdue high-risk actions will be reported through the relevant governance arrangements, with significant concerns escalated promptly. Improvement will be evidenced through the completion of risk assessments, a sustained reduction in overdue and high-risk actions, and documented verification that remedial actions are operating effectively. These arrangements will provide clearer assurance that water safety risks are being identified, prioritised and reduced, and that remedial works are completed within appropriate timescales.		

Recommendation	Commentary on planned actions	Completion date	Responsible officer
R7 The Health Board should develop and implement a comprehensive estates workforce plan to address workforce challenges, strengthen succession planning, and ensure the cost-effective use of contractors **(paragraph 103).**	**Accepted** The Estates function has previously reported workforce capacity, recruitment and resilience challenges through Executive and Committee forums. To provide a consolidated assessment, a detailed workforce paper will be developed setting out the key workforce challenges, associated risks and actions implemented to date. This will include targeted recruitment activity, apprenticeship programmes, succession planning, workforce development and the use of contractors. The paper will be supported by a concise Plan on a Page, setting out: • the current workforce position and key risks; • action already taken and the impact achieved; • the further measures proposed over the next three years; • arrangements to strengthen succession planning and workforce resilience.	31 March 2027	Chief Operating Officer Operational lead: Divisional Director of Estates and Facilities

Recommendation	Commentary on planned actions	Completion date	Responsible officer
	The paper will also propose appropriate workforce metrics, implementation milestones and reporting arrangements. These will be considered and agreed through the relevant governance forum before being incorporated into routine performance and assurance reporting. Once agreed, progress will be monitored against the Plan on a Page and the agreed measures, enabling oversight of delivery, workforce sustainability. This will provide a clear roadmap for addressing workforce pressures and evidence whether the actions taken are delivering the intended improvement.		

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Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Archwilio Cymru
Audit Wales

Zeroing in?

Follow-up on public sector decarbonisation

November 2026



We have prepared this report under section 41(1) of the Public Audit (Wales) Act 2004 and section 145A(1) of the Government of Wales Act 1998, and present it to the Senedd under section 145A(6) of the 1998 Act.

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Audit snapshot

What we looked at

1 In 2017, the Welsh Government announced its intention to achieve a carbon neutral public sector by 2030. In 2021, the Welsh Government more formally established a collective ambition for a net zero public sector by 2030.

2 We reported on progress in 2022 and found ‘clear uncertainty’ that public bodies would achieve the collective ambition. We made five calls for action. These were around leadership, strategic direction, data, finances, and skills.

3 This latest report takes a high-level look at what has happened since 2022. We have not examined public bodies’ approaches in detail or their spending decisions.

Why this is important

4 Climate change is one of the world’s defining challenges, and the Welsh Government declared a climate emergency in Wales in 2019. A crucial way to mitigate the impacts of climate change is to reduce carbon emissions.

5 The Secretary-General of the United Nations recently warned that the world’s efforts to reduce carbon emissions are dangerously off track. The public sector can lead by example in reducing emissions and being a catalyst for wider changes in the economy and society.

What we have found

6 It is now highly unlikely that the public sector will achieve the collective ambition. While there are many examples of changes relevant to our calls for action, overall, there has not been the acceleration we called for in 2022.

7 We came to this view because:

- Decarbonisation has become a lower priority for public bodies, partly due to financial pressures. It has not been fully embedded into day-to-day decision making, and public bodies are not doing enough to work together.
- The collective ambition has driven action but is poorly defined and criticised for being ‘unachievable’. Public bodies want more help to translate the Welsh Government’s Public Sector Route Map (the route map) into action. And the Welsh Government is not checking whether public bodies are achieving the route map milestones.
- More public bodies are now part of the Welsh Government’s carbon emissions reporting system and some gaps in data have been filled. Reported emissions have increased but trend data does not tell the full story as these improvements in reporting coverage have played a part. And public bodies have concerns about the quality of some of the data because of current calculation methods.
- Public bodies have made limited progress overall in understanding how much it will cost to decarbonise. Where costed near-term plans have been developed, they vary in quality and bodies would like greater certainty about future funding. And where public bodies have estimated the longer-term cost, some described it as unaffordable. Public sector decarbonisation is also only one part of the spending needed to achieve the Welsh Government’s wider net zero ambitions and adapt to climate change.
- Public bodies have identified decarbonisation skills gaps but lack a full understanding of their needs. Internal capacity is often limited to small, specialist teams and public bodies rely on consultants and the Welsh Government Energy Service (the WGES) to fill gaps.

What we recommend

8 Our recommendations focus on the Welsh Government in its leadership role. They address clarifying and supporting the strategic direction, improving carbon emissions reporting, and support for better financial planning.

9 Public bodies are responsible for their own operations. So, we are also recommending that they use the checklist we have developed to reflect on their own approach.

Key facts and figures



82 public bodies

Number reporting carbon emissions to the Welsh Government in 2024-25, up from 69 in 2021-22.[1]



3.96 million tCO_2e

Carbon emissions reported by Welsh public bodies in 2024-25.



84%

Proportion of public bodies' reported carbon emissions in 2024-25 that were scope 3 emissions, which relate mostly to their supply chains.



20% increase

Change in overall reported carbon emissions from Welsh public bodies between 2021-22 and 2024-25. This is due in part to changes in reporting coverage.



At least £2.3 billion

Estimated capital cost of decarbonising Welsh council buildings alone, according to work commissioned by the Welsh Government and Welsh Local Government Association (WLGA).



£144 million in loans and £84 million in grants

Provided by the Welsh Government to directly support public sector decarbonisation since our previous report (between 2022-23 and 2025-26).

Notes:

[1] For universities and colleges, the carbon emissions data included in 2021-22 and 2024-25 is for the 2020/21 and 2023/24 academic years respectively, the most recent published data for those bodies.

Our findings

Leadership

Decarbonisation has become a lower priority for public bodies

10 In 2022, we called on senior leaders to identify decarbonisation as a top priority and demonstrate they fully grasp the urgency of the situation. The Secretary-General of the United Nations recently reinforced the need for stronger leadership.[1] He warned that the world's efforts to reduce carbon emissions are dangerously off track and called for countries to over-deliver on their climate commitments.

11 Our work shows that some good examples of leadership have continued or developed since we reported. But, overall, decarbonisation has become a lower priority.

12 For the NHS, the Welsh Government has shown leadership through a refreshed delivery plan.[2] And the Welsh Government also included in its wider 2024 plan for health and social care, direct references to the climate and nature emergencies.[3]

13 In local government, a Climate Strategy Panel established by the Partnership Council for Wales is providing leadership. Its members include council chief executives who chair task and finish groups focused on the route map's themes.

14 The Future Generations Commissioner reported in 2025 that some public bodies have created dedicated leadership roles or have improved governance and scrutiny structures around decarbonisation.[4] The Commissioner also noted that most public bodies have built relevant commitments into their well-being objectives and/or steps to deliver their objectives.

1 United Nations, A Tale of Two Crises - UN Secretary-General at London Climate Action Week, June 2026
2 Welsh Government, NHS Wales Decarbonisation Strategic Delivery Plan 2025 to 2030, November 2025
3 Welsh Government, A Healthier Wales: our Plan for Health and Social Care, July 2024
4 Future Generations Commissioner for Wales, Future Generations Report 2025, April 2025

15 The Welsh Government has published a plan to reduce its own emissions, including actions to address emissions from its supply chain.[5] There is also strategic leadership within the Welsh Government through its Climate Change Portfolio Board.[6]

16 In general, public bodies in all sectors recognise decarbonisation is important. However, since 2022, financial and political pressures have caused decarbonisation to fall down the priority list. Public bodies told us their overall financial pressures mean they are struggling to invest in decarbonisation. We also heard how the need to decarbonise has become more politically contested in local government.

17 Some public bodies are moving away from treating decarbonisation as a standalone objective. Instead, they are positioning it as one of many ways of delivering linked organisational benefits. For example, some are reframing initiatives as ways to secure savings, rather than promoting carbon reduction for its own sake.

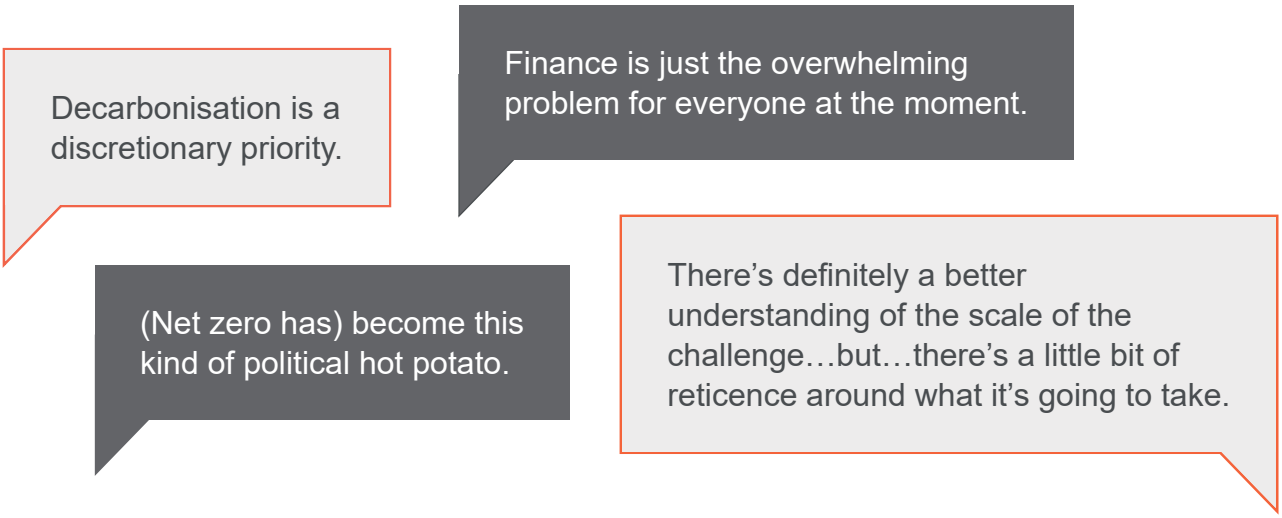
18 Such changes could be a good thing, if they result in a more integrated approach to prioritisation and planning. But there is a risk of public bodies diluting their focus on decarbonisation. The balance between direct cost and emission savings from decarbonisation measures varies. It is important that bodies consider these factors in parallel in their decision-making.

19 **Exhibit 1** shows some relevant quotes from our fieldwork about leadership and prioritisation.

5 Welsh Government, Net Zero Strategic Plan, September 2022

6 This is an internal Welsh Government board. It provides governance for the development and delivery of climate legislation and policy.

Exhibit 1: sample of quotes about leadership and prioritisation



Source: Audit Wales focus groups and interviews with public body officers

Public bodies have not fully embedded decarbonisation in day-to-day decision making

20 In 2022, we said that decarbonisation must be at the core of public bodies' day-to-day business decisions and operations.

21 The Welsh Government has pointed us to steps it has taken to support this. For example, it has made it a requirement that health capital schemes for new builds or major refurbishments must now follow a Net Zero Carbon Healthcare Building Standard. And for new builds and refurbishments in schools and colleges, the Welsh Government has provided extra funding for projects that aim to achieve net zero carbon (see **Exhibit 2**).[7] The WLGA also highlighted guidance it has developed with Ambition North Wales to help organisations consider carbon and biodiversity impacts when preparing business cases.[8]

7 **Paragraphs 80 to 81** show how the Welsh Government has also provided targeted funding to support public sector decarbonisation.

8 Guidance to be made available on the WLGA website shortly. Ambition North Wales is the public facing brand of the North Wales Corporate Joint Committee.

Exhibit 2: case study on the Sustainable Communities for Learning programme

A positive example to learn from is the Welsh Government's Sustainable Communities for Learning programme for school and college buildings. One of the programme's strategic objectives is to develop sustainable learning environments in line with the Welsh Government's carbon reduction commitments.

Through this programme, the Welsh Government typically provides 65% of the standard construction costs to build or refurbish buildings. If a project aims to achieve net zero carbon, and incurs extra costs as a result, the Welsh Government typically funds 100% of those extra costs. We are completing separate audit work looking at the programme in more detail.

Source: Audit Wales fieldwork

22 While there are positive examples of decarbonisation influencing day-to-day decisions, these remain the exception rather than the rule. Public bodies told us that financial and operational pressures can 'crowd out' this agenda.

23 Also, responsibility for decarbonisation largely remains concentrated in small specialist teams in many public bodies. As a result, it is often seen as the role of specialists rather than being something everyone has a stake in as part of their work (see also **paragraphs 97 to 101** on capacity and skills).

24 The Welsh Government told us there are exceptions to this. For example, how Isle of Anglesey County Council, with support from the WGES, had made progress in low carbon heating because of the commitment and involvement of people in different teams and from the top of the organisation down.[9]

9 For more information about this project see: Welsh Government, Isle of Anglesey County Council: low carbon heat retrofit of Llangefni offices, March 2026

Public bodies are not doing enough to work together on decarbonisation

25 In 2022, we called on public bodies to demonstrate stronger collective responsibility through effective collaboration.

26 There are some good examples of joint working. These include joint procurement of electric vehicles by local authorities, culture sector collaboration through the Culture and Climate Cymru network, peer-learning networks in local government and health, and the Climate Strategy Panel in local government.[10] The WGES has also supported private and public sector collaboration on renewable energy projects supplying NHS sites.

27 However, given the scale of the climate and nature emergencies in Wales, we have not seen enough evidence of system wide, cross-sector collaboration on decarbonisation. The response currently falls far short of the kind of collective responsibility that emerged during the COVID-19 pandemic.

10 Welsh Government, Procurement case study: Electric vehicle purchase collaborative procurement, March 2024

Strategic direction

The collective ambition has driven action but is poorly defined and seen as unachievable by many public bodies

28 In 2022, we called for a clear strategic approach to decarbonising the public sector, aligned with other key policy ambitions.

29 The collective ambition sets out the Welsh Government's strategic direction for public sector carbon reduction. It is more ambitious in its scope, scale, and timing than its nearest equivalents in England and Scotland.[11]

30 Since our 2022 report, the collective ambition has continued to drive action. It has provided a definite timescale and focal point for public bodies' actions.

31 There are, however, criticisms of the collective ambition. Some public bodies said it is not clear enough on who is accountable for delivery. Given it is 'collective', some public bodies were also unsure how much each body was expected to contribute. The Welsh Government told us it had repeatedly communicated with public bodies that they should own delivery and aim for their lowest achievable carbon footprint.

32 Another criticism is that the Welsh Government has not defined the collective ambition as a 'target'. There are also no penalties or incentives to drive compliance. Some public bodies told us this had added to uncertainty around the level of priority to attach to carbon reduction.

33 The Welsh Government told us it had not set the collective ambition as a target because it did not have robust evidence about the baseline position at that time. Its intention was to set an ambition for each public body to drive change.

34 Many public bodies believe the collective ambition is unachievable by 2030. And it is having less traction as more public bodies come to realise they will not achieve it.

11 The UK Government's Department for Energy Security and Net Zero has set a target to reduce emissions from public sector buildings in England by 75% by 2037. The Scottish Government has committed to all public sector buildings achieving net zero emissions by 2045.

35 Some public bodies felt that the Welsh Government should have set a more realistic ambition. However, others felt that having a stretching ambition was important to encourage action, and that bodies would have made far less progress without it.

36 The Future Generations Commissioner has recognised that the collective ambition has been a catalyst for action (see **footnote 4**). However, the Commissioner also believes public bodies should develop individual, realistic, medium-term pathways to net zero that align with the Third Carbon Budget for Wales.[12]

37 **Exhibit 3** shows some relevant quotes from our fieldwork about the collective ambition.

Exhibit 3: sample of quotes about the collective ambition



Source: Audit Wales focus groups and interviews with public body officers

12 Welsh Government, Climate change targets and carbon budgets, December 2025

The route map sets out a high-level framework, but public bodies want more help to translate strategy into action

38 In 2022, we reported that while the route map provides a high-level template to translate strategy into action, public bodies said they needed more clarity, support, and guidance on how to decarbonise.

39 Since 2022, some public bodies told us they have continued to use the route map to inform local strategies and decision-making. However, public bodies said they still needed more practical guidance and support to help them develop robust and costed action plans, prioritise interventions, select appropriate technologies, and achieve behaviour change.

40 Numerous public bodies have developed local decarbonisation plans or have included decarbonisation in wider organisational strategies. However, the quality and maturity of these plans – for example, how clear they are about priorities and actions – varies a lot. Some variation is natural and reflects differences in capacity and resources. But the extent of variation suggests that public bodies would benefit from clearer Welsh Government guidance.

The Welsh Government is not monitoring public sector progress towards the route map's milestones

41 The Welsh Government does not monitor progress against the milestones and actions in the route map. The route map also lacks clear, measurable indicators that would allow progress to be assessed consistently.

42 The route map states that during the period 2022-2026 Wales should be 'well on our way' to reducing public sector carbon emissions. It describes this as a position where low-carbon approaches are becoming the norm, and the public sector is clearly on the path to net zero. In our view, the public sector has not met this expectation overall.

Carbon emissions data

More public bodies are now part of the Welsh Government's reporting system and some gaps in reported data have been filled

43 In 2020, the Welsh Government launched a voluntary public sector carbon emissions reporting system. It is a standard framework for public bodies to report progress on decarbonisation.

44 In 2022, we called on public bodies to improve data quality and monitoring to support their decision making. Overall, public bodies have since improved their internal carbon emissions data monitoring and reporting processes.

