Audit, Risk and Assurance Committee

Tue 22 April 2025, 09:30 - 12:00

Microsoft Teams

Agenda

09:30 - 09:30
0 min

1.
PRELIMINARY MATTERS

ARAC 20250422 1.0 Agenda - Final.pdf (3 pages)

1.1.
Welcome and Introductions

Oral *Chair*

1.2.
Apologies for Absense

Oral *Chair*

1.3.
Declarations of Interest

Oral *Chair*

1.4.
Draft Minutes of the last Meeting held on 18th February 2025

Attached *Chair*

ARAC 20250422 1.4 Feb 2025 Minutes - Approved.pdf (9 pages)

1.5.
Committee Action Log and Matters Arising

Attached *Chair*

- Final Records Management Internal Audit - Following amendments.

ARAC 20250422 1.5 20252204 Action Log.pdf (4 pages)
ARAC 20250422 1.5a ABUHB 2425-16 Records Management Audit - Final Internal Audit Report for Client v2.pdf (16 pages)

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2.
ITEMS FOR APPROVAL/RATIFICATION/DECISION

2.1.
To Receive the Report on Financial Governance and Ratify Changes to Financial Control Procedures (FCPs)

Attached *Director of Finance and Procurement*

- Digital
- Charitable Funds

- Approving Orders Greater than 100k
- Overseas Visitors

ARAC 20250422 2.1 Finance Governance Report - 22.04.2025.pdf (10 pages)
ARAC 20250422 2.1 Appendix 1 ABUHB_Finance_0997 FCP Digital Procurement_.pdf (12 pages)
ARAC 20250422 2.1 Appendix 2 - ABUHB_Finance_0244 FCP Charitable Funds.pdf (77 pages)
ARAC 20250422 2.1 Appendix 3 ABUHB_Finance_0884 FCP Approving Orders Greater than 100K_Issue 3 draft.pdf (12 pages)
ARAC 20250422 2.1 Appendix 4 - ABUHB_Finance_0894 Overseas Visitors_Issue 3.pdf (18 pages)

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3. ITEMS FOR DISCUSSION

3.1.
To Receive the Report on the Use of Single Tender Action

Attached *Director of Finance and Procurement*

ARAC 20250422 3.1 Single Tender Action Report (self assesment) RJJ.pdf (7 pages)

3.1.1.
To Receive 2024/25 Single Tender Action self-assessment summary.

Attached *Director of Finance and procurement*

ARAC 20250422 3.1a Single Tender Action Report - 25.01.2025 - 01.04.2025.pdf (4 pages)

3.2.
To Receive Report of Losses and Special Payments

Attached *Director of Finance and procurement*

ARAC 20250422 3.2 Losses and Special Payments Feb 25.pdf (5 pages)

3.3.
To Receive Response to Audit Wales as part of the 2024/25 Annual Accounts process - Audit enquiries to those charged with governance and management.

Attached *Director of Finance and procurement*

ARAC 20250422 3.3 audit enquiries letter cover.pdf (3 pages)
ARAC 20250422 3.3 ABUHB Audit Enquiries Management final.pdf (22 pages)

3.4.
To review the Committee Terms of Reference

Attached *Director of Corporate Governance*

ARAC 20250422 3.4 ARAC Terms of Reference Review Cover Sheet 2025.pdf (3 pages)
ARAC 20250422 3.4 Appendix One Audit, Risk & Assurance Committee_Dec 2024.pdf (13 pages)

3.5.
To Receive the Draft Committee Annual Report 2024/25 including review of Committee Effectiveness 2024/25

Attached *Director of Corporate Governance*

ARAC 20250422 3.5 Cover Report Audit Risk and Assurance Committee Annual Report 2025-26.pdf (4 pages)
ARAC 20250422 3.5 Audit_Risk and Assurance Annual Report 2024_25docx.pdf (67 pages)

3.6.
To Receive the Full Report of all Offers of Gifts and Hospitality as Declared

Attached *Director of Corporate Governance*

- ARAC 20250422 3.6 DoI Update ARAC April 2025.pdf (5 pages)
- ARAC 20250422 3.6 1a Declaration of Interest April 2025.pdf (4 pages)
- ARAC 20250422 3.6 Attachment 1b Anonymised Archive Master Register of Interest.pdf (22 pages)
- ARAC 20250422 3.6 Attachment 2 Anonymised Gift Register 2024_25.pdf (2 pages)

3.7.
To Receive the Committee Risk and Assurance Report

Attached *Director of Corporate Governance*

- ARAC 20250422 3.7_Risk and Assurance Cover Report.pdf (8 pages)
- ARAC 20250422 3.7 Appendix A Strategic Risk Dashboard and Assessments April 2025.pdf (44 pages)
- ARAC 20250422 3.7_Appendix B_V2 DRAFT Risk Management Framework.pdf (53 pages)

3.8.
To Receive the Internal Audit Progress Report

Attached *Head of Internal Audit*

- ARAC 20250422 3.8 ABUHB April 2025 Audit Committee Progress Report v2.pdf (10 pages)

3.9.
To Receive the Draft Internal Audit 2025/26 Annual Workplan

Attached *Head of Internal Audit*

- ARAC 20250422 3.9 ABUHB Draft Internal Audit Plan 2025-26 v1.4.pdf (26 pages)

3.10.
To Receive Internal Audit Review Reports.

Oral *Head of Internal Audit*

3.10.1.
Speaking up Safely Framework (limited assurance)

Attached *Head of Internal Audit and Director of Workforce and Organisational Development*

- ARAC 20250422 3.10a ABUHB 24.25 Speaking Up Safely Final Internal Audit Report.pdf (13 pages)

3.10.2.
Divisional Governance Arrangements (reasonable assurance)

Attached *Head pf Internal Audit*

- ARAC 20250422 3.10b ABUB-2425-08-Divisional Governance Arrangements Final Report.pdf (10 pages)

3.10.3.
Mental Health and Learning Disabilities (reasonable assurance

Attached *Head of Internal Audit and Deputy Chief Operating Officer*

- ARAC 20250422 3.10c ABUHB 2425 Directorate Review MH&LD FINAL Report for Client.pdf (13 pages)

3.10.4.
Maternity Services Improvement Plan (reasonable assurance)

Attached *Head of Internal Audit*

- ARAC 20250422 3.10d 2024-25-10 Final Maternity Services Improvement Plan Report .pdf (6 pages)

3.10.5.
Staff Culture (Staff Survey) (reasonable assurance)

Attached *Head of Internal Audit*

ARAC 20250422 3.10e Final Internal Audit Report - Staff Survey.pdf (8 pages)

3.10.6.
The Grange Accident and Emergency Expansion (reasonable assurance)

Attached *Head of Internal Audit*

ARAC 20250422 3.10f ABU-SSU-2425-30 Grange AE Extension Final Internal Audit Report.pdf (18 pages)

3.11.
To Receive the External Audit Progress Report

Attached *Audit Wales*

ARAC 20250422 3.11 3997A2024 Audit Risk and Assurance Committee Update - April 2025.pdf (14 pages)

3.12.
To Receive the External Audit 2025/26 Annual Plan

Attached *Audit Wales*

ARAC 20250422 3.12 4709A2025 ABU Audit Plan 25.pdf (26 pages)

3.13.
To Receive Audit Wales' Review of Discharge Planning (Health Board)

Attached *Audit Wales and Director of Nursing*

- Including a progress overview of the 2022 Discharge Planning Audit Recommendations

ARAC 20250422 3.13 4753A2025_ABUHB_Discharge_Planning_Progress_Update_Eng.pdf (22 pages)
ARAC 20250422 3.13 Discharge Planning 2022 Progress Overview.pdf (4 pages)

3.13.1.
To Receive Audit Wales' Review of Patient Flow out of Hospital (Gwent Partnership)

Attached *Audit Wales and Director of Nursing*

ARAC 20250422 3.13a 4775A2025_Gwent_Region_Urgent_Emergency_Care_Flow_Hospital_Eng.pdf (62 pages)

3.14.
To Receive Audit Wales' Review of Cancer Services in Wales

Attached *Audit Wales and Deputy Chief Operating Officer*

ARAC 20250422 3.14 Cancer Services in Wales - English_0.pdf (72 pages)
ARAC 20250422 3.14 Appendix 1- Policy - Audit Wales - Management Response Form - Cancer Services - (English).pdf (9 pages)

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4.
ITEMS FOR INFORMATION

4.1.
Review of Committee Programme of Business 2025/26

Attached *Director of Corporate Governance*

ARAC 20250422 4.1 Audit, Risk and Assurance Committee Forward Work Plan Cover Report.pdf (3 pages)
ARAC 20250422 4.1a ARA Committee Work Programme 2025-26 Final.pdf (7 pages)

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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: Date of the Next Meeting:

Oral *Chair*

- Tuesday 20th May 2025

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

AUDIT, RISK & ASSURANCE COMMITTEE AGENDA	
Date and Time	**Tuesday 22nd April 2025 at 09:30**
Venue	**Microsoft Teams**

Item	Title	Format	Presenter
1	**PRELIMINARY MATTERS**		
1.1	Welcome and Introductions	Oral	Chair
1.2	Apologies for Absence	Oral	Chair
1.3	Declarations of Interest	Oral	Chair
1.4	Draft Minutes of the last Meeting held on 18 February 2025	Attached	Chair
1.5	Committee Action Log and Matters Arising - Final Records Management Audit – Following amendments	Attached	Chair
2	**ITEMS FOR APPROVAL/RATIFICATION/DECISION**		
2.1	To Receive the Report on Financial Governance and Ratify Changes to Financial Control Procedures (FCPs) - Charitable Funds - Digital - Approving Orders Greater than 100k - Overseas Visitors	Attached	Director of Finance and procurement
3	**ITEMS FOR DISCUSSION**		
3.1	To Receive the Report on the Use of Single Tender Action	Attached	Director of Finance and procurement
3.1a	To Receive 2024/25 Single Tender Action self-assessment summary.	Attached	
3.2	To Receive Report of Losses and Special Payments	Attached	
3.3	To Receive Response to Audit Wales as part of the 2024/25 Annual Accounts process - Audit enquiries to those charged with governance and management.	Attached	



3.4	To review the Committee Terms of reference	Attached	Director of Corporate Governance
3.5	To Receive the Draft Committee Annual Report 2024/25 including review of Committee Effectiveness 2024/25	Attached	
3.6	To Receive the Full Report of all Offers of Gifts and Hospitality as Declared	Attached	
3.7	To Receive the Committee Risk and Assurance Report	Attached	
3.8	To Receive the Internal Audit Progress Report	Attached	Head of Internal Audit
3.9	To Receive the Draft Internal Audit 2025/26 Annual Workplan	Attached	
3.10	To Receive Internal Audit Review Reports.	Attached	
3.10a	Speaking up Safely Framework (limited assurance)	Attached	
3.10b	Divisional Governance Arrangements (reasonable assurance)	Attached	Director of Workforce and OD
3.10c	Mental Health and Learning Disabilities (reasonable assurance	Attached	
3.10d	Maternity Services Improvement Plan (reasonable assurance)	Attached	Deputy Chief Operating Officer
3.10e	Staff Culture (Staff Survey) (reasonable assurance)	Attached	
3.10f	The Grange Accident and Emergency Expansion (reasonable assurance)	Attached	
3.11	To Receive the External Audit Progress Report	Attached	Audit Wales



3.12	To Receive the External Audit 2025/26 Annual Plan	Attached	Audit Wales
3.13	To Receive Audit Wales' Review of Discharge Planning (Health Board)	Attached	Audit Wales and Director of Nursing
3.13a	To Receive Audit Wales' Review of Patient Flow out of Hospital (Gwent Partnership)		Director of Nursing
3.14	To Receive Audit Wales' Review of Cancer Services in Wales	Attached	Audit Wales
4	**ITEMS FOR INFORMATION**		
4.1	Review of Committee Programme of Business 2025/26	Attached	Director of Corporate Governance
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: Tuesday 20th May 2025		

Motion to Exclude Members of the Public and the Press

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

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

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

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

DATE OF MEETING	Tuesday 18 February 2024
VENUE	Microsoft Teams

PRESENT	Iwan Jones - Committee Chair – Independent Member Dafydd Vaughan - Independent Member Neil Patrick - Independent Member
IN ATTENDANCE	Rob Holcombe - Director of Finance and Procurement *(Left at 11:00)* Lucy Windsor - Head of Corporate Risk and Assurance Mark Ross - Assistant Finance Director Stephen Chaney – Martyn Lewis - Senior Auditor, Internal Audit, NWSSP Sara Utley - Performance Audit Lead, Audit Wales Julie Rees - Audit Wales Finance Audit Lead, Audit Wales Martyn Lewis – Audit Wales Kathryn Bourne - Clinical Director of Pharmacy *(Item 1.5)* *Leeanne Lewis – Assistant Director for Quality and Patient Safety (Item 1.5)* James Calvert - Medical Director *(Items 1.5)* Paul Solloway – Director of Digital *(Item 3.5.1)* Gareth Lavington – Head of Counter Fraud (*Item 3.3*) Nathan Couch – Audit Wales *(Item 3.7)* Danielle Jackson – Secretariat
OBSERVING	None to Note
APOLOGIES	Richard Clark - Committee Vice Chair - Independent Member Rani Dash - Director of Corporate Governance

Minute Reference	Preliminary Matters
ARAC 1802/01	**Welcome and Introductions** The Chair welcomed everyone to the meeting.
ARAC 1802/02	**Apologies for Absence** Apologies were noted.
ARAC 1802/03	**Declarations of Interest** There were no declarations of interest raised to record.



ARAC 1802/04	**Minutes of the previous meeting** The minutes of the meeting held on the 12 November 2024 were agreed as a true and accurate record.
ARAC 1802/05	**Committee Action Log** The Committee reviewed the action log, noting actions that had been completed, those in progress, and those not yet due. Two actions scheduled for this meeting were discussed in detail, with assurance notes provided to support the discussions. **<u>Job Planning</u>** Kathryn Bourne (KB), Strategic Lead Medical and Dental Workforce, supported by James Calvert (JC) Medical Director provided a progress update on Job Planning implementation. The compliance target had increased from 85% to 90% in line with the Welsh Government's new IMTP framework. The Health Board's current compliance rate was noted as 33.54%. Neil Patrick (NP) Independent Member, requested insight into obstacles faced during implementation. KB highlighted inconsistencies in consultant contracts, on-call allocations, and travel time interpretation. Guidelines had been developed to address these issues. JC emphasised that Job Planning had a key role in optimising high-value workforce spending and assured the committee of its prioritisation. Committee Chair Iwan Jones (IJ) questioned the expected compliance progress in the coming months, expressing concern over the continued plateau and the potential need for escalation to the Board. Kathryn Bourne (KB) explained that a deep dive approach was underway, supported by increased staff capacity to facilitate job plan uploads. IJ requested a further report to the Committee, including visual representations comparing current compliance against the projected trajectory. James Calvert (JC) agreed to provide a detailed update paper in September **Action: Medical Director** Dafydd Vaughn (DV), Independent Member, proposed monitoring Job Planning through the Health Board's Performance Management Framework, focusing on divisions with low compliance. The Committee supported this suggestion. **Action: Medical Director** **<u>Clinical Audit</u>**

	Leeanne Lewis (LL) Assistant Director for Quality and Patient Safety, provided a progress update on the Clinical Audit delivery plan. Since the last update in November 2024, work continued on engaging divisions, developing standard audit report templates, and improving action plan scrutiny. JC noted that while the report provided an overview of activity and compliance, detailed oversight was conducted via the Patient Quality, Safety and Outcomes Committee (PQSOC). IJ asked whether a local audit plan was in place for divisions and how progress was monitored. LL acknowledged that this needed further development. JC agreed to develop local audit workplans for divisions and present them to PQSOC. It was also requested that a summary of progress against national and local audit plans be included within the next report provided to the Audit Committee. **Action: Medical Director** The Committee **AGREED** to remove completed actions from the Action Log and **NOTED** the assurance reports on Job Planning and Clinical Audit.
ITEMS FOR APPROVAL / RATIFICATION / DECISION	
ARAC 1802/06	**Development of Committee Annual Programme of Business 2025/26** Lucy Windsor (LW), Head of Corporate Risk and Assurance, provided an overview of the proposed 2025/26 Committee Programme of Business. The Committee was asked to approve adjusting the Audit Recommendation Tracker's reporting frequency to align with end-of-quarter reporting, allowing for more substantial progress on recommendations. The committee **APPROVED** the reporting frequency of the Audit Recommendations Tracker Report and **APPROVED** the 2025/26 Audit, Risk and Assurance Committee Annual Programme of Business.
ARAC 1802/07	**Audit Recommendations Tracker** Lucy Windsor (LW), Head of Corporate Risk and Assurance, reported on the status of audit recommendations as of the 31 December 2024, highlighting that 56 were completed, 31 had revised deadlines, and 1 remained overdue. Of the 31 revised deadlines, 8 exceeded the Committee's current agreed limit on acceptable extensions. Detailed assurance reports were provided to enhance oversight of their progress and status. Acknowledging the eight recommendations, Dafydd Vaughn (DV), Independent Member, asked whether implementation had reached a point where no further action could be taken to fully achieve the recommendation's scope. LW advised that if a reasonable position had

	been agreed upon and no further action was possible, the recommendation could be closed with approval from the responsible executive director and Internal Audit. LW agreed to review any recommendations with more than two extensions to assess their eligibility for closure. This approach would be implemented in the next reporting cycle. The Committee **APPROVED** the closing position of the audit recommendation tracker.
ARAC 1802/08	**Financial Governance Report and Charges to Financial Capital Procedures (FCP)** Mark Ross (MR), Assistant Finance Director, provided an update on financial governance. The Committee was informed that four Counter Fraud FCPs had been reviewed: • Counter Fraud Bribery and Corruption Policy • Counter Fraud and Workforce & OD Joint Working Protocol • Counter Fraud and Internal Audit Joint Working Protocol • Counter Fraud Communication Strategy Following the review, it was agreed to consolidate the protocols into a single document for ease of access and would sit under the Counter Fraud Bribery and Corruption Policy. It was also reported that, as part of NHS Wales Shared Services Partnership (NWSSP) Key Performance Indicators (KPIs), ABU Health Board had the highest performance across Wales for both NHS (90.9%) and non-NHS (97.8%) under the Public Sector Payment Policy (PSPP). Iwan Jones (IJ), Committee Chair, inquired whether any updates to the Counter Fraud Procedure were required in relation to The Crown Prosecution Service (CPS). GL confirmed that cases presented to the CPS are already subject to extensive review, and the process for presenting cases remains unchanged. The Committee **NOTED** the Financial Governance Report and **APPROVED** the updated Counter Fraud Bribery and Corruption Policy.
ITEMS FOR DISCUSSION	
ARAC 1802/09	**Use of Single Tender Action (STA)** Mark Ross (MR), Assistant Finance Director, presented the report on Single Tender Actions (STAs) approved between 19th October 2024 and 24th January 2025. The Committee was informed that eight requests were submitted and approved during this period, with a total annual value of £461,287.08 (excluding VAT). Of those:

	• Three were classified as goods only • Three as maintenance • One for services • One for both goods and services It was noted that an annual summary of all Single Tender Actions will be provided at the next Committee meeting for information. The Committee **APPROVED** the Single Tender Action Report.
ARAC 1802/10	**Committee Risk and Assurance Report** Lucy Windsor (LW), Head of Corporate Risk and Assurance, provided an update on the Health Board's strategic risks. Since the previous Committee meeting, several changes to the Strategic Risk Register had been approved by the Board, including: • The separation of SRR 004 into two distinct risks to differentiate those associated with Major Incident Preparedness and Business Continuity Preparedness. • The risk reduction of SRR 001A – Workforce recruitment and Retention • The approval of a new risk, SRR 011, acknowledging the challenges in meeting Welsh Government's decarbonisation targets. It was noted that six risks remained outside the Board's risk appetite and were subject to ongoing review with executive leads to identify additional measures for mitigating potential threats. The Committee was informed that work was underway to assess a potential new risk related to Nursing, following the announcement that Cardiff University intends to discontinue its Nursing programme. Neil Patrick (NP), Independent Member, asked whether an estimation had been made regarding the impact on ABUHB. LW confirmed that the impact had not yet been determined but would form the basis for the risk assessment. The Committee **NOTED** the Committee Risk & Assurance Report for Assurance.
ARAC 1802/11	**Counter Fraud Annual Report and 2025/26 Workplan Approval** Gareth Lavington (GL), Head of Counter Fraud, presented the 2024/25 Annual Progress Report and 2025/26 Workplan. The Committee noted the positive impact of fraud awareness initiatives, including increased referrals following International Fraud Awareness Week, and improvements in fraud reporting accessibility, with ongoing work to develop interactive reporting tools. In addition, the Committee

	was informed that the team had been strengthened with the recruitment of a Local Counter Fraud Specialist. Discussions covered fraud prevention efforts, focusing on risk assessments and proactive local exercises, as well as training improvements through enhanced e-learning. Rob Holcombe (RH), Director of Finance and Procurement, outlined a new NHS Wales fraud subgroup, chaired by the ABUHB Director of Finance and Procurement, to develop fraud prevention strategies. Iwan Jones (IJ), Committee Chair, raised concerns about Crown Prosecution Service (CPS) referrals, noting that two cases had been declined. GL confirmed that while one appeal was unsuccessful, internal disciplinary measures are used where necessary. The Committee **NOTED** the Counter Fraud Annual Report and **APPROVED** the 2025/26 workplan.
ARAC 1802/12	**Internal Audit Progress Report** Stephen Chaney (SC), Head of Internal Audit, reported on the ongoing Internal Audit Plan for 2024-25, with no concerns raised. The Committee was informed of a request to conduct an additional review on the Process of Reallocating Vacant Practices. To accommodate this, it was proposed that the Partnerships Arrangements Audit be deferred. The Committee **NOTED** the Internal Audit Progress Report for Assurance and **APPROVED** both the deferral of **the** Partnerships Arrangements Audit and the inclusion of the Process of Reallocating Vacant Practices Audit**.**
ARAC 1802/13	**To Receive Internal Audit Reports** Stephen Chaney (SC), Head of Internal Audit, presented the findings from the following audits: **Records Management – Limited Assurance** The review focused on the implementation of recommendations from the 2022/23 audit, relating to the storage and transport of physical records, a backlog of records for filing, and the quality of reports. Iwan Jones (IJ), Committee Chair, expressed concern about the lack of progress despite the implementation of the recommendations issued in the 2022/23 report. SC attributed this to systemic issues within the Health Board, requiring a broader approach to improvement. It was agreed Paul Solloway (PS), Director of Digital would review the management responses and share with the Director of Corporate Governance for quality assurance. The findings would be presented at the next Committee meeting. **Action: Director of Digital**



	Dafydd Vaughn (DV), Independent Member, supported by the Committee suggested escalating the issue of records management, specifically, digitalisation of records, to the Board for consideration. **Action: Secretariat.** **Declaration of Interests – Substantial Assurance** The review assessed the management of conflicts related to gifts, hospitality, and external interests. No concerns were raised. **End of Life Care – Reasonable Assurance** The review evaluated whether care arrangements for end-of-life (EoL) patients were planned sufficiently in advance to enable care in the community and avoid unnecessary hospital admission. It was reported that there is no mandatory framework for future care planning. A recommendation was made for the Health Board to produce a document outlining internal expectations and processes. IJ queried the lack of accountability regarding implementation dates and requested that the report be returned to the next Committee meeting with specific dates for when implementation is expected to be completed. **Action: Internal Audit and Director of Nursing.** **Intelligence Led Organisation – Reasonable Assurance** The review focused on evaluating processes for delivering information products to staff and maximising analytics use. The report over all was positive, but areas for improvement were identified, including strategy approval, data quality, and clearer definitions in information products. The Committee **NOTED** the internal audit reports for assurance.
ARAC 1802/14	**External Audit Progress Report 2024/25** Sara Utley (SA), Audit Wales, reported on the progress of the 2024/25 External Audit Plan. The Committee was informed that a National Report on Cancer Services had been completed and would be formally presented once a final response from Welsh Government had been received. It was also noted that the Charitable Funds Accounts had been completed and submitted to the Charitable Funds Committee. The Committee **NOTED** the report for Assurance.

ARAC 1802/15	**Review of Cost Efficiencies** Nathan Couch (NC), Audit Wales, provided the Committee with an overview of the Audit Wales Cost Efficiencies Review. It was reported that the Health Board had not met its deficit control or total savings targets for 2023/24, though it achieved significantly higher savings compared to previous years. The overall financial position remained challenging, and there was an urgent need to develop a longer-term financial plan. The review made 10 recommendations, which superseded those from the 2022 review. Iwan Jones (IJ), Committee Chair, inquired whether the training issues noted in the report were due to a lack of available training or a lack of uptake. NC was unable to provide a definitive answer and agreed to discuss the matter with the auditor and liaise with the Director of Finance and Procurement outside the meeting to ensure the final report accurately reflected the reason for the lower-than-expected training uptake. **Action: Audit Wales** The Committee **NOTED** the report.
ARAC 1802/16	**Structured Assessment Report 2024** Sara Utley (SA), Audit Wales, presented the 2024 Structured Assessment Report. It was reported that the Health Board's Board and Committee governance arrangements were stable and effective. However, nine recommendations for improvement were made, including: • Developing a new long-term strategy building on the Clinical Futures Strategy, focusing on population health, community-based services, and sustainable acute services. • Further integrating the Well-being of Future Generations Act. • Increasing the frequency of the Finance and Performance Committee. • Increasing the number of patient safety leadership walk-rounds and reviewing relevant policies. • Strengthening the link between strategic risk and strategic objectives/annual plans. Dafydd Vaughn (DV), Independent Member, inquired whether the upcoming changes to independent member posts and vacancies were considered in the report. SA confirmed that the vacancy position would be addressed in the 2025 Structured Assessment, as the current situation was stable. The Committee **NOTED** the report.



ARAC 1802/17	**Audit Wales' Annual Audit Report 2024 and Outline Audit Plan 2025** Sara Utley (SA), Audit Wales, provided the Committee with an overview of the External Audit 2024 Annual Report and the Outline Audit Plan 2025. The Committee **NOTED** both reports, with the final detailed audit plan for 2025 to be presented in April 2025.
ARAC 1802/18	**To consider the approach and timelines for the Annual Report and Accounts** Lucy Windsor (LW), Head of Risk and Assurance, provided the Committee with an overview of the Annual Report and Accounts Timeline. The deadline for submitting the final Annual Report and Accounts to Welsh Government is 30th June 2025. It was also noted that the final Manual for Accounts document is still awaited. The Committee **NOTED** the report.
Items for Information	
ARAC 1802/19	Nothing raised
Other Matters	
ARAC 1802/20	**Items to be Brought to the Attention of the Board and Other Committees** **Board** • Records Management Internal Audit **Other Committees** • Cost Savings Efficiencies to Finance & Performance Committee for information.
ARAC 1802/21	**Any Other Urgent Business** • Nothing reported.
ARAC 1802/22	**Date of the next meeting** • Tuesday 22nd April 2025

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

Outstanding	In Progress	Not Due	Completed	Transferred to another Committee

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
February 2025	**ARAC 11802/05** Committee Action Log – Job Planning	Provide a Job Planning update report, including visual representations comparing current compliance against the projected trajectory.	Medical Director	September 2025	**Not Due**
February 2025	**ARAC 11802/05** Committee Action Log – Job Planning	Discuss with the Chief Operating Officer the need for Job Planning to be considered through the Health Boards Performance Management Framework.	Medical Director	April 2025	**Completed** Job Planning is now included in the divisional performance framework reviews.



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

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
February 2025	**ARAC 11802/05** Committee Action Log – Clinical Audit	Develop local audit plans for divisions and present them to the Patient, Quality and Safety Committee (PQSOC).	Medical Director / Secretariat	Medical Director to Confirm date of presentation with PQSOC Secretariat	**Transferred to another Committee**
February 2025	**ARAC 11802/05** Committee Action Log – Clinical Audit	Provide a summary of progress against national and local audit alongside the next report provided to the Audit Committee.	Medical Director	December 2025	**Not Due**
February 2025	**ARAC 11802/13** Internal Audit Reports	Records Management Limited Assurance Report management responses to be reviewed, updated and presented back to the next Committee Meeting.	Internal Audit / Director of Digital	April 2025	**Completed** Report updated and included within April papers. Amendments on pages 9 and 11 of report.