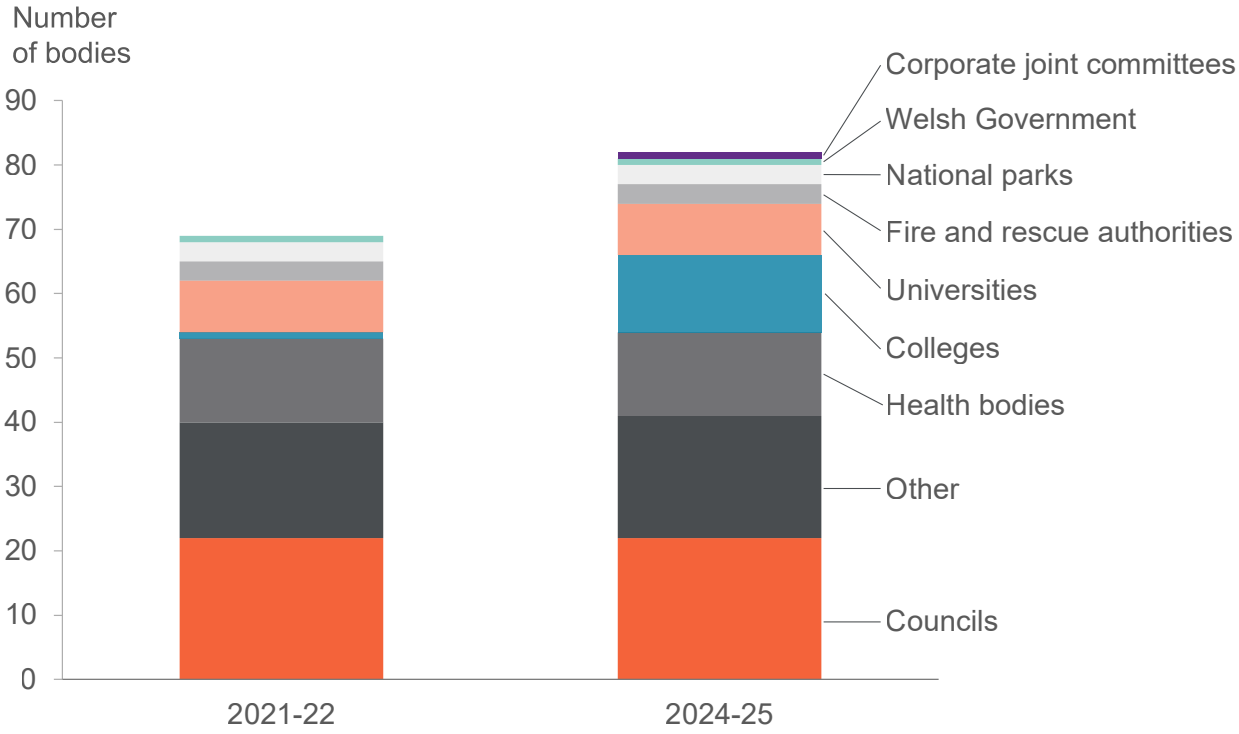
45 The Welsh Government has also continued to work with public bodies to increase coverage and respond to feedback on how to improve the reporting system. For example, gaps in the reporting of anaesthetic gases and waste management emissions are now filled, and reporting on supply chain expenditure has been expanded.[13] Also, the WGES is now running a project to improve land-based emissions reporting.[14]

46 As shown in **Exhibit 4**, the number of bodies reporting their carbon emissions to the Welsh Government has risen from 69 in 2021-22 to 82 in 2024-25. All councils, health bodies, universities, and colleges now report their emissions annually. For bodies to receive Welsh Government public sector decarbonisation funding, they must continue to report emissions.

13 Anaesthetic gases such as nitrous oxide are potent greenhouse gases that are released directly into the atmosphere after use.

14 Land-based emissions reporting covers greenhouse gas emissions and carbon removals from changes in land use and land management, including agricultural activity.

Exhibit 4: public bodies reporting carbon emissions data to the Welsh Government by type of body, 2021-22 and 2024-25 (number)



Source: Welsh Government, Welsh Public Sector Net Zero Reporting Interactive Dashboard

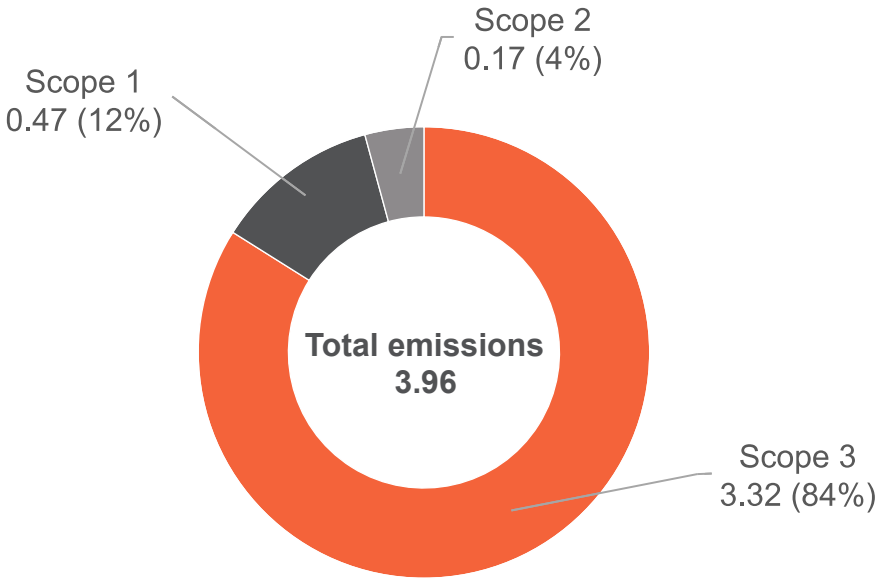
Note: For universities and colleges, the data included in 2021-22 and 2024-25 is for the 2020/21 and 2023/24 academic years respectively, the most recent published data for those bodies.

Public bodies trust the accuracy of their scope 1 and 2 emissions data and are using it to inform their actions

47 There are three standard categories of carbon emissions used across the world. These are described as scope 1, 2, and 3 (see **Appendix 3**).

48 **Exhibit 5** shows Welsh public bodies' reported emissions in 2024-25, for each scope and overall. Public bodies reported a total of 3.96 million tCO_2e in that year.

Exhibit 5: overall, and scope 1, 2 and 3, carbon emissions reported for Welsh public bodies, 2024-25 (million tCO_2e and percentage)



Source: Welsh Government, Welsh Public Sector Net Zero Reporting Interactive Dashboard

Note: We have rounded figures to two decimal places. The units are millions of tonnes of carbon dioxide equivalent (tCO_2e), a measure that expresses the climate impact of all greenhouse gases as the equivalent amount of carbon dioxide.

49 Public bodies have a lot of control over activities that drive scope 1 and 2 emissions, such as heating buildings, using electricity, and running vehicles. But these make up only 16% of total reported emissions.

50 Public bodies told us that Welsh Government guidance on scope 1 and 2 emissions is clear and widely accepted.[15] They had confidence in the accuracy of this data and are using it to inform action, especially in relation to buildings and vehicles. That said, the Welsh Government reports that in the early years of data collection, there were cases of public bodies missing or incorrectly recording data.

15 Welsh Government, Public sector net zero reporting guide, May 2021

Scope 3 accounts for the bulk of emissions but there is wide agreement that the data is not accurate enough to inform meaningful action

51 Scope 3 emissions are indirect emissions, such as those generated in the production of goods purchased by public bodies. So, public bodies have less direct influence over scope 3 emissions than scope 1 and 2. However, tackling scope 3 is important because, as shown in **Exhibit 5**, it accounts for 84% of reported total emissions. Supply chain emissions make up most of the scope 3 emissions.[16]

52 Much of the data that public bodies need to accurately calculate supply chain emissions can be difficult to obtain because it is held by suppliers or third parties. Public bodies might have many suppliers so calculating these emissions can be costly or impractical. It also depends on whether suppliers can report their emissions accurately. As a result, most supply chain emissions data is estimated using proxy data.[17]

53 The proxy approach for supply chain emissions uses 'emission factors' as standard conversion rates to translate public bodies' spending into an estimate of carbon emissions. The UK Government publishes updated factors periodically.

54 This means that current supply chain emissions data provides only a broad indication of emissions rather than a precise measure. Many public bodies felt that the current approach is not accurate enough to help them to target their actions to reduce supply chain emissions.

55 There was widespread frustration with the supply chain approach, which many public bodies described as crude or unfair. For example, if a body installs heat pumps for its buildings, this would result in it reporting higher emissions in the short term under scope 3 due to the spending on the installation. Yet the change to heat pumps away from conventional fossil fuel heating would likely reduce the body's emissions over time.

16 Activities that produce the most carbon tend to sit in supply chains, for example, manufacturing, food production, construction, and pharmaceuticals. In 2024-25, supply chain emissions made up 89% of scope 3 emissions and 75% of total emissions.

17 Of the scope 3 supply chain emissions reported to the Welsh Government in 2024-25, 92% was estimated using proxy data. For the remaining 8%, public bodies used supplier-specific data. The WGES reports that the health sector is more advanced in using supplier specific data. The Welsh Government's approach for supply chain emissions is consistent with internationally recognised greenhouse gas emissions accounting.

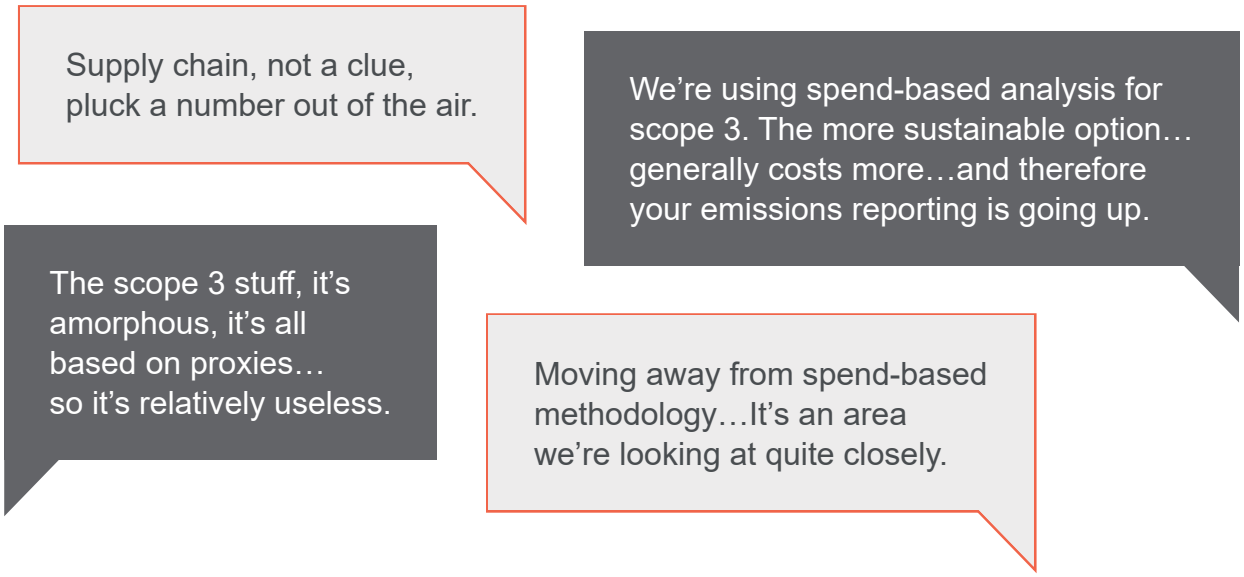
56 The Welsh Government recognises there are limitations. It has wanted to balance accuracy with the need for an approach that is not too resource intensive for public bodies. It has also seen the approach as something that can help public bodies focus their efforts around decarbonising their supply chains.

57 For all the concerns, many public bodies recognised that the current approach gives an indication of their wider carbon impact until better data becomes available. Some suggested that future policies and targets should more clearly distinguish expectations for scope 1 and 2, and scope 3 emissions.

58 With the aim of improving supply chain emissions data, the WGES has worked with public bodies to develop an optional supplier data collection template. The template has been introduced for the 2025-26 reporting year. The WGES is encouraging public bodies to engage with their top 10 suppliers (by emissions). It remains to be seen how much the template will be used. The WGES is also exploring digital solutions to streamline reporting.

59 **Exhibit 6** shows some relevant quotes from our fieldwork about supply chain emissions reporting.

Exhibit 6: sample of quotes about supply chain emissions reporting



Source: Audit Wales focus groups and interviews with public body officers

There is only limited verification of emissions data

60 Before public bodies submit their emissions data to the Welsh Government, they should be satisfied as to its accuracy. We have not looked at data quality arrangements at individual public bodies.

61 When public bodies submit their data, the WGES conducts basic checks for completeness, scale, and obvious gaps. As a result, some errors or inconsistencies may go undetected.

62 For 2025-26, more detailed building-level data is required and the WGES is planning more verification.[18] However, in the short term, this will not be at the level of verification of other environmental data, for example, around municipal waste management and recycling.

Overall reported emissions have increased but the published trend data does not tell the full story

63 As shown in **Exhibit 7**, reported Welsh public sector carbon emissions have increased since reporting began in 2019-20. Between 2021-22 (shortly before our previous report) and 2024-25, there was a 20% increase. Between 2019-20 and 2024-25, there was a 78% increase.

18 For reporting years before 2025-26, public bodies could submit more aggregated data. For example, where a submission might cover several buildings on a single site.

Exhibit 7: reported carbon emissions for Welsh public bodies, and number of bodies that reported emissions, 2019-20 to 2024-25 (million tCO_2e, number)

	Reported emissions (million tCO_2e)	Number of bodies that reported
2019-20	2.23	47
2020-21	3.32	54
2021-22	3.30	69
2022-23	3.12	71
2023-24	3.53	77
2024-25	3.96	82

Source: Welsh Government, Welsh Public Sector Net Zero Reporting Interactive Dashboard

Note: The increase in reported emissions is due in part to changes in reporting coverage.

64 Analysis of the Welsh Government's interactive dashboard shows that between 2021-22 and 2024-25:

- reported scope 3 emissions went up by 24% (largely due to increased emissions attributed to the supply chain); and
- reported scope 1 and 2 emissions barely changed overall (a 1% fall).

65 But the trends described above do not tell the full story. For example, improvements in reporting coverage have played a part (see **paragraphs 45 and 46**).

66 Another contributing factor is the increase in the number of public bodies reporting emissions data to the Welsh Government. We controlled for this by analysing the data for the bodies that reported in both 2021-22 and 2024-25. For those 67 public bodies, there was an 18% increase in reported carbon emissions.[19]

67 So, while it is difficult to analyse trends, the overall picture is that the public sector remains a long way from achieving the collective ambition. This aligns with what public bodies told us.

19 There were two public bodies that reported in 2021-22 that did not report in 2024-25.

Finance

Public bodies have made limited progress in understanding the costs of decarbonisation

68 In 2022, we called on public bodies to improve their understanding of the finances needed to decarbonise their operations.

69 Public bodies generally understand their capital spending on specific decarbonisation projects, such as heating systems, fleet replacement and vehicle charging. However, they lack a full picture of their total decarbonisation spending because costs are often embedded in wider estates, maintenance and replacement projects.

70 In addition, public bodies have made limited progress in understanding the broader, longer-term costs of achieving net zero carbon across all their activity.

71 The WGES told us that assessing the longer-term cost of decarbonisation had become a distraction for public bodies. It said that it was more important for public bodies to develop near-term, costed delivery plans. While we have not reviewed public bodies' decarbonisation plans in detail, we commented in **paragraph 40** on the variable quality and maturity of those plans.

Where public bodies have estimated how much decarbonisation will cost over the longer term, some described it as unaffordable

72 Where organisations have attempted to quantify the longer-term costs of decarbonisation, the estimates are substantial. Some public bodies described these costs as unaffordable.

73 A 2025 report commissioned by the Welsh Government and WLGA looked at the cost of decarbonising council buildings across Wales. Estimates ranged from at least £49 million in Ceredigion to at least £218 million in Cardiff. Across Wales, the total cost was estimated to be at least £2.3 billion.[20]

20 This report is not currently available online. The model used in the report covers 2024 to 2030. The £2.3 billion capital cost relates to the cost of implementing energy efficiency and renewable energy measures. For example, installing heat pumps, double glazing and solar power. This compares to an estimated cost of £153 million to replace current heating equipment on a like-for-like basis at the end of its useful life.

74 The WGES told us that public bodies need to change their approach to estimating longer-term decarbonisation costs. The WGES wants public bodies to consider the net cost of decarbonisation, recognising that there are substantial costs associated with continuing to run their operations without taking decarbonisation actions.

75 And the Welsh Government said it was unhelpful for public bodies to consider decarbonisation as a separate cost item. It said decarbonisation needs to become a standard aim that is allowed for in any renewal or replacement project.

76 Nevertheless, the level of spending required for public bodies to decarbonise their own operations presents a challenge. It is also just one part of the bigger picture of public spending needed to achieve the wider Welsh Government target of a 100% carbon reduction for Wales by 2050.[21]

77 However, investing now is about prevention. Failure to do so may lead to longer-term financial impacts. The future costs of needing to adapt services and assets to climate change will be considerable and may increase if action is delayed. Public bodies therefore need to consider both the costs of action and the costs of inaction when making spending decisions.

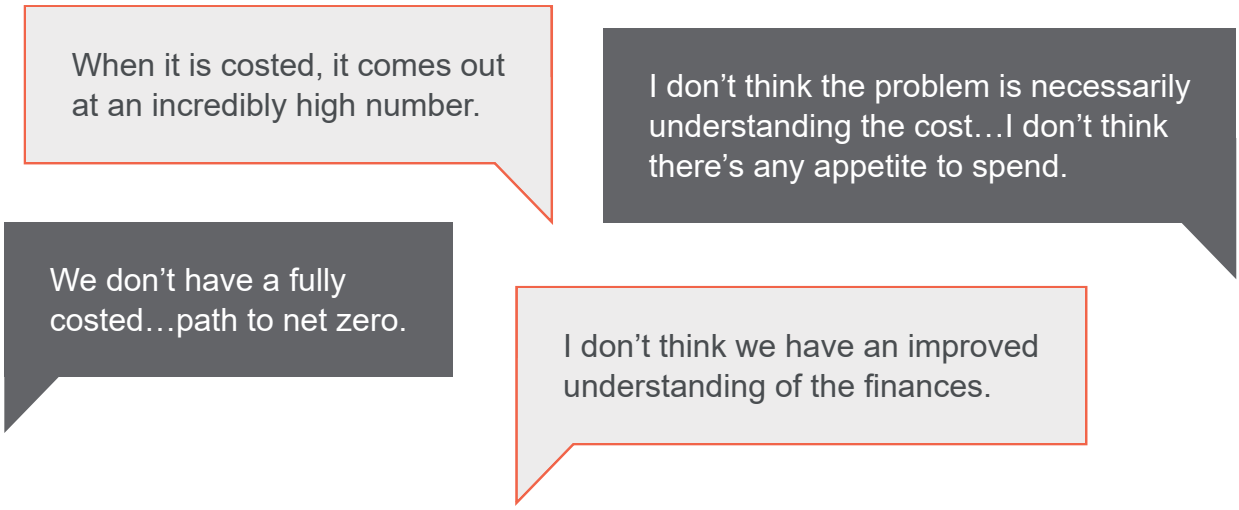
78 The UK Climate Change Committee has advised the Welsh Government to introduce a multi-year programme for decarbonisation specifically for public sector buildings, supported by long-term capital settlements.[22]

79 **Exhibit 8** shows some relevant quotes from our fieldwork about the cost of decarbonisation.

21 Welsh Government, Climate change targets and carbon budgets, December 2025

22 Climate Change Committee, Wales' Fourth Carbon Budget: Advice for the Welsh Government, May 2025

Exhibit 8: sample of quotes about the cost of decarbonisation



Source: Audit Wales focus groups and interviews with public body officers

Between 2022-23 and 2025-26, the Welsh Government provided £144 million in loans and £84 million in grants to directly support public bodies' decarbonisation

80 The Welsh Government is directly supporting public bodies to decarbonise by providing loan and grant funding.[23] As shown in **Exhibit 9**, the Welsh Government has provided £144.1 million in loans since our previous report (between 2022-23 and 2025-26). Overall, there has been a year-on-year increase during this time.

23 We use 'directly supporting' to mean the loans and grants that the Welsh Government sees as specific to public sector decarbonisation. This excludes funding with other core objectives that may also support decarbonisation.

Exhibit 9: Welsh Government loan finance directly related to public sector decarbonisation, 2022-23 to 2025-26 (£ million)[1]

Loan name	2022-23 (£ million)	2023-24 (£ million)	2024-25 (£ million)	2025-26 (£ million)	Total (£ million)
Wales Funding Programme[2]	2.3	13.9	7.1	6.5	**29.8**
Digarbon[3]	–	–	28.7	42.0	**70.7**
Invest to Save[4]	3.3	–	13.2	27.1	**43.6**
Total	**5.6**	**13.9**	**49.0**	**75.6**	**144.1**

Source: Welsh Government

Notes:

[1] We have rounded the figures to one decimal place, so figures do not necessarily add up to displayed totals.