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

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
February 2025	**ARAC 11802/13** Internal Audit Reports	Records Management and Digitalisation of Records to be escalated to the Board for consideration.	Secretariat	March 2025	**Transferred to The Board**
February 2025	**ARAC 11802/13** Internal Audit Reports	End of Life Care – Reasonable Assurance Report to be reviewed, updated and returned to the committee with numerical completion dates.	Internal Audit / Director of Nursing	22 April 2025	**In Progress** Meeting Scheduled between Head of Internal Audit and Director of Nursing – Delayed due to annual leave.
February 2025	**ARAC 11802/15** Review of Cost Efficiencies	Discuss the issues relating to training with the auditor and the Director of Finance and Procurement outside the meeting to ensure the final report accurately reflected the reason for the lower-than-expected training uptake.	Audit Wales	22 April 2025	**Completed** Audit Wales confirmed that the low uptake in training mentioned in the report was due to staff uptake, noting that there is a wide

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Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
					range of training available. However, stated that the management response is robust, in providing a clear update on the work and appropriate assurance regarding the recommendation

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

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

DRAFT



Records Management

Final Internal Audit Report

2024/25

Aneurin Bevan University Health Board



Limited Assurance

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Review Reference	ABU-2425-16
Fieldwork	December 2024
Executive Sign Off	07 February 2025
Audit Committee	18 February 2025
Executive Lead	Paul Solloway, Director of Digital
Audit Team	Stephen Chaney, Head of Internal Audit
	Krisztina Kozlovszky, Internal Audit Manager
	Mair Evans, Principal Auditor

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

To assess the implementation of the recommendations raised within the 2022/23 internal audit and to retest the agreed objectives.

Overview

We have concluded **limited** assurance on this area. We found that issues raised in our last report have not been fully addressed. In addition, we identified some additional issues related to the same objectives. The following matters require urgent management's attention:

- adherence to records management practices;
- a sample of unretrievable patient records (both paper and digital) identified;
- two examples of unauthorised access to patient records, due to system access granted;
- inappropriate storage conditions; and
- limited strategies to secure or optimize library / storage space going forward.

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

Furthermore, we identified the following minor issues, which are not included in the matters arising list above, but are detailed for completeness:

- the uptake of the supplementary awareness session, provided by the Health Records Team, is low;
- there is no centralised system to track the daily availability of ward clerks;
- the future plans for the use of Online House are still not confirmed; and
- there is no platform to share patient records with other health boards securely.

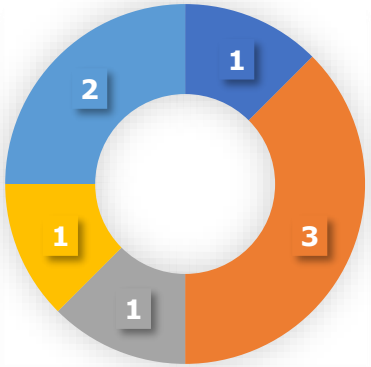
Scope & Assurance Summary

Objectives		Related Findings	Assurance
1	Appropriate policies, procedures and guidelines are in place for the management of records that encompasses the full records lifecycle.	1	**Reasonable**
2	Record quality is ensured. Documentation and records are kept to an appropriate standard	2,3,4	**Limited**
3	Records storage facilities ensure that records are protected from unauthorised access, destruction or theft, and from accidental damage from environmental hazards.	5,6	**Limited**
4	Physical records are transported appropriately, tracked and records are available when and where needed by operational staff.	7,8	**Limited**

Management Actions

4	4
High Priority	Medium Priority

Themes



- Approvals
- Information, Data Quality & Data Accuracy
- Lessons Learnt
- Physical Security
- Quality, Safety & Patient Experience

Risk Types

Financial Loss

Legal & Regulatory Non-Compliance

Quality or Safety Issues

Public Perception & Reputational Risk

Findings & Agreed Action Plan

Objective 1: Appropriate policies, procedures and guidelines are in place for the management of records that encompasses the full records lifecycle — **Reasonable**

Policies, procedures and guidelines

There are 106 standard operating procedures (SOPs) and policies in place at the Health Board, from which we have identified the following 10 Policies and SOPs as key:

Ref.	**Policy** Reference	Title of Policies and SOPs
1	SOP-DHR-0036	Quality Assurance
2	SOP-DHR-0037	DHR Retention and Destruction
3	SOP-DHR-0025	Emergency Admissions – scan on demand
4	SOP-LIB-0015	Transportation of records by WAST
5	ABUHB/IMT/0726	Clinical Record Keeping Policy
6	ABUHB/IMT/0405	Recording of Patients by ABUHB Staff – Use and Storage of Audio Recordings and Images Policy
7	ABHB/IMT/0162	Patient information: Policy for Ensuring Data Quality
8	SOP-STC-0006	Tracking
9	SOP-STC-0007	Stores & Archive
10	ABUHB/IMT/ 1042	Records Management Code of Practice

We reviewed the key policies and SOPs in detail and found that were available on Sharepoint. We found that the SOPs were aimed at staff within the Health Records team, while the policies were applicable for a wider audience. Both SOPs and policies remained within their review period, except for two local policies (numbers 7 and 10 listed above).

Training

The provision of records management training is a legislative requirement. Compliance with the regulatory requirements is ensured through the Information Governance (IG) training, with the IG Handbook including a 'Health records' section (section 2.5). The completion of all elements of the IG training is mandatory, and the results are formally monitored through ESR, with related KPIs reported back to the divisions every three months. We note that this data also presented to the Finance and Performance Committee.

The Health Records team provided bi-monthly, non-compulsory records awareness sessions throughout 2024, specifically for ward clerks. However, the uptake of these sessions is low, with 16 ward clerks attending (average 3.2 attendees per session), representing 10.88% of the ward clerk workforce.

Hierarchy

During our fieldwork, we visited 18 wards and identified that 39% of the wards did not have a ward clerk on site. Although there are opportunities to use bank staff to address staffing shortages, we still identified gaps. We found that where ward clerk positions were vacant the quality of records management was adversely impacted. (See further comments related to records quality under Objective 2).

Escalation process

Datix is used as an escalation route at the Health Board, however, this process is not consistently adopted by the wards. (See further information on Datix data for 2024 under Objective 4). We also note that robotic functionality has been implemented to identify exceptions through data comparisons, with the aim to prevent repeated occurrences. While the results are shared on the organisation's intranet, the number of monthly exceptions remained consistently high over the last six months. In addition, we also reviewed the live ADT (Admission, Transfer & Discharge) Power BI dashboard for January 2025 and two monthly reports to the Digital Records & Patient Engagement Group (RPA) for April and October 2024.

Key Findings		Risk & Impact	Agreed Management Action
1	Lesson learnt The escalation process through the Health Board is inconsistent, with issues prioritised differently across the organisation. We observed examples of record management issues raised at the Royal Gwent Hospital (RGH) and Nevill Hall Hospital (NHH), but no formal actions have been initiated resulting in sustained improvement. Furthermore, robotic functionality has been fully implemented to identify data issues with the output generated as an automatic email detailing the problem. While this approach appears sound, in practice, it results in multiple emails being sent to the same individual regarding issues across multiple patients. We note that the volume of the system-generated emails is significant and due to the high number, there is a risk that they may not be fully acknowledged or addressed by responsible individuals.	• Record management issues may go unaddressed.	Agreed Action: Datix is the incident reporting system for the Health board. We will highlight the inconsistent use of this system to the system lead and health and safety manager, and recommend more training offers, to training on documenting the formal actions that have been taken, as part of the management review. We recognise that the output from the robotic functionality requires analysis, and a more targeted follow up is necessary for improvement.
			Expected Evidence of Implementation: The Health and Safety team and Datix system lead would be required to provide evidence of training. Datix training sessions are scheduled regularly and staff are directed to the training video on the intranet for reporting incidents. We will review the current process with RPA and implement follow up meetings with individual directorates to support action. Documented evidence of this will be available for audit purposes.
		Medium Priority	Officer: Health and Safety Manager and Datix System Lead. Head of Health Records - DHR Date: 30 June 2025
	Theme: Lessons Learnt	Control Operation	

Objective 2: Record quality is ensured. Documentation and records are kept to an appropriate standard. **Limited**

Patient records at the wards are populated by nurses, clinicians, and other relevant staff. The wards are mandated to utilise and recycle soft yellow Digital Health Record (DHR) folders for patient records, and these folders are required to be tracked in the Welsh Patient Administration System (WPAS) for monitoring purpose. The ward clerks have responsibility to set up, check, organise and track the DHR files before the files are sent for coding and scanning.

We visited 18 wards across the Health Board. As part of our fieldwork, we found that, in addition to the DHR folders, some wards also used hard ring binders, primarily for nursing notes. These binders were typically merged with the corresponding DHR folders at the end of the process but were not formally recorded in the system. We have included a summary of our findings below:

Hospital	Wards visited	Summary of findings
The Royal Gwent Hospital (RGH)	• MAU - D1 West • C5 West ward (ex-St. Woolos) • C6 East ward (ex-St. Woolos)	75% of the files had general filing issues including loose papers, blank forms etc. We also identified patients who were transferred here without their physical records.
Nevill Hall Hospital (NHH)	• 3.1 Glan Ebbw ward • 4.2 Crickhowell ward	92.31% of the files had general issues. We also identified some patients who had not been formally discharged within CWS, however, they had already left the hospital.
Ysbyty Aneurin Bevan (YAB)	• Ebbw ward • Shirhowy ward	75% of the files had issues like loose papers, polly pockets and blank forms. We also found overflowing files and files which have not been raised in WPAS and patients who were transferred here without their physical records.
Ysbyty Ystrad Fawr (YYF)	• 1.1 Frailty ward • 2.1 Oakdale ward • 2.2 Rhymney ward • 3.2 Penalta ward • MAU	70% of the files had general filing issues. We also found patients who were not formally discharged within CWS, however, they had already left the hospital.
The Grange University Hospital (GUH)	• AMU • C1 ward - Butterfly section • A2 ward	47% of the files had general filing issues.
County Hospital	• Oak ward • Rowan ward	All files had general filing issues. In addition, we found some supplementary records, files with mixed patients records and multiple records where the patient's ID was missing. Furthermore, we also found transferred patients without their physical records and files which have not been tracked to the ward in WPAS.
Chepstow Community Hospital (CCH)	• Cas Gwent ward	100% of the files had general filing issues. We also found that files were not raised and tracked in WPAS, there were substantial supplementary notes left behind at the ward. Furthermore, we found original records from Cardiff & Vale University in a brown envelope.

We reviewed a sample of records for five patients from each ward, prior to their digitalisation into Clinical Workstation (CWS) and where we found issues we extended our sample selection. In total, we reviewed records for 90 patients. In addition, we selected two services (children and mental health), where currently the records are not digitalised, and reviewed a sample of five patients for each service.

In total, we found that references to the quality checks (e.g. audit checks) were included in the relevant policies. While many of these checks are being performed regularly, we found that they were not formally evidenced and the timing of the checks often occurred toward the end, or near the end of the digitalisation process. This limited the opportunity to address or rectify any issues identified during the checks.

At Online House, large scanning machines are used, and elsewhere, smaller machines are in place for scanning purposes. Invariably, these lead to a variance in the quality and timing of record digitisation across the Health Board.

However, we note that a new digital Welsh Nursing Care Records (WNCR) system was launched with the aim to reduce the number of paper forms used on the wards. Furthermore, there are plans to roll out an electronic Prescribing and Medicines Administration (ePMA) system to improve safety and patient experience.

Key Findings		Risk & Impact	Agreed Management Action
2	Paper records From our sample review of records for 90 patients we found evidence of poor records management. We also found issues, such as records not being kept in chronological order, files overflowing and the absence of patient IDs on certain records. We came across two instances where multiple patient records were bundled together in one file.	• Poor record management • Impact on patient care	Agreed Action: Although it is not evidenced that ward clerks were in place in each of these wards, the lack of records management does require to be addressed across the organisation. The service has previously requested for local health records management training to be mandatory. This was not approved and therefore there is limited engagement at Health Records Awareness sessions that are scheduled bi-monthly. We recommend mandated Health records management training for all ward clerks during induction, alongside refresher sessions, to provide a more in-depth understanding of the processes involved. Although there is a national Health records Management Module incorporated in the mandatory Information Governance training, this does not provide in-depth records management training in ABUHB processes. We are implementing a schedule of ward visits and training updates across the Health Board, to promote best practice and provide evidence of where there are gaps that need to be addressed but there is a resource gap to undertake extensive training across all sites. Discussions will be held with the Executive Director of Nursing on including some of these elements in the Ward Accreditation Programme. Expected Evidence of Implementation: Microsoft list with information on all wards and scheduled dates to visit, to commence from 21/02/2025. Microsoft form designed to gather information from the ward clerks across the Health Board regarding current records management processes, which we can analyse. A formal report can be generated from these findings. We can proactively support wards with records management training based on the evidence from the ward visits but there is a resource gap to undertake extensive training across all sites.

		High Priority	Officer: Head of Health Records - DHR Date: 31 December 2025
	Theme: Information, Data Quality & Data Accuracy	Control Operation	
3	System alerts We found some examples where mental capacity limitations are not always accurately reflected on CWS. While there are warning flags available in the system to alert system users about specific conditions of a patient, these flags are required to be switched on manually. We found six patients where the "This is me" document was on file, but no flag was turned on within CWS. We also note that Lasting Power of Attorney (LPA) is listed as a clinical alert in CWS, which links through from WPAS keynotes. This alert is added to WPAS by the Health Records Team when the LPA document is received for scanning, and this should also be recorded at ward level when documents are presented.	• Safeguarding of vulnerable adults	Agreed Action: We recommend that this forms part of the basic WPAS training for new starters, and also the refresher WPAS training. We will link in with the WPAS systems team to ensure this is incorporated into the new training packages that are being developed as part of the Planned Care Academy work.
			Expected Evidence of Implementation: Evident in training and guidance documentation for all staff.
		Medium Priority	Officer: Head of Health Records – DHR Date: 30 June 2025
	Theme: Quality, Safety & Patient Experience	Control Operation	
4	Spot checks Spot checks of patient records are conducted regularly; however, these assessments primarily take place at or near the final stages of the digitalisation process or following its completion. As a result, it is challenging to address any issues identified at this point of the time.	• Quality issues may not be rectified	Agreed Action: The Information Governance Team are in the process of gaining approval for an internal audit team who will undertake regular spot checks on wards, with data quality and record keeping being part of the remit.

			Expected Evidence of Implementation: Audit reports from the newly established IG Audit team.
		Medium Priority	Officer: Head of IG & DPO Date: 31 March 2026
	Theme: Information, Data Quality & Data Accuracy	Control Design	

Objective 3: Records storage facilities ensure that records are protected from unauthorised access, destruction or theft, and from accidental damage from environmental hazards

Limited

We found a wide range of record storage issues with the sites visited, as detailed below. However, we found that records previously stored at Llangennech have been destroyed as per policy or moved to Online House and NHH.

Visited Location	Post code	Date of visit	Number of areas used for storage	Storage conditions were appropriate	Records stored securely	Patients' data was properly stored
Nevill Hall Hospital (NHH)	NP7 7EG	11/12/2024	2	**No**	**No**	Yes
St. Cadoc's Hospital – Mental Health	NP8 3XQ	16/12/2024	3	**No**	**No**	**No**
St. Cadoc's Hospital – The White Valley Centre	NP8 3XQ	16/12/2024	3	**No**	**No**	**No**
On-line House	NP10 8BA	17/12/2024	3	Yes	Yes	Yes

Records are currently digitalised at two main locations within the HB (NHH and Online House). While the volume of records in storage has significantly reduced since our last visit, due to the lifting of embargos, the current retention policy mandates that records must be retained for six weeks after scanning. As the result, the organisation will require ongoing space for the storage of scanned records, preparation of records for scanning and operation of the scanning machines. Currently, there are no formal plans to continue or replace the existing storage facility at Online house, despite the lease expiring in October 2026.

Key performance indicators (KPIs) are set and calculated for monitoring purposes, by the Records Management Team, to understand scanning capacities. But there is no formal monitoring in place as to how many records may be processed for coding and scanning purposes from the wards, and which wards / areas are behind with submitting records for the digitalisation process.

	Key Findings	Risk & Impact	Agreed Management Action
5	Security of patient records *NHH:* The B3 storage block and related courtyard remained shared with Works & Estates. We also found that the gate to the courtyard was left wide open, and recyclable materials, including metals and cardboards were deposited in the area. Additionally, a couple of vehicles were parked in the courtyard. The lift to the Filing library had been out of service for the past two months, with maintenance staff actively working on it. As a result, we were asked to access the library through the back door. While the lift is equipped with a digital lock and is located within the building, the back door, opens from the courtyard, and was operated by a single metal key. Furthermore, we note that on the day of our visit, one of the keys to the backdoor was with OTIS (the lift contractors), and the other key was with Works & Estates. Subsequently to our visit, we were told that	• Unauthorised access to patient records	Agreed Action: The B3 storage block at Nevill Hall has been a communal area, shared with Works & Estates, for 20+ years. The courtyard area is a service area for works & estates with vehicular access required. Access is also required for delivery of records into this facility. The gates are locked out of hours. This area is for archived records, therefore limited access by health records staff. Records are stored in terminal digit order, therefore access to the WPAS system is required to access a specific record. This reduces the risk of unauthorised disclosure. Works & Estates staff are bound by the same rules of confidentiality as all Health board staff. However, the issues found at Nevill Hall Hospital will be reviewed and an action plan developed whilst the wider scanning project continues. Following review individual action items will be added to the audit recommendations tracker.

	the parts to the lift was ordered, and the repair was scheduled to be completed on 14/01/2025. *St. Cadocs:* Although we did not observe any files stored in the corridors during this visit, we noted that several of the entrance doors remained outdated and did not provide adequate security to patient records.		The lift to the filing library is now repaired and operational. The Mental Health Business case has been approved with 3 WTE, and a program of work is due to commence to start and remove records from St Cadocs for scanning. Priority will be given to areas that have inadequate security. Work is ongoing to configure the XDS Intelliscanner software and electronic document management system with the new categories required, and AD groups are required to be configured for some services. When the scanner configuration and groups are tested and assured, we will commence. Standard operating procedures and work packages will be developed. A group has been setup to develop options for the future of online house when lease expires in October 2026.
			Expected Evidence of Implementation: Reduction of records held at B3 due to the ongoing destruction process and at St Cadocs due to scanning.
		High Priority	Officer: Head of Health Records – DHR Date: 31 December 2027: complete destruction of deceased records in B3 (2016, 2017 & 2018 deceased records). Mental Health and Family and Therapy records: 30% complete over five years (2030).
	Theme: Physical Security	Control Design	
6	Storage conditions We found that storage conditions at St. Cadocs were inappropriate (e.g. leaks through the ceiling, high humidity levels etc).	• Records might get contaminated and damaged	Agreed Action: The Mental Health Business case has been approved with 3 WTE, and a program of work is due to commence to remove records from St Cadocs for scanning. Priority will be given to areas that have inadequate security. Work is ongoing to configure the scanners with required categories and when this is complete,

	We also found incorrect storage practices in operation to store patients' records (e.g. collapsing boxes, loose patients' records) creating opportunities for unauthorised access to patients' files). These issues at St. Cadocs were in-line with our previous findings.		work will begin. Alternative locations for St Cadocs records will be investigated whilst the wider scanning project continues. Expected Evidence of Implementation: Reduction of records in St Cadocs will reduce over time when scanning commences.
		High Priority	Officer: Head of Health Records - DHR Date: 30% completed over five years (2030)
	Theme: Information, Data Quality & Data Accuracy	Control Design	

Objective 4: Physical records are transported appropriately, tracked and records are available when and where needed by operational staff.	**Limited**

Systems in place

The Welsh Patient Administration System (WPAS) is used to track the Digital Health Record (DHR) folders which includes the patients' records. After the records are scanned, they are stored within Clinical Workstation (CWS). We note that beside the scanned records, CWS also holds manually inputted personal data for each patient. However, we note that patients' video and audio records are not stored here or any of the physical libraries. In addition, a new digital Welsh Nursing Care Records (WNCR) system was launched recently which is linked to WPAS but not CWS.

We also note that there are formal rules to ensure scanning on demand is completed, for example: if scanning requests are marked as "urgent" they are prioritised. We reviewed a sample of records for 90 patients across the Health Board and note that 53.3% of them were not sent for scanning promptly. The longest time being 207 days and the top five timeframes being: 207, 143, 123, 84 and 69 days with the average time that records were not sent for scanning being 27 days. We note that these findings mainly related to wards located at County and Chepstow Community Hospitals, where we found ward clerk shortages.

We also note that there are services which do not feed into the main clinical records, as such, they manage their own records, which are not digitalised. As part of this audit, we selected two services (Children and Mental Health Services) for review. The records for these services are kept in dedicated libraries and the databases (e.g. Children Health Records are stored in Cypris 4.3, Mental Health Records are stored in WCCIS – Welsh Clinical Care Information Service) which do not allow tracking of the records. In addition, neither of these systems use CRN codes, which is used by CWS, for patient identification purposes. We note that these systems have their own codes and methods to search for patients, as a result, these different databases are not easily linkable. Therefore, sometimes it can be challenging to retrieve a complete set of records for a patient.

Records retrieval

In our previous audit, we observed a backlog of paper records awaiting digitalisation. However, this has now been fully cleared. While it is planned to digitalise all records at one point, there are services where the digitalisation process has not been rolled out yet (e.g. mental health, children's health and therapies).

Transfer of records

We note that there is no formal tracking of records in place when patients' files are transferred between locations (e.g. in sealed envelopes or boxes). It is the responsibility of the departments or individuals to ensure that the correct delivery takes place.

Furthermore, we note that original patient records must not be sent out from the Health board; as only copies should be shared. We were told that when a ward clerk is unavailable to make copies original records are occasionally sent out and retrieving these records later in the process can be challenging. We came across one case where original patient records were received from Cardiff & Vale University Health Board, and these records remained at the ward after the patient was discharged.

Missing records

There is a formal reporting on missing / lost records as part of the Information Governance incidents reporting to the Finance and Performance Committee. However, the underlying data for this reporting is taken from Datix, which is currently not used the same way across the Health Board. As such, the report does not give an accurate picture of the missing / lost patients' records. We also note, that missing records statistics are currently included in the IG report to Digital Delivery Oversight Board.

In 2024, 290 Health Record Incidents have been raised in Datix, from which 15.17% was still open as of 10th January 2025, with the oldest one raised in March 2024. The report included the following main categories:

Ref.	Description	Number of incidents	%
1	Documentation missing (e.g. part of the file) or missing health records (e.g. the full file)	107	36.90%
2	Incorrect information documented	52	17.93%
3	Documents misfiled in healthcare record (wrong patient)	35	12.07%
4	Other – not specified	35	12.07%
5	Information not recorded in the health record	16	6.21%
	Total	**245**	**84.48%**

Furthermore, we reviewed the missing records tracking sheet for 3 months (Sep-Oct-Nov) at On-line House and note that seven patients' records were still missing. We were also told that some of these items might be recorded in Datix, however, it is likely that not all of them were included.

Key Findings		Risk & Impact	Agreed Management Action
7	Access to paper records We reviewed records for 90 patients from 18 different wards (see ward details listed under objective 2), we found the following issues: **Ref / Description of the issue / Number of patients** 1 – The alive / deceased patient file was not sent for scanning. – 47 2 – The patient was not formally discharged within 24 hours after left the hospital in CWS, and physical records were left behind at the ward. – 4 3 – The Patient was transferred without physical patient record within the HB. – 4 4 – The Patient was transferred with the physical records within the HB, but the DHR files were not tracked to the new location in WPAS. – 4 5 – No patient file was raised in WPAS during the inpatient period or after the discharge at the time of our visit. – 10 6 – Various supplementary paper records left behind after the patient's DHR file was sent for scanning. – 8 We note that many of the issues outlined above resulted from the pro-longed absence of the local ward clerk (for example: • no ward clerk worked at the Cas Gwent ward at Chepstow Community Hospital in the last 6 months; or • the Health Records Services were provided by temporary staff who had no access to any of the health records systems (e.g. WPAS and CWS).	• Unauthorised access to patient records • Unretrievable patient records • Loss of patient records	Agreed Action: The lack of records management does require to be addressed across the organisation. The service has previously requested for local health records management training to be mandatory. This was not approved and therefore there is limited engagement at Health Records Awareness sessions that are scheduled monthly. We recommend mandated Health records training for all ward clerks during induction to provide a more in-depth understanding of the processes involved. We are implementing a schedule of ward visits and training updates across the Health board to promote best practice and provide evidence of where there are gaps that need to be addressed but there is a resource gap to undertake extensive training across all sites. A board development session will also be undertaken on records management to improve support by the executive team and independent members. Expected Evidence of Implementation: A Microsoft list with information on all wards and scheduled dates to visit, to commence from 21/02/2025. Microsoft form to gather information from the ward clerk regarding current processes which we can analyse and support where required. A formal report can be generated from these findings.

			The Information Governance Team are in the process of establishing an internal audit team who will undertake regular spot checks on wards, with data quality and record keeping being part of the remit.
		High Priority	**Officer:** Head of Health Records – DHR Head of IG & DPO **Date:** Health Records – 31 December 2025 and IG – 31 July 2025
	Theme: Quality, Safety & Patient Experience	Control Operation	
8	Access to systems We found that only two out of 18 wards, that we have visited, currently have ward clerks with "write access" to WNCR and were regularly tasked inputting data, such as inpatient notes related to ambulance bookings and assisting with patient discharge records. While there is an expectation that all ward clerks will be required to perform these duties in the future and possess the necessary skills to use WNCR accordingly, it is important to note that only 34 ward clerks received training and were granted access to WNCR in 2024. During our fieldwork, we noted that in the absence of a ward clerk, records management tasks were delegated to a Health Care Assistance (HCA), however, certain tasks remained incomplete, as the HCA did not have the same level of system access as the ward clerk (e.g. access to CWS and WPAS).	• Inconsistent roles and responsibilities • Insufficient training	Agreed Action: To ensure WNCR training sessions are available to ward clerks. Expected Evidence of Implementation: Training logs.
		Medium Priority	Officer: Chief Nursing Information Officer (CNIO) Date: 31 July 2025
	Theme: Approvals	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.

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 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]

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING	
DYDDIAD Y CYFARFOD: DATE OF MEETING:	22 April 2025
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**

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

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

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

The Audit, Risk and Assurance Committee is requested to:

- Note the contents of this report.



- Approve the updated financial control policy and procedures.

    - Digital Procurement (Appendix 1)
    - Charitable Funds (Appendix 2)
    - Approving Orders Greater than £100k (Appendix 3)
    - Overseas Visitors (Appendix 4)

Cefndir / Background

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 presented were considered and approved by the Executive Committee at their meeting on the 10th April and are now being presented to the Audit, Risk and Assurance Committee for approval.

A table has also been included to provide an update of the status of all financial control procedures.

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:

- Digital (Appendix 1) (NEW)
- Charitable Funds (Appendix 2)
- Approving Orders Greater than £100k (Appendix 3)
- Overseas Visitors (Appendix 4)

Together with a summary of all FCP review dates.

1.1 Digital Procurement

Owner: Director of Finance, Procurement and Value
Review Date: New

The procedure is a new document that details the steps to follow when purchasing Digital items to ensure both local and national strategies are followed and represent value for money.

The procedure identifies the different categories of Digital spend, the process to follow and responsibilities of staff.

The Director of Finance, Procurement and Value owns the procedure, however, the overall responsibility for implementation sits with the Director of Digital.

The document has been reviewed by the following:

- Head of Business Assurance – DDaT
- Director of Digital
- Head of Financial Services & Accounting
- Head of Management Accounting & Costing
- Head of Capital Finance
- NWSSP - Audit and Assurance Services

1.2 Charitable Funds

Owner: Director of Finance, Procurement and Value
Review Date: July 25

Charitable Funds relates to money that is donated to the Health Board which is administered through a registered charity. The Health Board is the Corporate Trustee and the Charitable Funds Committee oversees the management of funds.

The procedure documents the processes that should be adopted by Charitable Fund Holders in order to ensure adequate controls over funds and compliance with Charity Commission regulations.

The document has been reviewed by the following:

- Assistant Head of Financial Accounting
- Head of Financial Services & Accounting
- Charitable Funds Committee
- NWSSP - Audit and Assurance Services

The Charitable Funds FCP has been presented to, and ratified by, the Charitable Funds Committee, at the committee meeting in March 2025, as part of the annual review of the FCP.

A summary of the main changes to the FCP is set out below. The full revised FCP is included in Appendix 2.

Main changes to the document

Paragraph	Summary of change
9	**Accessing Charitable Funds** – paragraph added to identify 'if staff do not have access to Charitable Funds, they may request from other Charitable Fund Holders, provided they meet the criteria of that fund'
10.3.6	**Grants** – Clarification of Process -paragraph added to explain the process of how to show interest in applying for a grant ie form completed with appropriate sign offs
10.3.7	**Grants** – Clarification of Process - paragraph added to explain the Charitable Funds Manager responsibility once an interest form is received

10.3.8	**Grants** – Clarification of Process – paragraph added to explain the process to formally apply for a grant ie form completed with appropriate sign offs
10.3.9	**Grants –** Clarification of Process **–** paragraph added to explain the Charitable Funds Manager responsibility once a grant application is received
10.5.2	**Fundraising –** paragraph added to state that 'cake sales may take place within Health Board premises' as long as Health & Safety policies are followed
11.4	**Investments –** Change of Process **–** Interest and dividends to be 'allocated in accordance with the wishes and agreement of the Charitable Funds Committee,' rather than historically based on the average monthly fund balance
12.7.11/12	**Expenditure –** Clarification of Process – paragraph added to explain that 'events and initiatives that promote staff wellbeing' are allowed to be funded from Charitable Funds if a direct benefit can be demonstrated
Appendix 6	**Accessing Charitable Funds Guide –** Flowchart and wording updated. Small Grants Scheme Application and Small Grants Evaluation forms added
Appendix 7	**Request to Apply for External grant Funding –** form added
Appendix 15	**Charitable Funds Committee Bids –** bid for equipment or service template added

1.3 Approving Orders Greater than £100k

Owner: Director of Finance, Procurement and Value
Review Date: April 25

The Procedure highlights the need for scrutiny in large value spend. The procedure was required to have its triennial review and was confirmed to remain as current. The only change to policy is reflecting the adjustment in the scheme of delegation table in line with that approved in October 2024.

1.4 Overseas Visitors

Owner: Director of Finance, Procurement and Value
Review Date: April 2025

The Procedure highlights the process of identifying, invoicing and collecting charges for care of Overseas Visitors. The procedure was required to have its triennial review and was confirmed to remain as current, except for the current practice of inflating costs by 50%, prohibited under Welsh Government direction effective 1 April 2025:

In the absence of Welsh guidance on the basis for charging, the English approach provides a degree of consistency. Charges should be based on costing, by specialty ~~x 150%~~.

It should be noted that work is currently underway to release new dashboards and ways of working to support in the process of overseas visitors. Once released the policy should be reconsidered for review to ensure it remains relevant to any new practices implemented, which may be earlier that the next planned Triennial

1.5 Summary Position on Financial Control Procedures

FCP	Year Due	Approved	Committee Approved	Review Date	Notes
Approval of Orders over £100K	23/24	INCLUDED	Feb-21	04-Feb-24	Scheduled for Apr 25
Overseas Visitors	24/25	INCLUDED	Feb-22	03-Feb-25	Scheduled for Apr 25
Digital Procurement	New	New, INCLUDED	New	New	Scheduled for Apr 25
Charitable Funds	25/26	INCLUDED	Apr-22	19-Jul-25	Scheduled for Apr 25
Budgetary Control Policy & Procedure	25/26	Y	Aug-22	02-Aug-25	
Losses and Special Payments	25/26	Y	Oct-22	06-Oct-25	
Stores & Stocks	25/26	Y	Oct-22	06-Oct-25	
Engaging Off Payroll Workers	25/26	Y	Feb-23	02-Feb-26	
Patients' Property	25/26	Y	Feb-23	02-Feb-26	
Purchasing Cards	25/26	Y	Feb-23	02-Feb-26	
General Ledger	26/27	Y	Apr-23	18-Apr-26	
Policy and Governance approach for Commissioning Additional (External & Insourced) Non NHS Clinical Services	26/27	Y	Apr-23	18-Apr-26	
Procurement Policy	26/27	Y	Sep-23	12-Sep-26	
Capital Procedures and Guidance Notes	26/27	Y	Nov-23	28-Nov-26	
Patients' Travel Costs Policy	26/27	Y	Nov-23	28-Nov-26	
Cash and Bank	26/27	Y	Nov-23	28-Nov-26	
Petty Cash	26/27	Y	Feb-24	08-Feb-27	
Petty Cash - Mental Health	26/27	Y	Feb-24	08-Feb-27	
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	

2. Technical Accounting Issues

Technical updates

Since the last committee meeting in February 2025, there have been three technical accounting updates issued by Welsh Government.

Update note 6 covered the following areas in relation to the financial year-end and a number accounts disclosures and submissions:

- 2024/25 Losses – submission deadline of 2024/25 losses information including novel & contentious approval requests.
- 2024/25 NHS Charities Accounts – Materiality threshold submission deadline
- 2024/25 NHS Charities Accounts – Leases information submission deadline
- Transfers - Submission deadline for confirmation of transfers between NHS Wales bodies in 2024/25, including final transfer values.
- Pension Assurance Statement – confirmation of submission requirements for 2024/25



- Agreement of Balances Exercise Month 11 - Notification of Month 11 exercise requirements.
- 2024-25 Year-end arrangements with Welsh Government – notification of deadline for submitting invoices to Welsh Government in March 2025.
- Last day for cash payments between NHS organisations and Welsh NHS Charitable funds – notification of deadline for cash payments between NHS organisations
- Non-Cash Requests **-** Notification of the submission deadlines for submitting non-cash requirements including IFRS16 in April.
- Arbitration Deadlines – notification of the year-end deadline for submitting arbitration cases during April.
- Year-end Arrangements for Notional Pensions
- Cash Arrangements – final submission deadlines for cash requirements for March 2025, including Strategic Cash and Working Balances
- Greenbury Information arrangements
- Return of LHB bank interest – notification of submission deadline
- Welsh Risk Pool Returns – timetable for submissions as part of year-end issued.

Update note 7 covered the following areas:

- LHB Final Non-Cash Returns Date – update for submission deadline
- 2025 Annual PFI data collection – notification of submission requirements for year-end and 2025/26 data collection timetable.
- Welsh Risk Pool Returns – notification of timetable and the pro-forma to be used for WRP submissions

Update note 8 included only 1 update relevant to the Health Board:

- No Purchase Order No Pay - Secondments of Welsh Government Staff. Information on who to issue Purchase Orders to within Welsh Government for organisations with secondees from Welsh Government.

The 2024-25 final Manual for Accounts was also issued by Welsh Government on the 13th March 2025. The final manual has been reviewed internally, and the queries raised following the draft manual issued in December 2024 have been clarified in advance of the 2024/25 Annual Accounts.

3. Public Sector Payment Policy (PSPP)

The following table shows the Public Sector Payment Policy performance for the month of March 2025 and on a cumulative basis for 2024/25 Financial Year.

Category	Invoices	In Mth %	YTD %
NHS	Value	99.4	98.1
	Number	96.9	91.9
Non NHS	Value	98.2	96.6
	Number	97.4	97.7

The Health Board has achieved the target to pay 95% of the number of Non-NHS creditor invoices within 30 days of delivery of goods/services in March and for the 2024/25 financial year.

The Health Board has achieved the target to pay 95% of the number of NHS creditor invoices within 30 days in March, having also achieved this in February. However, the target has not been achieved on a cumulative basis for the 2024/25 Financial Year.

The cumulative figure of 91.9% is an improvement on previous financial years (2023/24 – 88.5%, 2022/23 – 88.6%). In February, a letter was issued to our NHS Wales counterparts, reiterating that for Aneurin Bevan UHB, Welsh NHS invoices are not an exception to the All Wales No PO No Pay policy, and all invoices should have a valid PO to enable swift processing. We are confident this letter will have a positive impact on our ability to process NHS invoices in a timely manner and subsequently improve our PSPP compliance percentage above the 95% target in the new financial year.

As part of their reporting of key performance indicators (KPIs), NHS Wales Shared Services Partnership (NWSSP), have shared the latest all-Wales statistics on PSPP performance up to the end of February 2025. The below table shows that Aneurin Bevan currently have the best PSPP percentages against other Health Boards for both NHS and Non-NHS by the number of invoices processed.

Invoice	Health Board	In Month %	YTD %	RANK
NHS by Number	**Aneurin Bevan UHB**	**95.7**	**91.4**	**1st**
	Betsi Cadwaladr UHB	91.6	88.5	3rd
	Cardiff & Vale UHB	90.9	89.0	2nd
	Cwm Taf Morgannwg UHB	86.9	81.0	
	Hywel Dda UHB	87.5	87.4	
	Powys tHB	61.9	70.9	
	Swansea Bay UHB	88.6	83.8	
Non-NHS by Number	**Aneurin Bevan UHB**	**98.3**	**97.7**	**1st**
	Betsi Cadwaladr UHB	95.3	95.5	
	Cardiff & Vale UHB	95.6	97.0	
	Cwm Taf Morgannwg UHB	96.0	96.0	3rd



	Hywel Dda UHB	97.3	96.6	2nd
	Powys tHB	94.5	93.8	
	Swansea Bay UHB	97.5	94.8	

4. Payments in Excess of £100K

There were no exceptional payment approvals to report for the period January to March 2025.

5. Standing Financial Instructions

There is no update on the standing financial instructions (SFIs), however we have been notified by Welsh Government that they will updating the SFIs in 2025-26, with a revised section in relation to the updated Procurement Act.

Argymhelliad / Recommendation

The Audit, Risk and Assurance Committee is requested to note the report and approve the updated/ new procedures:

- Digital Procurement (Appendix 1)
- Charitable Funds (Appendix 2)
- Approving Orders Greater than £100k (Appendix 3)
- Overseas Visitors (Appendix 4)

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

Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve the Wellbeing and engagement of our staff Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	FCP – Financial Control Procedure PSPP – Public Sector Payment Policy NWSSP – NHS Wales Shared Services Partnership KPI – Key Performance Indicators SFI – Standing Financial Instructions
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment: • **Workforce** • **Service Activity & Performance** • **Financial**	**Is EIA Required and included with this paper?** A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following: Not Applicable Yes, outlined within the paper Yes, outlined within the paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk



Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives



Aneurin Bevan University Health Board

Digital Procurement

Financial Control Procedure

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

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

Issue date: DRAFT
Review by date: DRAFT
Ref Number: ABUHB/Finance/0997

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1. Introduction

Aneurin Bevan Health Board is committed to ensuring all Digital, Data & Technology (DDaT) purchases align with both local and national strategies and represent value for money to public funds.

This Financial Control Procedure sets out a series of steps to follow to ensure all Digital purchases meet the Health Boards strategic direction and satisfy Information Governance legislation, Health Records standards, Cyber Security legislation, technical alignment, data governance and clinical safety.

The procedure must be followed to ensure all requests for new Digital investments follow the correct governance and assurance arrangements before being committed into the directorates operational plan.

2. Statement

The Health Board must meet its statutory financial duties and this procedure sets out how digital spend will be governed to ensure the organisation meets its objectives. It should be read in conjunction with the Health Boards Standing Financial Instructions; Scheme of Delegation; Budgetary Control and Procurement procedures.

It is the responsibility of Digital, Data & Technology to oversee the implementation of the Digital Strategy, including commissioning additional developments, systems and resources as required.

3. Aims

The aim of this procedure is to set out the responsibilities of all staff, budget holders and procurement in relation to digital purchasing and ensuring the organisation fulfils its legal obligations in relation to Information Governance (UK Data Protection Act 2018) and Cyber Security (Network and Information Systems Regulations 2018).

As well as regulatory and financial control, the procedure also aims to enable strong strategic local and national alignment of digital initiatives, whilst supporting service objectives and innovation.

4. Objectives

This procedure aims to provide a clear framework for procurement controls to enable the organisation to meet its financial and strategic objectives. These objectives are:

- Describe how digital initiatives and spend is approved based on the Health Board's Digital Strategy, Integrated Medium Term Plan and the Digital and Data Strategy for Health and Social Care in Wales published by Welsh Government.

- Ensure all staff route their request via the Halo Portal.

- Explain the methods by which new digital procurements, projects and enhancements / upgrades to existing systems will be approved, prioritised, and allocated resources.

- Ensure new software and system procurements are assessed against the following criteria and legislation:

    - Health Records standards where applicable (record keeping, interoperability, open standards):
        - Access to Health Records Act (1990)
        - NHS Wales Records Management Code of Practice (2022)
    - Clinical Safety standards DCB0129 (Clinical Risk Management in Manufacture of Health IT Systems) and DCB0160 (Clinical Risk Management in Deployment and Use of Health IT Systems) where applicable
    - Medical Devices Regulation where a Digital service or software is classed as a medical device
    - Information Governance legislation (Data Protection Act 2018)
    - Cyber Security legislation (Security of Network & Information Systems Regulations 2018)
    - Effective ongoing support arrangements in line with industry best practice (ITIL – IT Infrastructure Library)
    - Fit with the Health Board's Infrastructure Services
    - The principles set out in the Digital Service Standards for Wales

5. Scope

This procedure covers all staff in Aneurin Bevan Health Board and the definition of digital includes the following services:

- Requests for new electronic systems, software, and services including Cloud Based software and services
- Telecommunications (Telephones, paging, and mobiles)

- Desktop Equipment (PC's, printers, scanners, projectors, and other peripherals)
- Mobile Equipment (Tablets, Android / Apple devices, Carts)
- Medical devices that connect to the Health Board network or includes software which needs to be assessed
- Audio-Visual Equipment
- Equipment to support health & safety assessments in relation to the use of display screen equipment regulations
- Office moves and refurbishments
- New Health Board builds.
- Information / Data Science Developments

6. Roles and Responsibilities

Director of Digital

The Director of Digital (Senior Information Risk Owner) shall have overall responsibility for the implementation of this procedure.

NWSSP / Procurement

NWSSP and the Health Board's local procurement teams will be required to comply with this procedure and ensure any requisitions / invitations to tender / request for quotes they receive for Digital related equipment (or contain a Digital element as defined by the scope outlined in this procedure) are not processed unless this procedure has been followed.

Anything outside of this procedure should be signposted to the Digital, Data & Technology Directorate.

The Digital team will ensure that procurement exercises are verified for their compliance with current legislations with the Head of Procurement for ABUHB prior to issuing tenders or orders.

Capital Planning / Finance

Capital Planning/Finance will need to ensure that all New Builds, via a project, contain a costed ICT equipment estimate, based on requirements identified in the project. The estimate will be included in the business case for approval.

For all other capital schemes approved via the Project Proposal Document process, Capital Planning / Finance should ensure costing estimates are included in the bid. Head of Capital Finance / Finance Business Partners will review the financial sections of the bids prior to approval.

Divisional Director of Facilities

The Divisional Director of Facilities will be responsible for dissemination of this procedure to relevant Facilities teams, in order to ensure it is considered when planning new builds and refurbishments of Health Board property.

Divisional Directors / General Managers

Will be required to be aware of this procedure to ensure Digital implications are considered when planning service change, new projects, and new services.

Heads of Department / Budget Holders

Will be required to be aware of this procedure to ensure it is followed when requesting Digital services.

7. Digital Request Categories

The procedure to be followed for approval of digital requests is dependent on the context of the request as outlined below:

- Procurement of Standard Digital Equipment - purchasing of standard hardware, software, mobile phones / smartphones, and peripherals such as printers and scanners should follow the procedure in Section 8.
- Ad hoc Departmental Moves and Changes – any moves and changes of clinical and administrative areas which may impact Digital equipment and services should follow the procedure in Section 9.
- New Digital Service Request – new Digital projects, news builds / refurbishments and upgrades / enhancements to existing systems should follow the procedure in Section 10.

8. Procurement of Standard Digital Equipment

This covers the purchase of all digital hardware, software, peripherals (scanners, printers, headsets, cameras etc.) and mobile phones* in addition to PC's, laptops, and tablets.

*All mobile phone purchases should be authorised in line with the eligibility criteria in Section 11 of the ABUHB Telephone Use policy.

Advice from Digital Services should also be sought where network attached equipment is being procured. This includes medical devices, laboratory analysers, security systems and Closed-Circuit Television (CCTV).

All equipment purchases will conform to Digital Services specifications and will be authorised prior to ordering by the Digital Procurement team.

All purchases must be channelled through Digital Services, via the Halo system or contacting the service desk directly. Digital will not accept request that do not follow this process.

8.1 Revenue New Equipment/Replacements

Services will need to raise a request via Halo or by contacting the Service Desk

The procurement of revenue new equipment/replacements will be charged to departmental budgets or specific identified funding routes.

Examples of revenue digital equipment items are:

- Monitors
- Keyboards
- Mice.

8.2 Recharge of Digital Purchases

The following equipment will be purchased centrally by the Digital team and costs will subsequently be recharged to the cost code provided by the budget holder:

- Mobile phones
- Pagers
- Laptops
- Revenue digital equipment (e.g. keyboard, mouse, laptop battery)

All other Digital equipment will be purchased directly against the cost code provided by the budget holder.

Provision of recharge information

A schedule of all required recharges will be provided by the Digital team to the Central Management Accounting team on a monthly basis, stating the equipment details, username where appropriate, and the cost code which should be charged. The Central Management Accounting team will then action a journal to post all recharges to the General Ledger on a monthly basis.

Changes to users of mobile devices

When a mobile phone is ordered, ABUHB are committing to a two-year contract where the budget holder will be liable for all the charges associated with the phone. This is usually the line rental and call charges but could also include any cancellation charges incurred if a mobile phone is no longer required.

If a mobile phone is transferred to another department it is the budget holder's responsibility to inform the Digital team. In the absence of any additional information, the cost code provided at the time of procurement will continue to be recharged for the full term of the mobile phone contract.

Similarly, if the user of the mobile phone changes, it is the budget holder's responsibility to inform the Digital team. This will allow the username to be updated and included as part of the monthly recharge journal.

8.3 Capital Digital Equipment

IT hardware may be capitalised if it is attached to a network, and all three criteria below apply:

1. The items are acquired at about the same date and are planned for disposal at about the same date
2. The items are under single managerial control
3. Each individual asset thus grouped has a value of at least £250

Examples of capital equipment are:

- High end printers
- PC's
- Laptops
- Tablets

For the purchase and disposal of Capital Equipment, please refer the Capital Assets and Charges procedure.

8.4 Capital Replacement Programme

When equipment is assessed as being "end of life" it will be replaced under the Replacement Programme, subject to available funding levels within the Capital Programme. This includes, but is not restricted to,

PC's, printers, scanners, servers, network devices, infrastructure components, software, and telecommunications.

The Replacement Programme is funded from the Health Board's Discretionary Capital Programme (DCP) and will be managed by Digital Services in line with the wider capital programme governance.

8.5 New Capital Equipment (not replacement)

Requests for new digital equipment, which are additional to the current digital estate, will require a Project Proposal Document to be completed and submitted to capital planning for approval.

For the purchase and disposal of Capital Equipment, please refer the Capital Assets and Charges procedure.

8.6 Ordering Process

All requests for software packages, computer hardware, peripherals (scanners, printers, etc.) or network / telecommunications services should be made by completion of the relevant forms via the Halo Digital Portal and navigating through the "Raise a ticket" option.

ABUHB Self-Service Portal (haloitsm.com)

All sections in the form require completion before processing and once received Digital Services will process in line with local procedures. The request must be authorised by a responsible officer e.g. budget holder or service manager. Once the request is received, the responsible officer will receive a notification with a prompt to approve or deny the request.

Any request "deemed" as non-standard will be forwarded to the Head of Business Assurance for consideration and may fall under the remit of the "Digital Project Approval" in Section 10.

8.7 Value Added Tax (VAT)

Assessment of VAT should be performed before any new orders are placed. For non-standard equipment, liaising with the Health Board's Corporate Finance team and VAT advisors should take place before all orders are completed.

8.8 External Funding

Occasionally the Health Board will receive external funding which is placed into ring fenced budgets eg Welsh Government Research & Development,

requests utilising these monies will be managed by Digital Services and Finance on a case-by-case basis.

9. Ad hoc Departmental Moves and Changes

This section outlines the process that will be followed to gain approval for digital to support departmental moves and changes. The scope includes Health Board employees requiring:

- New data points for network access
- New telephone points, handsets, and numbers
- Moving of extension numbers between locations
- Move of Digital equipment between locations

It is important that Digital Services should be engaged as soon as possible using the process below to ensure any associated works can be scheduled and completed prior to any staff moving offices.

All requests for departmental moves should be made by completion of the relevant electronic form on the Halo Digital Portal.

ABUHB Self-Service Portal (haloitsm.com)

All sections in the form require completion for Digital Services to process and once received the request will be completed in line with local procedures. The request must be authorised by a responsible officer e.g. budget holder or service manager Once the request is received, the responsible officer will receive a notification with a prompt to approve or deny the request.

On receiving the request, Digital Services will review within 5 days and respond to the requester with a schedule for completion and any associated costs. If the resources required, by digital, is extensive the New Digital Service Request Process will be followed which is outlined in Section 10

Once the schedule for completion has been communicated, any moves and changes outside of the document will be potentially rejected.

10. New Digital Service

This section outlines the process that will be followed to gain approval for a new digital project which would be added to the Digital Operational Plan (depending on funding and resources). Examples of such projects include:

- Implementation of new digital systems (e.g. clinical or administrative systems)
- Upgrades to existing digital systems
- Office 365 developments
- Adoption of cloud-based services and systems
- Requests that would have a significant resource impact for the Health Board
- Significant accommodation moves
- New builds and refurbishments (digital colleagues would typically log this request so as not to interfere with existing governance arrangements)

The link below is how staff can request a new digital service:

New Digital Service Request Form

Once submitted these requests will be discussed by the Digital Senior Team for consideration and prioritisation. If approved and the project has available funding, a schedule will be completed and resources allocated.

If no funding is available and the request is not approved, the request will be deferred to the Digital, Data and Technology Sub-Committee for further consideration.

11. Implementation

This procedure will be implemented via:

- Communication through divisional digital engagement meetings
- Communication to Finance Business Partners
- Targeted communications to be undertaken to the groups identified in the responsibilities section of this procedure.
- Health Board wide communications via the Intranet and E-mail
- Specific sessions with Procurement colleagues to ensure they have a full understanding of this procedure
- Specific sessions with the Digital Service Desk who receive first line calls from Health Board colleagues

12. Audit

This document is a key organisational procedure and as such will be subject to regular internal audit reviews by the NHS Wales Shared Services Partnership (NWSSP) to ensure it is working effectively and that the processes set out in the procedure are being complied with across the organisation.

13. Review

This procedure will be reviewed after 3 years in line with the Health Boards governance framework, or sooner if significant changes demand.

Aneurin Bevan University Health Board

CHARITABLE FUNDS

Financial Control Procedure

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

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1 Introduction

Charitable Funds is the term given to money that is donated to the Aneurin Bevan University Health Board and which is administered through a registered charity, Aneurin Bevan University Local Health Board Charitable Fund and Other Related Charities, number 1098728. The Health Board is the Corporate Trustee of the charity and has appointed the Charitable Funds Committee to oversee the management of its funds. The charity uses the working name "Aneurin Bevan Health Charity" which is used throughout this document.

2 Policy Statement

Aneurin Bevan University Health Board is committed to ensuring that it has sound financial controls in place to ensure that there is good control and probity over the use of charitable funds. It is also committed to ensuring that it is compliant with charity regulations set out by the Charity Commission.

3 Aims

The document will set out procedures that are to be adopted by delegated Charitable Fund Holders in the day-to-day management of charitable funds and in setting out the corporate responsibilities of the Health Board.

4 Scope

The document is relevant to staff within the Corporate Finance Department and specifically the Charitable Funds Office. It is also relevant to staff that have been identified as Charitable Fund Holders and have been delegated a specific charitable fund account to manage on behalf of the trustee.

5 Roles and Responsibilities

5.1 Corporate

~~5.1.1.~~5.1.1 The Director of Finance is responsible for ensuring that proper financial controls and segregation of duties exist for charitable funds. The Assistant Director of Finance (Financial Systems & Services) assumes managerial responsibility for Charitable Funds, with the day-to-day management delegated to the Charitable Funds Manager.

~~5.1.2.~~5.1.2 Individuals must not set up a charity using the name of the Health Board or any of the Health Boards' hospitals without prior permission from the Health Board.

~~5.1.3.~~5.1.3 Individuals must not set up their own bank account to receive monies intended for the Aneurin Bevan Health Charity.

5.1.4 All correspondence relating to charitable funds must be passed to the Charitable Funds Manager immediately. Disciplinary action will be taken where monies are misappropriated or mislaid because staff have not

receipted monies promptly or not informed the Charitable Funds Manager of pertinent information.

~~5.1.4.~~

5.2 **Charitable Funds Committee**

The role and responsibility of the Charitable Funds Committee is defined within the Terms of Reference of the committee and their work plan which is reviewed annually.

5.3 **Charitable Fund Holders**

This policy applies to all staff that have been identified as Charitable Fund Holders to manage those accounts.

6 General Information

6.1 Charitable Funds are variously described as Trust Funds, Endowment Funds, Gift Funds or Non-Exchequer Funds. Property can only be held for charitable purposes if it is for public benefit and exclusively charitable.

6.2 The legal objects of the Aneurin Bevan Health Charity are as follows:

The trustees shall hold the trust funds upon trust to apply income, and at their discretion, so far as permissible, capital, for any charitable purpose or purposes relating to the National Health Service in the area of Gwent.

6.3 All expenditure and activities of the charity and individual accounts within charitable funds must be within the scope of the objects shown above.

6.4 Charitable Funds are used for items of expenditure relating to the Health Service which are not normally paid from revenue funds ~~either~~ because it would be inappropriate to do so ~~or because revenue funds are insufficient~~. Funds are intended to provide those additional amenities that will improve the conditions under which patients are cared for and treated or staff work. Examples of items typically purchased from charitable funds are shown in Appendix 1.

6.5 Charitable funds may not be used to supplement remuneration directly or indirectly.

6.6 Income generated through the normal course of NHS staff activities should not be accounted through charitable funds but be part of the normal revenue income of the Health Board.

7 Financial Controls

7.1 The Director of Finance is responsible for maintaining all financial records to enable the production of reports and annual accounts that comply with accounting standards and Charity Commission regulation.

7.2 All transactions must be coded correctly in the General Ledger and all supporting documentation must be retained for audit purposes.

7.3 Overdrawn funds are not permitted and therefore expenditure against a specific fund can only be allowed when sufficient funds exist.

7.4 In the unlikely event that an overdrawn fund balance occurs the account manager must ensure that the account is returned to credit within a reasonable period. Overdrawn funds must be reported to the Charitable Funds Committee.

7.5 Control accounts must be reconciled monthly by the Charitable Funds Manager and approved by the Assistant Head of Financial Accounting.

7.6 All inter-organisation balances between the charitable funds and the Health Board's revenue funds must be reviewed and cleared monthly.

7.7 The banking services for charitable funds must be in a separate bank account to those used for revenue funds.

7.8 All costs directly involved in the administration of the Charitable Funds must be identified in reports and annual accounts to reduce any subsidy from the Health Board.

7.9 Procedures, duties and controls must be reviewed for current relevance, practicability and efficiency on an ongoing basis.