[2] The Wales Funding Programme provides loan funding for energy efficiency and decarbonisation projects for public bodies registered in Wales.

[3] Digarbon supports decarbonisation, energy efficiency, renewable energy (including low carbon heat), and electric vehicle infrastructure projects in further and higher education institutions in Wales.

[4] Invest to Save supports decarbonisation and energy efficiency projects in Welsh public bodies. It is for bodies that are not able to borrow through other public sector borrowing routes, such as health boards.

81 As shown in **Exhibit 10**, Welsh Government grant funding to directly support public bodies' decarbonisation totalled £84 million between 2022-23 and 2025-26. As with loan finance there has been a year-on-year increase during this time.

Exhibit 10: Welsh Government grant funding directly related to public sector decarbonisation, 2022-23 to 2025-26 (£ million)[1]

Grant name	2022-23 (£ million)	2023-24 (£ million)	2024-25 (£ million)	2025-26 (£ million)	Total (£ million)
Local Authority Low Carbon Heat Capital Grant[2]	–	14.2	20.0	31.2	**65.4**
Public Sector Heat Grant[3]	–	–	1.6	1.7	**3.3**
Transport Grant[4]	1.2	4.4	6.2	2.7	**14.5**
Project Design and Development Grant[5]	–	–	–	0.7	**0.7**
Total	**1.2**	**18.6**	**27.8**	**36.3**	**83.9**

Source: Welsh Government

Notes:

[1] We have rounded the figures to one decimal place, so figures do not necessarily add up to displayed totals.

[2] The Local Authority Low Carbon Heat Capital Grant funds up to 90% of the cost of installing low carbon heating solutions in local authority-owned buildings.

[3] The Public Sector Heat Grant funds up to 90% of the initial capital cost of installing low carbon heating solutions in public sector buildings. It is not available to councils or higher education institutions.

[4] The Transport Grant funds up to 90% of the cost of installing charging infrastructure and associated capital works and top up funding for the purchase of zero emission vehicles. The grant is available to all Welsh public sector bodies, including universities and further education colleges.

[5] The Project Design and Development Grant is available to all public bodies that report carbon emissions to the Welsh Government. It funds up to 50% of the design and development work needed to get projects ready for investment.

82 In addition to the funding set out in **Exhibits 9 and 10**, the Welsh Government is funding the WGES. Between 2023-24 and 2025-26, funding for the WGES's core work has totalled around £11.6 million.[24] The Welsh Government has also provided £1.4 million of funding for the WLGA Climate Change Support Programme between 2022-23 and 2025-26.[25]

83 Public bodies told us that Welsh Government funding and WGES support are important enablers of decarbonisation activity. However, some bodies do not access the Welsh Government grant funding that is available. Even where public bodies have received funding, they also told us that it is not enough to deliver the scale of change required.

84 In 2022, we said that while the Welsh Government is providing funding to public bodies, it has said it cannot fund everything. We urged public bodies to think carefully about how they can use existing funding in different ways, explore other funding opportunities, and consider how they might share costs with partner organisations. These points are still valid.

85 Difficult questions remain about where the money will come from for the public sector to decarbonise and to contribute to the wider Welsh Government target of a 100% carbon reduction by 2050 (see **paragraph 76**).

86 Further spending will also be required to adapt to climate change. With public bodies also juggling many other priorities, a wider national conversation is needed about the level of investment required and by whom.

24 The Welsh Government provides the WGES with additional, ad-hoc revenue funding for specific work outside of its core service. The core service covers supporting public bodies to plan and deliver local energy projects and public sector emissions reporting. The current framework for WGES support began in 2023.

25 The WLGA Climate Change Support Programme supports local authorities to deliver decarbonisation and climate adaptation activities. It provides leadership, guidance, tools, training and collaborative forums to help councils share learning, avoid duplication, build capability and accelerate progress towards the ambition of a net zero Welsh public sector by 2030. Since it started in 2020-21, and including 2026-27, total funding for the programme comes to £2.2 million.

Public bodies identified concerns about current funding approaches

87 Public bodies told us about how Welsh Government funding is often short term and tied to annual cycles, making it difficult to plan and deliver long-term decarbonisation programmes. These concerns reflect issues that we have commented on in previous reports, including our recent report on wider funding for local government.[26]

88 Public bodies also reported challenges accessing funding. For example, limited capacity to develop business cases, short application windows, and a reluctance or inability to take on additional debt with potentially long pay back periods. Some felt these issues favour organisations with the resources and expertise to secure funding. As a result, there is a risk that funding is not always directed to projects that would necessarily deliver the biggest impact.

89 The Welsh Government told us it had repeatedly encouraged public bodies to develop pipelines of decarbonisation projects. This would help them be better prepared to access funding.

26 Audit Wales, Funding councils: how the Welsh Government funds councils, July 2026

Skills

Public bodies have identified decarbonisation skills gaps but lack a full understanding of their needs

90 In 2022, we called for public bodies to get to know their skills gaps and increase their capacity.

91 Since then, public bodies have developed a broader understanding of the skills needed to achieve net zero carbon. However, this is often high-level and not supported by more detailed workforce assessments or development plans.

92 Areas where specific skills gaps have been identified include energy engineering, retrofit delivery, facilities management, low-carbon construction, and scope 3 decarbonisation.[27] Public bodies also report gaps in data and analytical skills to support decision-making.

93 The Welsh Government has taken some steps of its own to try to help strengthen wider workforce planning for decarbonisation. Since 2022, it has published a plan to identify future skills needs and coordinate action across the private and public sectors.[28] The Welsh Government told us it intends to review the plan ahead of a broader Skills Strategy for Wales in 2027.

94 The Welsh Government has also developed sector-specific skills roadmaps and completed a Green Skills Review.[29, 30] The review made recommendations to inform future skills policy. Its findings are informing ongoing discussions with wider stakeholders on the future direction of net zero skills.

95 The Welsh Government has also produced a library of case studies showing how organisations can invest in net zero skills in areas including buildings, electricity and heat generation, and transport.[31] However, what we heard from the public body officers we engaged with suggested that awareness of some of these actions and resources could be improved.

27 Energy engineering refers to skills to design, assess and deliver energy efficiency, renewable energy, and low-carbon heat projects. Retrofit delivery is when energy-efficiency and low-carbon improvements are made to existing buildings.

28 Welsh Government, Net Zero Skills Action Plan, February 2023

29 Welsh Government, Draft emission sector skills roadmaps, October 2024

30 Welsh Government, Greens Skills Review, October 2025

31 Welsh Government, Net zero skills: case studies, April 2023

96 The Welsh Government recognises that more needs to be done, and that net zero skills remains a long-term challenge. It is continuing to work with other relevant bodies, such as Regional Skills Partnerships. Areas of focus include improving skills mapping, sharing data, and making sure skills planning is considered early in major policy initiatives.[32]

Internal capacity is often limited to small, specialist teams and public bodies rely on consultants and the WGES to fill gaps

97 Public bodies told us that internal capacity is often limited to small decarbonisation teams. Many highlighted carbon literacy as an important way of building wider capability in public bodies. Carbon literacy is the ability to understand, communicate about, and act on climate change issues. So, improving carbon literacy could help make decarbonisation everyone's responsibility.

98 However, carbon literacy and decarbonisation skills are not routinely part of mandatory training, workforce strategies, or professional development frameworks. And where public bodies offer carbon literacy training, we heard that take-up is often low.

99 Public bodies also reported persistent problems retaining staff with decarbonisation skills. There is competition for these staff, both within the public sector and because of better paid opportunities outside it.

100 To address skills gaps, many public bodies rely on consultants and the WGES for technical expertise, feasibility studies, and delivery support. The WGES is not resourced to lead public bodies' projects. However, the Welsh Government told us that the support provided by the WGES is spreading learning that it hopes will help to build capacity in public bodies over the longer term.

101 Several public bodies described using short-term grants and project funding to create temporary posts. However, this does not provide a long-term solution to capacity issues.

32 The four Regional Skills Partnerships in Wales bring together employers, skills providers and other stakeholders. Their role is to drive investment in skills by developing responses to local and regional need.

4 Recommendations

Recommendation to public bodies that report carbon emissions to the Welsh Government

R1 Public bodies should use our checklist at a senior leadership or governance forum, to self-assess their approach to decarbonisation and support scrutiny.

(See **Appendix 2**).

Recommendations to the Welsh Government

R2 To clarify and support delivery of the strategic direction for public sector decarbonisation, the Welsh Government should:

2.1 Decide whether the collective ambition will be retained in its current form.

2.2 Set clear and measurable expectations for public bodies on decarbonising their operations across their scope 1, 2, and 3 emissions in the context of wider policy ambitions.

2.3 Build on the publication of emissions data with an annual statement, describing progress towards the collective ambition (or any replacement), and milestones in the route map, including the likelihood of success and factors affecting delivery.

2.4 Work with public bodies to understand and respond to their needs for more practical and delivery-focused guidance to support decarbonisation work.

(See **paragraphs 28 to 42**)

R3 To improve carbon emissions reporting, the Welsh Government should work with public bodies to:

3.1 Establish and maintain consistent and comparable emissions reporting over time to enable robust, long-term monitoring of progress in public sector decarbonisation.

3.2 Agree how reported emissions data will be verified and assured in future.

3.3 Set out plans to address the current limitations in supply chain emissions reporting.

(See **paragraphs 43 to 67**)

R4 To support better financial planning, the Welsh Government should:

4.1 Work with public bodies to develop guidance and support aimed at making sure all bodies have good quality, costed, near-term decarbonisation action plans.

4.2 Lead a national conversation about how decarbonisation, across the public sector or more widely, should be funded in future, informed by data on the likely long-term costs of decarbonisation, the costs of adapting to climate change, and the potential costs of inaction.

4.3 Set out how much dedicated funding it expects will be available to the public sector for the next three years, in grants and/or loans, to inform public bodies' plans for financing their own decarbonisation.

(See **paragraphs 68 to 89**)

Appendices

1 About our work

2 Checklist for public bodies

3 Key terms in this report

1 About our work

Scope of the audit

This report is a follow-up to our 2022 work, which considered how the public sector was preparing to achieve the collective ambition for a net zero public sector by 2030.[33]

Our follow-up was deliberately high level. We focussed on the collective ambition, with our scope framed around our five calls for action. We limited our scope to public sector action on decarbonisation. Wider issues, such as progress against statutory net zero carbon targets covering more than just the public sector and adaptation to a changing climate, were not within scope.

Our 2022 work covered 48 public bodies. These were the 44 local government, NHS and central government bodies covered at the time by the Well-being of Future Generations (Wales) Act 2015 (the Act). Also, the Welsh Ambulance Services University NHS Trust, Digital Health and Care Wales, Health Education and Improvement Wales, and the NHS Wales Shared Services Partnership which is hosted by Velindre University NHS Trust.

In our follow-up, we covered the same 48 bodies but also considered the wider context of public sector decarbonisation by engaging with bodies brought under the Act in 2024. We also covered other bodies, including higher and further education institutions, which submit carbon emissions data to the Welsh Government. This increased the number of bodies in our scope to 82.

We have not examined public bodies' approaches in detail or their spending decisions. We have drawn heavily on what we have learnt through our engagement with public bodies, through interviews and focus groups, but we have not conducted detailed fieldwork at each public body.

33 Audit Wales, Public Sector Readiness for Net Zero Carbon by 2030, July 2022 and Public Sector Readiness for Net Zero Carbon by 2030: Evidence Report, August 2022

Audit questions and criteria

Questions

We focused our work around two specific questions:

- Has the public sector made progress towards achieving the collective ambition?
- Has the public sector, at an all-Wales and local level, made progress in responding to the calls for action from our report?

Criteria

To develop audit criteria to assess public bodies' progress, we drew on the detail under each of the calls for action in our 2022 report. Those calls for action were:

- Strengthen your leadership and demonstrate your collective responsibility through effective collaboration.
- Clarify your strategic direction and increase your pace of implementation.
- Get to grips with the finances you need.
- Know your skills gaps and increase your capacity.
- Improve data quality and monitoring to support your decision making.

Methods

We conducted most of our fieldwork between January and April 2026, using the following methods:

- Review of key legislative, policy, and guidance documents. We also considered reports from other bodies including Senedd committees, the UK Climate Change Committee, and the Future Generations Commissioner for Wales.
- An information request to the Welsh Government asking for details of its organisational response to the five calls for action.
- Analysis of financial and other data, as described in the main body of this report and taken from other sources. We have not independently verified the data we are drawing on.
- Interviews with representatives from the Welsh Government, Future Generations Commissioner, WLGA, NHS Wales, the WGES, Natural Resources Wales, and WWF Cymru.
- Seven focus groups with representatives from local government, health, central government, universities, and colleges. There were 72 attendees in total from 57 bodies. Attendance included decarbonisation practitioners, as well as directors and other senior leaders.
- We used Microsoft Copilot (artificial intelligence) to help us analyse themes emerging from the transcripts of our focus groups. Auditors present at the focus groups checked and updated the results where required.

In June 2026, we shared our emerging findings at a meeting with Welsh Government officials.

2 Checklist for public bodies

This checklist sets out key questions that we think those charged with leadership and governance in public bodies should be asking to reflect on their body's approach to decarbonisation. The questions do not cover everything that bodies may need to consider but reflect the main themes outlined in this report.

Leadership

- Is decarbonisation high on your priority list; and if not, why not and what can be done about it?
- With Wales having declared climate and nature emergencies, are you comfortable with the level of priority your organisation is giving to decarbonisation?
- Do you have an integrated approach, where aims and objectives around decarbonisation align well with other corporate plans and priorities?
- Is decarbonisation part of day-to-day working and key decision-making processes?
- Is there effective collaboration between internal teams on decarbonisation projects?
- Are you demonstrating collective responsibility for decarbonisation by working effectively with other public bodies?

Strategic direction

- Do you understand your role in relation to the collective ambition?
- Do you remain committed to doing all you can to reduce your carbon emissions by 2030?
- Are you using the route map to guide your strategic approach?
- Do you have a well-developed decarbonisation plan that is widely understood and monitored?
- Is decarbonisation a standard consideration in building refurbishment and replacement projects?

Carbon emissions data

- Are you ensuring that the carbon emissions data you report to the Welsh Government is accurate?
- Are you using carbon emissions data to inform effective action on decarbonisation, including in relation to scope 3 supply chain emissions?

Finance

- Do you have a prioritised and costed near-term decarbonisation plan?
- Are you taking steps to improve your understanding of the longer-term cost of decarbonising your operations?
- Do you have a medium-term plan setting out how you intend to afford to fund decarbonisation?
- Are you managing the risk that not investing now may lead to larger, longer-term costs to adapt services and assets to climate change?
- Are you making the most of the central funding available from the Welsh Government?
- Are you finding other ways to fund decarbonisation, beyond Welsh Government funding?

Skills

- Is decarbonisation seen as everyone's business rather than the responsibility of a small specialist team?
- Do you provide carbon literacy training to staff, to widen understanding and influence behaviour; and is the training well attended?
- Have you identified skills gaps in decarbonisation planning and delivery, and do you have a plan to address them?
- Are you making the most of support and skills available from the WGES?

3 Key terms in this report

Term	Description
Carbon budgets	Wales uses five-year carbon budgets to track progress towards net zero by 2050 for the country as a whole. Each budget sets a limit on greenhouse gas emissions over a five-year period. The third carbon budget covers 2026 to 2030 and requires emissions to be 58% lower than in 1990.
Carbon emissions	The Welsh Government's Welsh Public Sector Net Zero Carbon Reporting Guide defines carbon emissions as shorthand for greenhouse gas emissions that are included in the Kyoto Protocol. Carbon dioxide is the most common greenhouse gas, and other gases can be measured in relation to it, reported in tonnes of carbon dioxide equivalent (tCO_2e).
Climate Strategy Panel	This local government panel was established by the Partnership Council for Wales. It brings together officers from councils and national parks, as well as Natural Resources Wales and the Welsh Government. And it has task and finish groups focused on themes from the route map.
Collective ambition	In 2017, the Welsh Government announced its intention to achieve a carbon neutral public sector by 2030. In 2021, the Welsh Government confirmed an ambition for the Welsh public sector to collectively achieve net zero carbon emissions by 2030, through the publication of Net Zero Carbon Status by 2030: A Route Map for Decarbonisation Across the Welsh Public Sector. The ambition does not require every public body to reach net zero individually by that date. Instead, it provides a shared direction of travel and an expectation that all public bodies contribute towards reducing emissions.
Decarbonisation	The process of reducing greenhouse gas emissions.
Net zero carbon	The Welsh Government defines net zero as balancing greenhouse gas emissions with the amount of gases removed from the atmosphere.

Term	Description
Public Sector Route Map (the route map)	The route map is the Welsh Government's strategic overview of the key priority areas for action and milestones needed for the Welsh public sector to reach net zero greenhouse gas emissions by 2030.
Scope 1 emissions	The Welsh Government defines scope 1 as direct emissions, in line with the globally understood definition: Emissions from operations that are owned or controlled by the reporting organisation. This includes generation of heat or transportation of employees/goods in company-controlled vehicles.
Scope 2 emissions	The Welsh Government defines scope 2 as indirect emissions from energy, in line with the globally understood definition: Emissions from the generation of purchased or acquired electricity, steam, heating, or cooling generated by a third party and consumed by the reporting organisation.
Scope 3 emissions	The Welsh Government defines scope 3 as indirect emissions, in line with the globally understood definition: All indirect emissions (not included in scope 2) from a body's activities, including emissions from its supply chain. Scope 3 also includes activities such as business travel, employee commuting, and the recycling and/or disposal of waste.
Supply chain emissions	Supply chain emissions are indirect emissions from a body's demand for purchased goods, services, or works. Supply chain activities are typically a major component of scope 3 emissions, often accounting for a significant proportion of a body's overall carbon footprint.
Welsh Government Energy Service (WGES)	The WGES is a Welsh Government-funded programme that helps public bodies and community groups deliver energy and decarbonisation projects by providing funding, specialist advice, and technical, commercial and procurement support.

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Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

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Archwilio Cymru
Audit Wales

Finding the right match

Latest results for Wales from the National Fraud Initiative

October 2026



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Audit snapshot

What we looked at

1 The National Fraud Initiative (NFI) is a UK-wide data matching exercise. The UK Government's Public Sector Fraud Authority (PSFA) leads the NFI at a UK-level and in England, but it is delivered in Wales under the Auditor General's data matching powers.

2 Data from various bodies is compared electronically to look for and help address anomalies that may indicate fraud, overpayment, or error. This could, for example, include cases of:

- people receiving council tax discounts or other benefits, being on housing waiting lists, or using blue badge parking permits, when not entitled;
- payments for adult social care or pensions still being made after a person's death; and
- duplicate payments to suppliers, or people being on two different payrolls at the same time in roles with overlapping shifts.

3 This report sets out findings for Wales from the most recent NFI exercise. It covers outcomes for the period 1 April 2024 to 31 March 2026. This includes late reported outcomes from the previous exercise. The report also draws on evidence from our engagement with the 50 Welsh public bodies involved.