7.10 Transaction listings and reconciliations must be reviewed for completion, reasonableness and evidence of posting.

8 Charitable Fund Holders

8.1 Signatories

All delegated charitable fund accounts must have two nominated signatories. The first signatory is the Charitable Fund Holder who takes primary responsibility for the management of the account and must be aware of and be compliant with this financial control procedure. The second signatory must be a person of equivalent or more senior position to the Charitable Fund Holder.

8.2 Delegation of Charitable Accounts

Charitable funds are formally delegated to Charitable Fund Holders on an annual basis by letter from the Director of Finance on behalf of the Charitable Funds Committee. The letter which will be issued in March of each financial year is shown in Appendix 2 and will cover the following areas:

- The basis that the account is being delegated.
- The terms of reference of the account.
- Authorised signatories of the account.
- The requirement to read and be familiar with the Charitable Funds Financial Control Procedure and Management Guide.
- The requirement to provide an annual return in relation to the activities and expenditure of the account.
- The withdrawal of the right to be a Charitable Fund Holder if compliance with requirements is not followed.

8.3 Reporting the Use of Delegated Funds

Charitable Funds Holders are required to submit an annual report to the Charitable Funds Committee setting out how the account has been used in the previous financial year. The reporting requirements vary depending on the fund balance on the account and is summarised as follows:

AVERAGE VALUE OF FUND	*REQUIREMENT*
Less than £25K	A simple proforma return setting out what the fund was used for and the main purchases and income activity made in the year. A proforma is attached in Appendix 3.
Greater Than £25K	A more detailed report setting out the activities and spending over the following headings: **In the last Year** Main activities Income sources Expenditure – detailing the items purchased and how they have improved the services provided by the ward/dept. **Plans for the Forthcoming Year** Main activities Income sources Expenditure **Plans for Future Years** Main activities Income sources Expenditure A proforma is attached in Appendix 4.

Reports must be submitted to the Charitable Funds Manager by 30th April following the end of the preceding financial year.

For significant funds with balances greater than £25K it is important that spending plans are in line with the strategic direction of the Board and additional level of scrutiny is required at a departmental or service level to ensure that funds are used appropriately.

8.4 **New Charitable Fund Accounts**

New charitable fund accounts must be approved by the Charitable Funds Committee by using the form shown in appendix 5. The purpose of the fund must be identified together with two signatories.

9 Accessing Charitable Funds

Where individuals with no funds of their own wish to engage with Health Board Charitable Fund Holders to potentially access their charitable funds, providing they meet the criteria/purpose of that fund, the process shown in appendix 6 should be followed.

~~9~~10 Income

10.1 ~~9.1.~~11.1 Types of Funds

Monies may be given to be held for a specific or general purpose but how they are accounted for depends on the specific terms on which they have been given:

- Restricted Funds - can only be spent in accordance with written instructions imposed at the time the funds were donated or granted or in accordance with the specific terms of a fundraising appeal. They consist of legacies and grants where a legal document and signed agreement restricts the use to the terms of the bequest/agreement.
- Unrestricted Funds – may be spent at the discretion of the trustees in line with the objectives of the charity and fall into the following below categories.
    - Designated funds whereby a particular part of the hospital or activity was nominated by the donor at the time their donation was made. Whilst their donation is not binding on the trustee, these types of donations are allocated to the designated funds.
    - General Funds – these relate to donations received by the charity where no specific preference has been expressed by the donor as to the utilisation of the funds. This type of donation is assigned to the Charitable Funds Committee to decide how the funds are best used.

10~~9~~.2 Legacies

10~~9~~.2.1 The Charitable Funds Manager will: -

- Send a letter of thanks to the Executors, if appropriate.
- Process and act on correspondence to ensure that the bequest is received promptly.
- Record the legacy details in the legacy register.
- Set up a separate restricted fund for each legacy received.
- Advise the Director of Finance of any issues arising from a legacy.
- Inform the Health Board's Property Group of any land and property bequeathed to the Health Board and act on their advice.
- Ascertain paperwork when advised of bequests, to provide a full audit trail.

109.2.2 All legacies must be reported to the Charitable Funds Manager and used in accordance with the terms of the will and within a reasonable timescale.

109.3 Grants

109.3.1 Grants are usually restricted income given for a specific purpose and have terms and conditions on how it can be used by the charity.

109.3.2 Grants will often have additional requirements attached such as performance-related conditions and they are usually subject to numerous monitoring and evaluation reports.

109.3.3 Grant income can only be recognised when there is a formal offer of funding, or the income is received.

109.3.4 Where the charity is unable to meet certain agreed criteria the grant may have to be returned in full.

109.3.5 All paperwork must be ascertained when advised of/on receipt of the grant to provide a full audit trail.

109.3.6 Before applying for a grant, all staff will:

- Complete the ~~attached~~ form in appendix 7 identifying the provider of the grant, the nature of the grant, the amount of the grant and the beneficiary of the grant.
- Ensure that the attached form is signed off by the General Manager and the Executive Sponsor in support of a grant application being made.
- Send completed form to the Charitable Funds Manager who will ensure that the proposed bid fits with the objectives of the Charity.

109.3.7 The Charitable Funds Manager will:

- Consolidate potential grant applications and present a report to Executive Committee for approval to proceed to the application stage.
- Inform applicants of the outcome of the grant requests.
- Refer any requests for Research grants to the Research and Development department, unless the Research is solely for public benefit; if not for public benefit, it does not fit within the objects of the Charity.
- Return any requests that are deemed too onerous or not in line with the objectives of the Charity and the Health Board.

109.3.8 Once Executive Committee approval has been given:

- The requestor will submit the completed grant application form signed off by the Head of Service and

- Provide a copy of the application to the Charitable Funds Manager.

10~~9~~.3.9 The Charitable Funds Manager will:

- Maintain a register of all grant requests (successful and unsuccessful)
- Set up a separate restricted fund for each successful grant received.
- Advise the Director of Finance of any issues arising from a grant.
- Ascertain paperwork when advised of successful grants, to provide a full audit trail.
- Notify the Charitable Funds Committee of significant (over £5k) grants received in their Finance Report which is presented at each meeting.

10~~9~~.4 Donations

10~~9~~.4.1 All monetary donations, including funds raised by the staff such as raffle monies, must be receipted into Charitable Funds. Staff must not keep cash donations at a local level.

~~9.4.2~~ 10.4.2 Charitable Fund Holders must ensure that when a donation is received any condition or direction, which is attached, is noted and complied with. It may be necessary to decline the gift if the attached conditions are unduly onerous or if the Health Board is incapable of meeting the conditions. Charitable Fund holders must report potential donations that could generate additional running costs to their Directorate Manager. The Directorate Manager must determine how these costs are to be met before accepting the donation.

~~9.4.3~~ 10.4.3 The Charitable Funds Manager must ensure that the Charitable Funds do not contain funds received for Clinical Trials. These funds are not deemed to be Charitable as it is the sponsoring company that benefits from the trial. Funds for research are permissible providing the research is published in the public domain.

~~9.4.4~~ 10.4.4 The Charitable Funds Manager must ensure posters and leaflets are distributed across the Health Board informing people how they can make a monetary donation to the charity. Both the poster and leaflet must emphasise that donors must obtain a receipt for their donation. The procedure for making a monetary donation, with a sample poster, is shown in Appendix 8~~7~~.

~~9.4.5~~ 10.4.5 Documentation should include an option for the donor to make a 'Gift Aid' declaration allowing the Health Board to reclaim tax.

~~9.4.6~~ 10.4.6 Cheques should be made payable to Aneurin Bevan Health Charity.

~~9.4.7~~ 10.4.7 The Charitable Fund Holder or their nominated individual or the Charitable Funds Manager must send a letter of acknowledgement to the

donor. Some examples of wording to be included within thank you letters can be found in Appendix 98.

9.4.8 10.4.8 Small personal gifts such as chocolates and flowers given by grateful patients, relatives or friends need not be accounted for in the formal sense.

9.4.9 10.4.9 Gift cards and vouchers can be accepted and must be recorded as a donation and used for the benefit of the ward/department.

109.5 Fundraising

109.5.1 Most health service bodies raise funds on a regular basis through fetes, coffee mornings, lotteries and appeals etc. For small society lotteries, the charity must be registered with the licensing authority in the area where the principal office of the charity is located. Aggregated proceeds from all lotteries that take place across the Health Board must not be more than £250,000 in any one year.

109.5.2 Cake sales may take place within Health Board premises providing that they adhere to the Health Board's Health & Safety policies around food safety. Further guidance and advice is available from the Health & Safety department.

10.5.3 Raffles may take place in Aneurin Bevan University Health Board, providing the following points are complied with:

- Raffles must be registered with the Charitable Funds Team using the 'Raffle Request Form' in Appendix 910.
- The Charitable Funds Team will issue pre-printed raffle tickets together with a Raffle Return Form
- Every ticket in the raffle must cost the same and the ticket fee must be paid before entry into the draw is allowed
- Tickets must not be sold to, or by, those under the age of 16
- Proceeds must not exceed £5,000 for a single draw
- All proceeds of the raffle must be credited to the Charitable Funds account using the ward/department receipt book
- No single prize may be worth more than £1,000
- Alcohol donated as raffle prizes may be accepted at the discretion of the Ward/Department Manager
- Prizes may be purchased from charitable funds if sufficient funds are available, but alcohol must not be purchased. Prizes should cost significantly less than the anticipated income from the raffle
- Raffle tickets must be drawn randomly and the winners must be notified by telephone or in writing by the designated staff member
- The Raffle Return Form must be completed and returned to the Charitable Funds Team together with any unused tickets within a month of the actual draw
- The winning tickets must be attached to the Raffle Return Form
- The rules governing the use of raffles will be printed on the back of the raffle return form for ease of reference

- The Charitable Funds Team will maintain a register of raffles in order to complete the required lottery return to the licensing authority in Torfaen County Borough Council.
- Aggregated proceeds from all raffles that take place across the Health Board must not be more than £250,000 in any one year.

10~~9~~.5.4~~3~~ Guidelines on sponsorship are detailed in Appendix 1~~1~~0.

10~~9~~.6 Gift Aid

10~~9~~.6.1 Donations and Fundraising (Sponsorship) Income can be Gift Aided.

10~~9~~.6.2 The Gift Aid scheme allows the Charity to collect an additional amount over and above the donation in lieu of income tax.

10~~9~~.6.3 Donors must sign a declaration, prior to making their donation or undertaking their fundraising activity, that

- they wish the Charity to reclaim the tax relief
- they are currently UK taxpayers and the amount of tax they pay exceeds the amount of tax reclaimable

10~~9~~.6.4 The Charitable Fund Manager can provide gift aid declarations and advice on the scheme.

~~9.7~~10.7 Acknowledgement

10~~9~~.7.1 The process for acknowledging donations, legacies and grants is shown in the diagram in Appendix 12.~~6~~

1~~1~~0 Investments

1~~1~~0.1 The investment policy is attached in Appendix 1~~3~~1.

1~~1~~0.2 The Charitable Funds Committee is responsible for appointing an investment management company or companies to manage the Charitable Fund's investments. The Investment Management Company must be informed of the Investment Policy of the charity and the trustees may rely on the professional advice of the Investment Management Company in formulating the policy. The policy should be reviewed annually to ensure it still fits with the overall aims of the charity.

1~~1~~0.3 The Charitable Funds Committee or a nominated representative should instruct the Investment Management Company to: -

- Provide details of all transactions undertaken on behalf of charity.
- Hold stock and share certificates for safekeeping.
- Provide details of dividends and interest received.
- Provide valuations on request.

- Attend the Charitable Funds Committee at least annually to formally present the investment performance of the period.

~~10.4~~ 11.4 The Assistant Director of Finance (Financial Systems & Services) is responsible _____for: -

- Maintaining an Investment Register to record details of all investments held.
- Calculating realised gains or losses (profit/loss) on sale of investments.
- Calculating unrealised gains or losses on investments.
- Informing the Charitable Funds Committee at each meeting of the investment valuation.
- Ensuring all interest and dividends received are allocated/utilised in accordance with the wishes and agreement of the Charitable Funds Committee~~apportioned to individual funds based on the average monthly fund balance~~.
- Ensuring any unrealised gains or losses on investments are allocated/utilised in accordance with the wishes and agreement of the Charitable Funds Committee
- Ensuring the investments held is reflected in the charity's annual accounts.
- Ensuring working balances are kept in a Government Banking Service, interest bearing, bank account.

~~11~~ 12 Expenditure

12~~1~~.1 The detailed procedure for purchasing goods and services from Charitable Funds is detailed in Appendix 1~~4~~2– Purchases from Charitable Funds.

12~~1~~.2 All purchases are subject to the following approval hierarchy:

Purchases Up To	Approvers
£5,000	Two individual fund holders
Additional approvals for	
£5,001 - £15,000	Divisional General Manager
£15,001 - £25,000	Executive Director
>£25,000	Charitable Funds Committee

~~11.3~~ 12.3 In addition to the approval hierarchy set out in the previous table for more significant funds, because of their relatively high value, an additional level of scrutiny is required at a departmental or service level to ensure that funds are used for the strategic benefit of the service or department and where a wider engagement would be desirable. Therefore, evidence of planning engagement and specific plans for the account is required to support purchases where fund balances exceed £25K.

~~11.4~~ 12.4 Any expenditure over £25k or expenditure relating to the employment of staff must ~~also~~ be approved by the Charitable Funds Committee. ~~to ensure that contracts are fixed term and under a period of two years~~by completing

the bid application form showed in Appendix 15. This should ensure that staff contracts are fixed term and under a period of two years.

~~11.5~~ 12.5 An authorised signatory list is maintained by the Charitable Funds Manager. The approval hierarchy is also contained in the Oracle iProcurement module.

~~11.6~~ 12.6 The Charitable Funds Manager will be responsible for ensuring that certification of expenditure by Authorised Signatories is within the limits set out in this procedure.

~~11.7~~ 12.7 Expenditure can be incurred provided it falls within the remit of the fund from which it is being paid and satisfies the following criteria:

~~11.7.1~~12.7.1 It is not for the benefit of an individual (e.g., retirement gifts) unless it is a payment to an individual that benefits a wider group – an example being a training course for the benefit of the department or service.

~~11.7.2~~12.7.2 Charitable funds cannot be used as funding support for staff without the approval of the Charitable Funds Committee.

~~11.7.3~~12.7.3 No alcohol to be purchased.

~~11.7.4~~ 12.7.4 Where meals are provided (for example as part of a conference for speakers) alcohol and tobacco cannot be claimed.

~~11.7.5~~ 12.7.5 A distinction should be made between work and work networking opportunities as opposed to purely social activities; the latter being inappropriate.

~~11.7.6~~12.7.6 The need to be proportionate and reasonable in expenditure.

~~11.7.7~~12.7.7 Consumable items should be paid from NHS funds not charitable funds.

~~11.7.8~~12.7.8 All minor works requests not available on Oracle should be submitted via the Charitable Funds Office where availability of funds and authorised signatory will be confirmed before the Works department initiates any works.

~~11.7.9~~ 12.7.9 Where expenses and reimbursements are to be reclaimed via charitable funds, claims must be made within 3 months of the date the expenditure was incurred in line with the wider Health Board policy.

12.7.10 Loyalty cards may only be used to purchase goods if the card is registered to the department and not the individual.

~~11.7.11~~

1~~1~~2.7.11 Events and initiatives that promote staff wellbeing are allowed from charitable funds, but they need to demonstrate a direct benefit to the wellbeing of our staff which will then have an indirect benefit to our patients.

Wellbeing can be defined as being happy, healthy, contented, comfortable, or a combination of all these things and apply to both an individual's physical and mental state. It can be understood as how individuals are satisfied with their life or how they evaluate their life both at work and at home, how they feel and how they function.

Such events and initiatives need to be agreed in advance with the Charitable Funds Manager.

12.7.12 Team building activities can be a powerful way to develop collaboration and trust, increase motivation, nurture strengths, address weaknesses and promote cooperation. They need to have a real purpose and be properly planned to make a genuine impact.

Team building must be collective types of activities and events, often involving collaborative tasks, causing a group of people to work together effectively as a team, enhancing social relations and defining roles within teams.

The benefits are listed below:

- Improves problem-solving skills – Taking on new challenges at a different level helps your brain grow and develop, allowing you to get more for your experiences.
- Relieves stress –Work also involves a level of stress. While stress is an excellent motivator at times, knowing how to manage it is key to long-term success.
- Builds teamwork skills – This creates better working relationships allowing your team to be more productive.
- Playing games is fun – All work and no play makes Jack a dull (and unproductive) staff member.
- Improves learning retention – By actively engaging your employees you're enhancing their capabilities for learning retention.

~~11.7.10~~• Active participation in learning improves how much information and skill a person retains from the training.

~~11.7.11~~ 121.7.13 Examples of items typically purchased from charitable funds are shown in Appendix 1.

~~12~~ 13 Value Added Tax - VAT

132.1 Certain items purchased from charitable funds may be exempt from VAT where the goods are: -

- Purchased wholly from charitable funds.
- Purchased by an eligible body wholly from funds provided by a charity or voluntary contributions.

132.2 The following items are exempt from VAT if used for the purposes stated

- Medical, scientific, computer, video, sterilising, laboratory, or refrigeration equipment used in medical research, training, diagnosis, or treatment
- Parts and accessories for use with the above items
- Qualifying aids for people with disabilities
- Computer software solely for use in medical research, diagnosis or treatment and its repair and maintenance

~~12.3~~ 13.3 Zero rating only applies when the item being purchased is used solely for the declared purpose e.g., a computer may qualify where used entirely for medical research. However, zero rating does not apply if the computer were used partly for research and partly for general administrative work.

~~12.4~~ 13.4 Charitable Fund Holders should refer to the VAT Guidelines - HM Custom & Excise - Notice 701/6 (4.11) Appendix 1~~6~~3 to determine the eligibility of purchases for VAT exemption.

~~12.5~~ 13.5 The Procurement Department will complete a VAT exemption certificate, when placing the order, for those goods that are zero rated. A proforma VAT exemption certificate is shown in Appendix 174.

~~12.6~~ 13.6 The Charitable Funds Manager will be responsible for clarifying VAT issues.

~~13~~ 14 Accounting

143.1 The Assistant Director of Finance (Financial Systems & Services) is responsible for configuring the Oracle Financials System to be able to satisfy financial reporting regulation for Charities.

143.2 Accounts must be produced annually and be subject to external audit opinion and be filed with the Charities Commission before 31 January following the accounting year end.

143.3 The accounts must be submitted to the Charitable Funds Committee for approval and signed off by the Aneurin Bevan University Health Board, who act as Corporate Trustee for the charity

~~14~~ 15 Administration Charges

154.1 All costs of administering the funds must be charged to the Charitable Funds accounts. Exchequer funds must not be used to subsidise charges.

154.2 The administration fee should cover the cost of administering the funds on a day-to-day basis and includes charges from the investment companies, finance and general administrative costs and auditors' fees.

154.3 Administration charges are charged to the funds annually. The total charges incurred by the Charity are apportioned based on the average monthly fund

balance. During the year an estimated charge may be applied to ensure that individual fund accounts do not exceed available funds.

~~15~~ 16 Corporate Reporting

16~~5~~.1 On an annual basis the Assistant Director of Finance (Financial Systems & Services) will ensure that year end accounts and reports are prepared, in line with current accounting regulation for Charities and that the Charitable Funds Committee approve the audited accounts.

15~~6~~.2 The Assistant Director of Finance (Financial Systems & Services) will provide a financial report to each Charitable Funds Committee meeting giving details of the current financial position.

16~~5~~.3 The Charitable Funds Manager will ensure that reports, showing opening and closing balances together with transactions, on each fund are available to view by fund managers through the Oracle Reporting Suite – Qliksense~~Financial Business Intelligence (FBI)~~.

17~~6~~. Training

17~~6~~.1 In addition to this Financial Control Procedure a Management User Guide has been developed which is issued to all Charitable Fund Holders. The guide gives practical advice to help managers know their responsibilities and to assist them in common activities such as receiving donations and purchasing goods or services from funds.

17~~6~~.2 The Charitable Funds Team will meet with Charitable Fund Holders on a regular basis to ensure they understand and comply with these procedures.

17~~6~~.3 Further advice and training is available if necessary and can be arranged through the Charitable Funds Office.

~~17.~~ 18 Audit

18~~7~~.1 Internal Audit and Audit Wales will audit Charitable Fund Holders, General Offices and the Finance department periodically to determine the effectiveness of this procedure.

~~17.2~~ 18.2 Auditors will present a report of their findings and recommendations to the Audit, Finance and Risk Committee, Charitable Funds Committee and the Health Board.

~~18.~~ 19 Review

19~~8~~.1 This procedure will be reviewed every three years unless a requirement arises for this to be reviewed earlier.

Appendix 1

Aneurin Bevan Health Charity

CHARITABLE FUNDS
Examples of Items Typically Purchased from Funds

The Health Board (the trustees) are keen that funds are used as soon as practicable following donation. The list below has been developed as an aid to managers and Charitable Fund Account Managers about the type of items that charitable funds can be used for.

If you wish to discuss any specific issues in more detail, please contact:

Charitable Funds Team
Tel No: 01495 765431 (internal calls to ext 55431)
E-mail: Charitable.Funds.ABB@wales.nhs.uk
Chat with us on Teams

Patients Expenditure	**Notes**
Medical equipment	• Donations are often received with a wish that equipment is purchased • Individuals fundraise to purchase a particular piece of equipment • Providing additional equipment would benefit both patients and staff. For example, on a cardiology ward where patients are required to be weighed daily, there is a hoist provided at each end of the ward, but an additional hoist would improve conditions. • Medical equipment when purchased through the charitable funds is VAT exempt • Maintenance costs and consumables need to be considered as these are usually met by revenue budgets
Seasonal activities/Occasions	• Gifts for patients resident in hospital over Christmas • Easter eggs, Halloween items • Decorations for wards and departments at Christmas, Diamond Jubilee etc

	• Ward/Department buffets – open to all, patients, staff and visitors
Therapies	• Dance classes for older adult patients • Musical equipment • Gardening for Mental Health patients • Trips for diabetic and renal patients to show how they can manage their condition in normal day to day activities • Craft items
Environment	• Replacement of bay curtains that are adequate but worn • Cot bedding and mobiles • Pictures and murals • Plants at hospital entrances • Christmas trees and lights at hospital entrances • Garden furniture and benches • Refurbishment of areas to provide bereavement rooms • Redecoration to encompass new ideas of highlighting certain features by using different colours for patients to identify them more easily such as toilet doors, toilet seats
Other equipment	• Game consoles and games – as well as keeping children occupied it also improves patient co-ordination in stroke patients • Televisions • Music centres • Storage containers to tidy up areas • Dignity pegs – to clip bay curtains together • Bariatric equipment such as toilet seats, commodes, anaesthetic cushions and chairs as the Health Board provides standard items but unfortunately the physical size of patients treated is increasing and this exceeds the working load limit. • Bereavement memory boxes • Sympathy cards • Toys for children play areas
Staff Expenditure	**Donations are often given with a wish that they are spent on the staff**

Training courses and conferences (including accommodation and travel expenses)	• Knowledge gained by an individual on a training course can be passed on to other staff and will indirectly benefit patients
International conferences/courses	• Revenue budgets do not usually support international events due to the cost, but knowledge gained from this wider platform can improve practise here
Staff Awards (not cash)	• Prizes for poster presentations at Nurse Conference • Staff Recognition Award – in the form of a trophy • Team building events
Training equipment	• Provide the necessary equipment to enable in-house training • In-house training can be much cheaper than sending staff away on courses as there are no travel costs and staff are on hand in case of emergencies
Other equipment	• Kettles, Microwaves, Fridges. Additional items • as what is provided is not always within staff proximity • Laptops – so staff can access information while away from their area of work • Computers with higher specifications than Health Board standard required to run certain types of software • Storage items – to tidy areas • Smart phones – provided in areas such as district nursing so that staff can access information and also in cardiology where GPs can access on call Consultants • Educational books
Team Building~~Other~~	• Professional Team building events etc. • Escape Rooms • Outdoor Pursuits – with trained personnel • Games – It's a Knockout, Treasure Hunts, Bowling, Paint balling etc. • Invited speakers (motivational) • Room/Hall Hire • Food can be included with above activities but **no alcohol.** • Travel – e.g., bus hire from place of work can be included for above activities within reason.

Staff Wellbeing ~~Environment~~	• Events and Initiatives that promote staff wellbeing which shows a direct benefit in the wellbeing of our staff that has an indirect benefit to our patients. (To be agreed in advance with the Charitable Funds Manager). • ~~Refurbishment of areas to provide additional storage~~ • ~~Improvements to workstation areas~~
Research	• Provided it has gone through the Research and Development Committee • Provided it is for public benefit
Service Promotion	• Items for stands at Big Cheese Event in Caerphilly and the Eisteddfod

Appendix 2

Dear Charitable Fund Holder

Delegation of Charitable Funds

Fund No: Fund Name:

This letter formally delegates responsibility for the management of the above account to you as a Charitable Funds Holder for the financial year commencing 1 April 20XX.

All charitable funds within Aneurin Bevan University Health Board are managed within the umbrella of a registered charity no 1098728. Good governance is essential and therefore as the Charitable Funds Holder there are several responsibilities that you have and must be aware of and comply with as follows:

Authorised Signatories
All accounts must have two signatories identified to support all requests for expenditure from the account; the second signatory to the account must be at least of equivalent seniority in the organisation. Expenditure over certain thresholds will also require additional authorisation in accordance with the following table:

Purchases Up To	Approvers
£5,000	Two account signatories
Additional approvals for	
£5,001-£15,000	Divisional General Manager
£15,001-£25,000	Executive Director
>£25,000	Charitable Funds Committee

Use of the Charitable Account
A "*USER GUIDE"* for Charitable Fund Holders has been developed which provides essential information about how to manage an account from receiving donations and income to how to go about making purchases from the account. Please ensure you are familiar with this document which is attached.

The detailed procedures for managing charitable funds are contained in the Charitable Funds Financial Control Procedure with which you should also be familiar. This can be accessed from the Health Board's intranet.

Annual Reporting
The Charitable Funds Committee has introduced a requirement for account managers to provide an annual report on how the fund has been used in the last

financial year and what the main sources of income were. Most funds are small in value and so only a brief pro-forma return will be required.

For larger funds that exceed £25K in value a slightly more detailed return is required describing the activities of the previous year and also to set out plans for the forthcoming and future years.

The Charitable Funds Committee reserves the right, as trustee of the charity, to delegate the use of the account to another manager if the requirements set out in this letter are not observed.

I would be grateful if you would sign this letter as acceptance of these terms and return it to the Charitable Funds Team by e-mail by no later than 30th April. Charitable.Funds.ABB@wales.nhs.uk

If you have any queries, I would be grateful if you would contact the Charitable Funds Manager on 01495 765414 by TEAMS or by e-mail Charitable.Funds.ABB@wales.nhs.uk
Yours sincerely

Director of Finance

Signature 1 **Signature 2**

Name: **Name:**

Appendix 3

Charitable Fund Holder – Annual Report 20XX/20XX
For the Charitable Funds Committee
For funds less than £25K

Account No: **Account Name:**	
Provisional Fund Balance as at 28.02.20XX	**£**

Financial Summary

Income

Expenditure

Describe your main source of income for the year:

Please describe how the fund was used in the year, including the items purchased and how they were used to improve the service providing examples of benefits to patients and staff. If appropriate, please provide photographs.

Please could you provide quotes from patients and staff about the difference purchases from charitable funds have made to them.

This information is used in the Charitable Funds Annual Report and to provide information to the Charitable Funds Committee.

Non-Cash Items

Have you received goods donated during the year?
Excluding food and other perishable items, please could you list these items indicating an approximate monetary value.

Item Received from Approximate Value

Examples		
Toiletries for patients	*Abergavenny School*	*£75*
I-Pad	*Relatives of patient JB*	*£300*
Hand cream for Staff	*Patient JD*	*£5*
We have to include a value for donated goods within our accounts		

Signed:	
	Charitable Funds Holder
Date:	

Signed:	
	2nd Signatory
Date:	

If you require assistance in completing this form, please contact the Charitable Funds Manager on 01495 765414, by TEAMS or by e-mail Charitable.Funds.ABB@wales.nhs.uk

This form must be completed and returned to the Charitable Funds department by 30th April

Appendix 4

Charitable Fund Holder – Annual Report 20XX/20XX
For the Charitable Funds Committee
For funds more than £25K

Account No: **Account Name:**	
Provisional Fund Balance as at 28.02.XX	

Financial Summary

Income

Expenditure

Describe your main source of income for the year:

Please describe how the fund was used in the year, including the items purchased and how they were used to improve the service providing examples of benefits to patients and staff. If appropriate, please provide photographs.

Please describe detailed plans with estimated costs for the fund in the next twelve months and over the medium term of three years, describing the benefits these purchases will make to both staff and patients.

Please could you provide quotes from patients and staff about the difference purchases from charitable funds have made to them.

Non-Cash Items
Have you received goods donated during the year? **Excluding food and other perishable items, please could you list these items indicating an approximate monetary value.** Item Received from Approximate Value *Examples* *Toiletries for patients Abergavenny School £75* *I-Pad Relatives of patient JB £300* *Hand cream for Staff Patient JD £5*
We have to include a value for donated goods within our accounts
This information is used in the Charitable Funds Annual Report and to provide information to the Charitable Funds Committee.

Signed:	
	Charitable Funds Holder
Date:	

Signed:	
	2nd Signatory
Date:	

If you require assistance in completing this form, please contact the Charitable Funds Manager on 01495 765414, by TEAMS or by e-mail Charitable.Funds.ABB@wales.nhs.uk

This form must be completed and returned to the Charitable Funds department by 30th April

Appendix 5

Request Form to open New Charitable Fund Account Signatories

All delegated charitable fund accounts must have two nominated signatories. The first signatory is the Charitable Fund Holder who takes primary responsibility for the management of the account and must be aware of and be compliant with this financial control procedure. The second signatory must be a person of equivalent or more senior position to the Charitable Fund Holder.

Proposed Name of Account:	
Hospital:	
Department/Ward:	
Purpose of Account:	
1st Account Signatory:	
Name:	
Designation:	
Signed:	
Date:	
2nd Account Signatory:	
Name	
Designation	
Signed	
Date	
Please note the second signatory must be of equal or higher grade	
For Finance Use	
Fund Name:	
Fund No:	
Date Set Up:	

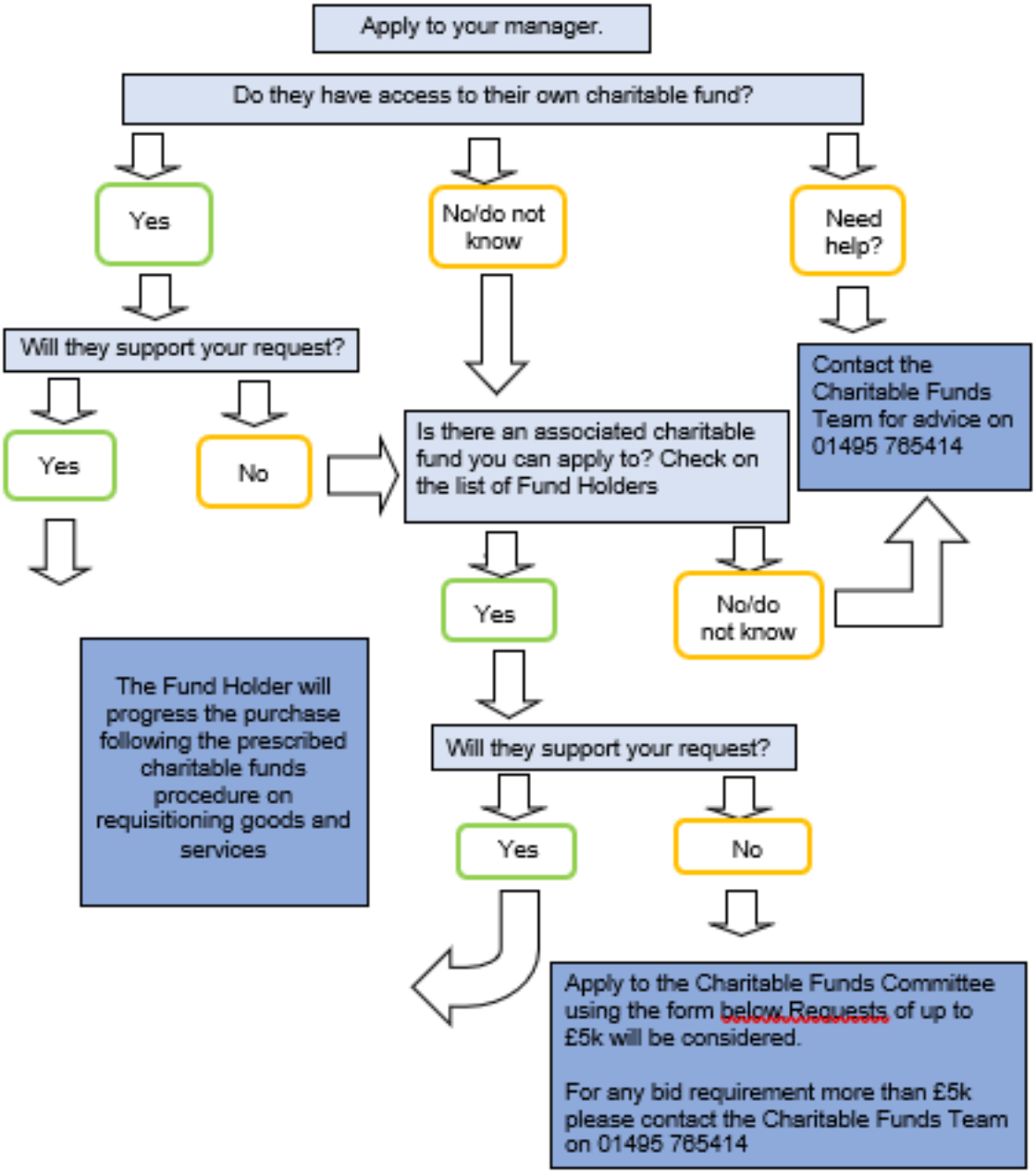
Appendix 6

ACCESSING CHARITABLE FUNDS GUIDE



To ensure that everyone in the Health Board is aware of the charitable funds held and the potential means of accessing these funds, a flow chart follows that will help you access charitable funds that may be available. We have also documented the stages below.

How to apply for Charitable Funds



Stage 1 – Do you have access to your own fund

- Do you have access to your own Charitable Fund within your area of work?
- If yes, you can contact the fund holder to request the use of the fund for the items required.
- If there are sufficient funds available and the request meets the Charitable Funds criteria, then the fund holder can approve the use of the fund for your purchase.
- The purchase will then progress via the normal route which the fund holder will instigate.

Stage 2 – Are there other funds available to use within your direct area of work?

- If the fund is being retained for a specific purchase and the fund holder is unable to support your request, review the list of funds held by other fund holders within your area of work to see if any other funds are held
- If you identify a similar fund, contact the fund holder to see if they would be able to support your request.
- If they can support your request and the purchase meets the Charitable funds criteria the fund holder can approve the use of the fund for your purchase.
- The purchase will then progress via the normal route which the fund holder will instigate.

Stage 3 - Potential use of "related" funds outside your direct area of work

- If the fund holder is unable to support your request due to the funds being held for a specific purchase or insufficient funds, review the list of funds held to see if there are any cross-over funds. These types of funds are held within a specific area but could involve multi-functional teams e.g., a fund held under Stroke where the funding required is for a member of a physiotherapy to attend a stroke related training course.
- Contact the various fund holders to see if they can support your request.
- If they can support your request and the purchase meets the Charitable funds criteria the fund holder can approve the use of the fund for your purchase.
- The purchase will then progress via the normal route which the fund holder will instigate.

Stage 4 – Apply for a small grant scheme

- If (once all avenues have been exhausted in relation to divisional and cross-divisional charitable funds) no funds have been identified, you can apply to the charitable funds committee to seek support of your bid up to a value of £5K.

- At this stage you will need to complete the form below and submit this to the Charitable Funds department who will then take you through the process regarding review/approval for bids under £5K from general charitable funds held by the Charitable Funds Committee.
- If you need help with the completion of the form, please contact the Charitable Funds Team.
- The funds available to the Charity are limited and as such even though this may meet the criteria your bid may not be approved by the Committee due to lack of funds or prioritisation of other requests.
- The Charitable Funds Committee meet quarterly and requests should be completed and submitted accordingly.
- Complete the evaluation form below to show the Charitable Funds Committee how the funds were spent and what a difference this has made.

IF YOU ARE UNCLEAR AS TO THE CORRECT ROUTE TO FOLLOW REGARDING A POTENTIAL BID APPLICATION, PLEASE CONTACT THE CHARITABLE FUNDS TEAM.

Charitable Funds
Small Grants Scheme Application – Max £5k
CFC/SGS xxx

1. Name of ward or department and hospital:
2. Description of item/service required:
3. Cost of item/service plus supplier information: *Please provide a quote if available and ensure that any costs for delivery and installation are included.* *Please state if your costs include VAT.* *If there is any ongoing maintenance or consumable costs, please explain how you intend paying for this.*
4. How will this item/service benefit patients and staff:
5.Have you applied for funding for this item/service elsewhere, including your own charitable fund: *Please give details of who you approached, and the response received.*
6. Other supporting information:
7. Submitted by:

Name:	Job title:

Telephone:	Email:
8. Supported by: *This must be signed by the Directorate Manager/Head of Service*	
Name: Job title: Signature:	Date:
9. Sponsored by: *This must be signed by the Executive Director*	
Name: Job title: Signature:	Date:

Please note you will be asked to complete an evaluation form to demonstrate how your small grant has made a difference.

Please e-mail completed application to: Charitable.Funds.ABB@wales.nhs.uk

For Executive Committee Use

Approved	**Not Approved**
Next Action:	Reason:

For Charitable Funds Committee Use

Approved	**Not Approved**
Next Action:	Reason:

Charitable Funds
Small Grants Evaluation Form

CFC/SGS xxx Amount of Grant £

1. Name of ward or department and hospital:	
2. Description of grant given:	
3. How did your grant make a difference:	
4. How did patients & staff benefit directly or indirectly:	
5.How did you evaluate the impact of your grant:	
.	
6. Please provide patient and staff comments received resulting from the receipt of the grant:	
7. Submitted by:	
Name:	Job title:
Date:	

Appendix 7

Charitable Funds
Request to Apply for External Grant Funding
CFC/EGF xxx

1. Who are you applying to:
2. Description and amount of grant to be applied for:
3. How were you made aware that this grant funding is available:
4. Who will this grant benefit:
5. Please detail below how you plan to spend the grant:
6. What are the reporting/evaluation requirements and timeframes for the grant and please demonstrate below how you plan to achieve this:
7. Where the grant supports staffing costs, what plans are in place to cover unexpected costs such as maternity leave and sickness.

8. Other supporting information:

9. Submitted by:	
Name:	Job title: Department/Service:
Telephone:	Email:
This must be signed by the Head of Service	Name: Signature: Date:

10. Supported by: *This must be signed by both the General Manager and Executive Lead*	
General Manager Name: Job title: Signature: Date:	**Executive Lead** Name: Job title: Signature: Date:

For Executive Committee Use

Approved	**Not Approved**
Next Action:	Reason:

Appendix 8

Donations Procedure

1 Introduction

This procedure for monetary donations is based on the guidelines and recommendations of the Charity Commission and Wales Audit Office.

All donations must be receipted and paid into the Charitable Funds Account.

2 Poster & Leaflets

A poster and leaflet informing people of how to make monetary donations must be displayed in each ward/department. The poster is not designed to ask people for money but to inform potential donors of the procedure. Both the poster and leaflet emphasise that donors must obtain a receipt for their donation.

The poster is included within this appendix as 8a. The Charitable Funds Manager will supply copies of the donation leaflet on request.

3 Ward/Department Level

Authorised Officers, who have been nominated by the Authorised Signatory of each fund, are the only members of staff permitted to accept donations.

Each fund will have its own receipt book.

A receipt must be issued for each donation received. The receipt will be pre-numbered and in three parts and is included in this appendix as 8b:

- Top copy (white) to the donor
- Second copy (pink) to be sent either
  a) to the Charitable Funds Manager, Finance Dept, Ty Gwent, with the donation (**please do not send cash in the post**) or
  b) taken to the General Office with the donation
- Bottom copy (yellow) to be retained in receipt book

The Authorised Officer must sign the receipt. The receipt should clearly indicate which ward or department the donation is for and whether the donation is cash/cheque or other.

Spoilt receipts (the top two copies) should be sent to the Charitable Funds Manager with the bottom copy being retained at ward level.

Fund Holders may request the Charitable Funds Manager to send a letter of thanks when a receipt is deemed to be insufficient.

Cash and cheques must be kept in a locked safe or cash box in the ward/department until it is convenient to take the donation to the General Office or send to the Charitable Funds Manager. The use of a cash box is only suitable for amounts up to £100. Cash Donations exceeding £100 must be taken to the General Office immediately.

Unauthorised persons should not accept donations but should direct the donor to one of the following: -

- An authorised person
- An information leaflet for making monetary donations
- The General Office.

Account managers should ensure that all staff within their area are aware of the donation process.

The Charitable Manager shall be responsible for: -

- Controlling and issuing pre-printed receipts to wards and departments.
- Monitoring receipts
- Ensuring continuity of receipt numbers
- Recording the income in the accounts.

4 General Office

Donations may be made at any General Office in accordance with the Charitable Funds Financial Procedure.

All receipts received from wards/departments by General Offices must be forwarded to the Charitable Funds Manager with their Cash Receipt and Bank Deposit sheets.

5 Post

All postal donations should be sent to: -

The Charitable Funds Manager
Aneurin Bevan University Health Board
PO Box 163
Cwmbran
NP44 3HR

6 Banking

All donations should be banked within one week of receipt.

APPENDIX 8a

Charitable Donations

Members of the public sometimes wish to make a donation for the benefit of our patients and staff. All such donations are gratefully accepted into the registered charity of the organisation. If you wish to make a donation please follow the steps below. Thank you.

Give donation to Staff-in-Charge

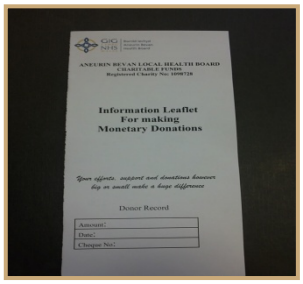


OR

pick up a leaflet for further information

Hand in donation at General Office





Cheques should be made payable to: -
Aneurin Bevan Health Charity

ALWAYS ASK FOR A RECEIPT

Donations are used for the general benefit of patients and staff of Aneurin Bevan University Health Board.

For more details please contact the Charitable Funds Department - Tel No: 01495 765414
Aneurin Bevan University Health Board Charitable Fund and Other Related Charities
Registered Charity No. 1098728

Receipt No: CF D00001

APPENDIX 8b

Aneurin Bevan Health Charity

Registered Charity No: 1098728

RECEIPT FOR INDIVIDUAL CHARITABLE DONATION

I, *Name of Donor*		
Of, *Address of Donor*	Post Code:	
Give to Aneurin Bevan Health Charity		
The sum of	£ (Cheque/Cash/other) Please make cheque payable to Aneurin Bevan Health Charity	For the general purposes of the charity, to be used for patient and staff welfare.
Without imposing any trust it is my wish that my donation should be used for:	Ward/Dept: Hospital: Other - please specify:	

GIFT AID DECLARATION giftaid it

We are able to recover the tax on your donation which allows us to claim a further 25p for every £1 donated. In order that we can qualify for tax relief you must supply us with your full name, home address and post code and tick the box below.

The amount of Income Tax and /or Capital Gains Tax you pay for each tax year must be at least equal to the amount of tax that the charity will reclaim on your gifts for that tax year.

Please Tick if you would like Aneurin Bevan Health Charity to treat this donation as a Gift Aid donation. ☐

Donor's Signature:	
Date:	
Receiving Staff's Signature:	
Staff Name: (please print)	
For Finance Use	
Oracle Receipt No:	
Fund No:	
Gift Aid Ref:	

Appendix 9

Example of thank you letters

The information in bold will need to be changed as required. Please note this is just a guide and covers the basic elements of a thank you letter.

General Donation

Dear ***Name***

Thank you for your donation of ***amount*** *to* ***ward/department.***

We are grateful to receive donations which help to provide additional benefits for the care and treatment of patients, purchase medical equipment, improve the hospital environment and support the continuing education for staff.

On behalf of Aneurin Bevan Health Charity and in particular the staff on the ***ward/department*** I would like to thank you for this kind gift.

Please do not hesitate to contact me if at some time in the future you would like to know how this money is spent.

Yours sincerely

In Loss

Dear ***Name***

We are very sorry to hear of your sad loss. It is kind of you to think of us at this time.

On behalf of Aneurin Bevan Health Charity and in particular the staff on ***name*** ward I would like to thank you for donations totalling ***amount*** in memory of ***name***. This money will be placed in the charitable fund for the ***ward/ department*** at the ***Hospital*** and will be used at the discretion of the Nurses and Doctors to provide additional benefits for the care and treatment of patients and also for the benefit of staff on the ***ward/department.***

Please do not hesitate to contact me if at some time in the future you would like to know how this money is spent.

Yours sincerely

In Lieu of Flowers

Dear ***Name***

Thank you for your donation received in lieu of flowers at the funeral of ***Name***. It is so kind of you to think of us at this sad time.

On behalf of Aneurin Bevan Health Charity and in particular the staff on ***ward/department*** I would like to thank you for donations totalling ***amount.*** This money will be placed in the charitable fund for the ***ward/ department*** at the ***Hospital*** and will be used at the discretion of the Nurses and Doctors to provide additional benefits for the care and treatment of patients and also for the benefit of staff.

Please do not hesitate to contact me if at some time in the future you would like to know how this money is spent.

Yours sincerely

Care Received

Dear ***Name***

Thank you for your donation of ***amount*** in respect of the care you received while a patient at our hospital.

On behalf of Aneurin Bevan Health Charity and in particular the staff on the ***ward/department*** I would like to thank you for this kind gift. The money will be placed in the charitable fund for the ***ward/department*** at the ***Hospital*** and will be used at the discretion of the Nurses and Doctors to provide additional benefits for the care and treatment of patients and also for the benefit of staff on the ***ward/department***.

Please do not hesitate to contact me if at some time in the future you would like to know how this money is spent.

Yours sincerely

Appendix 10

Aneurin Bevan Health Charity

Charitable Fund Procedures

Raffle Request Form



Charitable Fund No.	
Name of Requester:	
Participating Dept:	
Hospital:	

Price per Ticket:	
No of tickets required	

Tickets will be issued in booklets of 4
The maximum number of tickets issued on initial request is 200
Further tickets can be made available for the same raffle if needed.

Date of Draw:	

Please note the closing date will automatically be set to the day before the actual draw

Prize Details	
1st Prize	
2nd Prize	
3rd Prize	
4th Prize	
5th Prize	

If there are more than 5 prizes, the 5th prize will read "Runner-up prizes"

APPENDIX 11

GUIDELINES RE SPONSORSHIP

Aneurin Bevan University Health Board is grateful to individuals who wish to raise money for its hospitals and clinics through sponsorship. All monies raised in this way are placed within the charitable funds of the Aneurin Bevan University Health Board. Charitable funds are intended to provide those additional amenities that will improve the condition under which patients are cared for and treated or the conditions under which staff work.

The following guidelines are provided to help you the organiser and us to ensure that monies raised for the Health Board via sponsorship does come to us.

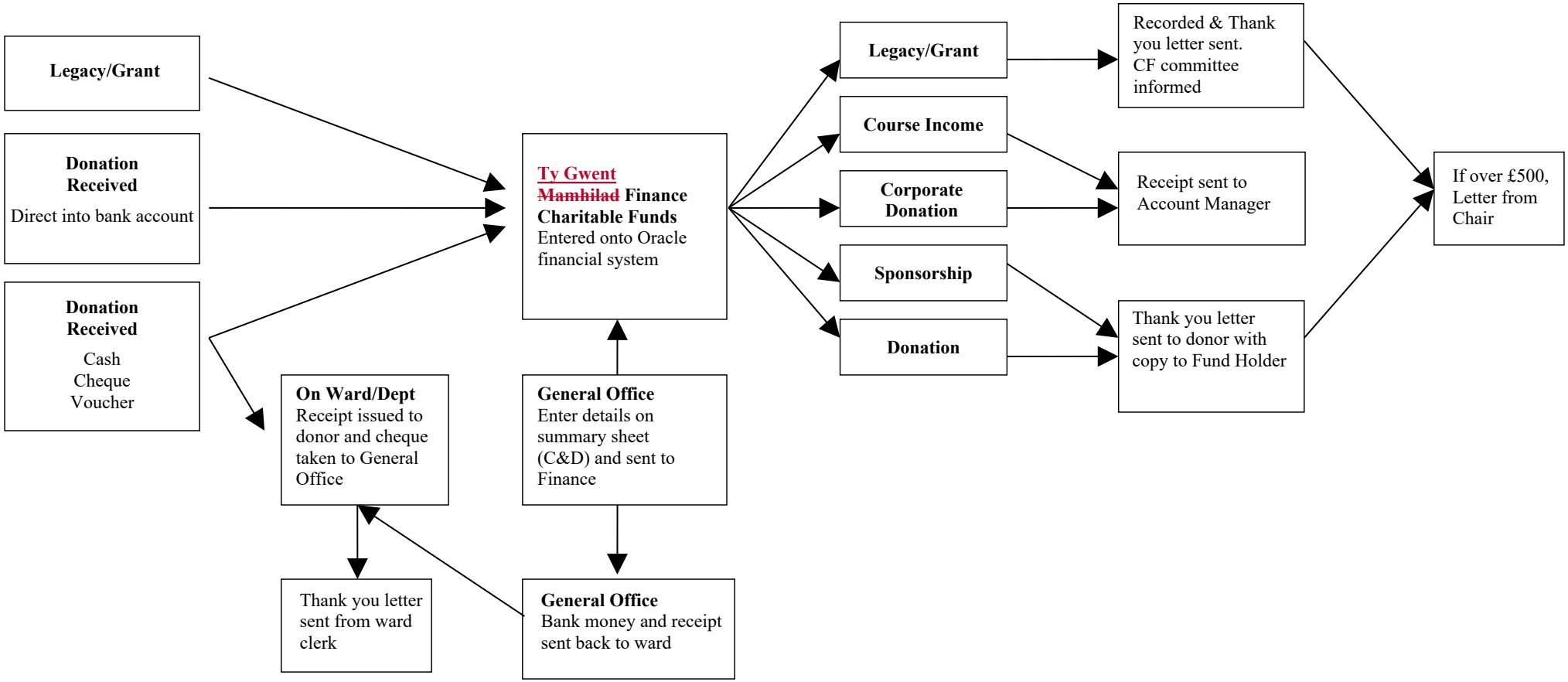
By giving us as much information as possible we may adapt the sponsor form to suit your needs. We need to ensure that people contributing know who is participating in the sponsorship, what type of event is being sponsored, where and when the sponsorship is taking place and most importantly what and where the money is being raised for.

1) Sponsorship Forms can be obtained from the Charitable Funds Manager.
2) If you wish to donate on-line, please visit the website www.justgiving.com and type in Aneurin Bevan and follow the instructions
3) All cheques are to be made payable to Aneurin Bevan Health Charity.
4) All forms and total sponsorship are to be returned to the Charitable Funds Manager.
5) On receiving the sponsorship, the Charitable Funds Manager will issue a receipt or certificate showing the total raised.
6) Certificates may also be obtained for presentation on the day to thank individuals for participating.
7) Arrangements can be made for formal cheque presentation to the relevant department within the Health Board.

If you have any queries or if you require further information, please contact the Charitable Funds Team: -

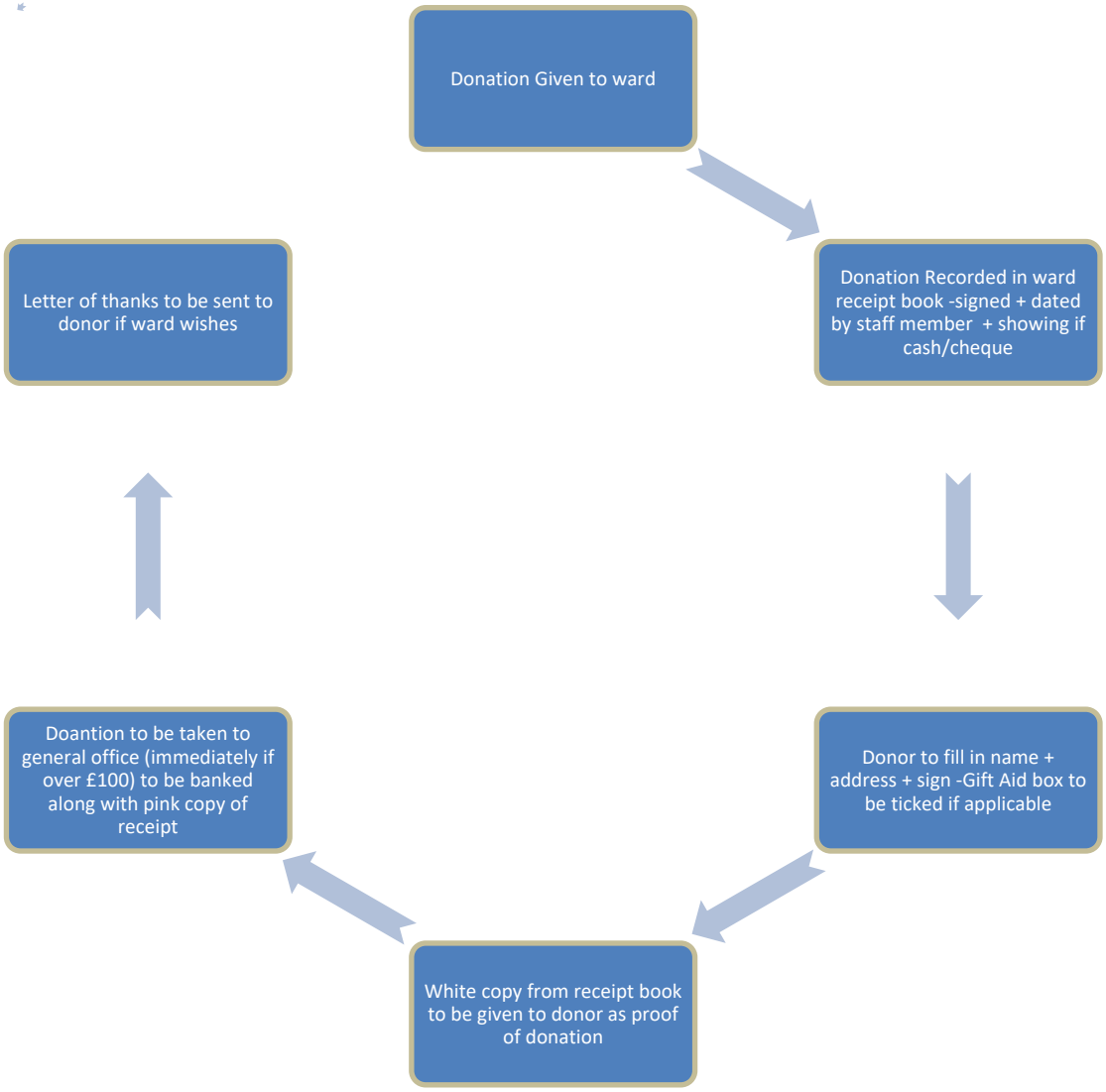
Charitable Funds Team
Aneurin Bevan University Health Board
P O Box 163, Cwmbran NP44 3HR **Tel No: 01495 765431**
Charitable.Funds.ABB@wales.nhs.uk

APPENDIX ~~6~~12 - PROCESS for ACKNOWLEDGING DONATIONS



Appendix 12~~6~~a

Ward Donation Procedure



Appendix 7

Donations Procedure

1 Introduction

This procedure for monetary donations is based on the guidelines and recommendations of the Charity Commission and Wales Audit Office.