Why this is important

4 Making the most of every pound of public spending is essential. While much of the public money spent by Welsh public bodies is well managed, there is still waste, error, and fraud that can be prevented and detected.

5 Exercises like the NFI – just one way in which bodies can use data analytics – are an important part of the counter-fraud landscape. And if those looking to commit fraud sense a lack of vigilance, the risks could increase. But a data match is only an indicator, so follow-up work is needed before bodies draw any conclusions.

6 Beyond any financial savings, NFI results can provide assurance around bodies' systems of internal control. They may also highlight areas for improvement.

What we have found

7 The NFI continues to support Welsh bodies to prevent and detect fraud, strengthen internal controls, and improve data quality. Since it began in 1996, the NFI has reported outcomes for Wales amounting to £65.2 million. Outcomes being the financial value given to identified cases of fraud, overpayment, or error.

8 The latest exercise, NFI 2024-25, reports outcomes for Wales of £8.7 million. This is £1.6 million higher than the previous exercise, with the number of identified frauds, overpayments and errors increasing by 26%. Bodies reported various wider benefits. Data submitted by Welsh bodies has also been linked with £2.1 million of the outcomes reported for bodies elsewhere in the UK.

9 Overall, bodies' have engaged better with NFI 2024-25, but there are still areas for improvement. Those areas include:

- completing follow-up work on data matches in a timely way;
- properly recording follow-up work in the NFI system to avoid under-reporting of outcomes – £1.1 million of the total outcomes reported came from corrections following our own review;
- how bodies report locally on their NFI and other data matching work, for example to their audit committees or equivalents; and
- how bodies with access could make better use of the NFI's application checking tool to prevent some NFI cases up front.

What we recommend

10 We are not making recommendations in this report. However, bodies can use our NFI checklist to reflect on how they go about their work. NFI results, and what we know about how bodies manage their NFI activity, might also inform other audit work.

11 Some more Welsh public bodies are joining the NFI for the next exercise, extending its reach and impact. We intend to continue engaging with bodies to promote an active but risk-based approach to reviewing data matches and to support shared learning.

12 We also want to make sure that bodies are recording outcomes properly. We can then tell as full a story as possible about the impact of the NFI. And we are continuing to explore how bodies may be able to use data / functions within the NFI system in new ways, such as around claims for ophthalmic services.

13 Meanwhile, the PSFA is progressing pilot work in areas including business rate and social housing fraud. It is also planning wider NFI system developments, including to support a move to more real-time prevention.

Auditor General's view

The NFI is a key tool in the fight to prevent and detect fraud, overpayment, and error which, if left unchecked, can chip away at public trust and confidence in our vital public services and lead to financial losses.

Ensuring fraudsters are identified, and that every pound of public money is well spent on services which matter to the people of Wales and reflect what they are entitled to, is crucial. That is why we will continue to develop our work on the NFI as we know there is more that we and public bodies can do.

Catherine Mealing-Jones
Auditor General for Wales



Key facts and figures



£8.7 million

Value of fraud, overpayment, and error reported for Wales in NFI 2024-25.



£1.6 million

Increase in value of fraud, overpayment, and error reported for Wales in NFI 2024-25 compared to the previous exercise (NFI 2022-23).



£65.2 million

Cumulative value of fraud, overpayment, and error reported for Wales through the NFI since 1996.



5,472

Individual cases of fraud, overpayment, and error identified for Wales in NFI 2024-25, up by 26% on the previous exercise (NFI 2022-23).



£2.1 million

Outcomes reported elsewhere in the UK linked to data submitted by Welsh bodies.



50

Number of Welsh bodies participating in NFI 2024-25.

Our findings

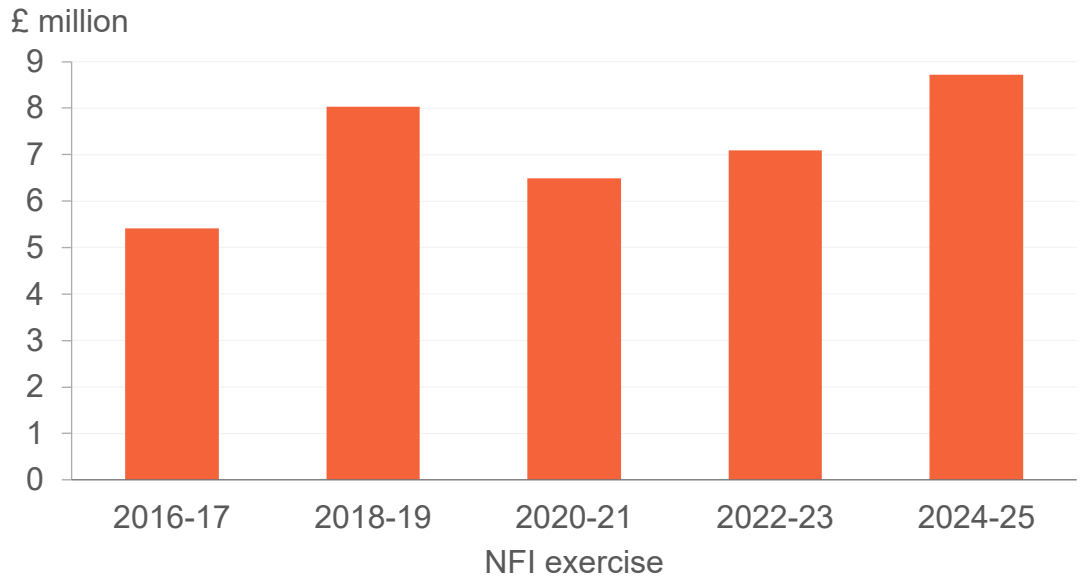
Overall outcomes

NFI outcomes for Wales increased to £8.7 million, the highest reported over the last five exercises, and up by £1.6 million on NFI 2022-23

14 There were 5,472 reported cases of fraud, overpayment, and error for NFI 2024-25. This was up by 26% on NFI 2022-23.

15 Outcomes reported for NFI 2024-25 amount to £8.7 million. This is up by £1.6 million (23%) on the £7.1 million reported for NFI 2022-23. It is also the highest figure reported over the last five exercises (see **Exhibit 1**).

Exhibit 1: value of outcomes over time, NFI 2016-17 to NFI 2024-25 (£ million)



Source: Audit Wales analysis

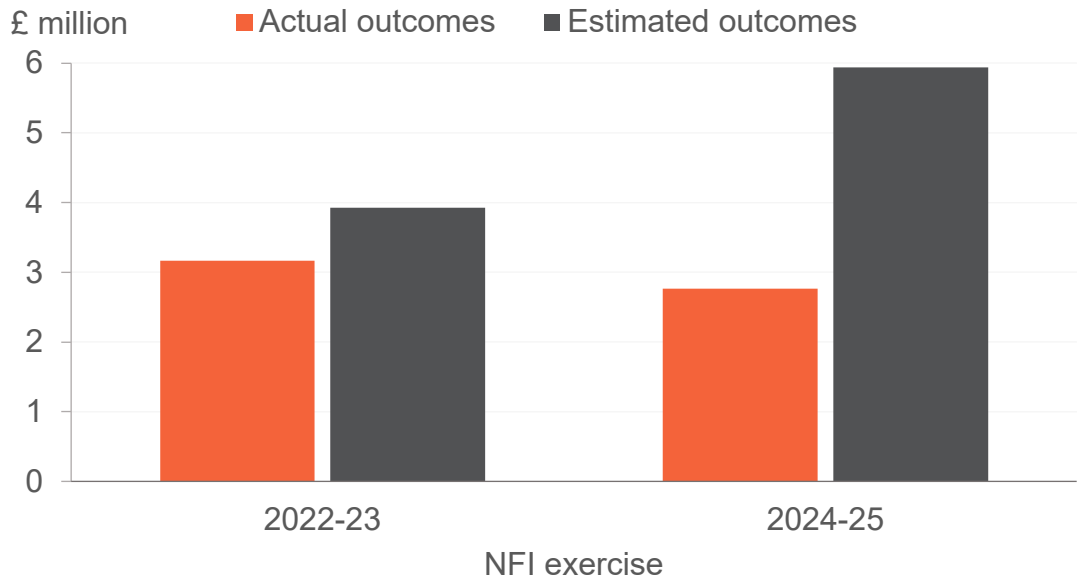
Note: Figures for each exercise cover a two-year period, starting from 1 April in the year shown, and include any late reported outcomes from the previous exercise.

16 Overall, since the NFI began in 1996 Welsh bodies have recorded cumulative outcomes of around £65.2 million. Those have contributed to UK-wide outcomes of around £3.5 billion.

17 Outcomes comprise both 'actual' and 'estimated' figures. **Exhibit 2** shows that, of the £8.7 million total outcomes for Wales in NFI 2024-25:

- actual outcomes account for £2.8 million (32%), down by £0.4 million (13%) on NFI 2022-23; and
- estimated outcomes account for £5.9 million (68%), up by £2.0 million (51%) on NFI 2022-23.

Exhibit 2: value of actual and estimated outcomes, NFI 2022-23 and NFI 2024-25 (£ million)



Source: Audit Wales analysis

Notes:

Actual outcomes refer to amounts bodies have recorded as fraud, overpayment, or error, which they can recover. Estimated outcomes seek to capture the value of loss from a fraud or error detected, and the value of any future losses that bodies may have incurred without intervention following an NFI match.

Figures for each exercise cover a two-year period, starting from 1 April in the year shown, and include any late reported outcomes from the previous exercise.

18 Within the actuals figure, outcomes reported directly by Welsh bodies rose by £0.3 million. But UK Department for Work and Pensions reported Welsh housing benefit outcomes fell by £0.7 million.[1]

19 At the end of the NFI 2024-25 reporting period (31 March 2026), bodies reported that £2.5 million (92%) of the actual outcomes had been recovered or were in the process of recovery.

20 The increase in estimated outcomes is from two main areas, blue badge parking permit cancellations and the removal of ineligible applicants from housing waiting lists.

21 Some £1.0 million (12%) of total outcomes relate to cases from NFI 2022-23 matches where bodies completed their follow-up work after March 2024. Most of this comes from data matches for housing benefit and the council tax reduction scheme.

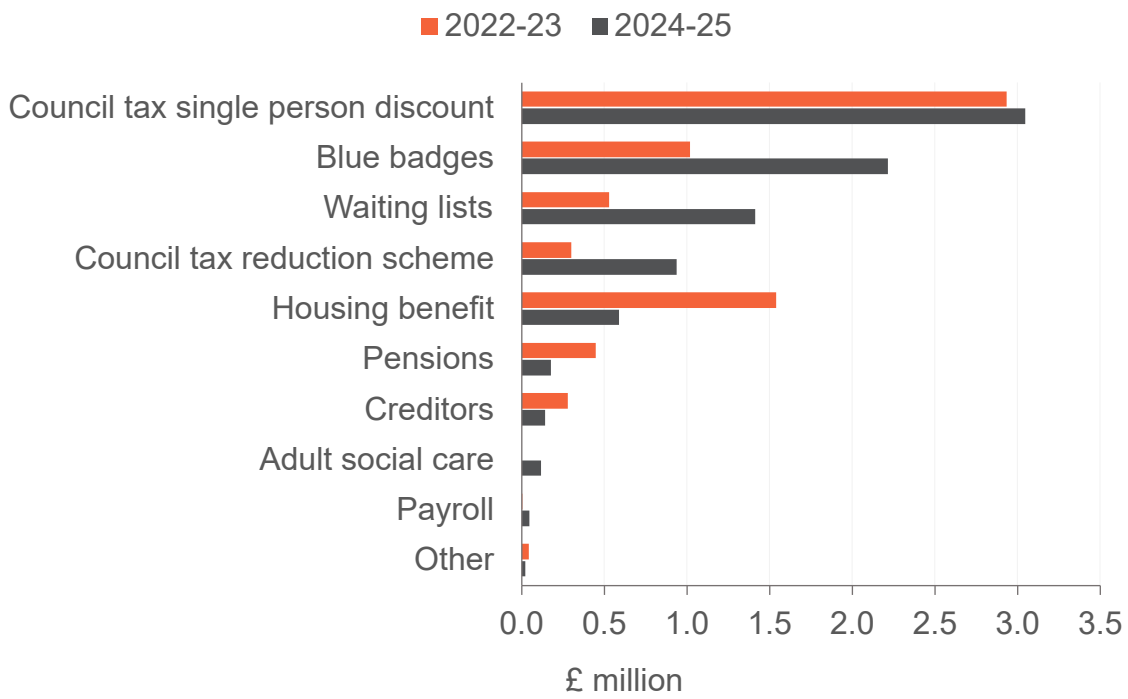
22 The NFI supports data sharing across bodies, sectors, and national borders. For NFI 2024-25, the PSFA reports that data submitted by Welsh bodies has been linked with £2.1 million of the outcomes reported for bodies elsewhere in the UK (from 1,582 matches).

1 Local authorities follow up housing benefit data matches themselves where a processing error has occurred. But they refer cases to the Department for Work and Pensions for follow-up where fraud is suspected.

Council tax single person discount again delivered the biggest outcome, with results remaining steady compared with bigger changes in other areas

23 **Exhibit 3** shows how the £8.7 million in outcomes for NFI 2024-25 breaks down across the main data match areas. It also compares this with the previous exercise.

Exhibit 3: value of outcomes by data match area, NFI 2022-23 and NFI 2024-25 (£ million)



Source: Audit Wales analysis

Note: Figures for each exercise cover a two-year period, starting from 1 April in the year shown, and include any late reported outcomes from the previous exercise.

24 **Appendix 2** sets out further analysis of outcomes and cases by data match area for NFI 2024-25. It includes more historic analysis. Key messages from the main data matching areas include:

- At £3.0 million, council tax single person discounts continue to generate the highest reported outcomes, and similar to the figure for NFI 2022-23. The average outcome per cancelled claim rose from around £1,410 to £1,670.
- The number of cancelled blue badge parking permits increased by 78% to almost 2,800, the highest level recorded across the last five exercises. This led to outcomes estimated at £2.2 million.
- The number of ineligible applicants removed from housing waiting lists increased from 124 to 330. Those 330 cases equated to around £1.4 million in estimated outcomes. This compares with £0.5 million in the previous exercise.
- Outcomes from council tax reduction scheme matches more than trebled during this reporting period, reaching almost £1.0 million. The average value per case rose from around £1,580 to £3,080.
- Outcomes from housing benefit matches fell by more than 60%, reflecting the declining number of claims as people move to Universal Credit, together with unusually high outcomes for NFI 2022-23 due to pandemic-related backlogs.
- The number of pension overpayment cases fell from 40 to 26, with pension outcomes reducing from £0.45 million to £0.18 million, although the value of recoverable overpayments (actual outcomes) slightly increased.
- Duplicate creditor payment cases reached their highest level across the last five NFI exercises, increasing from 42 in NFI 2022-23 to 71. However, the total value of outcomes fell by almost half, to £0.14 million.
- The reintroduction of adult social care data matching identified overpayments totalling £0.12 million.[2]

2 Data on adult social care was only able to be collected in autumn 2025, once relevant legislation had been passed, with matches released shortly before the end of 2025. The PSFA is expecting to carry out more detailed data matching on adult social care data in future.

The wider benefits of the NFI extend beyond its financial outcomes

25 As well as financial outcomes, bodies told us about wider benefits arising from NFI data matching. These include:

- reinforcing the importance and raising the profile of fraud prevention and detection work, particularly with audit committees (or equivalent);
- improving internal processes – such as those relating to employee declarations of interest;
- identifying training needs for staff;
- improving data quality and integrity, for example through cleansing creditor and housing records;
- helping identify and correct data quality issues within their systems, such as incorrect National Insurance numbers; and
- the NFI detected one instance of potential identity theft.

How bodies follow up on data matches

Overall, bodies have engaged better with NFI 2024-25, but there are still areas for improvement

26 Realising the benefits of the NFI relies on bodies investing time and effort to assess and review data matches effectively. Measuring the overall impact of the NFI also relies on bodies recording their activity and outcomes.

27 At the end of NFI 2022-23, we reported that our review of data matching reports highlighted inconsistencies in local follow-up arrangements.[3] There were also some large variations in outcomes between bodies of a similar type and this is still the case, although it could reflect a range of factors.

28 During NFI 2024-25, we developed a new tool to analyse data from the NFI system. This helped us to provide local updates on bodies' data matches, and progress with their follow-up work. It also informed our engagement with bodies, all of which has given us a better understanding of their activity.

29 Our overall view is that bodies have engaged better with NFI 2024-25 than they did with the previous exercise. Evidence from the NFI system about how bodies have followed up on data matches and the overall number of cases processed also supports this.

30 However, there are still areas for improvement, as set out in the sections that follow, and with some bodies still showing less commitment to NFI work than others.

3 Audit Wales, The National Fraud Initiative in Wales 2022-23, October 2024

Follow-up work is not always completed in a timely way

31 Competing priorities and limited capacity can make it difficult for bodies to complete NFI work on time. Delays in following up data matches can reduce the effectiveness of the exercise. Potentially fraudulent activity, along with incorrect payments, discounts, and awards, may continue for longer, increasing losses and reducing opportunities to recover funds.

32 However, as a guide the PSFA suggests that, for the biennial data matches released in December 2024, bodies should have aimed to have identified plans for follow-up work as follows:

- all time-critical / very high risk matches by 31 March 2025; and
- the remainder of the match reports by 30 May 2025.

33 In some cases, our engagement with bodies through the second half of 2025-26 prompted further follow-up activity. Overall, around a quarter of the biennially released data matches that bodies processed during NFI 2024-25 were recorded as such between 1 October 2025 and 31 March 2026.[4]

34 Work on data matches can also continue after the end of each NFI reporting period. As of 31 July 2026, bodies had processed around a further 6,270 of NFI 2024-25 biennial exercise data matches after 31 March 2026. They were still reviewing around another 1,490 matches.[5]

35 There have also been delays in following up annual council tax single person discount matches. For example, £1.6 million of the council tax single person discount outcomes reported for NFI 2024-25 came from data matches in late 2023. Around one third of these outcomes were from cases not processed until after the next set of matches had been issued in late 2024.

4 This analysis excludes council tax single person discount data matching that happens annually. Overall, of around 243,600 biennial matches released to bodies as part of NFI 2024-25, bodies had recorded around 64,900 (27%) as processed by 31 March 2026.

5 Bodies processed some 10,000 matches from the NFI 2022-23 biennial matches after the end of the reporting period for that exercise (31 March 2024).

36 Also, the NFI system includes a ‘shared comments’ function to support collaboration between bodies across the UK. It allows them to exchange information on specific matches and helps avoid duplicate follow-up work. However, we found that bodies do not always respond to information requests on a timely basis, if at all.

37 Bodies deliver NFI activity in different ways:

- In some, the key contact responsible for overseeing NFI work and their team, such as internal audit or counter fraud, lead the exercise. They carry out risk assessments and follow-up work, working with service departments where necessary.
- In others, the key contact takes more of a coordinating role, while service departments assess and follow up matches using their knowledge of the specific data match areas.

38 We have not tried to measure the amount of time different bodies put into their NFI work. It is for them to decide what is proportionate as part of their wider counter fraud activity.

39 However, we heard mixed views about how NFI work is resourced. Some bodies consider that they are putting enough resources in. Others believe that more resource centrally or within service areas, and better engagement, would improve follow-up work and increase the value of the exercise.