All donations must be receipted and paid into the Charitable Funds Account.

2 Poster & Leaflets

A poster and leaflet informing people of how to make monetary donations must be displayed in each ward/department. The poster is not designed to ask people for money but to inform potential donors of the procedure. Both the poster and leaflet emphasise that donors must obtain a receipt for their donation.

The poster is included within this appendix. The Charitable Funds Manager will supply copies of the donation leaflet on request.

3 Ward/Department Level

Authorised Officers, who have been nominated by the Authorised Signatory of each fund, are the only members of staff permitted to accept donations.

Each fund will have its own receipt book.

A receipt must be issued for each donation received. The receipt will be pre-numbered and in three parts (see Appendix 11):

- Top copy (white) to the donor
- Second copy (pink) to be sent either
  a) to the Charitable Funds Manager, Finance Dept, C Block, Mamhilad House with the donation (**please do not send cash in the post**) or
  b) taken to the General Office with the donation
- Bottom copy (yellow) to be retained in receipt book

The Authorised Officer must sign the receipt. The receipt should clearly indicate which ward or department the donation is for and whether the donation is cash/cheque or other.

~~Spoilt receipts (the top two copies) should be sent to the Charitable Funds Manager with the bottom copy being retained at ward level.~~

~~Fund Holders may request the Charitable Funds Manager to send a letter of thanks when a receipt is deemed to be insufficient.~~

~~Cash and cheques must be kept in a locked safe or cash box in the ward/department until it is convenient to take the donation to the General Office or send to the Charitable Funds Manager. The use of a cash box is only suitable for amounts up to £100. Cash Donations exceeding £100 must be taken to the General Office immediately.~~

~~Unauthorised persons should not accept donations but should direct the donor to one of the following: -~~

- ~~An authorised person~~
- ~~An information leaflet for making monetary donations~~
- ~~The General Office.~~

~~Account managers should ensure that all staff within their area are aware of the donation process.~~

~~The Charitable Manager shall be responsible for: -~~

- ~~Controlling and issuing pre-printed receipts to wards and departments.~~
- ~~Monitoring receipts~~
- ~~Ensuring continuity of receipt numbers~~
- ~~Recording the income in the accounts.~~

~~4 General Office~~

~~Donations may be made at any General Office in accordance with the Charitable Funds Financial Procedure.~~

~~All receipts received from wards/departments by General Offices must be forwarded to the Charitable Funds Manager with their Cash Receipt and Bank Deposit sheets.~~

~~5 Post~~

~~All postal donations should be sent to: -~~

~~The Charitable Funds Manager~~
~~Aneurin Bevan University Health Board~~
~~PO Box 10~~
~~Pontypool~~
~~NP4 0XG~~

~~6 Banking~~

~~All donations should be banked within one week of receipt.~~

APPENDIX 7

Charitable Donations

Members of the public sometimes wish to make a donation for the benefit of our patients and staff. All such donations are gratefully accepted into the registered charity of the organisation. If you wish to make a donation please follow the steps below. Thank you.

Give donation to Staff in Charge

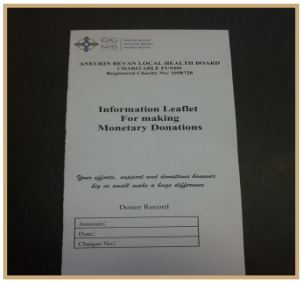


OR

Hand in donation at General Office



Pick up a leaflet for further information



Cheques should be made payable to: -
Aneurin Bevan Health Charity

ALWAYS ASK FOR A RECEIPT

Donations are used for the general benefit of patients and staff of Aneurin Bevan University Health Board.

For more details please contact the Charitable Funds Department - Tel No: 01495 765414
Aneurin Bevan University Health Board Charitable Fund and Other Related Charities
Registered Charity No. 1098728

Receipt No: CF D00001

APPENDIX 7

Aneurin Bevan Health Charity

Registered Charity No: 1098728

RECEIPT FOR INDIVIDUAL CHARITABLE DONATION

I, *Name of Donor*		
Of, *Address of Donor*	Post Code:	
Give to Aneurin Bevan Health Charity		
The sum of	£ (Cheque/Cash/other) Please make cheque payable to Aneurin Bevan Health Charity	For the general purposes of the charity, to be used for patient and staff welfare.
Without imposing any trust it is my wish that my donation should be used for:	Ward/Dept: Hospital: Other - please specify:	

GIFT AID DECLARATION giftaid it

We are able to recover the tax on your donation which allows us to claim a further 25p for every £1 donated. In order that we can qualify for tax relief you must supply us with your full name, home address and post code and tick the box below.

The amount of Income Tax and /or Capital Gains Tax you pay for each tax year must be at least equal to the amount of tax that the charity will reclaim on your gifts for that tax year.

Please Tick if you would like Aneurin Bevan Health Charity to treat this donation as a Gift Aid donation. ☐

Donor's Signature:	
Date:	
Receiving Staff's Signature:	
Staff Name: (please print)	
For Finance Use	
Oracle Receipt No:	
Fund No:	
Gift Aid Ref:	

Appendix 8

Example of thank you letters

The information in bold will need to be changed as required. Please note this is just a guide and covers the basic elements of a thank you letter.

General Donation

Dear ***Name***

Thank you for your donation of ***amount*** *to* ***ward/department*****.**

We are grateful to receive donations which help to provide additional benefits for the care and treatment of patients, purchase medical equipment, improve the hospital environment and support the continuing education for staff.

On behalf of Aneurin Bevan Health Charity and in particular the staff on the ***ward/department*** I would like to thank you for this kind gift.

Please do not hesitate to contact me if at some time in the future you would like to know how this money is spent.

Yours sincerely

In Loss

Dear ***Name***

We are very sorry to hear of your sad loss. It is kind of you to think of us at this time.

On behalf of Aneurin Bevan Health Charity and in particular the staff on ***name*** ward I would like to thank you for donations totalling ***amount*** in memory of ***name***. This money will be placed in the charitable fund for the ***ward/ department*** at the ***Hospital*** and will be used at the discretion of the Nurses and Doctors to provide additional benefits for the care and treatment of patients and also for the benefit of staff on the ***ward/department*****.**

Please do not hesitate to contact me if at some time in the future you would like to know how this money is spent.

Yours sincerely

In Lieu of Flowers

Dear ***Name***

Thank you for your donation received in lieu of flowers at the funeral of ***Name***. It is so kind of you to think of us at this sad time.

On behalf of Aneurin Bevan Health Charity and in particular the staff on ***ward/department*** I would like to thank you for donations totalling ***amount.*** This money will be placed in the charitable fund for the ***ward/department*** at the ***Hospital*** and will be used at the discretion of the Nurses and Doctors to provide additional benefits for the care and treatment of patients and also for the benefit of staff.

Please do not hesitate to contact me if at some time in the future you would like to know how this money is spent.

Yours sincerely

Care Received

Dear ***Name***

Thank you for your donation of ***amount*** in respect of the care you received while a patient at our hospital.

On behalf of Aneurin Bevan Health Charity and in particular the staff on the ***ward/department*** I would like to thank you for this kind gift. The money will be placed in the charitable fund for the ***ward/department*** at the ***Hospital*** and will be used at the discretion of the Nurses and Doctors to provide additional benefits for the care and treatment of patients and also for the benefit of staff on the ***ward/department***.

Please do not hesitate to contact me if at some time in the future you would like to know how this money is spent.

Yours sincerely

APPENDIX 9

Aneurin Bevan Health Charity

Charitable Fund Procedures

Raffle Request Form



Charitable Fund No.	
Name of Requester:	
Participating Dept:	
Hospital:	

Price per Ticket:	
No of tickets required	

Tickets will be issued in booklets of 4
The maximum number of tickets issued on initial request is 200
Further tickets can be made available for the same raffle if needed.

Date of Draw:	

Please note the closing date will automatically be set to the day before the actual draw

Prize Details	
1st Prize	
2nd Prize	
3rd Prize	
4th Prize	
5th Prize	

If there are more than 5 prizes, the 5th prize will read "Runner-up prizes"

APPENDIX 10

GUIDELINES RE SPONSORSHIP

Aneurin Bevan University Health Board is grateful to individuals who wish to raise money for its hospitals and clinics through sponsorship. All monies raised in this way are placed within the charitable funds of the Aneurin Bevan University Health Board. Charitable funds are intended to provide those additional amenities that will improve the condition under which patients are cared for and treated or the conditions under which staff work.

The following guidelines are provided to help you the organiser and us to ensure that monies raised for the Health Board via sponsorship does come to us.

By giving us as much information as possible we may adapt the sponsor form to suit your needs. We need to ensure that people contributing know who is participating in the sponsorship, what type of event is being sponsored, where and when the sponsorship is taking place and most importantly what and where the money is being raised for.

1) Sponsorship Forms can be obtained from the Charitable Funds Manager.
2) If you wish to donate on-line, please visit the website www.justgiving.com and type in Aneurin Bevan and follow the instructions
3) All cheques are to be made payable to Aneurin Bevan Health Charity.
4) All forms and total sponsorship are to be returned to the Charitable Funds Manager.
5) On receiving the sponsorship, the Charitable Funds Manager will issue a receipt or certificate showing the total raised.
6) Certificates may also be obtained for presentation on the day to thank individuals for participating.
7) Arrangements can be made for formal cheque presentation to the relevant department within the Health Board.

If you have any queries or if you require further information, please contact the Charitable Funds Team: -

Charitable Funds Team
Aneurin Bevan University Health Board
P O Box 10, Pontypool NP4 0XG **Tel No: 01495 765431**
Charitable.Funds.ABB@wales.nhs.uk

Appendix 1~~3~~1

Charitable Funds – Investment and Reserves Policy

1. Purpose

Aneurin Bevan University Health Board, as a Corporate Trustee, needs to ensure it can demonstrate effective management of current charitable funds, whether invested or held as liquid assets to meet forecast expenditure. It also needs to ensure donations are spent on a timely basis whilst maintaining a level of reserves that will ensure the ongoing viability of the charity.

The purpose of this document is to detail the current investment and reserves policy for Aneurin Bevan Health Charity.

2. Investment Overview

The power of investment given to trustees is detailed in Section 3 of the Trustees Act 2000. This act imposes a duty on those acting as Charity trustees, when exercising their powers of investment, to consider the need for diversification, to reduce the risk of loss should an investment fail.

In addition, as Corporate Trustee, Aneurin Bevan University Health Board, in line with the ethos of promoting patient care, will attempt to ensure that all investments are ethically and environmentally sound and are not opposed to the purpose of the charity.

3. Investment Policy

The overall aim in investment of funds is to maximise total return whilst balancing risks and requirement for income. It has been agreed that:

a) The Health Board's Charitable Funds can be invested in several different forms of investments, in line with the Trustees Investment Act 1961.
b) The Charitable Fund Committee, on behalf of Aneurin Bevan University Health Board, has the delegated authority to appoint investment advisors. The investment management company will operate within the limits set down in this policy.
c) The performance of the investment management company will be reviewed annually by the trustee and will be subject to re-appointment on a 3 yearly basis with an agreement

to extend for a further 2 years. Any proposed change in provider shall be subject to a formal tender process.

d) The managed investment portfolio will be a minimum of 75% of the total funds held.
e) The working capital balance will be retained in a Government Banking Service, interest bearing, account which will be distinct from Aneurin Bevan University Health Board's 'revenue' account, to enable daily cash requirements to be met. At all times, it must be ensured that sufficient liquid resources are maintained to meet routine payment requirements.
f) Investments are to be made within the limits of the Health Board's Ethical Policy, which is to exclude those companies whose main business is related to the production or sale of tobacco or alcohol and companies with significant involvement in coal, oil and gas, armaments, gambling and pornography.
g) The Charitable Funds Committee or a nominated representative should instruct the Investment Management Company to: -
    - Provide details of all transactions undertaken on behalf of charity.
    - Hold stock and share certificates for safekeeping.
    - Provide details of dividends and interest received.
    - Provide valuations on request.
    - Attend the Charitable Funds Committee at least annually to formally present the investment performance of the period

4. Reserves Policy

The Charitable Funds Committee has considered the Charity's reserve policy, observing both Charity Commission guidance on reserves and the current level of funds held.

If reserves are too high, the charity is retaining funds without justification and this could constitute a breach of trust. If reserves are too low, the fund's ability to meet future commitments or needs may be at risk.

The Charity operates on the basis that it only spends what it has received and does not rely on future donations to meet its commitments. Therefore, the reserves should be set at a level sufficient to cover the liabilities that face the charity, namely the cost of administering the funds and any unrealised losses.

The value of reserves held will change each year and will be maintained from several sources including those unrestricted funds that have not been committed and are freely available to spend on any of the charity's purposes and any unrealised gain.

5. Review

The Health Board's Charitable Funds Investment and Reserve policy will be reviewed annually by the Charitable Funds Committee.

Appendix 1~~4~~2

PURCHASES FROM CHARITABLE FUNDS

I. Purchases For Goods and Services

Purchases for goods and services, including reimbursements, should be made via the ABUHB Oracle Financial system and be supported by an official order. An order can be issued to a supplier from the procurement department on receipt of an approved requisition. When goods are received, they need to be receipted to allow invoices to be paid. The process of requisition, order, receipt and payment is shown below and included as a flow chart in appendix 1~~4~~2a

A. Requisition

Requisitions are raised via Oracle SSP **(**Self Service Procurement) and requisitioners must:

- Provide as many details as possible of the goods or services to be ordered and any quotations received must be attached.
- Clearly indicate "CHARITABLE FUNDS".
- Include financial code (fund number).
- Be authorised in accordance with the approval hierarchy set out in section 8 above.
- Ensure that all requisitions are submitted via the Charitable Funds Manager

Before processing the requisition, the Charitable Funds Manager will:

- Check that sufficient funds exist against the specific fund being used.
- Check the appropriateness of expenditure from Charitable Funds.
- Check eligibility for VAT exemption.
- Check authorisation as per approval hierarchy.

B. Order

Once the requisition has been approved the Procurement Department will issue an official order together with a VAT exemption certificate where necessary and the supplier will deliver goods or services in due course.

An electronic copy of the order will be available on the Oracle system.

C. Receipt of Goods/Services

When goods have been received, the account manager should immediately acknowledge delivery of goods to enable subsequent invoices to be paid. The delivery must be 'receipted' in the Receipting module of the Oracle SSP system detailing the date of receipt, number of units received etc.

D. Payment

When an invoice is issued from the supplier the Charitable Funds Section will match the invoice to the receipted Oracle order to enable payment to be processed.

E. Payment to Fund Holder

Charitable Fund Holders must obtain authorisation from a second authorised signatory when requesting reimbursement of purchases, they have made on behalf of the charitable fund.

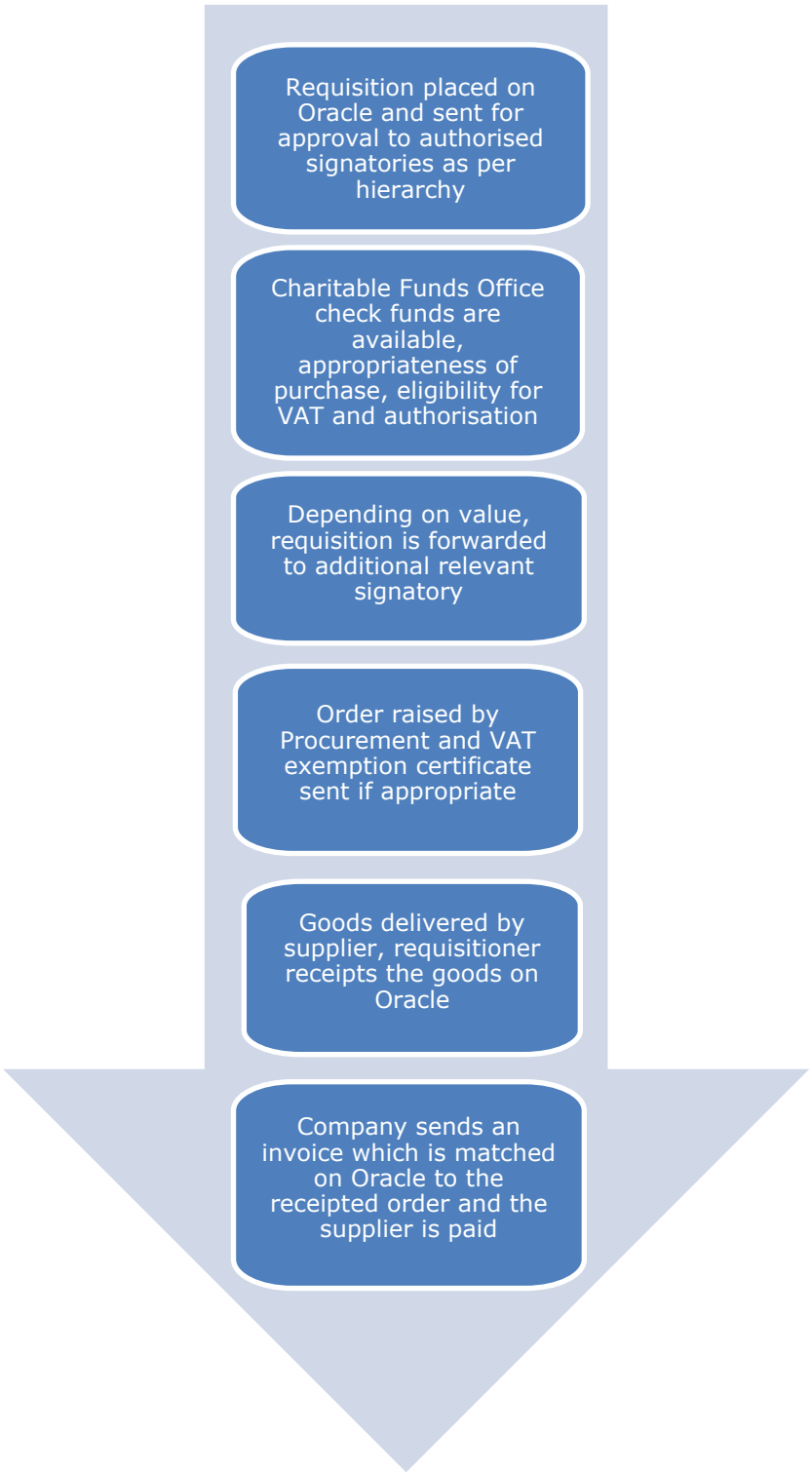
F. Requests to Pay Employees

Where an additional payment is required to be made to an individual employee for undertaking tasks relating to the objects of the charitable fund then a **Staff Payments Claim Form** must be completed. An example is shown in **Appendix 1~~2~~4b.**

Please note that ABUHB has a responsibility to ensure all income due to employees complies with taxation regulations and this responsibility extends to charitable funds, including staff prizes given as cash.

Appendix 1~~4~~2a

Charitable Funds Ordering Process



APPENDIX 142b

ANEURIN BEVAN UNIVERSITY HEALTH BOARD
CHARITABLE FUNDS
STAFF PAYMENTS - CLAIM FORM
(For staff that are employed by Aneurin Bevan ULHB)

PAYMENTS TO STAFF THROUGH PAYROLL

To be completed by claimant

Name:

Address:

Payroll No:	**Grade:**

Dates Worked	**Sessions Worked**	**Payment Claimed**

Signed: _____

Date: _____

To be completed by Authorised Signatory / Fund Holder

Payment to be made:
Fund to be charged:
Authorised by:
Date:

Please send claim to Payroll Services, Floor 4, Companies House, Cardiff or email Payroll.Services2@wales.nhs.uk

Please e-mailsend a copy of this form to ~~Charitable Funds, Finance Department, C Block, Mamhilad or email to~~ Charitable.Funds.ABB@wales.nhs.uk

To be completed by Paymaster Services

Actioned by: _____ Month / Week_____

Appendix 15~~3~~

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Charitable Funds Committee
Bid Ref: CFC –

Bid for **(equip/service)**
For **(Dept /Service)**
At **(Site)**

1. Introduction

This section should give a succinct summary of what the committee is being asked to support. It should not contain detail.

It should contain the total cost of the bid.

2. Background

This section should give a brief background to the service for which the bid forms part and how the requirement for the bid has arisen.

3. Key Issues

3.1 Category of Bid

This bid relates to: *(please delete as appropriate)*

Purchase of equipment.

Patient's welfare and amenities.

Staff education and welfare.

3.2 Description of the Bid

This section should detail the key issues that the successful bid will address in terms of the service.

Please explain why this request is not being met through core funds.
What alternatives have been considered?

3.3 Outcome Measures & Benefits

3.3.1 Activity Analysis

Show activity relating to the proposed equipment or new service. For example relating to equipment:

- *No of patients/procedures per annum.*
- *Frequency of use (e.g. twice / week)*

3.3.2 Benefits

Benefits should be clearly described relating to the bid. Outcome measures should be described in activity terms if applicable. For example, if the bid says that the investment in a new post will lead to a specific outcome then the activities leading to the outcome and the change in the outcome measures should be described and quantified.

Whilst the committee does not generally encourage bids to support additional staff any such bid will need to have carefully developed this section.

In the case of bids for the benefit of staff projects and programmes the report will need to demonstrate how it meets 'public benefit'. This is a Charity Commission requirement and is usually easy to demonstrate in the case of equipment purchases but may be more tenuous in the case of staff projects and programmes.

3.4 If the Bid is not Supported

This section should set out what the alternatives are to the department submitting the bid if it is turned down.

3.5 Bids relating to Additional Staff Resources

These kinds of bids are not generally supported but that is not to say they are never supported. However, the following additional information is required:

- *What period is the committee being asked to fund staff?*
- *What is the tenure of appointment proposed for the new staff?*
- *Who has accountability for the staff?*
- *What happens when funding comes to an end to the staff and the new service that they have provided?*
- *It must be clear what plans are in place to cover unexpected costs such as maternity leave and sickness. This particularly applies to grant funding as they will not normally support these items.*

4. Financial Analysis

4.1 Funding Requested

This should state the total costs, how much the committee is being asked to fund and the basis of how it has been costed. If costs straddle more than 1 financial year a clear profile of costs much be shown.

What is the proposed procurement route?

4.2 Availability of Local Charitable Funds

It should be clearly stated in this section if there are any available local charitable funds. Full explanations must be given if these funds cannot be used.

Fund Ref: Current balance

4.3 Revenue Costs

This section should set out any revenue costs associated with the bid (e.g. maintenance contracts) or say that there are none if that is applicable.

4.4 Revenue Costs - Affordability

This section should describe how any increased revenue costs will be paid for. It is not sufficient to simply say 'from the budget' in the context of the current financial position of the health board. It

should describe other wider financial benefits. For example, new equipment which may lead to a lower length of stay in hospital. In this example it might not be possible to describe actual cost savings but it is nevertheless a definite benefit and should be included.

5.0 Conclusions and Recommendations

This section should summarise what the committee is being asked to support.

Bid Prepared by:

Name:	
Title:	
Date:	

Supported by Division

General Manager:	
Signature:	
Date:	

Executive Sponsor

Signature:	
Date:	

Appendix 16

Charitable Purchases – VAT Guidance
HM Customs and Excise Notice 701/6 (4.11)
Charity funded equipment for medical, veterinary etc uses

Not eligible for relief	Goods	Eligible for relief as:
X	Air Conditioners	
	Air control systems, specialist (capable of precisely controlling pressure, temperature and humi	Laboratory equipment
X	Air filters, general	
	Air filtration systems, specialist (built to meet specific circumstances)	Laboratory equipment
X	Air showers	
X	Alarms, security or smoke	
X	Alarm bracelets	
X	Alcohol spray	
	Anaesthetic apparatus	Medical equipment
	Animal cages, specialist (for example, free from chemicals and not available for consumer use)	Laboratory equipment
	Aprons, lead lined for x-ray protection	Medical equipment
X	Aprons, other	
	Artificial Limbs	Goods for use of disabled person
	Autoclaves	Sterilising equipment
X	Bactericides	
	Bandages	Medical equipment
	Barometers	Scientific equipment
	Bedding, specialist (for example, free from chemicals) for animal cages	Laboratory equipment
	Bedpans	Medical equipment
	Bedpan washers, with sterilising steam cycle	Sterilising equipment
X	Bedpan washers, other	
	Beds, highly specialised e.g. net suspension or medical water beds	Medical equipment

	Beds, hospital – with tilting action or variable height features	Goods for use of disabled person
X	Biocidal sprays	
X	Blankets	
	Bunsen burners	Laboratory equipment
	Bottle washers, animal cage specific	Laboratory equipment
	Cages, animal, specialist (for example, free from chemicals and not available for consumer use)	Laboratory equipment
X	Cameras, still	
	Cameras, video	Video equipment
X	Cameras, digital (with video capability)	
	Cameras, thermal imaging	Scientific Equipment
X	Cartridges, printer	
X	Catering equipment	
	Catheters	Medical equipment
X	CD players or recorders	
	Centrifuges	Scientific or laboratory equipment
	Clamps – medical	Medical equipment
X	Cleaning equipment	
X	Closed circuit television systems	
	Commode chairs	Goods for use of disabled person
	Computer disks and tapes	Accessory to computer equipment
	Computer keyboards	Computer equipment
	Computer mouse	Accessory to computer equipment
	Computer printers	Accessory to computer equipment
	Computer screens	Accessory to computer equipment
	Computer screen filters	Accessory to computer equipment
	Computer servers	Computer equipment

X	Computer stationery	
	Computer tablet, including iPads	Computer equipment, provided there is evidence the item is to be used mainly for medical or veterinary research, and so on.
X	Cotton wool	
X	Curtains	
X	Data	
	Deep freezers	Refrigeration equipment
	Dental chairs	Medical equipment
	Dental drills	Medical equipment
	Dental mirrors	Medical equipment
	Dental spittoons	Medical equipment
X	Disinfectants	
	Drip poles	Medical equipment
X	Drugs trolleys	
	DVD players, recorders or blank DVDs	Video equipment
	Endoscopes	Medical equipment
	Electro-cardiographs	Medical equipment
X	Ethernet	
	Eye test charts	Medical equipment
	Examination couches, adjustable	Medical equipment
	First aid kits – supplied as pre-packaged units	Medical equipment
	Forceps	Medical equipment
X	Fuel	
	Fume cupboards	Laboratory equipment
X	Gloves, nitrile	
	Gloves, surgical	Medical equipment
X	Gloves, other	
X	Gymnasium equipment	
X	Hearing aids	
	Heart pacemakers	Medical equipment or goods for use disabled person
	Hoists and patient lifting devices	Goods for use disabled person
	Howie-style lab coats (reusable)	Laboratory equipment

X	Howie-style lab coats (disposable)	
	Hypodermic needles	Medical equipment
	Ice making machines	Refrigeration equipment
	Identification bracelets for patients	Medical equipment
	iPads	Computer equipment
X	iPhones	
	Kidney bowls	Medical equipment
	Lab coats, including Howie-style reusable lab coats	Laboratory equipment
X	Laboratory animals	
	Laboratory benches	Laboratory equipment
	Laboratory glassware	Laboratory equipment
X	Lockers	
	Mattresses, specially designed for the relief/prevention of pressure sores	Medical equipment
	Medicine measures, graduated	Medical equipment
	Microscopes	Scientific or laboratory equipment
X	Mobile phones	
X	Nurse call systems	
X	Occupation therapy materials	
	Operating lights	Medical equipment
X	Overbed tables	
X	Overhead projecting units	
	Pacemakers	Medical equipment or goods for use disabled person
X	Pagers	
	Patient trolleys and stretchers	Medical equipment
	Physiotherapy equipment, specialised – other than gymnasium equipment	Medical equipment
	Pillows orthopaedic, specially designed and used for neck or spinal injuries	Medical equipment

X	Pillows, other	
	Pipettes	Laboratory Equipment
X	Power supplies, including UPS	
X	Printer cartridges	
X	Projectors (including ceiling mounted options)	
	Rack washers, animal cage specific	Medical equipment
	Radiography equipment	Medical equipment
	Renal dialysis units	Medical equipment or goods for use of disabled person
	Resuscitation equipment	Medical equipment
	Resuscitation dummies	Resuscitation training model
X	Routers	
	Scalpels	Medical equipment
X	Screens	
	Sharps bins	Medical equipment
X	Smartphones	
X	Sound systems	
	Specialist animal cages (for example, free from chemicals and not available for consumer use)	Laboratory equipment
	Specialist bedding (for example, free from chemicals) for animal cages	Laboratory equipment
	Sphygmomanometers	Medical equipment
	Splints	Medical equipment
X	Stationery	
X	Sterilising Solutions	
X	Sterilising wipes	
	Stethoscopes	Medical equipment
	Surgical gloves	Medical equipment
	Surgical gowns	Medical equipment
	Surgical masks	Medical equipment
	Suture needles	Medical equipment
	Swabs	Medical equipment
	Syringes	Medical equipment
	Tablet, computer (including iPads)	Computer equipment, provided there is evidence the item is to be used mainly for

		medical or veterinary research, and so on.
X	Tape recorders	
X	Telephones	
X	Television Sets	
	Test tubes	Laboratory equipment
	Thermal imaging cameras	Scientific equipment
	Thermometers, clinical	Medical equipment
	Thermometers, other	Scientific equipment
	Tongue depressors	Medical equipment
X	Towels	
X	Uniforms	
	USB memory sticks	Computer equipment
	Video cameras	Video equipment
	Video tapes	Video equipment
	Video players	Video equipment
	Video monitor	Video equipment
X	Wall screens or monitors	
X	Waste disposal bags, boxes, jars & snacks	
X	Waste disposal machinery	
	Weighing machines	Scientific equipment
	Wheelchairs	Goods for use of disabled person
X	WiFi systems	
X	Wipes, clean room	
X	Wipes, sterilising	
	Wound dressings	Medical equipment
	X-ray films/plates	Medical equipment
	X-ray machines-medical	Medical equipment
	X-ray machines-other	Scientific equipment
	X-ray viewers	Medical equipment

Appendix 174

Aneurin Bevan Health Charity

Certificate for purchases/imports using donated funds

Purchase/import by an eligible NHS body of medical, scientific equipment, etc

1	I	
2	of	Aneurin Bevan University Health Board PO Box 1630 ~~Pontypool~~ Cwmbran NP44 3HR ~~0XG~~
3	Which is	A National Health Service Health Board
4	Declare that the above named is purchasing/importing	Relevant Goods (Medical Equipment)
5	Which I believe are	Medical Equipment, Scientific Equipment, Computer Equipment, Video Equipment, Sterilising Equipment, Laboratory Equipment, Refrigeration Equipment or parts of accessories of the equipment named above.
6	From	

and paid for this supply with funds provided entirely by charitable or voluntary contributions.