Follow-up work is not always properly recorded in the NFI system, which risks leading to under-reporting of outcomes

40 When it is not practical to follow up all data matches, bodies should use a risk-based approach to plan their work. This includes deciding which matches to review, in what order, and what work is needed.[6] Many bodies receive several thousand matches and some much more than that.

41 The NFI system includes risk scoring. The system had classed most of the matches that bodies processed for NFI 2024-25 as ‘high’ or ‘very high’ risk. It is still then for bodies to make their own judgement.

6 Risk assessments and follow-up decisions may be influenced by several factors. These include past trends, known control weaknesses, NFI risk scores, and the need to act quickly on time-sensitive reports.

42 Bodies could usually explain to us how they risk assess matches and conduct follow-up work. But they do not always record or fully explain the work they have done within the NFI system itself. For example, we found that one body followed up around 500 pensions data matches but only processed in the NFI system those cases where it found errors.

43 We also found other examples where the way bodies described follow-up work did not appear to address the purpose of the data match, comply with recommended NFI guidance, or support the conclusions reached.

44 For 11 of the 50 bodies involved, the NFI system recorded that they had processed fewer than 10% of their main biennial data matches by 31 March 2026. Bodies have the option to record cases as processed following risk assessment, even if they decide not to take further action.

45 Our review of bodies' reported outcomes also led us to question the processed status applied to some data matches. Around £1.1 million of the overall outcomes figure of £8.7 million would not have been captured without changes following our queries. Most of this related to blue badge permits (see **Appendix 2**), with some also for housing waiting lists and pensions.

46 Other action following our enquiries will lead to around £0.6 million of blue badge and housing waiting list outcomes being reported in the next NFI exercise because bodies corrected issues after 31 March 2026 (see **Appendix 2**).

47 Proper recording is important for capturing processing activity and outcomes. It also helps improve how data matches are risk scored and prioritised in future. And it supports oversight by the PSFA and Audit Wales, and the sharing of good practice.

Bodies can improve how they report locally on their NFI and other data matching work

48 How bodies report NFI activity and outcomes to those charged with governance varies. For example, some report their NFI outcomes and activity to their audit committees (or equivalent), while others do not. Where reporting takes place, the frequency, quality, and level of detail provided varies.

49 However, we found examples of good practice, with bodies producing clear, balanced reports on NFI activity and outcomes. We also saw examples of effective working and reporting between officers leading on NFI work and senior management.

50 Some bodies use third-party providers for data matching instead of using the NFI data matches. This is most common for council tax single person discounts, with 10 of the 22 Welsh local authorities using third-party providers. They use these providers to run data matching more often and for follow-up work because they lack capacity or specialist skills in-house.

51 Reporting on non-NFI data matching helps provide members and/or senior officers with a more complete picture of counter-fraud activity. However, only two of the local authorities using third-party providers for council tax single person discount matching told us they report the outcomes of this work to their audit committee.

52 A 2025 Fraud Behaviours Survey by Cifas found that around one in six people (16%) either falsely claimed a single person discount or said they knew someone who had done so in the past year.[7] These findings support the need for clear reporting of the results of both NFI and external providers' council tax single person discount data matching.

Bodies with access could make better use of the NFI's application checking tool to prevent some NFI cases up front

53 AppCheck, the NFI's fraud prevention and application checking tool, helps prevent fraud, overpayment, and error before they occur. It allows bodies to verify certain information at the point of application, reducing the risk of incorrect payments or providing services to people who are not eligible.

54 Local authorities and NHS bodies have full access to AppCheck, but their use of it has remained low in recent years. We have worked with bodies, and with the NFI system provider, to support AppCheck training and awareness raising and to explore how bodies might use it more and better.

7 Cifas is a not-for-profit body that brings members from across different sectors together for the common goal of eliminating fraud and financial crime. Findings from the 2025 survey are based on a nationally representative sample of 2,000 UK adults.

Appendices

1 About our work

2 Analysis of outcomes by data match area and case studies

3 Key terms in this report

1 About our work

Scope of the audit

We lead the NFI in Wales under the Auditor General's powers in the Public Audit (Wales) Act 2004. The Auditor General's Code of Data Matching Practice summarises the key legislation, and controls, governing the exercise.[8]

NFI data matching draws on a wide range of datasets from across bodies. The main service areas providing data include payroll, creditor payments, and pensions. Local authorities also typically provide council tax, housing benefits, housing, adult social care, licensing, and permit schemes data.

The NFI also uses UK Government data provided by the General Register Office (Deceased Persons Data Repository Information), HM Revenue & Customs (property ownership, household composition, and earnings and capital) and Companies House (registered company information).

The main NFI national data matching exercise is every two years, but council tax single person discount matching is annual.

The NFI 2024-25 exercise covers the period 1 April 2024 to 31 March 2026. The following Welsh bodies took part:

- The 22 local authorities, three fire and rescue authorities, four police forces, and the South-East Wales Corporate Joint Committee.
- The seven local health boards, three NHS trusts, two special health authorities, and NHS Wales Shared Services Partnership (hosted by Velindre University NHS Trust).
- The Welsh Government and certain of its arm's length bodies; the Arts Council of Wales, National Library of Wales, Natural Resources Wales, Sport Wales, and Transport for Wales.
- Audit Wales itself.

8 Similar arrangements to Wales apply in Scotland (led by Audit Scotland) and Northern Ireland (led by the Northern Ireland Audit Office).

Our main objectives in preparing this report and in our supporting audit work were to:

- report the outcomes of the NFI 2024-25, which include late reported outcomes from the previous exercise;
- provide insight into the results and how bodies follow up their data matches; and
- develop a clearer understanding of the factors influencing NFI outcomes and activity across bodies, raise awareness of the NFI, and identify opportunities to enhance its impact.

During the NFI 2024-25 period, we also completed work on a data matching exercise on General Practitioner (GP) patient lists. We published a report on the outcomes from that work in January 2026. While that exercise matched data through the NFI system, the results are not part of the outcomes set out in this report.

Audit questions and criteria

Questions

Our audit work sought to establish:

- what outcomes Welsh bodies are reporting from the NFI 2024-25 exercise; and
- whether, at a high-level, NFI governance and follow-up arrangements across Welsh bodies are operating effectively.

Criteria

Two main sources informed our audit criteria:

- Our past knowledge of the NFI and outcomes from previous exercises.
- Areas covered in a checklist we prepared to help bodies self-appraise how they engage with the NFI. The checklist addressed themes around:
  - leadership, commitment, and communication;
  - planning and preparation;
  - effective follow-up of data match results; and
  - recording and reporting outcomes.

Methods

The main stages of the NFI process are set out below:

- Bodies submit data to a secure NFI system.
- The NFI system compares data within and across bodies to identify anomalies that may indicate fraud, overpayment, or error. These are known as ‘data matches’.
- Bodies receive their data matches through the NFI system in match reports.
- Bodies review and risk assess match reports to determine which of the potentially many data matches they should follow up.
- Bodies record the results of follow-up work in the NFI system.
- The system captures a financial value for outcomes from the data matching where fraud, overpayment, or error is detected. Most NFI data match areas include both actual and estimated outcomes.

We used the following methods to gather and analyse the data and wider evidence that informs this report:

- **Data analysis**. We developed a data analysis tool to support our review of bodies’ follow-up activity and reported outcomes. The tool used data from reports downloaded from the NFI web system. All percentage-based calculations in this report are based on unrounded figures.
- **Interviews**. We spoke with the officers responsible for the NFI at each Welsh public body. We discussed how bodies follow up on matches and how they report on NFI activity. We also spoke with other relevant officers to review specific aspects of data match processing and reported outcomes.
- **Document review**. Where available, we reviewed bodies’ NFI self-appraisal checklists to help us understand their NFI approach. We also reviewed reports, meeting minutes, and papers submitted to audit committees (or equivalents).
- **Engagement with the PSFA and other UK audit bodies**. We attend quarterly NFI meetings with the PSFA, Audit Scotland, and the Northern Ireland Audit Office. These meetings support shared learning. We also maintain other regular communication with these bodies and Synectics Solutions Ltd, the NFI system provider, to discuss day-to-day issues and system improvements.

Costs

There is no direct cost for Welsh public bodies to take part in the NFI. Audit Wales meets the costs involved in the central data matching and support through funding it receives that the Senedd approves each year.

Costs paid by Audit Wales to the PSFA over two years for NFI 2024-25 came to around £0.21 million. This includes costs for some bodies to be able to access the ‘AppCheck’ function.

The main cost for bodies is staff time. This includes preparing and submitting data and follow-up work once they receive matches. We have not tried to estimate that cost. Bodies should take a risk-based approach.

2 Analysis of outcomes by data match area and case studies

This Appendix provides further detail to support the high-level analysis in the main body of this report.

Our ordering of the data match areas reflects the financial value of outcomes reported for NFI 2024-25 (from highest to lowest). The detail of the analysis differs by data match area, as we draw out issues of note for each.

Our case studies include examples of positive results and good practice as well as examples where we think bodies can improve how they act on data match results.

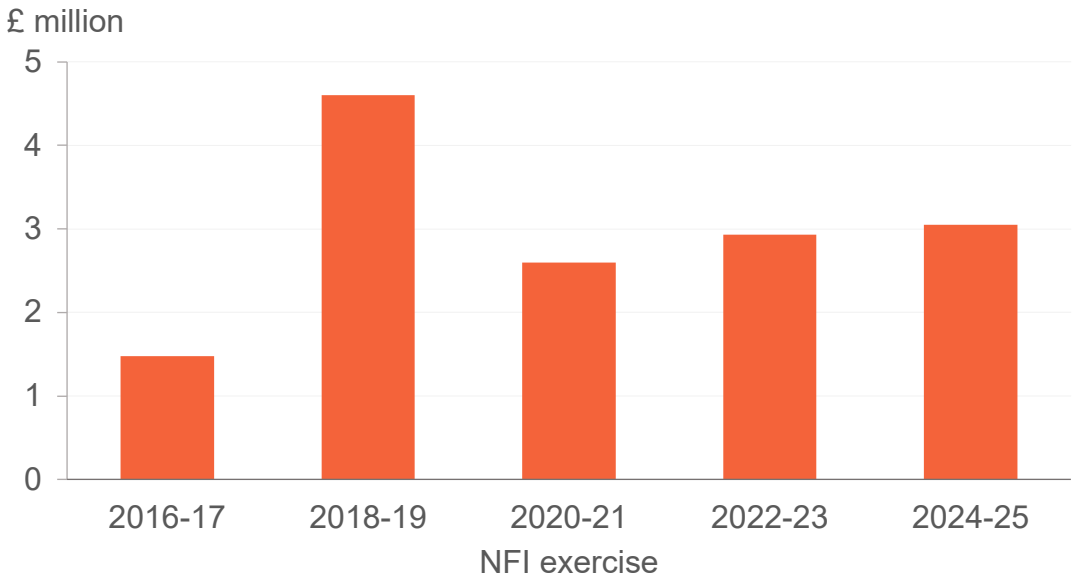
Council tax single person discounts

Outcomes (NFI 2024-25)	**Cases** (NFI 2024-25)
£3.0 million	**1,825**

Council tax single person discount data matching looks to identify potentially incorrect discount awards. Specifically, it looks at whether matched data suggests that more than one adult who is liable to pay council tax is occupying a property receiving a single person discount of 25%.

Exhibit 4 shows that outcomes from cancelling council tax single person discount claims increased slightly to £3.0 million for NFI 2024-25. Of this, £1.2 million relates to ineligible discounts individuals had already benefited from (actual outcomes), and that bodies can recover. Estimated losses of a further £1.8 million have been prevented. These are calculated for each case by multiplying the annual council tax discount by two years.

Exhibit 4: value of council tax single person discount outcomes over time, NFI 2016-17 to NFI 2024-25 (£ million)



Source: Audit Wales analysis

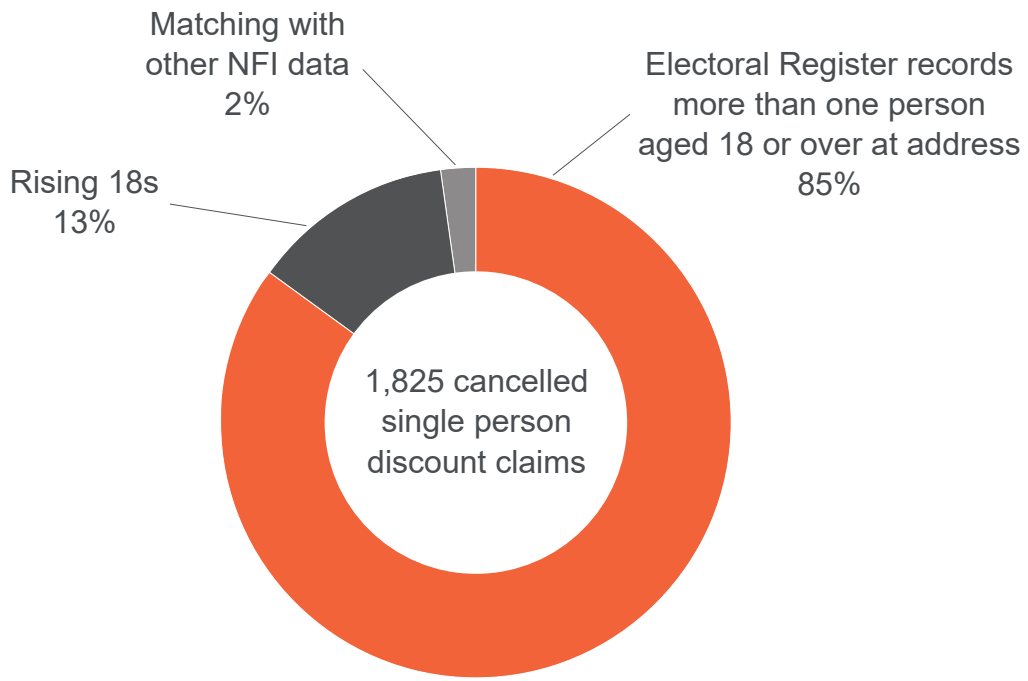
Note: Figures for each exercise cover a two-year period, starting from 1 April in the year shown, and include any late reported outcomes from the previous exercise.

Outcomes increased despite the number of cancelled claims falling from 2,084 to 1,825. As a result, the average outcome per cancelled claim rose from around £1,410 to £1,670.

The NFI matches single person discount data against the Electoral Register and other data. **Exhibit 5** shows that:

- most cancelled claims (1,559, 85%) relate to properties where the Electoral Register recorded more than one adult;
- a further 236 cancellations (13%) relate to cases where the NFI data matching identified that another household member had reached, or was close to reaching, age 18 after the data was submitted; and
- other NFI data identified the remaining 30 cancellations (2%), including situations where the local authority was not aware the person claiming the discount had died.

Exhibit 5: breakdown of reasons for cancelling council tax single person discounts, NFI 2024-25 (percentage)



Source: Audit Wales analysis

Notes:

Figures cover a two-year period, starting from 1 April 2024, and include any late reported cases from the previous exercise.

'Rising 18s' refers to cases where a young person living in a household receiving a single person discount had reached, or was close to reaching, age 18 after the data was submitted and would then also have become liable for council tax.

As **Exhibit 6** shows, some local authorities do not do enough to review matches indicating potential single person discount fraud.

Exhibit 6: case study on inconsistent follow-up work on council tax single person discount data matches

Council tax single person discount data matching happens annually around the end of the calendar year.

One data match report flags households claiming a single person discount where the Electoral Register suggests more than one adult may live at the property.

Ten local authorities told us they did not review this report for the 2024-25 single person discount exercise because they used third-party services to check the legitimacy of single person discounts instead of the NFI.

We found variation in how the other 12 local authorities responded to this data match report. Five did not review any matches in this report, and a further two reviewed only three matches between them.

Limited follow-up increases the risk that incorrect single person discounts go undetected.

Source: Audit Wales analysis

Blue badges

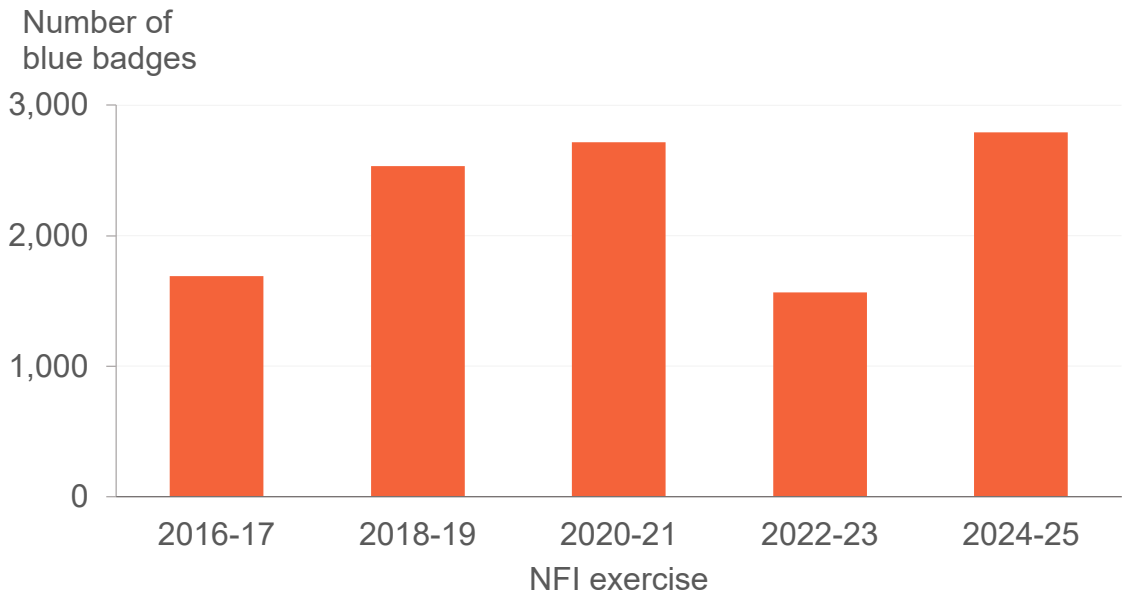
Outcomes (NFI 2024-25)	Cases (NFI 2024-25)
£2.2 million	2,791

Blue badge data matching looks to prevent the misuse of blue badge parking permits. Data matching identifies blue badges that may no longer be valid, allowing local authorities to cancel badges where appropriate.

The NFI matches blue badge records with deceased persons and police data on false identities. It also matches records with blue badge data from across the UK to identify people who may hold more than one badge.

NFI 2024-25 saw 2,791 blue badges cancelled. This is the highest number recorded in the last five exercises. It is also up by 78% on NFI 2022-23 (see **Exhibit 7**).

Exhibit 7: cancelled blue badges over time, NFI 2016-17 to NFI 2024-25 (number)



Source: Audit Wales analysis

Note: Figures for each exercise cover a two-year period, starting from 1 April in the year shown, and include any late reported outcomes from the previous exercise.

Blue badges can be misused and may be sold illegally. Misuse reduces the availability of parking spaces for others. The main financial benefit is avoiding parking charges, which can lead to long-term savings for those using badges without permission.