I also declare that the goods will be used in either medical research, treatment, diagnosis or training and I claim relief from value added tax under item 5, Group 15 of Schedule 8 to the Value Added Tax Act 1994.

SIGNATURE	
DATE	

Aneurin Bevan University Health Board

Financial Control Procedure

Approval of Orders Greater Than £100K

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

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Procedure Statement **2**
Aims **2**
Objectives **2**
Scope **2**
Roles and Responsibilities **3**
General **3**
Resources **9**
Further Information **9**
Audit **10**
Review **10**
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1 Introduction

All purchase orders raised (and invoices subsequently paid) by Aneurin Bevan Health Board must adhere to requirements under standing orders (SOs), standing financial instructions (SFIs), financial control procedures (FCPs), the scheme of delegation and Welsh Government requirements.

2 Procedure Statement

To ensure that the correct authorisation is obtained in all cases, the following sets out the procedure to approve requisitions for purchases of goods or services, with a value greater than £100k. Authorisation to purchase goods or services with a value of more than £100k must be sought according to section 7 of this document **before** a commitment is made. All purchases must follow the appropriate procurement route according to standing financial instruction (SFIs). Authorisers must be recorded on the authorised signatory list (ASL) held within the corporate finance department.

3 Aims

To provide guidance to all staff ordering goods or services with a total value in excess of £100,000.

4 Objectives

To ensure that all goods and services ordered by Health Board staff are properly authorised in line with SOs, SFIs, FCPs, the scheme of delegation and Welsh Government requirements.

5 Scope

This procedure relates to the authorisation of all requisitions (including capital) raised in Oracle. In line with the all Wales No PO No Pay policy, all purchases of goods and services (unless the purchase has been agreed on an all Wales basis as an exception) must be supported by a Health Board official order which has been properly authorised. See Table 1 for general scheme of delegation.

Where the purchase of goods and services to meet the day to day needs of the organisation regularly exceed £100,000 there are specific approval limits within the scheme of delegation to accommodate this see Table 2.

Losses and special payments are subject to a separate FCP.

6 Roles and Responsibilities

6.1 Budget holders

Are responsible for:

- Ensuring that the relevant authorisers (i.e. Chief Executive, Chair, Board) are made aware of the intention to place any requisition with a total value (inclusive of VAT) for goods or services over £100,000 (except where specific approval limits apply within the scheme of delegation: Table 2)
- Completing the relevant documentation and obtaining the correct level of approval prior to submitting a requisition within the Oracle system
- Ensuring that the correct procurement procedure is followed

6.2 Procurement services

Are responsible for:

- Ensuring that the correct documentation is in place prior to placing an order for goods or services with a total value (inclusive of VAT) over £100,000 (except where specific approval limits apply within the scheme of delegation: Table 2).
- Providing procurement advice

6.3 Chief Executive, Chair, Board

Are responsible for:

- Authorisation of expenditure over £100,000 in line with the scheme of delegation

7 General

All Purchase Orders raised by Aneurin Bevan Health Board must adhere to

- SOs, SFIs, and FCPs
- The scheme of delegation
- Welsh Government requirements

- The relevant procurement requirements
- Any other policy or procedure which may apply

To ensure that the correct approval is obtained in all cases, the following sets out the procedure to approve orders greater than £100k (inclusive of VAT).

7.1 Approval & Purchase Orders

Approval must be sought **before** a commitment is made to purchase all goods or services. Therefore a Purchase Order must be raised in all cases before receipt of any goods or services and associated invoices. Invoices must not be paid without an official order except for the approved exceptions, being pharmacy, CHC and nurse agency invoices.

The correct procurement route should be adhered to for all purchase orders (see SFIs). Additionally where the total order value is:

Greater than £100,000 (including VAT), but less than £500,000 (including VAT) and not covered by specific approval limits in the scheme of delegation table 2 below.

- All requisitions with a value in this range must be authorised in the first instance within Oracle by the budget holder through the normal authorisation hierarchy.
- Following approval through the Oracle hierarchy, all requisitions within this range will be automatically forwarded, in Oracle, to the Chief Executive (or Deputy Chief Executive) and subsequently the Chair (or Vice Chair), who must both authorise within Oracle.
- The Head of Procurement must ensure that all relevant documentation is in place before raising the purchase order.
- No additional approval is required for invoices receipted and matched to the purchase order.

Greater than £500,000 (including VAT), but less than £1,000,000 (including VAT) where not covered by specific approval limits in the scheme of delegation table 2 below.

Where the value of a requisition is in this range and is not covered by the specific approval limits shown in table 2 they must have Board approval and be noted within Welsh Government (see SFIs, Schedule 2, page 77).

Exceptionally, purchase orders and their payment may require urgent processing and waiting for the next Board meeting may not be practicable. In such cases a formal 'Chair's Action' is required. This is where approval is sought outside a Board meeting. Chair's actions must be signed by the Chair, Chief Executive and two independent members. This action must be formally reported to the next Board meeting.

For all requisitions in this value range the following steps must be taken:

- Board approval must be obtained. (Evidenced by official Board minutes) **OR**:

- Chair's action must be obtained. (When urgent approval is required between board meetings).
- All requisitions with a value in this range must be authorised in the first instance within Oracle by the budget holder through the normal authorisation hierarchy.
- Following approval through the Oracle hierarchy, all requisitions within this range will be forwarded in Oracle, to the Chief Executive (or Deputy Chief Executive) and subsequently the Chair (or Vice Chair), who must both authorise within Oracle.
- Once approved by the Chief Executive (or Deputy Chief Executive) and Chair (or Vice Chair), the requisition will be forwarded by Oracle to the Board Secretary (or Deputy), who must check that all relevant documentation has been properly completed and all relevant permissions are in place before approving the requisition.
- The Head of Procurement must ensure that all relevant documentation is in place before raising the purchase order.
- No additional approval is required for invoices receipted and matched to the order.

Greater than £1,000,000 (including VAT) where not covered by specific approval limits in the scheme of delegation table 2 below.

Where the net value (inclusive of VAT) of a Purchase Order exceeds £1M and is not covered by specific approval limits shown in table 2, ministerial approval must be sought before proceeding.

For all orders in this value range the following steps must be taken:

- Ministerial approval must be obtained before raising the requisition.
- All requisitions with a value in this range must be authorised in the first instance within Oracle by the budget holder through the normal authorisation hierarchy.
- Following approval through the Oracle hierarchy, all requisitions within this range will be forwarded in Oracle to the Chief Executive (or Deputy Chief Executive) and subsequently the Chair (or Vice Chair), who must both authorise within Oracle.
- Once approved by the Chief Executive (or Deputy Chief Executive) and Chair (or Vice Chair), the requisition will be forwarded by Oracle to the Board Secretary (or Deputy), who must check that all relevant documentation has been properly completed and all relevant permissions are in place before approving the requisition.
- The Head of Procurement must ensure that all relevant documentation is in place before raising the purchase order.
- No additional approval is required for invoices receipted and matched to the order.

8 Capital Schemes

The authorisation of capital expenditure will differ depending on whether they are:

- All Wales capital programme projects
- Other capital projects (discretionary programme)

8.1 All Wales Capital Schemes

Each all Wales capital scheme will have gone through a rigorous business case process culminating in the allocation of funding through the CRL. For every all Wales capital scheme over £100,000, the Director of Strategy, Planning and Partnerships will have delegated authority to approve all expenditure.

8.2 Discretionary Programme

Approval of expenditure for all other capital projects (orders over £100,000) must follow the process in section 7 above.

9 Pharmacy

Orders for pharmacy products are placed by the pharmacy department and do not follow the Oracle Purchase Order processing procedure. Pharmacy products ordered directly through the pharmacy system, also need to follow requirements under SFIs. To ensure that orders greater than £100,000 (including VAT) placed by the pharmacy department, section 7 of this document must be adhered to with the exception of processing in Oracle.

For reference the Scheme of Delegation has the following approvals limits:

General Delegated Financial Approval Limits:

Table 1

Body/Committee / Post	**General Financial Limit £'000**	**Individual Patient Placements (Including CHC) Annual Contract Limit £'000**
Welsh Government	>1,000	N/A
Board	1,000 (note 1)	N/A
Chief Executive and Chairman / (Deputy Chief Executive/ Vice Chairman in their absence)	500	N/A
Chief Executive / Deputy Chief Executive	~~100~~25-	500
Executive Team Members	~~75~~125	250 (note 2)
Divisional Directors/General Managers / Assistant Directors	50	50
Other Delegated Budget Holders	25 and below	N/A

Note (1) above: urgent issues between scheduled Board meetings should be referred to the Board Secretary to seek approval via chairs action.
Note (2) above: this relates specifically to the Director of Primary, Community and Mental Health Services and the Director of Operations

Specific Approval Limits

The following payments, that typically exceed £100K, have been included in the Scheme of Delegation with specific approval delegated as follows:

Table 2

Company	Description	Approver
Abbott Laboratories Ltd.	Pathology biochemistry managed service contract for analysers and consumables	Pathology Directorate Manager
Baywater Healthcare Ltd. formerly Air Products Ltd.	Home oxygen supplies	Director of Primary, Community and Mental Health Services
Department for Energy & Climate Change (DECC)	Annual Purchase of Carbon Reduction allowances	Divisional Director of Facilities
Fujifilm UK Ltd.	PACS managed service contract	Radiology Directorate Manager
Honeywell Control Systems Ltd.	Energy PFI Contract	Divisional Director of Facilities
Kintra	Chepstow PFI	Divisional Director of Facilities
Local Authorities	Section 28a agreements	Divisional Director of Primary Care and Community Services
Local Authorities	Payment to Local Authorities for their Share of Integrated Care Funding.	Chief Executive
NHS Dental Services	Reimbursement to NHS Dental Services of the	Assistant Director of Finance

	payments they have made to Dental Contractors on behalf of ABUHB	(Financial Systems and Services)
Monmouth Facilities Ltd.	Monnow Vale PFI	Divisional Director of Primary Care and Community Services
Utilities	Invoices for gas, electricity, rates and water	Divisional Director of Facilities
Retinue	Medical agency management service	Associate Director of Operations
SLA's agreements with NHS bodies		Relevant Divisional Director
Audit Wales	Annual audit fees	Assistant Director of Finance (Financial Systems and Services)
LTA Agreements with NHS Bodies		Chief Executive
Velindre NHS Trust (NWSSP)	Invoices for stock issued from NWSSP stores for ABUHB	Director of Operations
Velindre NHS Trust (NWSSP)	Annual Charge for Oracle Finance and iProcurement System	Assistant Director of Finance (Financial Systems and Services)
Velindre NHS Trust (NWSSP)	Annual Charge for the procurement and maintenance of GPICT systems for GP practices	Chief Executive
Velindre NHS Trust (NWSSP)	Medical Trainees (core and speciality)	Director of Finance (Financial Systems and Services)

10 Resources

This document should be read in conjunction with the relevant SOs, SFIs, and FCPs (including Capital FCP).

11 Further Information

Enquiries regarding this policy should be directed to the Treasury Manager, Head of Financial Services and Accounting or the Assistant Director of Finance (Financial Systems and Services).

12 Audit

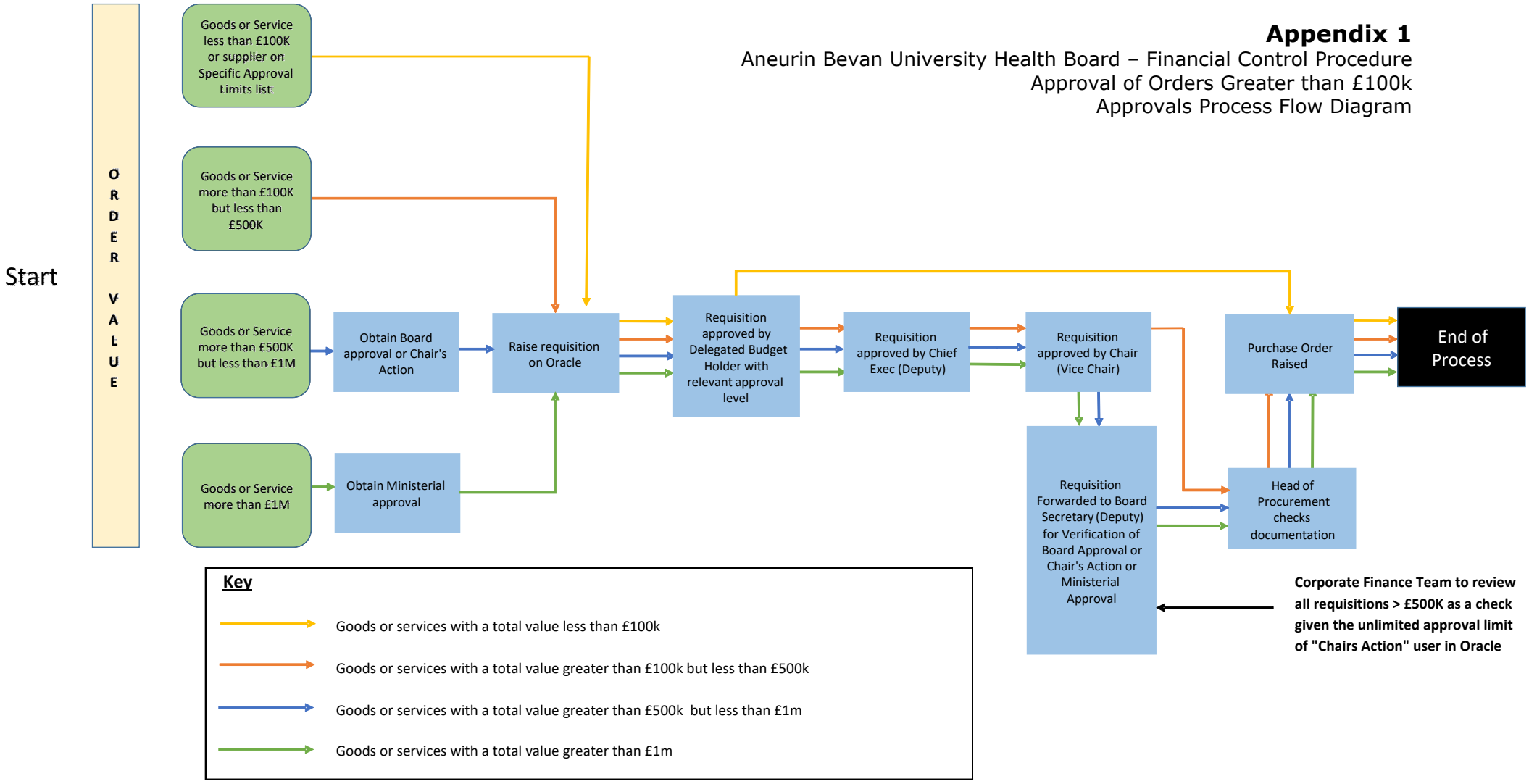
The Internal Audit programme shall, from time to time, review the compliance with this position. In addition External Audit may review compliance with this procedure as part of their financial accounts audit work.

13 Review

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

Appendix 1

Aneurin Bevan University Health Board – Financial Control Procedure
Approval of Orders Greater than £100k
Approvals Process Flow Diagram



Aneurin Bevan University Health Board

Overseas Visitors Policy

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

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1. Introduction/Overview

Aneurin Bevan Health Board (ABUHB) has a legal obligation to levy charges to overseas visitors (OSV) who have received healthcare services with ABUHB.

This policy sets out the processes to be followed for identifying and charging overseas visitors where charges are applicable.

2. Policy Statement

Not everyone is entitled to free NHS hospital treatment in Wales. Overseas visitors must be identified and assessed for eligibility for free NHS treatment and those not entitled must be charged for services received. This document provides a framework within which staff can identify patients from overseas who may be chargeable for the treatment they receive in the NHS.

3. Aim/Purpose

The aim of the policy is to provide guidelines to ABUHB staff on the identification and treatment of overseas patients in order for the Health Board to meet its legal obligations. The policy provides guiding principles for staff to ensure that all overseas visitors are identified and that income relating to overseas visitors is maximised and collected from the individual or body liable.

4. Objectives

The objectives of this policy are to:

- Set out which departments and frontline staff are covered by this policy.
- Set out the process for staff to identify overseas visitors by specifying a series of questions that should be asked of all patients.
- Make it clear that a treatment which is considered by clinicians to be immediately necessary must never be withheld from an overseas visitor, even when that overseas visitor has indicated that they cannot pay.
- Set out the role of the Overseas Patient Manager in determining the applicability and value of charges depending on the country of origin of the patient.
- Provide a basis for charging to ensure that the Health Board is reimbursed for the full cost of treatment.

- Once identified as a chargeable overseas episode, the process to ensure payment is collected.

5. Scope

This policy relates to the process of overseas visitor identification, determination of the applicability and level of charges and the recovery of charges from a chargeable overseas episode of care with ABUHB. As such it affects:

All staff that admit patients through the following departments:

- Emergency
- Wards including surgical assessment unit and medical assessment unit
- Outpatient
- Antenatal clinic
- Maternity

Staff that determine the applicability and level of charges:

- Overseas Visitors Manager and their staff

Staff that recover charges:

- Finance Department

5.1. Statutory Framework

The statutory provisions which enable NHS Wales to charge for overseas visitors are found in Section 124 of the National Health Service Act (Wales) Act 2006 (the 2006 Act). Authority to make regulations and charges is devolved to National Assembly for Wales by virtue of the National Assembly for Wales (Transfer of Function) Order 1999. These also give the Assembly powers to calculate such charges on any appropriate commercial basis.

The Immigration Act 2020 defines the meaning of 'ordinary residence' and allows the Home Secretary to introduce an immigration health charge (known as the Health Surcharge) to be paid by non-EEA residents, who apply to reside temporarily in the UK for 6 months or longer.

Department of Health 'NHS (Charges to Overseas Visitors) Regulations 2015 and (Amendment) Regulations 2017'- obliges relevant NHS bodies to make reasonable enquiries regarding the residence of and liability for charges in order to make and recover charges when it determines that a patient is not entitled to free NHS hospital care.

5.2. Other Statutory Obligations that apply

This policy must be implemented within the Health Board's statutory obligations in relation to the statutory framework as detailed above. In addition, NHS bodies are subject to other legal duties when exercising their functions to levy charges.

Below is a list of key legal duties relative to the identification and charging of OSVs, with which the Health Board must comply. The list is not exhaustive:

Human Rights Act 1998
This prohibits discrimination on any grounds such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.

The Equality Act 2010
Under the Equality Act 2010, relevant NHS bodies, as public authorities, have a general equality duty in the exercise of their functions.

5.3. Overlap with other legal provisions

There are occasions where patients may be affected by other legal provisions:

- Injuries as a result of criminal actions – patients may be eligible to claim compensation from the Criminal Injuries Compensation Authority. It is for the patient to pursue such a claim and the recovery of charges should not be suspended pending the outcome of a claim.
- Injuries as a result of road traffic accident and personal injury – the amount that insurers are required to pay to NHS bodies, where charges have been made to an overseas visitor are zero.

If there is any doubt whether charges should be levied, then legal services should be contacted to seek legal advice as soon as possible.

5.4. Interpretation of charging regulations

Guidance on implementing hospital charges for overseas visitors can be found in the 'The National Health Service (Charges to Overseas Visitors) (Amendment) (Wales) Regulations 2020. Guidance relating to Biometric Residency Permits can be found in The National Health Service (Charges to Overseas Visitors) (Amendment) (Wales) (EU Exit) Regulations 2020

6. Main Policy

6.1. Main Principles of the Policy

The charging and applicability criteria for overseas visitors is complex and therefore it is unrealistic to expect frontline staff who admit patients to be fully conversant with all rules. The main principle of this policy is to make frontline staff aware of how to identify an overseas visitor or possible overseas visitor and log them onto the Administration Systems for Patients (Myrddin, Clinical Work Station (CWS) and Symphony) with an overseas postcode, and charging status unknown. The Overseas Visitors Manager or their staff will then follow up all patients identified as overseas visitors or possible overseas visitors in order to determine the final assessment of whether the patients should be charged or whether an exemption applies.

In addition the Overseas Visitors Manager will ensure that a comprehensive programme of awareness training is undertaken with the relevant frontline staff groups that are charged with the responsibility of identifying potential overseas visitors.

6.2. Process for identification of Overseas Visitors

A key principle of this policy is that all patients are treated consistently and asked the same series of questions to determine whether or not a patient is identified as an overseas visitor. Discriminatory measures such as racial profiling must not be used.

The rules for charging vary according to which country the patient is resident in and therefore the rules are complex. As such it will be for frontline staff to identify whether or not a patient is an overseas visitor or possible overseas visitor and for the Overseas Visitors Manager or their staff to determine charges. It is for the Overseas Visitors Manager to determine the final status and charges for potential overseas visitors initially identified by frontline staff.

6.2.1. Operational guidelines

In order to avoid discrimination, all patients must be asked how long they have lived in the UK. Emergency Department (ED) treatment is free for all, but if the patient is admitted, or requires further treatment or outpatient appointment, charges must be made. To ensure that any chargeable treatment is identifiable, the following steps must be followed in all cases:

Emergency Department (ED)

ED treatment is free for all regardless of whether they are resident in the UK. Once a patient has been admitted to a ward or has been given an outpatient appointment, charges must be made. Therefore a patient's residence status must be established at the earliest opportunity.
When registering patients for treatment ask all patients:

- How long have you lived in the UK?
- If the answer is less than 6 months or you are unsure about the answer, tell the patient:
    - All treatment in ED is free for everyone, but if you require further treatment in hospital, this may be chargeable.
    - You will be contacted by the overseas visitor department to check your NHS eligibility status.
- Record the patient on Myrddin with an overseas post code and charging status unknown.
- Record the patient's home address if provided.
- If the patient offers any documentation regarding their eligibility, immigration or visitor status (Passport, Visa, EHIC, National ID Card, Biometric Residency Permit, NI or NHS number), scan these to CWS and Myrddin.
- Inform the overseas visitor department OverseasVisitors.ABB@wales.nhs.uk
- Triage and treat the patient as usual.

All other admissions and outpatients

When registering patients for clinic appointment or admitting a patient to for treatment, ask all patients:

- How long have you lived in the UK?
- If the answer is less than 6 months or you are unsure about the answer tell the patient:
    - You will be contacted by the overseas visitors department to check your NHS eligibility.
- Record the patient on Myrddin with an overseas postcode and charging status unknown.
- Record the patient's home address if provided
- If the patient offers any documentation regarding their eligibility, immigration or visitor status (Passport, Visa, EHIC, National ID Card,

Biometric Residency Permit, NI or NHS number), scan these to CWS and Myrddin.
- Inform the overseas visitor department OverseasVisitors.ABB@wales.nhs.uk

6.2.2. Determining the Applicability and Value of Charges for Identified Overseas Visitors

The Overseas Visitors Manager (OVM) is the designated person to oversee the implementation of the Charging Regulations.

Once it is established that a patient is an overseas visitor, or their status is uncertain, the Overseas Visitors Department (OVD) must be informed by entering an overseas postcode and charging status unknown on Myrddin. The Overseas Visitors Department will view a download of this information each day (Monday to Friday) to identify patients requiring a follow up interview. The Overseas Visitors Department will follow up within 3 working days where possible

The OVD will then determine the patient's status in the UK following the steps below:

Step 1
Determine if the patient is insured by another member state

The UK is able to recover the cost of treatment provided to any patient who is insured by another EEA state or Switzerland, including those patients who are ordinarily resident in the UK or covered under another exemption category. All patients should be asked if they have an EHIC, S1 or S2. It is possible that a patient may be ordinarily resident in the UK but continue to be insured by another state (and costs can still be recovered).

If the patient is not insured by another member state proceed to step 2.

Step 2
Determine if the patient is ordinarily resident in the UK

All patients must be assessed against the test for ordinary residence in the UK.

The OVD must determine whether a patient is ordinarily resident in the UK. Ordinary residence is essentially a three-fold test (four-fold for non EEA residents), assessing whether the individual:

- Is lawfully in the UK.
- Is here voluntarily.

- Is properly settled for the time being; and
- In the case of non-EEA nationals subject to immigration control, has indefinite leave to remain (ILR) in the UK.

If the patient is ordinarily resident in the UK they must not be charged.
If the patient is not ordinarily resident in the UK, proceed to step 3.

Step 3
Determine if the patient is covered by an exemption in the Charging Regulations or if the patient is liable for charges

Patients who are not ordinarily resident in the UK and are not insured by other European Economic Area (EEA) or Switzerland need to be assessed against exemptions in the charging regulations (Resource Number 1, see sections 7.3.6 – 7.3.7).

Step 4
Make and recover charges from chargeable overseas visitors

Where treatment is non-urgent or elective, the Health Board should obtain payment or collect a deposit in advance of providing treatment.

ABUHB must comply with their legal duties when asking questions of patients. In particular, they must avoid discriminatory measures or practicing racial profiling to identify chargeable patients or cherry-picking which patients to question.

6.2.3. When not to withhold hospital treatment from those not entitled to free treatment

Immediately necessary treatment must be provided to a person even if they have not paid either in full or a deposit or have indicated that they cannot pay. Only clinicians can make an assessment as to whether a patient's treatment is immediately necessary.

Immediately necessary treatment is that which a patient needs promptly:

- To save their life; or
- To prevent a condition from becoming immediately life threatening; or
- To prevent permanent serious damage from occurring

Due to the severe health risks associated with conditions such as eclampsia and pre-eclampsia and in order to protect the lives of both

mother and unborn baby, all maternity services, including routine antenatal treatment must be treated as immediately necessary.