NFI 2024-25 estimates an outcome of £794 for each cancelled blue badge. This compared to £650 per badge for NFI 2022-23 and £575 for the previous three exercises. Sixteen of the 22 local authorities cancelled badges, contributing to the total reported outcomes of £2.2 million.[9]

We questioned the processed status that local authorities had applied to some data matches in the NFI system. Four initially recorded the wrong processed status in the system for 1,351 cancelled blue badges. Without correction, bodies would not have reported around £1.1 million of the NFI 2024-25 outcomes.

A further two authorities also gave incorrect processing statuses to cancelled badges. Because they corrected these cases after 31 March 2026, £0.25 million will be recorded as late outcomes in the next NFI exercise.

Some authorities review blue badge reports promptly after receiving them and cancel badges quickly. Others do not, increasing the risk that invalid badges remain in use. **Exhibit 8** shows the slow pace of follow-up work in some local authorities.

9 The estimated outcome of £794 for each cancelled blue badge is a UK wide figure reflecting potential losses in parking and congestion charge revenue. It is based on the average annual cost associated with misuse per badge, the proportion of badges likely to be issued, and the period over which such misuse may continue undetected. Therefore, the £794 will not necessarily reflect lost parking revenue within the local authority area cancelling the badge.

Exhibit 8: case study on untimely follow-up work on blue badge data matches

Most blue badge cancellations related to cases where local authorities were unaware that the badge holder had died.

By September 2025, nine months after the release of data matches, six local authorities had not reviewed any matches within a report linking blue badge holders to deceased persons.

By 31 March 2026, two of these authorities had processed all their matches in this report and had cancelled a combined total of 197 blue badges.

By 31 July 2026, a further authority had processed all its matches, although it completed most of this work after 1 April 2026. Of the three remaining authorities, two had processed only 6% and 24% of their matches in this report, while one had not reviewed any of its matches.

Delaying follow-up work means blue badges belonging to deceased individuals remain active for longer than necessary, increasing the risk of misuse.

Delays can also reduce outcomes. Blue badges are typically issued for up to three years. Many badges identified for cancellation had already expired, meaning they could no longer be cancelled through the exercise or reported as outcomes.

Source: Audit Wales analysis

Families may not always report the death of a blue badge holder to local authorities. Blue badge teams can, if they wish, identify such deaths by matching local death records with blue badge records and checking information from the UK Government's 'Tell Us Once' service.[10] The NFI data matching helps authorities identify deaths outside their area more easily. And it provides a further check on deaths that have occurred locally.

10 'Tell Us Once' is a free UK Government service that allows someone who is dealing with the affairs of a person who has died to report their death to most government departments and local authorities in a single process.

Housing waiting lists

Outcomes (NFI 2024-25)	Cases (NFI 2024-25)
£1.4 million	330

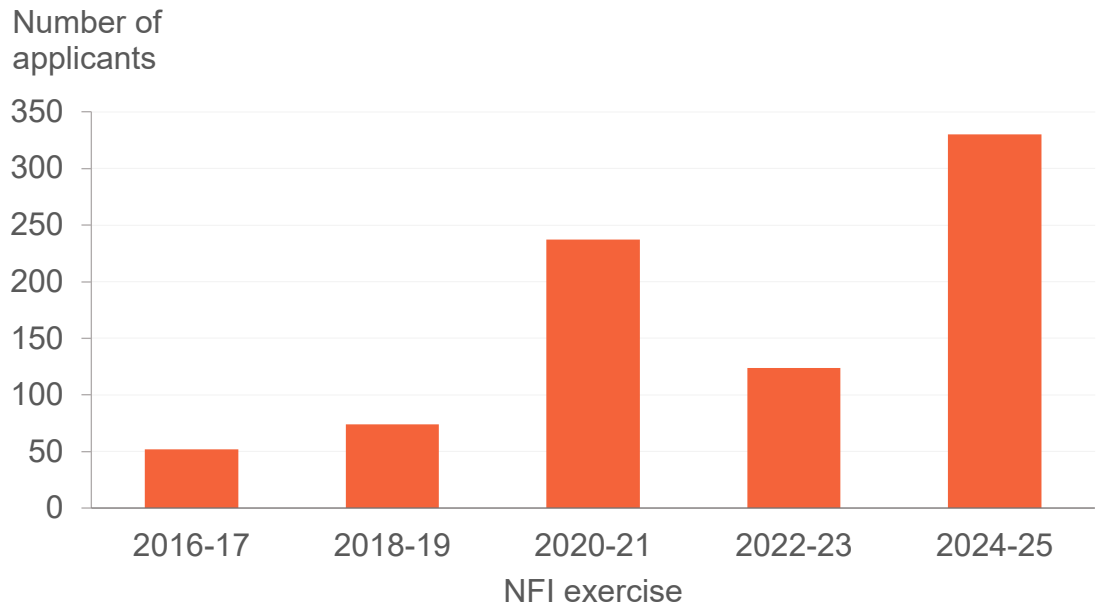
Housing waiting list data matching looks to identify potentially inaccurate or fraudulent housing applications.

It helps those local authorities who still manage housing stock keep their waiting lists accurate where people have not reported changes in circumstances or have provided incorrect information. This means housing resources can be allocated fairly to those with a genuine need.

The NFI matches housing waiting list data with housing benefit records, tenancy data, death records, and police data on false identities.

Local authorities cancelled 330 ineligible applications from housing waiting lists in NFI 2024-25. This is an increase of 206 cases (166%) compared with the previous exercise. And it is the highest number in the last five exercises (see **Exhibit 9**).

Exhibit 9: ineligible applicants removed from housing waiting lists over time, NFI 2016-17 to NFI 2024-25 (number)



Source: Audit Wales analysis

Note: Figures for each exercise cover a two-year period, starting from 1 April in the year shown, and include any late reported outcomes from the previous exercise.

Using the PSFA estimate of £4,283 per case, cancelled applications led to around £1.4 million in estimated outcomes.[11] This compares with £0.5 million in the previous exercise. Late reported outcomes from work on NFI 2022-23 data matches contributed £0.15 million to the total.

For NFI 2024-25, 18 local authorities submitted housing waiting list data for matching, with 17 following up their matches. In NFI 2022-23, one local authority reported most of the cancelled applications. While this local authority still accounts for around half of the 330 cancelled applications for NFI 2024-25, a further six authorities also reported cancellations.

11 The approach to calculate the estimated outcome per case considers the annual cost of housing a family in temporary accommodation, the likelihood a waiting list case would have been provided a property, and the duration for which a fraudulent case may continue undetected.

Authorities cancelled 141 applications because they were not aware applicants had died. However, outcomes related to this data match report are under-reported for NFI 2024-25 because authorities did not appear to assign the correct processed status to some data matches. **Exhibit 10** shows one example.

Exhibit 10: case study on under-reporting of cancelled housing waiting list applications

One local authority reported no outcomes from their follow-up work on the match report linking housing waiting list applicants to deceased records. However, their work had in fact seen 89 applications cancelled.

The authority has since updated the NFI system, and outcomes of around £0.38 million will now be reported in the next NFI exercise.

Source: Audit Wales analysis

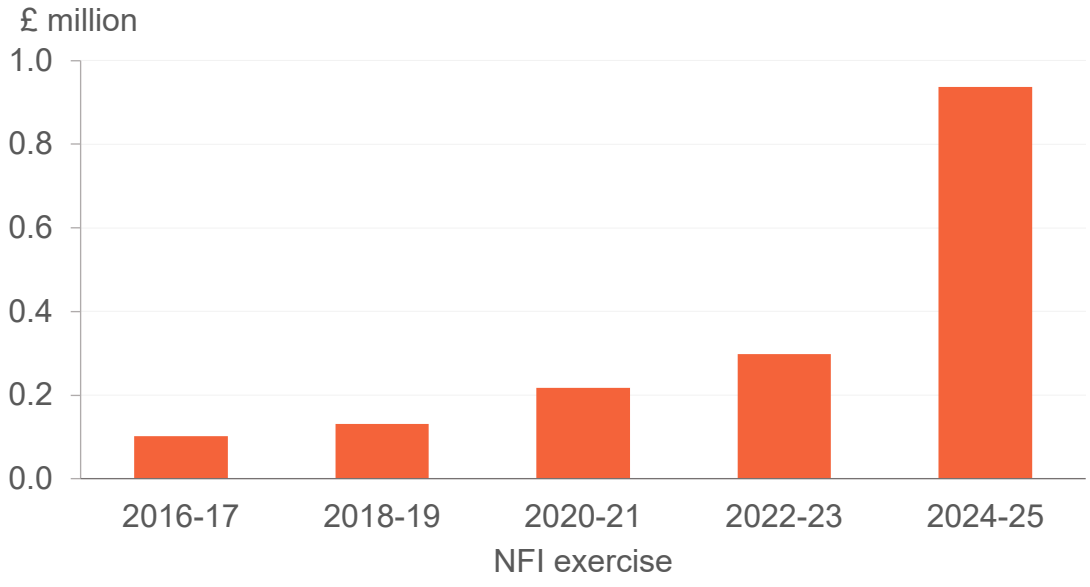
Council tax reduction scheme

Outcomes (NFI 2024-25)	Cases (NFI 2024-25)
£0.94 million	304

Council tax reduction scheme data matching looks to identify potentially fraudulent or incorrect awards. The council tax reduction scheme and council tax single person discount are different.

For NFI 2024-25, local authorities reported outcomes of £0.94 million from cancelling or amending council tax discounts arising from undeclared income or changes in circumstances. This is an increase of just over 200% on the previous exercise. It also exceeds the combined outcomes total of £0.75 million across the previous four exercises (see **Exhibit 11**).

Exhibit 11: council tax reduction scheme outcomes over time, NFI 2016-17 to NFI 2024-25 (£ million)



Source: Audit Wales analysis

Note: Figures for each exercise cover a two-year period, starting from 1 April in the year shown, and include any late reported outcomes from the previous exercise.

The number of cancelled or amended cases increased from 189 to 304. Actual outcomes made up £0.72 million of the total outcomes. While late reported actual or estimated outcomes from the previous exercise contributed around £0.32 million and a quarter of all cases (73). The average value per case rose to £3,080, compared with £1,580 in the previous exercise.

Local authorities processed just over 7,200 NFI 2024-25 matches, around 40% more than in the previous exercise. **Exhibit 12** shows how more follow-up activity improved outcomes for one local authority. **Exhibit 13** highlights the highest outcome linked to a match.

Exhibit 12: case study on the impact of increased follow-up activity on council tax reduction scheme outcomes

One local authority reviewed 475 council tax reduction scheme data matches, compared with just 40 in the previous exercise.

This increase in follow-up work contributed to outcomes of almost £0.13 million, up from none in the previous exercise. It is also the highest amount reported by any local authority for NFI 2024-25.

Of this total, £95,000 relates to reductions already applied, which are recoverable. A further £34,000 reflects estimates of prevented future discounts.

Source: Audit Wales analysis

Exhibit 13: case study of the highest outcome linked to the council tax reduction scheme

One local authority's data matches identified a fraud of £57,000.

The match came originally from the NFI 2022-23 exercise. Initial checks by the local authority raised concerns about undeclared property ownership and rental income. These issues affected both council tax reduction scheme and Universal Credit claims.

Because the UK Department for Work and Pensions handles Universal Credit work, the local authority referred the case on and paused its own enquiries.

The case remained open into the NFI 2024-25 exercise. Further local work and by the Department for Work and Pensions confirmed the individual was not entitled to the reduction scheme or Universal Credit due to undeclared income.

The individual had benefited from £12,000 of council tax reductions since 2020. The local authority has recovered this through council tax billing for 2026-27. A further estimated £2,000 in losses has been prevented.

The Department for Work and Pensions identified £43,000 of ineligible Universal Credit payments to the individual. The local authority is waiting to hear if the Department for Work and Pensions will prosecute this case.

Source: Audit Wales analysis

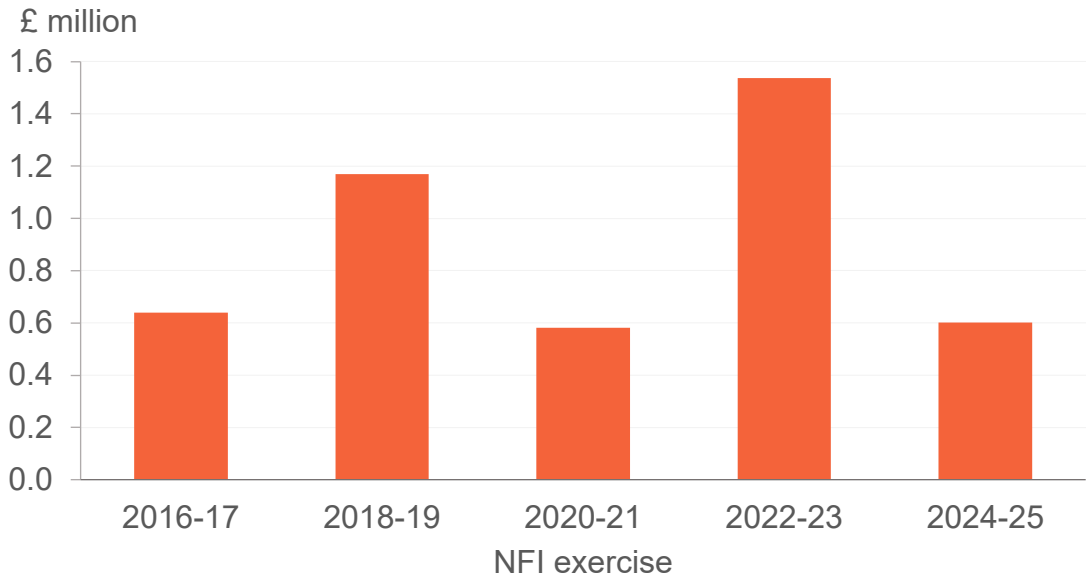
Housing benefit

Outcomes (NFI 2024-25)	Cases (NFI 2024-25)
£0.60 million	100

Housing benefit data matching looks to identify cases of fraudulent or incorrect claims, or where an individual's entitlement has changed but records have not been updated.

Housing benefit outcomes relate to cases where individuals did not declare income or changes in their circumstances. **Exhibit 14** shows how these outcomes have changed over time. It also shows that levels have returned to those seen in the 2016-17 and 2020-21 exercises.

Exhibit 14: value of housing benefit outcomes over time, 2016-17 to 2024-25 (£ million)



Source: Audit Wales analysis

Note: Figures for each exercise cover a two-year period, starting from 1 April in the year shown, and include any late reported outcomes from the previous exercise.

The large fall in outcomes from £1.6 million in NFI 2022-23 is due mainly to lower outcomes reported for Wales by the UK Department for Work and Pensions. Nevertheless, it still reported just under 90% of the total NFI 2024-25 outcomes and cases.[12] Local authorities reported the remainder.

This reduction in housing benefit outcomes is expected. The number of housing benefit claims is falling as people move to Universal Credit. Also, outcomes for NFI 2022-23 were higher than expected due to pandemic-related backlogs at the UK Department for Work and Pensions. Around £0.50 million of the outcomes for NFI 2024-25 relate to cases from the previous exercise.

Exhibit 15 shows how a local authority's follow-up of potential undeclared income identified housing benefit overpayments and ineligible claims of council tax reduction.

Exhibit 15: case study on undeclared income resulting in housing benefit overpayment and ineligible council tax reduction

Data matching between taxi driver licence records and housing benefit claims helped one local authority identify undeclared income. The individual had been claiming both housing benefit and council tax reduction.

The local authority identified a £21,000 housing benefit overpayment and £3,000 of ineligible council tax reduction. The NFI also estimated £1,500 in future council tax reduction savings.

Source: Audit Wales analysis

12 The 86 cases reported by the UK Department for Work and Pensions comprise 68 actual cases and 18 estimated cases. After transitioning to a new system during NFI 2024-25, it no longer provides case counts by country. The estimated cases are apportioned based on the number of referrals made by each country.

Pensions

Outcomes (NFI 2024-25)	Cases (NFI 2024-25)
£0.17 million	26

Pensions data matching allows bodies to identify cases where pension payments continue after a person has died. It also helps to identify issues such as pensioners going back into employment that could result in an abatement of their pension, and incorrect enhanced injury pensions.

Of the 12 bodies that administer pensions directly, seven identified a total of 26 cases where payments continued after death. This compares with 40 cases on the previous exercise.

Total financial outcomes were down from £0.45 million previously. Of the £0.17 million reported for NFI 2024-25, £0.11 million relates to the value of future overpayments prevented through stopping the payments.[13] Despite the lower number of cases, the value of recoverable pension overpayments (actual outcomes) rose slightly from £41,000 to £62,000.

Exhibit 16 details the highest-value pension overpayment. This arose because the pension scheme administrator had not been told about a pensioner's death overseas.

13 The approach to calculate estimated pension outcomes multiplies the pensioner's annual pension by the number of years until the pensioner would have reached the age of 85 (based on Office for National Statistics data on life expectancy for an individual over 65). If the pensioner is 85, a one-year multiplier is applied.

Exhibit 16: case study on the NFI identifying pension overpayments due to an unreported overseas death

The NFI helped one local authority identify that pension payments had continued for an individual who died overseas in 2021.

The pensioner, a widow with no known next of kin, died in a country that does not take part in routine ‘proof of life’ checks. As a result, the authority was not aware of the death, and payments continued until early 2026.

The authority is taking action to recover the £19,000 overpayment. Identifying this case helped prevent a further estimated £44,000 in pension overpayments.

Source: Audit Wales analysis

Creditor payments

Outcomes (NFI 2024-25)	Cases (NFI 2024-25)
£0.14 million	71

Creditor payments data matching looks to identify potentially duplicate, incorrect, or irregular payments to suppliers. It also helps to cleanse creditor records.

The number of duplicate creditor payment cases identified through the NFI increased from 42 on the previous exercise to 71. This is the highest number of cases recorded across the last five exercises. However, the total value of outcomes halved to £0.14 million (see **Exhibit 17**).

Exhibit 17: identified cases and value of duplicate creditor payments over time, NFI 2016-17 to NFI 2024-25 (number and £ million)

	Number of cases	Outcomes (£ million)
2016-17	61	0.08
2018-19	53	0.09
2020-21	54	0.10
2022-23	42	0.28
2024-25	71	0.14

Source: Audit Wales analysis

Note: Figures for each exercise cover a two-year period, starting from 1 April in the year shown, and include any late reported outcomes from the previous exercise.

Some bodies actively review NFI creditor matches. Others do not, instead relying on system controls to prevent duplicate or incorrect payments, detect potential fraud, and identify past issues.

The number of bodies identifying duplicate payments nearly doubled, rising from seven for NFI 2022-23 to 13 for NFI 2024-25. Some of these 13 bodies also use third-party detection and prevention tools.

Adult social care

Outcomes (NFI 2024-25)	Cases (NFI 2024-25)
£0.12 million	6

NFI 2024–25 reintroduced adult social care data matching part way through the exercise. This data matching highlights potential cases of:

- payments to residential care homes where a resident has died, but the local authority may not have been told and payments continue; and
- direct payments where the recipient has died but payment continues, or a person is claiming direct payments from more than one local authority.

Most, but not all, local authorities submitted data in September 2025. They received their matches in December 2025, but with mixed progress following up on them after that.

Authorities reported outcomes totalling £0.12 million for residential care home data matches. This included £62,000 in recoverable overpayments and £55,000 in estimated future savings. These related to five cases.

One authority identified an overpayment of £31,000 linked to direct payments where the recipient had died. The value of that case was confirmed after 31 March 2026, so it will be recorded as an outcome in the next NFI exercise.

Payroll

Outcomes (NFI 2024-25)	Cases (NFI 2024-25)
£46,000	5

Payroll data matching targets potential employment fraud. This includes cases where individuals work for more than one body at the same time, including roles with overlapping shifts.

Payroll matching can also identify individuals who receive long-term sickness payments from one employer while working for another. And it looks for cases where secondary employment has not been declared, which may breach contracts or policies.

Three bodies identified five cases of fraud, overpayment, and error between them for NFI 2024-25, with total outcomes of £46,000. This compares with outcomes of just £3,000 on the previous exercise. **Exhibit 18** explains the highest-value payroll data match.

Exhibit 18: case study on the highest recorded outcome linked to a payroll data match

Following an NFI payroll-to-payroll match, one health board identified around £26,000 in salary overpayments made in error after an individual had left employment.

The payments continued for six months while the individual was working for another health board. They have since been recovered.

The health board followed up on its payroll matches soon after receiving them. This prompt action helped limit the size of the overpayment and identified controls to prevent similar occurrences.

Source: Audit Wales analysis

Procurement

Outcomes (NFI 2024-25)	Cases (NFI 2024-25)
£0	0

Procurement data matching looks to prevent and detect potential procurement fraud. It matches payroll data with Companies House records and creditor data to highlight potential undeclared conflicts of interest and irregular supplier payments.

Follow-up work on this data matching did not identify any cases. However, some bodies identified opportunities to strengthen how they obtain declarations of interest. For example, extending declaration requirements to more staff, and providing more guidance and training about them.

Housing tenancy

Outcomes (NFI 2024-25)	Cases (NFI 2024-25)
£0	6

Housing tenancy data matching flags potentially fraudulent or inappropriate occupation of social housing. It helps protect social housing resources for those entitled to them.

None of the 11 local authorities with their own housing stock reported any cases of tenants fraudulently subletting their property based on their follow-up work.

One authority reported six cases of legitimate tenancy succession following bereavement. Information recorded in the NFI system by other local authorities suggests such cases are under-reported.

3 Key terms in this report

Term	Description
Actual outcomes	Actual financial amounts recorded as fraud, overpayment, or error. These are potentially recoverable.
AppCheck	The NFI's fraud prevention and application verification tool.
Blue badge permits	The blue badge scheme operates across the UK. Badges are issued to people with mobility difficulties to allow them to park free of charge in certain situations. These include on-street parking meters, pay and display bays, designated blue badge spaces, and, where permitted, on single or double yellow lines.
Case / cases (of fraud, overpayment, or error)	A data match that has been followed up by a body and where fraud, overpayment, or error has been confirmed. A fraud is where there has been a deliberate act of deception to obtain a payment, discount, service, or entitlement that the person knew they were not entitled to receive. An error is where an incorrect payment, discount, or entitlement arose unintentionally. An overpayment is when someone receives more than they were entitled to. It may result from fraud, error, or another reason.
Council tax reduction scheme	The council tax reduction scheme is a means-tested benefit. It is managed by local authorities and reduces the cost of council tax for low-income households in full or, more usually, in part.
Council tax single person discount	Council tax liability is based on at least two adults living in a property. A 25% council tax single person discount applies where a person lives alone, or where all other adult occupants are exempt from paying council tax.
Creditor payments	Payments to suppliers of goods and services.
Data match	An anomaly or inconsistency identified through data matching that may indicate potential fraud, overpayment, or error and meriting follow-up.
Data match area	A collection of NFI data match reports for specific subjects, such as council tax single person discount, housing benefit, or payroll.

Term	Description
Data match report	A report of data matches from comparing two or more sets of data.
Estimated outcomes	Estimated financial value of losses from frauds, overpayments, or errors detected and any future losses that bodies may have incurred without intervention following an NFI match. Estimated outcomes are calculated using agreed approaches that the PSFA reviews before each NFI exercise with input from others. When a body records a fraud, overpayment, or error, the NFI system automatically generates the estimated outcomes element.
Housing benefit	A means-tested benefit that helps eligible people on a low income meet their housing costs.
National Fraud Initiative (NFI)	A UK-wide counter-fraud exercise first created in 1996. It helps prevent and detect fraud by sharing and matching sets of data from various bodies. The PSFA leads the NFI at a UK-level and in England, but it is delivered in Wales under the Auditor General's data matching powers.
NFI 2024-25 **NFI 2022-23** **NFI 2020-21** **NFI 2018-19**	NFI 2024-25 is the exercise that reports outcomes recorded by bodies between 1 April 2024 and 31 March 2026 and including late reported outcomes from the previous exercise. Most of the data matching takes place biennially, but for council tax single person discount it is annual.
NFI 2016-17	Similarly, each previous NFI exercise covers a two-year period, starting from 1 April in the year shown, with data matched and figures collated on the same basis.

Term	Description
NFI system	A secure data matching platform that: • receives data from bodies; • matches data between datasets; • generates match reports highlighting potential fraud, overpayment, or error; and • provides a web portal through which bodies review and follow up matches, and record outcomes.
Outcomes	The financial value of fraud, overpayments, and errors detected and prevented through data matching. Includes actual outcomes and estimated outcomes.
Processed data matches	Processed data matches are those bodies record as 'closed' within the NFI system. Bodies have the option to record data matches as processed following risk assessment, even if they decide not to take further action.
Public Sector Fraud Authority (PSFA)	The PSFA works with UK Government departments and public bodies to understand and reduce the impact of fraud. It leads the National Fraud Initiative at a UK-level and in England. The PSFA is now part of the UK Government's Department for Work and Pensions, having moved from the Cabinet Office during 2026.

About us

The Auditor General for Wales is independent of the Welsh Government and the Senedd. The Auditor General's role is to examine and report on the accounts of the Welsh Government, the NHS in Wales and other related public bodies, together with those of councils and other local government bodies. The Auditor General also reports on these organisations' use of resources and suggests ways they can improve.

The Auditor General carries out their work with the help of staff and other resources from the Wales Audit Office, which is a body set up to support, advise and monitor the Auditor General's work.

Audit Wales is the umbrella term used for both the Auditor General for Wales and the Wales Audit Office. These are separate legal entities with the distinct roles outlined above. Audit Wales itself is not a legal entity.

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Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

v1.0/P2145

Governance of Escalation Level

Final Internal Audit Brief

Aneurin Bevan University Health Board

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

Introduction

Aneurin Bevan University Health Board (the 'Health Board') is subject to the NHS Wales Oversight and Escalation Framework, which sets out the arrangements for monitoring organisations where additional support or intervention is required.

The Health Board is required to have appropriate governance arrangements in place to manage the areas subject to escalation, monitor delivery of agreed actions and provide assurance on progress against the relevant de-escalation requirements.

This audit will review the arrangements in place for overseeing the Health Board's response to escalation, including how actions are managed, monitored and reported through the organisation.

Scope, Risks & Approach

Scope	A review of the Health Board's governance and processes for managing, monitoring and reporting progress around the escalation framework and de-escalation actions. Objectives of the area under review: 1. To assess whether clear governance arrangements are in place for managing the Health Board's escalation requirements and de-escalation actions. 2. To assess whether escalation and de-escalation actions are clearly defined, appropriately assigned and subject to effective monitoring and follow-up. 3. To assess whether progress against escalation requirements and de-escalation actions is reported accurately, consistently and in a timely manner.
Associated risks	• Unclear governance and accountability for managing escalation and de-escalation requirements. • Actions are not effectively monitored, leading to delays or incomplete delivery. • Progress reporting is inaccurate or untimely, limiting effective oversight and assurance.
Limitations to scope	The audit will not assess or conclude on whether the Health Board should be de-escalated.
Approach	The approach to audit assignments is risk based, where the risks are identified with management. Controls are identified to manage those risks and the assignment scope is designed to provide assurances on those issues. Additionally, we reserve the right to liaise with Audit Wales, Welsh Government or any other parties pertinent to the review. Assurance opinions and action plan risk ratings
Access to information, records and correspondence	Access to information, documents and correspondence to support this review, is requested in accordance with the following: The Audit Committee has approved the Internal Audit Mandate and Charter reference 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.' The Health Board has approved Standing Financial Instruction 3.2.2: *'The designated internal and external audit representatives are entitled (subject to provisions in the Data Protection Act 2018 and the UK General Data Protection Legislation) without necessarily giving prior notice to require and receive:* *a) Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;'*
Link to Health & Care Quality Standards	This review may support assurance over the Health & Care Quality Standards.

Contacts & Timings

Client contacts	Hannah Evans	Director of Strategy, Planning and Partnerships
Audit & Assurance contacts	Stephen Chaney Eifion Jones Laura Howells	Head of Internal Audit Deputy Head of Internal Audit Internal Audit Manager
Indicative timings	Fieldwork Debrief meeting Audit Committee	October / November 2026 November 2026 11th February 2027
Brief agreement	Director of Strategy, Planning and Partnerships 14th October 2026	

Audit and Assurance Services conform with the Institute of Internal Auditors (IIA's) professional standards and to the Global Internal Audit Standards in the UK Public sector through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023

Disclaimer notice

This audit brief has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit, Risk & 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.

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 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.

Welsh Risk Pool Lessons

Final Internal Audit Brief

Aneurin Bevan University Local Health Board

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

Introduction

The Welsh Risk Pool (WRP) supports NHS Wales organisations to learn from claims, redress cases, complaints and adverse events to improve patient safety, strengthen governance and reduce the risk of recurring harm. The WRP expects organisations to identify lessons learned, implement and monitor improvement actions, and share learning across services.

This review will assess whether the Health Board has effective arrangements for identifying, recording, disseminating and monitoring lessons learned from WRP claims and redress cases. It will also evaluate whether actions arising from claims have been implemented, embedded in practice, and resulted in measurable service improvements in line with WRP requirements and the Putting Things Right framework.

Scope, Risks & Approach

Scope	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. Objectives of the area under review: 1. To assess whether divisions learn lessons from Welsh Risk Pool claims and redress cases are appropriately identified, recorded and communicated to relevant services and staff. 2. Determine whether divisional action plans arising from Welsh Risk Pool claims and redress cases are clearly defined, assigned and implemented within agreed timescales, including central reporting. 3. Evaluate the effectiveness of divisional arrangements for monitoring, reviewing and obtaining assurance that agreed actions have been fully implemented, sustained and achieved measurable improvements in practice by reducing risks and / or preventing the recurrence of similar incidents or claims.
Associated risks	• Lessons learned are not effectively identified, recorded and disseminated resulting in reputational damage • Actions arising from lessons learned are not implemented effectively or within agreed timescales. • Progress and completion of actions are not adequately monitored and reported resulting in insufficient improvements or prevent the recurrence of similar incidents.
Approach	The approach to audit assignments is risk based, where the risks are identified with management. Controls are identified to manage those risks and the assignment scope is designed to provide assurances on those issues. Additionally, we reserve the right to liaise with Audit Wales, Welsh Government or any other parties pertinent to the review. Assurance opinions and action plan risk ratings
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Link to Health & Care Quality Standards	This review may support assurance over the Health & Care Quality Standards.

Contacts & Timings

Client contacts	Jennifer Winslade	Executive Director of Nursing
	Tracey Partridge Wilson	Deputy Director of Nursing
	Garvin Jones	Head of Legal Services
Audit & Assurance contacts	Stephen Chaney	Head of Internal Audit
	Eifion Jones	Deputy Head of Internal Audit
Indicative timings	Fieldwork	October 2026
	Debrief meeting	November 2026
	Audit Committee	T.B.C
Brief agreement	Jennifer Winslade, Executive Director of Nursing and Tracey Partidge Wilson, Deputy Director of Nursing 09.10.26	

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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.

Procurement of Digital Services

Final Internal Audit Brief

Aneurin Bevan University Health Board

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

Introduction

The Digital, Data & Technology (DDaT) Directorate regularly procures IT products on behalf of Aneurin Bevan University Health Board (the 'Health Board'). The audit will seek to gain assurance that these procurements align with general procurement principles to ensure that best value is secured.

Scope, Risks & Approach

Scope	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. Objectives of the area under review: 1. To confirm that appropriate policies and procedures define the approach to IT procurement, and that roles and responsibilities are clearly documented. 2. To determine whether IT procurement activities are undertaken in accordance with relevant legislation, NHS Wales procurement policies, Standing Orders, Standing Financial Instructions (SFIs), and delegated authority requirements. 3. To assess whether IT procurement arrangements achieve value for money and ensure that contracts are effectively managed throughout their lifecycle.
Associated risks	• Inadequately defined control framework leading to significant non-compliance with procurement requirements. • Failure to achieve best value.
Limitations to scope	The audit will not consider whether IT procurements appropriately consider information governance, cyber security, and operational risks before contracts are awarded and systems are implemented.
Approach	The approach to audit assignments is risk based, where the risks are identified with management. Controls are identified to manage those risks and the assignment scope is designed to provide assurances on those issues. Additionally, we reserve the right to liaise with Audit Wales, Welsh Government or any other parties pertinent to the review. Assurance opinions and action plan risk ratings
Access to information, records and correspondence	Access to information, documents and correspondence to support this review is requested in accordance with the following: The Audit Committee has approved the Internal Audit Mandate and Charter reference 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.'* The Health Board has approved Standing Financial Instruction 3.2.2: *'The designated internal and external audit representatives are entitled (subject to provisions in the Data Protection Act 2018 and the UK General Data Protection Legislation) without necessarily giving prior notice to require and receive:*

	a) Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;'
Link to Health & Care Quality Standards	This review may support assurance over the Health & Care Quality Standards.

Contacts & Timings

Client contacts	Paul Solloway	Director of Digital
	Robert Holcombe	Executive Director of Finance & Procurement
Audit & Assurance contacts	Stephen Chaney	Head of Internal Audit
	Eifion Jones	Deputy Head of Internal Audit
Indicative timings	Fieldwork	October 2026
	Debrief meeting	November 2026
	Audit Committee	To be confirmed
Brief agreement	Director of Digital 14th October 2026	

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Hospital Sterilisation and Disinfection Unit (HSDU)

Final Internal Audit Brief

Aneurin Bevan University Health Board

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

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

Introduction

The HSDU provides a critical patient safety function by supporting the safe reprocessing and availability of reusable medical devices for use across the Health Board. Effective delivery is dependent on clear operational ownership, compliant procedures, robust equipment maintenance and validation arrangements, accurate records, and effective traceability throughout the decontamination cycle.

This audit will focus on the operational controls supporting HSDU services across the Health Board, including how these arrangements are governed, monitored and evidenced in practice.

Scope, Risks & Approach

Scope	The purpose of this audit is to evaluate the processes and procedures that support the service delivery of the Hospital Sterilisation & Disinfection Unit (HSDU) across the Health Board. Objectives of the area under review: 1. To determine whether clear governance, accountability and reporting arrangements are in place to support the safe and effective delivery of HSDU services across the Health Board; 2. To assess whether equipment, maintenance, validation and service continuity arrangements comply with procedural requirements and are sufficient to support the reliable operation of HSDU services; and 3. To evaluate whether effective traceability, record-keeping and quality assurance arrangements are in place to evidence that reusable medical devices are processed, released and monitored appropriately.
Associated risks	• Inadequate governance and oversight of HSDU risks, performance and compliance. • Failure to maintain, validate or repair HSDU equipment, impacting service safety or continuity. • Incomplete traceability or records to evidence safe decontamination and release of reusable medical devices. • Reusable Medical devices / equipment and other applicable items are not effectively / safely sterilised or disinfected.
Approach	The approach to audit assignments is risk based, where the risks are identified with management. Controls are identified to manage those risks and the assignment scope is designed to provide assurances on those issues. Additionally, we reserve the right to liaise with Audit Wales, Welsh Government or any other parties pertinent to the review. Assurance opinions and action plan risk ratings

Link to Health & Care Quality Standards	This review may contribute towards assurance over the following Health & Care Quality Standards:

Quality Domains	Quality Enablers
Safe	Information
Effective	Whole systems approach
Efficient	

Contacts & Timings

Client contacts	Leanne Watkins	Chief Operating Officer
Audit & Assurance contacts	Stephen Chaney	Head of Internal Audit
	Eifion Jones	Deputy Head of Internal Audit
	Warren Alexander	Audit Manager
Indicative timings	Fieldwork	August 2026
	Debrief meeting	September 2026
	Audit Committee	November 2026
Brief agreement	Chief Operating Officer 29th July 2026	

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023

Disclaimer notice

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

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with the Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Primary Care, Community Services, and Complex and Long Term Care Divisional Review

Final Internal Audit Brief

Aneurin Bevan University Health Board

GIG CYMRU NHS WALES

Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Introduction

Primary Care, Community Services, and Complex and Long Term Care are central to the Health Board's delivery of place-based care, care closer to home and sustainable primary/community services. This review will assess a sample of divisional management arrangements, including delivery of IMTP / Annual Plan objectives and the management of key risks.

Scope, Risks & Approach

Scope	The purpose of this audit is to provide an assessment of a sample of operational and functional management arrangements, including the delivery of divisional IMTP objectives and the management of key risks. Objectives of the area under review: 1. To assess whether governance, accountability and performance management arrangements support the delivery of divisional objectives and oversight of key risks. 2. To evaluate whether divisional objectives are translated into deliverable plans, with owners, milestones and performance measures. 3. To confirm that arrangements are in place to monitor delivery and expected benefits from divisional priorities, and to identify, monitor and escalate key risks and performance matters through appropriate governance structures.
Associated risks	• Governance arrangements may not provide effective oversight, escalation or action tracking. • IMTP / Annual Plan objectives may not be supported by clear delivery plans, milestones and ownership. • Key operational, workforce, quality, performance and financial risks may not be identified, monitored or escalated effectively.
Approach	The approach to audit assignments is risk based, where the risks are identified with management. Controls are identified to manage those risks and the assignment scope is designed to provide assurances on those issues. Additionally, we reserve the right to liaise with Audit Wales, Welsh Government or any other parties pertinent to the review. Assurance opinions and action plan risk ratings
Access to information, records and correspondence	Access to information, documents and correspondence to support this review is requested in accordance with the following: The Audit Committee has approved the Internal Audit Mandate and Charter reference 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.'* The Health Board has approved Standing Financial Instruction 3.2.2:

	'The designated internal and external audit representatives are entitled (subject to provisions in the Data Protection Act 2018 and the UK General Data Protection Legislation) without necessarily giving prior notice to require and receive: *a) Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;'*
Link to Health & Care Quality Standards	This review may support assurance over the Health & Care Quality Standards.

Contacts & Timings

Client contacts	Leanne Watkins	Chief Operating Officer
	Lloyd Hambridge	Divisional Director of Primary Care, Community Care and CHC
	Laura Melrose	Assistant Head of Business and Performance
Audit & Assurance contacts	Stephen Chaney	Head of Internal Audit
	Eifion Jones	Deputy Head of Internal Audit
Indicative timings	Fieldwork	October / November 2026
	Debrief meeting	November 2026
	Audit Committee	TBC
Brief agreement	Chief Operating Officer 14th October 2026	

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Charitable Funds

Final Internal Audit Report

2026/27

Aneurin Bevan University Health Board



Reasonable Assurance

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Findings & Agreed Action Plan 3
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Review Reference	ABU-2627-04
Fieldwork	July – September 2026
Executive Sign Off	November 2026
Audit Committee	November 2026
Executive Lead	Rob Holcombe, Director of Finance and Procurement
Audit Team	Stephen Chaney, Head of Internal Audit
	Eifion Jones, Deputy Head of Internal Audit

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

Executive Summary

Purpose

The purpose of this audit was to assess the adequacy and effectiveness of key controls relating to the management of charitable funds, specifically donations, restricted funds, financial reporting and decision-making by the Charitable Funds Committee. The review considered whether appropriate governance, accountability and oversight arrangements are in place to provide assurance that charitable funds are managed transparently, accurately and in accordance with their intended charitable purposes.

Overview

We have concluded reasonable assurance in this area as the overall governance and control framework for charitable funds is operating effectively, with arrangements for donations, fund management and Committee oversight generally functioning as intended. However, opportunities remain to strengthen the control environment. The matters requiring management attention include:

- Periodic Committee review of recurring activities, such as the Casting Course, would confirm ongoing value for money, alignment with charitable objectives and proper accounting for income.
- Less reliance should be placed on direct staff reimbursements over established procurement routes requiring documented approval prior to incurring the costs.
- The strategy for low value slow-moving funds requires a comprehensive review.

Further matters were discussed with management for consideration but do not impact the opinion:

- The Health Board reconciled donations received via JustGiving and Gift Aid but could seek further assurances over other risks such as GDPR and anti-money laundering.
- The reasonableness of support costs should remain under committee review and considered alongside the implementation of the Growth Strategy.

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

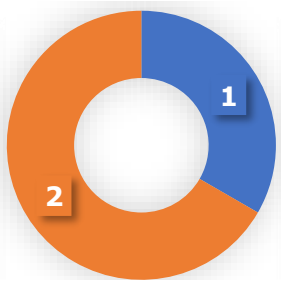
Scope & Assurance Summary

Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	Confirm whether decisions in respect of charitable funds are transparent, well governed, evidence based, and compliant with key charitable funds policies	1	**Reasonable**
2	Assess whether controls ensure donations are received, recorded, safeguarded and designated in line with donor intent	-	**Substantial**
3	Charitable funds expenditure is appropriate, properly authorised and accurately recoded	2	**Reasonable**
4	Evaluate whether restricted and delegated funds are correctly defined, monitored, and committed in accordance with donor intent and charitable objectives	3	**Reasonable**

Management Actions

-	3
High Priority	Medium Priority

Themes



- Governance
- Finance Management & Control

Risk Types

Financial Loss

Legal & Regulatory Non-Compliance

Public Perception & Reputational Risk

At a Glance

Charitable funds comprise of monies donated, bequeathed or otherwise received for charitable purposes and administered through the Aneurin Bevan University Health Board Charitable Fund and associated charitable funds. The Health Board, as Corporate Trustee, has delegated responsibility for the management and stewardship of these funds to the Charitable Funds Committee. The Committee is responsible for ensuring funds are governed appropriately, invested prudently and utilised in accordance with donors' wishes, charity law and the Charity's objectives, as set out within its terms of reference. Executive responsibility rests with the Director of Finance, Procurement and Value.

The overall objective for charitable funds is defined within the financial control procedure and the terms of reference of the Charitable Funds Committee to ensure charitable funds are managed effectively, sustainably and in accordance with donor intent and charitable objectives. The financial control procedure also outlines the investment and reserves approach.

The draft 2025/26 accounts, currently being finalised, report charitable income of £1.132 million and closing fund balances of £4.188 million, emphasising the importance of effective governance and financial management arrangements to safeguard assets and maximise benefits for patients, staff and services. Income received through JustGiving has varied significantly over time, declining from £185,523 in 2020/21, during the exceptional fundraising activity associated with the COVID-19 pandemic, to £37,818 in 2025/26.

Fund Type	**(£)**
Unrestricted	£3,397,000
Restricted	£769,000
Legacy	£22,000

Findings & Agreed Action Plan

Objective 1: Confirm whether decisions in respect of charitable funds are transparent, well governed, evidence based, and compliant with key charitable funds policies	**Reasonable**

Overview / Summary of Observations

The Charitable Funds Committee has a clear governance structure, defined accountability arrangements and an appropriate membership framework compliant with charitable funds policies.

The Committee is evolving from a primarily transactional approval function towards a stronger focus on governance, impact, financial sustainability and oversight of charitable funds. Evidence from Committee papers demonstrated scrutiny of fund utilisation, accountability and dormant balances. Annual reporting requirements for Charitable Funds Holders further support transparency and accountability.

As reviewed within the previous audit in this area, the Health Board continues to operate an ethical investment portfolio, aligned with the Charity's medium-risk, long-term investment strategy.

Expenditure proposals between £15,000 and £25,000 are required to be submitted to the Executive Committee for approval, ensuring an appropriate level of scrutiny is applied to medium value funding decisions. In addition, the introduction of a Review Panel to assess funding bids represents a positive control enhancement, providing a formal mechanism for further scrutiny and challenge. While the Panel had only met once at the time of fieldwork, its remit includes reviewing staff funding requests, expenditure proposals exceeding £25,000, and project-related funding bids, providing assurance that higher-value and higher-risk proposals will be subject to enhanced oversight.

At the point that our testing was completed there was no 2026/27 expenditure exceeding the £25,000 threshold requiring committee approval, and only two purchases in 2025/26 (totalling £137,495 and equating to 13% of in-year expenditure). Recurring expenditure, such as the Casting Course, should be subject to periodic Committee review based on cumulative value to ensure continued value for money and that income generated is appropriately returned to charitable funds.

Overall, the Committee has established a sound framework for governance and oversight, although recently introduced controls require further time to become fully embedded and demonstrate their effectiveness.

	Key Findings	Risk & Impact	Agreed Management Action
1	**Committee Oversight** The Casting Course (and any similar recurring activities) that are recurrent in nature, generating income and incurring associated expenditure should form part of the Committee's oversight arrangements to ensure they continue to deliver value for money, remain financially viable, and align with the objectives of the relevant charitable funds. A periodic review would also support transparency and provide assurance that charitable resources are being used effectively and in accordance with intended purposes.	Reduced Committee oversight of recurring expenditure may weaken accountability, transparency and assurance.	**Agreed Action:** As part of the quarterly finance update provided to board the nature and materiality of income is already clearly and transparently presented. However, a VFM and strategic alignment of training revenues will be implemented to further bolster governance. **Expected Evidence of Implementation:** The finance team will enhance the reporting in the quarterly Finance & Performance reports to identify regular income and expenditure items, as appropriate.

		Medium Priority	**Officer: Assistant Director of Finance, Financial Systems and Services)** **Target Implementation Date: Jan 2027**
	Theme: Governance	Control Design	

Objective 2: Assess whether controls ensure donations are received, recorded, safeguarded, and designated in line with donor intent	**Substantial**

Overview / Summary of Observations

The review identified that appropriate controls were in place to ensure donations and other sources of charitable income were received, recorded and allocated in accordance with donor intentions. Testing was undertaken on a sample of 14 donations received between April 2025 and April 2026 to confirm that donations had been appropriately recorded, banked and allocated to the correct charitable funds in line with the requirements of the Charitable Funds Financial Control Procedure. No issues were identified from the sample tested.

The work undertaken provided assurance that income was correctly attributed to the relevant charitable funds and was supported by regular reconciliation and monitoring processes. Audit testing confirmed that fund balances were routinely reconciled and reviewed to ensure the accuracy and completeness of financial records.

A review of JustGiving income found that donations were routinely monitored, reconciled and reported to the Charitable Funds Committee through quarterly finance and performance reports. Spot checks are undertaken at least quarterly, with donations recorded on the JustGiving platform matched to amounts received in the bank. While these checks provide assurance over the completeness and accuracy of income received, we have suggested that further assurances could be obtained from JustGiving in respect of GDPR and anti-money laundering for example.

Objective 3: Charitable funds expenditure is appropriate, properly authorised and accurately recorded	**Reasonable**

Overview / Summary of Observations

The purchasing of goods and services from charitable funds was undertaken through the Oracle finance system with financial approvals adequately documented.

Testing was undertaken to demonstrate compliance with section 12.7 of the Financial Control Procedure to ensure that expenditure satisfies the acceptable use criteria. Testing found that audit trails were not always clearly demonstrating the rationale, approval route, or compliance with requirements.

Circa £106,620 of the £894,061 total expenditure for 2025/26 (i.e. 11.93%) was reimbursed to individuals for course lunch, gift cards, accommodation and travel – in such instances, approvals to incur costs were not formally documented as would be required if these were processed via Oracle. Many of the activities were known in advance and could have been approved and processed before the expenditure was incurred. For example, recurring events such as the annual Casting Course provide opportunities for expenditure to be planned and approved in advance.

In addition, expenditure of £71,000 for ECG machines was not recorded within the formal Charitable Funds Committee meeting minutes.

Clearer guidance is required on appropriate expenditure, including spending limits for food and refreshments, acceptable purchasing arrangements, and restrictions on deliveries to home addresses. Strengthening pre-approval requirements and clarifying the circumstances in which reimbursements may be used would improve governance, transparency and consistent compliance with charitable funds procedures. Reimbursements should remain the exception rather than the standard method of processing expenditure.

	Key Findings	Risk & Impact	Agreed Management Action
2	**Management and approval of expenditure** Out of a sample of 29 purchases: • 1 of 2 expenditure items over £25k tested (value £71k) was not evidenced as having been approved through the formal Charitable Funds Committee minutes. • 6 of 29 expenditure items were processed as staff reimbursements, including buffet lunches, travel and accommodation (£1,065.57 from our sample of £95,835.92). A number related to planned activities which could reasonably have been approved and processed through standard procurement arrangements in advance, reducing reliance on reimbursement claims. • From our sample of 29, 5 purchase orders were placed with the same company within 7 days totalling £12,437, with no further purchases in 2026/27. Had these been processed together, the approval of the Divisional Manager (or equivalent) would have been required because of the total value.	Weak pre-approval processes and incomplete audit trails may reduce transparency and increase the risk of expenditure being incurred without clear evidence of approval or alignment to charitable objectives.	**Agreed Action:** Clear guidance is provided to all Health Board staff on permitted expenditure, and the requirements for pre-approval. Whilst it is acknowledged that utilising the standard procurement process would be the preferrable route, it should also be noted that in some cases, reimbursement is the only way to process a payment. This is particularly the issue with travel and accommodation, where the Health Board does not have contracts with each supplier or the dedicated travel partner is not able to secure services in an appropriate timeframe. In relation to multiple orders, it is understood to have been a one-off exception to ensure that the correct products were ordered and delivered separately, which combining the order would have caused difficulty.

	From the wider population, one other instance was identified where two orders were processed on the same day at a value of £3,520 each. Clearer staff guidance on permitted expenditure, pre-approval requirements and reimbursement processes would strengthen governance, transparency and compliance with charitable funds procedures. Reimbursements should be used only as an exception, not as standard practice.		**Expected Evidence of Implementation:** The Charitable Funds team will remind Fund Holders of the procurement guidelines and request training is provided to those that regularly order items for the Charity, to ensure correct guidance is followed. The Finance team will ensure that the Committee acknowledge the approval of the £71k ECG machines, by retrospective approval in the next Committee.
		Medium Priority	**Officer: Assistant Director of Finance, Financial Systems and Services)** **Target Implementation Date: April 2027**
	Theme: Finance Management & Control	Control Design	

Objective 4: Evaluate whether restricted and delegated funds are correctly defined, monitored, and committed in accordance with donor intent and charitable objectives

Reasonable

Overview / Summary of Observations

Restricted and delegated funds were clearly defined and subject to oversight through the Charitable Funds Committee. Funds were monitored and utilised in line with donor intentions and the Charity's objectives, providing assurance that charitable resources were being managed appropriately and that sufficient funds were available to meet current and future commitments. The Committee recognised rising administration costs and began reviewing whether its charging arrangements were sustainable enough to support the Charity's ongoing effective management.

Overall, governance, monitoring and accountability arrangements were operating effectively and provided a framework for the stewardship of charitable funds. Regular reporting to the Committee supported transparency and oversight, including the monitoring of fund balances and expenditure. High value slow-moving funds were routinely reported, and fund holders were invited to attend Committee meetings to explain the purpose and intended use of funds where limited activity had been identified. From a total of 391 funds, the following reported no expenditure in 2025/26 or 2026/27 to date:

Fund Value	No. of Funds	Cumulative Value of Funds
£0 - £4,999	173	£292,171
£5,000-£14,999	52	£430,190
£15,000-24,999	13	£242,595
£25,000+	14	£667,847
	252	**£1,632,803**

Opportunities exist to provide greater scrutiny of low value inactive and slow-moving funds to help ensure charitable resources are utilised in a timely manner and continue to support intended objectives. In addition, reserves and administration fee arrangements should be reviewed periodically to ensure they remain appropriate and sustainable.

Regular benchmarking against comparable NHS charitable fund organisations has also been undertaken and reported to the Charitable Funds Committee.

	Key Findings	Risk & Impact	Agreed Management Action
3	**Slow moving funds and Legacies** A Slow-Moving Funds Report was presented to the Committee regularly as a dedicated agenda item or within fundholder presentations, and high value fund holders were invited to explain their plans for utilising funds. Analysis of charitable fund activity identified that, of 391 funds reviewed (excluding the ABUHB Charitable Funds accounts), 238 funds below £25,000 had recorded no expenditure during 2025/26 and 2026/27 to date – the cumulative value of these funds was £964,956. The volume of inactive funds indicates a need for enhanced scrutiny to managing dormant balances.	Charitable funds may remain unused, reducing their impact and the delivery of intended charitable benefits.	**Agreed Action:** The Committee already receives a regular report on funds in excess of £25k which have been identified as "Slow-moving". Subsequently, the Committee invites the fund holders to the Committee to discuss their spending plans, and to manage the funds. In addition to the above, the Committee has also agreed a process to highlight funds that have been identified as "slow-moving" over an 18-month period. This is not limited to funds with balances over £25k but will apply to all funds. The next Committee in February 2027 is already scheduled to receive the report identifying these funds and recommended actions to be taken. This may include the merging of funds, or

			"implementing a % reduction of the fund to deploy to other charitable aims", depending on the nature of the fund.
			Expected Evidence of Implementation: Report to be presented to Committee in February 2027 identifying full list of funds that have been inactive or "Slow-moving" over the previous 18 months. Clear recommended actions will be provided to the Committee on how to manage these funds.
		Medium Priority	**Officer: Assistant Director of Finance, Financial Systems and Services)**
	Theme: Finance Management & Control	Control Design	**Target Implementation Date: February 2027**

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.

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Public Sector Internal Audit Standards

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

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	24 November 2026
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Audit, Risk and Assurance Committee - Review of Committee Forward Work Plan 2026/27
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Governance Support Officer

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

Er Gwybodaeth/For Information

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Audit, Risk and Assurance Committee is asked to review the agreed Committee Forward Work Plan appended to this report. The Forward Work Plan has been developed with due regard to recommendations from the Committee Self-Assessment 2026/27 and to enable the Committee to:

- Fulfil its Terms of Reference;
- Seek assurance and provide scrutiny on behalf of the Board, in relation to those items identified within the Committees terms of reference, and,
- Seek assurance that governance, risk, and assurance arrangements are in place and working well.

Cefndir / Background

Across the 2026/27 financial year, the Committee has received all items as scheduled in its Forward Work Plan.

Asesiad / Assessment

In line with good governance practice, the Committee has a Forward Work Plan that was developed to ensure statutory requirements for items of Committee business are scheduled in across the year. The Forward Work Plan can therefore

be utilised as a tool for informing and pre-empting Committee business and support the agenda setting process.

To aid the Committee when reviewing its programme of business, the Forward Work Programme captures the timing of when reports are to be submitted, identifies items that have been deferred and captures new requests for reports and enables the Committee to monitor and review its business at each meeting.

During the period there have been no adjustments made to the agreed forward work programme.

Argymhelliad / Recommendation

The Committee is requested to

- **NOTE** the updated Committee forward work plan as provided in **Appendix 1**.

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:	N/A

Glossary of Terms:	
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’.

DRAFT

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	19th May 2026 *Draft Accounts*	23rd 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 and Welsh Health Circulars (WHC)	**BI**	DofCG		√			√	
Review of Standing Orders, Standing Financial Instructions, and Scheme of Delegation	**An**	DofCG						√
Audit Recommendations Tracking Report *(April-June, July-September, October-December, January-March.)*	**Qu**	DofCG	√Q4			√Q1	√Q2	√Q3
Annual Review of Risk Management Framework	**An**	DofCG			√			
Report on the Implementation of the Risk Management Framework	**An**	DofCG			√			
Committee Risk & Assurance Report	**SI**	DofCG	√		√	√	√	
Self-Assessment of Committee Effectiveness	**An**	DofCG						√

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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	19th May 2026 *Draft Accounts*	23rd June 2026 *Final Accounts*	15th Sept 2026	24th November 2026	11th Feb 2027
Financial Governance and Control								
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**	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 2028***)	**3-Yearly**	DofF&P	-	-	-	-	-	-
Receive the Counter Fraud Annual Report and Agree the Counter Fraud Functional Standard Return Declaration	**An**	HofCF		√				
Agree the Counter Fraud Annual Workplan	**An**	HofCF	√					√
Receive a Progress Report on Counter Fraud Activity	**Quarterly**	HofCF			√	√		√

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Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2025/26					
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			28th April 2026	19th May 2026 *Draft Accounts*	23rd June 2026 *Final Accounts*	15th Sept 2026	24th November 2026	11th Feb 2027
Post Payment Verification								
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 2025 - 2026	**An**	Medical Director			√			
Agree the Clinical Audit Plan 2026 - 2027	**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**	HofIA	√					
Receive Internal Audit Progress Report	**SI**	HofIA	√	√	√	√	√	√
Receive Internal Audit Review Reports, reviewing the adequacy of executive & management responses to any issues identified, ensuring that they are acted upon	**SI**	HofIA	√	√	√	√	√	√
Review and approve Internal Audit terms of reference (charter) and the effectiveness of internal audit	**An**	HofIA with Chair	√					
Input clear numerical implementation dates against recommendations in the Capital Projects Report.	**SI**	HofIA			√			
Management actions and implementation dates within the GUH Extension report be updated to enable effective tracking ensuring clarity around actions taken or to be taken	**SI**	HofIA			√			
External Audit – Audit Wales								
Receive the External Audit Annual Audit Report	**An**	AW		√	√			
Agree the External Audit Annual Plan	**An**	AW	√					
Receive the 2026 Structured Assessment	**An**	AW					√	
Receive External Audit Progress Report 2025-26	**SI**	AW	√	√	√	√	√	√

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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						
Additional Papers/Actions								
Receive Deep Dive into all live digital audit recommendations	**Ad hoc**	DoCG		√				
Receive Deep Dive into Discharge Planning audit recommendations	**Ad hoc**	DoCG		√				
To Receive a targeted review of all pre 2023 audit recommendations	**Ad hoc**	DoCG		√				
Total Items Scheduled (excluding preliminary items) -to be updated prior to each meeting			**13**	**16**	**21**	**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

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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

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