Treatment which is not immediately necessary, but is nevertheless classed as urgent by clinicians, as it cannot wait until the overseas visitor can return home, should also be provided regardless of the patient's ability to pay.

Patients should be made aware that their treatment is chargeable at the earliest opportunity. Every effort should be made to obtain payment or a deposit in the period before treatment starts.

Whilst urgency of treatment is a matter for clinical judgement, this does not mean that treatment should be unlimited. In many cases a patient may be stabilised allowing them to be safely discharged. This should be done where possible unless ceasing or limiting treatment would precipitate deterioration of the patient's treatment.

Non-urgent treatment is routine, elective treatment that could wait until the patient leaves the UK. Such treatment does not have to be provided if the patient does not pay in advance.

Non-urgent, or elective, treatment should not begin until full payment has been received.

6.2.4. Exempt services and the individual

This section summarises services which are free of charge to patients, and to groups of individuals who are entitled to receive healthcare on the same basis as an otherwise ordinarily resident person.

Exempt Treatment

Except where the overseas visitor has travelled to the UK for the purpose of seeking that treatment, the following services are free at the point of use for all patients.

A charge cannot be made or recovered from any overseas visitor for:

- Accident and emergency (A&E) services, this includes all A&E services provided at an NHS hospital, e.g. those provided at a walk-in centre or urgent healthcare centre. This does not include those services provided after the overseas visitor has been accepted as an inpatient, or at a follow-up outpatient

appointment, for which charges must be levied unless the overseas visitor is exempt from charge in their own right;
- Services provided outside an NHS hospital, unless the staff providing the services are employed by, or working under the direction of, an NHS hospital;
- Family planning services (does not include termination of pregnancy);
- Diagnosis and treatment of specified infectious diseases, (refer to guidance);
- Diagnosis and treatment of sexually transmitted infections; (refer to guidance;
- Treatment required for a physical or mental condition caused by:
  - torture;
  - domestic violence; or
  - sexual violence.

6.2.5. Exempt categories of person

The categories of overseas visitors listed below are exempt from NHS charges.
Exempt categories of person are listed below:

- Those who have paid the health surcharge or are covered by transitional arrangements.
- Those with an enforceable EU right to free healthcare.
- Vulnerable patients and those detained.
- Government employees and war pensioners.
- Those covered by reciprocal healthcare agreements, other international obligations and employees on UK registered ships.

The Health Board may recover costs from the Department for Works and Pensions (DWP) for patients with an enforceable EU right to free health care.

6.2.6. Health Surcharge

From April 2015, an immigration health charge (referred to in this policy as the health surcharge) is payable by non-EEA nationals who apply for a visa to enter or remain in the UK for more than six months. People with indefinite leave to remain in the UK and those not subject to immigration control (e.g. diplomats posted to the UK) are not liable to pay the surcharge, but may be ordinarily resident and entitled to free NHS healthcare on that basis.

Payment of the health surcharge entitles the payer to NHS-funded healthcare on the same basis as someone who is ordinarily resident. On paying the health surcharge, patients will be issued with a Biometric Residency Permit (BRP) and this should be shown when accessing healthcare. Holders of a BRP are entitled to free NHS services, including NHS hospital care, **except** for services for which an ordinary resident must also pay, such as dentistry.

There are some circumstances under which individuals will be exempt from the surcharge. The exemption applies to the period of leave to enter or remain in the UK.

6.2.7. Countries with reciprocal arrangements

The UK has reciprocal healthcare agreements with some non-EEA countries. Overseas visitors who can present evidence that they are nationals, citizens or lawful residents of one of these countries should be treated as exempt from charges in respect of treatment that the relevant agreement entitles them to.

Within the reciprocal agreements there are a number of variations in the level of free treatment afforded to visitors travelling to the UK. Generally, only immediate medical treatment is to be provided free of charge, to allow the overseas visitor to return home for other needs. Also, the agreements do not usually apply when the person has travelled to the UK for the purpose of obtaining healthcare.

6.3. Charging Patients and Recovering Payment

6.3.1. Basis for Charging

In the absence of Welsh guidance on the basis for charging, the English approach provides a degree of consistency. Charges should be based on costing, by specialty, calculated by reference to the latest HRG tables ~~x 150%.~~ .

No further charges should be made even where they relate to costs incurred as a result of the fact that the patient is an overseas visitor (e.g. translation etc). The only exception to this is when an inpatient episode lasts more than 17 days in which case a daily charge, in line with the Non Contracted Activity (NCA) daily charge should be made.

6.3.2. The Process to Ensure Payment is made

Once an overseas visitor has been identified and/or has received a chargeable treatment, the OVD should request a 100% deposit for treatment from the patient. The patient should be given letter OSV 4.1 (100% deposit for OSV treatment, APPENDIX 12) and the OVD must send a copy to Finance Department.

Where monies cannot be recovered at this time the OSV should sign an undertaking to pay and provide their home address. A billing request must be sent to the Accounts Receivable section to allow an invoice to be raised. The chargeable patient remains liable for charges for their (chargeable) treatment even if they do not sign an undertaking to pay.

The Finance Department – Accounts Receivable section must raise invoices for overseas patients promptly and often at short notice in order to ensure wherever possible that an invoice can be presented before the patient is discharged. The Accounts Receivable department will act in line with the Health Board's Accounts Receivable Financial Control Procedure in their processes to recover income. This FCP can be found on the Health Board's intranet site.

Any charges made to overseas visitors must be recorded in the accounts to separately identify income from overseas patients.

Chargeable patients are liable to pay for their treatment even where an undertaking to pay by a third party or sponsor has been received (e.g. the patient has travel or health insurance or is sponsored by an employer or government). Before billing a third party (e.g. insurer or sponsor) rather than the individual, the risk that the third party will not pay must be considered.

A decision must be made by the Overseas Visitors Department as to whether to accept such a risk.

The contracting department must provide DWP with the relevant EHIC information in all cases where EEA/Swiss patients are treated even if the treatment is exempt.

7. Resources

This policy is not exhaustive and must be implemented within the Welsh Government (and Department of Health for information on Biometric Residence Permit) Guidelines.

Below is a list of resources to help those dealing with identifying and collecting payment from Overseas Visitors.

1. **Implementing the Overseas Hospital Charging Regulations (Guidance for Hospitals in Wales) 2009'**

   http://howis.wales.nhs.uk/sites3/documents/743/wag%20guidance.pdf

2. **NHS (Charges to Overseas Visitors) Regulations 2015 and (Amendment) Regulations 2017'**
   https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/771515/Guidance_on_implementing_the_overseas_visitor_charging_regulations.pdf

3. **The National Health Service (Charges to Overseas Visitors) (Amendment) (Wales) Regulations 2020 (SI No 2020/113) adds Coronavirus to the list of diseases listed in Schedule 1.**

   https://gov.wales/sites/default/files/publications/2020-05/the-national-health-service-charges-to-overseas-visitors-amendment-wales-regulations-2020.pdf

4. **The National Health Service (Charges to Overseas Visitors) (Amendment) (Wales) (EU Exit) Regulations 2020 (No. 2020/1607) preparing the UK to leave the EU.**

   https://www.legislation.gov.uk/wsi/2020/1607/introduction/made

For advice and further information relating to Aneurin Bevan Health Board overseas visitors, please contact the overseas visitors department by email on overseasvisitors.abb@wales.nhs.uk

8. Training

The OSM will establish a training program to facilitate the training of all those involved in the identification, assessment and income recovery relating to OSVs. This training will promote awareness of:

- OSV legislation.
- OSV Policy.
- Individual staff roles and responsibilities.
- The importance of OSV management within ABUHB.

Training for frontline staff involved in initially identifying overseas

visitors will be provided by the OVD. This will concentrate on the main points of entry to NHS care (i.e. Emergency Department, Outpatient Departments, Maternity and Wards).

The OVM will keep a record of all staff for whom training has been provided and will provide training material for new staff (involved in identifying OSVs).

An online resource will be provided for staff wishing to obtain further information.

9. Equality

The department of health has carried out an equality analysis on the overseas visitors charging regulations and guidance. It summarises that:

"There are some differences within the charging regulations for some of the protected groups within the overseas visitor population. For the most part these are minor and justifiable based on international obligations or safeguarding welfare. The greatest differential is probably based on residence status, but this is inherent in a residency based healthcare system of entitlement".

The full assessment can be found by clicking the link below:

DOH Equality analysis: the NHS (Charges to Overseas Visitors) Regulations 2015

10. Audit

The policy be subject to periodic compliance review as part of the internal audit programme of the Health Board.

11. Review

Generally 3 years unless legislation requires differently.

Appendix 1

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

OSV 4.1

PP Office
St Woolos Hospital
Stow Hill
Newport
NP20 4SZ

T 07817 102503
E overseasvisitors

Overseas Visitors Webpage

[Recipient's Name]
[Position, Company]
[First address line]
[Second address line]
[Town/city Postcode]

[Date]

Dear [Name] ,

Your NHS treatment costs

As an Overseas Visitor to the UK the Health Board has determined that your treatment under the NHS is chargeable.

The cost of the treatment you have received / are to receive is **£[Price] .** This is the standard charge for your treatment.

This sum is a deposit in respect of your charges, which is non-refundable, regardless of early discharge, and is based on the cost of your treatment. It includes your inpatient stay on the specialist NHS ward (up to 17 days, after which a daily charge will be made), all medical and nursing care, drugs and dressings, diagnostics and any therapy required.

Credit/debit card payments can be made by telephone on **01495 765422** or by cheque made payable to "Aneurin Bevan University Health Board" and sent to PO Box 10, Income Recovery Section, Mamhilad House, Pontypool, NP4 0XG.

If you would like to discuss this or arrange to share any relevant information please contact the Overseas Visitors Department on 07817 102503.

Yours sincerely,

Overseas Visitors Manager

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	22 April 2024
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	**Review of Single Tender Actions (Self Assessment) for 2024/25**
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**
This report provides the Audit, Risk and Assurance Committee with a review of the Single Tender Actions (STA's) for 2024/25 to give an overview of the Health Boards performance in this area. The Audit Committee receive an STA report from Procurement at most meetings throughout the year, detailing reasons for the STA's and an analysis of the approvals, this summarises those reports.
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. Consequently, it is a requirement of Aneurin Bevan Health Board Standing Orders and Standing Financial Instructions that all requests for a Single Tender action or a Single Quotation action are submitted to the Director of Finance and Chief Executive for consideration. The Deputy 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

Volume of STAs within ABUHB

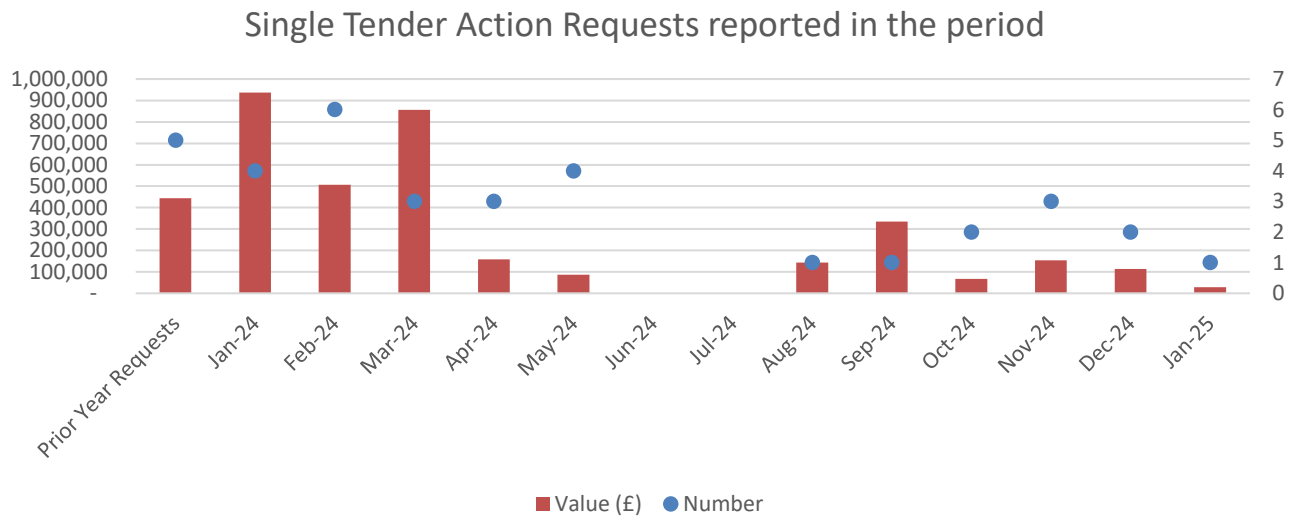
It is important that ABUHB robustly manage contracts awarded by single tender in order to ensure that best value through open tendering is obtained.

For 2024, £3.8m of goods and services were procured through 35 STAs. This represents less than 1% of ABUHBs controllable spend:

Analysis of Single Tender Actions reported to the ARAC 2024/25

Total Value (£)	3,831,890
Number	35
value per STA (£)	109,483
Value as a % of total non pay controllable spend	0.96%
Total controllable spend (£)	400,000,000

Over the period, it can also be seen that STA volume decreased in the second half of the period in both volume, and value, considered by the Head of Procurement as a result of increased scrutiny and requirement to go to tender:



It is expected however that the transfer of ownership of maintenance contracts from central to ABUHB will see this increase again in 2025/26. This is because of the likelihood of STAs required to maintain warranty from an original supplier for maintenance of plant and machinery now transferred.

ABHUB has no benchmark data from other Health Boards to ascertain if performance of <1% of spend going through STAs is appropriate, however the value is considered low enough to reduce any material risk of insufficient VFM

(Value for Money). The Head of Procurement is looking to seek benchmark data for the forthcoming period.

Rationale for STAs over the period

The SFI's require that STAs only occur under specific circumstances.



The current log used does not always make it clear the rationale for why the STA was appropriate, and consequently the ability to identify and report route cause becomes more limited. Discussion with the Head of Procurement agreed that changes to the current pro forma and log would be made so that the circumstances type would be more readily understandable in line with the SFI's. A manual review of each STA was retrospectively performed to categorise their rationale:

	Number	Annual Value
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);	1	57,645.65
A technical compatibility issue which needs to be met e.g. specific equipment required, or compliance with a warranty cover clause;	12	633,222.26
The need to retain a particular contractor for genuine business continuity issues (not just preferences)	11	1,400,544.64
An interim agreement prior to joining an all Wales Collaborative Agreement.	5	437,252.00
Failed Tender Exercise	3	223,130.46
Retrospective Request / Not Endorsed by Procurement	3	1,080,095.00
	35	3,831,890.01

It can be seen that most STAs occur due to the warranty/maintenance needs of specific capital (12) followed by business continuity reason (11). Three of the reported STAs were the result of failed tender exercise, and consequently could be challenged as not requiring to follow the STA process as Competition had been sought. The STAs not endorsed by procurement (three) are considered further below.

STAs and the due process

The ABUHB SFI's require that any procurement through STA must have:

Requirement 1 – Procurement services must be consulted prior to an STA approval

Requirement 2 – Appropriate approval of STA via:

a. Approval by the Director of Finance for applications under £25k
b. Approval by both the Director of Finance and the Chief Executive for applications over £25k
c. In addition, approval by Welsh Government where the value exceeds £1m

Requirement 3 – That an STA is approved prior to procurement

Requirement 4 – That All STAs are reported to the Audit Committee

Of the 35 STAs reported in the period, a total of 7 were shown not to fully comply with the due process:

	Volume	Value	% (Number)	% (Value)
Process Followed correctly	28	2,504,453	80%	65%
Requirement 3 That an STA is approved prior to procurement	2	883,937	6%	23%
Requirement 4 failed to be followed - All STAs are reported to the Audit Committee	5	443,500	14%	12%
	35	3,831,890	100%	100%

Requirement 3 failed to be followed – That an STA is approved prior to procurement

Two items totalling £884k which could not supported by Procurement because they were retrospective - they were however retrospectively approved in line with the SFI's and reported to the ARAC.

Requirement 4 failed to be followed - All STAs are reported to the Audit Committee

In terms of governance, the most significant items are the five that got reported late to the committee - reported in September 2024 but relating to March 2023. These agreements had been identified following an audit of RPB payments. The audit found that whilst the STA's had been signed and approved in line with the correct governance, the STA's had not been reported to the Audit, Risk and Assurance committee for oversight. Additional checks have since been put in place within the procurement team to ensure STA's are included in the report in a timely manner.

Actions Agreed:

1. The Head of Procurement will seek to obtain benchmark data from other Health Bodies, July 2025



2. The Head of Procurement will consider how improvements to the STA pro forma template can better reflect the rationale why the STA is being used, and that the scrutiny applied aligns with the SFI's, May 2025

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 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:	SFI – Standing Financial Instructions STA – Single Tender Action VFM – Value for Money
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	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:**	22 April 2025
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	**Update on Single Quotation and Tender Actions –25th January 2025 to 1st April 2025**
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 Quotations / Actions that have been submitted and approved for the period 25th January 2025 to 1st April 2025.
Cefndir / Background It is a requirement of Aneurin Bevan Health Board Standing Orders and Standing Financial Instructions that all requests for a Single Tender action or a Single Quotation action are submitted to the Chief Executive for consideration. The Deputy Head of Procurement will provide a summary for each Audit, Risk and Assurance Committee detailing all actions submitted for

consideration. The Audit, Risk and Assurance Committee's work plan includes a standing item for review of the following at each meeting:

- Review of Single Quotation and Tender Requests.

Asesiad / Assessment

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

There have been 10 requests submitted which has been approved during the period with an annual value of £367,739.56 Ex VAT. The overall value of these 10 awards comes to £367,739.56 Ex VAT.

Each award was assessed against the underlying reason justifying the STA:

Category under the SFI justifying the use of 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;	**9**	**326,062**
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.	**1**	**41,678**

With all STAs confirmed as being a justifiable rationale.

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 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:	
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	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:**	22 April 2025
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	**Update on Losses and Special payments – 1st April 2024 – 28th February 2025**
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, Finance & Risk Committee with information in relation to financial losses and special payments made by the Health Board between 1st April 2024 and 28th February 2025.

Cefndir / Background

Losses and Special payments are reported in the financial position monthly and reported to the Audit, Finance & Risk Committee in line with the Committee's terms of reference.

The main content of the report is in the Losses and Special Payments table and sets out the recorded "loss" for the year to date alongside where this category of expense is considered and scrutinised within the Health Board.

The report also provides details of the provision held by the Health Board in relation to all outstanding Medical Negligence, Personal injury and redress claims which are currently under review.



Asesiad / Assessment

The losses and special payments recorded during the period 1st April 2024 to 28th February 2025 totalled £15.0m of which £13.0m is recoverable from the Welsh Risk Pool (WRP), this means the actual loss to the Health Board is £2.0m.

The losses & special payments for which the Health Board are accountable for including movements in provision are recorded as expenditure and are reflected in the reported and forecasted expenditure.

In addition to the cost recorded above, a provision for clinical negligence and personal injury cases is recorded on the balance sheet and is based on the estimated potential liability as advised by Welsh Health Legal Services of the maximum possible future cost for all known cases. It has decreased by £17.1m since 31st March 2024 to an overall provision of £196.2m of which it is expected that £190.5m is recoverable from WRP leaving potential future losses to the Health Board of £5.7m.

1 Financial Analysis of Losses

LOSSES AND SPECIAL PAYMENTS
01.04.24-28.02.25

	No. of Cases	Amount of Loss or Payment			Type of loss/ payment	Where reported/reviewed
		ABUHB £'000	Welsh Risk Pool £'000	TOTAL £'000		
LOSSES:						
Bad Debts	0	0	0	0	Various	Authorised by Division and notified/approved by Audit Risk and Assurance Committee
SPECIAL PAYMENTS:						
Loss of personal effects	13	5	0	5	Minor Losses	Losses form completed - Authorised by Division and Putting Things Right team
Clinical negligence with advice	249	1,407	12,689	14,096	Clinical Negligence	Clinical negligence and personal injury - payment verified and lessons learnt addressed by the litigation committee for claims over £25K. Feedback into the quality and patient safety committee re Lessons Learnt. Reimbursement of payment made not processed by WRP until satisfied that lessons learnt have been clearly documented and implemented. Annual Report to Quality & Patient Safety Committee by the Litigation Department. Includes case type, numbers, financial information, and historic comparisons.
Personal injury with advice (includes Permanent Injury Benefit)	105	545	52	598	Personal Injury	As above



Other clinical negligence and personal injury	27	20	265	285	Clinical Negligence and Personal Injury - claims under £25K	Redress committee for payments under £25K. Lessons learnt fed back to division
Penalties	8	20	0	20	Penalties	Penalties issued by Welsh Risk Pool for late submission of Learning from Events.
Other	26	16	0	16	Various	Ombudsman cases - confirmed by putting things right team, other losses reports completed as appropriate
TOTAL LOSSES AND SPECIAL PAYMENTS	**428**	**2,014**	**13,007**	**15,021**		
Of which, cases of £300,000 or more:						
Clinical negligence with advice	8	27	12,082	12,109		

2 Clinical Negligence and Personal Injury Provisions

The table below shows the analysis of the estimated liability for losses as at 28th February 2025 compared to the position reported at 31st March 2024. It reflects the estimated liability in relation to cases advised by Welsh Health Legal Services for both clinical negligence, personal injury and redress with the provision updated to reflect new or changed cases.

After the expected recoveries from the Welsh Risk Pool are taken in to account the estimated liability to the Health Board at 28th February 2025 is £5.7m.

Losses & Special Payments Provisions	31-Mar-24		28-Feb-25	
	No. of Cases	£'000	No. of Cases	£'000
Clinical Negligence	255	209,755	276	192,678
Personal Injury	59	204	73	127
Permanent Injury Benefit	22	3,027	21	3,169
Redress	33	270	21	189
Sub Total	**369**	**213,256**	**391**	**196,164**
Less WRP Recoverable: Clinical Negligence	-134	-207,760	-171	-190,278
Less WRP Recoverable: Personal Injury	-2	-87	0	0
Less WRP Recoverable: Redress	-32	-254	-20	-180
Net Liability	**201**	**5,155**	**200**	**5,706**

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 February none of the Personal Injury cases out of the 73 cases are over £25K whereas 171 of the 276 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.



Agenda Item: 3.3

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	22 April 2025
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Audit Enquiries Response to Audit Wales
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Rob Holcombe, Director of Finance, Procurement and Value Based Healthcare
SWYDDOG ADRODD: **REPORTING OFFICER:**	Robert Jones, Assistant Finance Director

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

ADRODDIAD SCAA **SBAR REPORT**
Sefyllfa / Situation As part of their annual audit process, Audit Wales have request documented consideration and understanding on a number of governance areas that impact on the audit of the financial statements. These considerations are relevant to both the management of Health Board and those charged with governance (the Board and Audit Committee). The information provided will inform the auditors' understanding of the Health Board and its business processes and support their work in providing an audit opinion on the 2024-25 financial statements.
Cefndir / Background As above

Asesiad / Assessment

The completed document is included in the attachment The responses have required input from a number of individuals from the Health Board, in particular, the Head of Internal Audit, Head of Counter Fraud and Head of Financial Accounts.

The responses in draft form will be sent to Audit Wales to assist them with their audit.

Argymhelliad / Recommendation

The Committee is asked to note the report for Information.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3.5 Record Keeping Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Not Applicable Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item. FInance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	

Rhestr Termau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

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

Audit enquiries to those charges with governance and management. Please contact us in Welsh or English / cysylltwch â ni'n Gymraeg neu'n Saesneg.

Appendix 1: Enquiries of management

Enquiries of management – in relation to fraud

Question	2024-25 Response
1. What is management's assessment of the risk that the financial statements may be materially misstated due to fraud? What is the nature, extent and frequency of management's assessment?	The risk of misstatement remains low. The basis being an effective system of internal controls and sound control environment mitigate against the risk. This is likely to be supported by 2024/25 Internal Audit reports and the imminent Head of Internal Audit Opinion.
2. Do you have knowledge of any actual, suspected or alleged fraud affecting the audited body?	Yes. All instances of fraud and suspected fraud have been recorded, investigated and reported to the Director of Finance and the Audit Risk and Assurance Committee. In the reporting year 2024/25 (until 04/03/2025) there have been 52 referrals in relation to suspected fraud committed against ABUHB. The subsequent investigations have involved, the retention of salary overpayments where dishonesty is suspected; staff working elsewhere whilst employed by ABUHB; community pharmacy out of pocket expense issues; the selling on of prescription only medications; the theft and fraudulent use of prescriptions.
3. What is management's process for identifying and responding to the risks of fraud in the audited body, including any specific risks of fraud that management has identified or that have been brought to its attention?	The processes for identifying and responding to risks around fraud are enhanced by a robust and well-resourced counter fraud programme. The Cabinet Office NHS requirement GOV S013 requires that all counter fraud risk assessments are carried out by the Counter Fraud Team. Following on from the initial assessment all informed Fraud Risk is reviewed by the counter fraud team. This can be achieved via management ownership, post-investigation, thematic exercise, or central NHS trends reported from

Question	2024-25 Response
	NHS Counter Fraud Authority (CFA). A thorough assessment is conducted, and recommendations made which are reported to Directorate, Executive Director with responsibility for the risk domain, Executive Director of Finance and Audit Risk and Assurance Committee. The aim of the risk assessment is to fraud-proof processes, address any identified weakness and with the goal of reducing the opportunity of fraud in that area to an absolute minimum. All fraud risks remain live on a document within the Counter Fraud department and are subject to regular review but held by the directorate that holds the process and therefore the risk. All completed fraud risks are recorded and reported to the NHS CFA via the case management system (CLUE). All fraud risk work carried out is compliant with the organisations over riding Risk Management Policy and the requirements of Compliance set by the NHS CFA. In addition, there is a Post Payment Verification Panel which evaluates and monitor 'errors' with claims that have been submitted to Primary Care Services by the individual GP Practices and Opticians. All senior staff in accounting roles in the Finance Department must be professionally qualified accountants whose professional institutes have strong codes of conduct and professional ethics. All reported/alleged reports of suspected fraud are routed through to ABUHB's Counter Fraud Team for consideration of investigation and/or referral to NHS Counter Fraud Service Wales team where the significance and complexity of the suspected fraud lends itself to an All-Wales approach. This work is fully reported to the Audit, Risk and Assurance Committee at its regular business meeting in its private/public sessions via the counter fraud progress report. Also, as part of their private meetings, the Board

Question	2024-25 Response
	receives minutes from the private meeting of the Audit, Risk and Assurance Committee, which include reference and any significant points highlighted in the Counter Fraud Progress Reports. ABUHB's senior management team seek and will receive advice from its Counter Fraud team on recommended next steps regarding investigations and prosecutions if appropriate.
4. What classes of transactions, account balances and disclosures have you identified as most at risk of fraud?	Those areas most at risk of fraud can be generally identified in two ways. By severity of consequence or by likelihood. Those areas most at risk of fraud by consequence are Mandate Frauds, Invoice Frauds and Procurement Frauds. These areas are high risk generally due the nature of the fraud and the usual high value that is associated with it. But because the processes in place to combat these are robust and are regularly reviewed and have strict governance the instances are rarer. Those areas most at risk from fraud by likelihood examples of which are payroll fraud and staff overpayments; dual working; working whilst sick and trade creditor duplication. These frauds are generally of lower value and due to the nature of theses frauds are easier to investigate and recoup the subsequent losses.

Question	2024-25 Response
5. Are you aware of any whistleblowing or complaints by potential whistle blowers? If so, what has been the audited body's response?	All complaints made in relation to fraud are directed to the Local Counter Fraud team via the reporting routes available. These can be anonymous or named. There have been a number of complaints/referrals this year involving whistle blowers and the response is always consistent. Whistle blowers are treated in accordance with policy and identity is protected where appropriate. ABUHB has a clear Whistle Blowing Policy that would be adhered to in any instances of whistle blowing by staff or contractors etc. If staff wish to report matters concerning suspected fraud, there are a number of ways of doing this, including utilising the NHS Fraud and Corruption Reporting line and remaining anonymous in doing so. These referrals are then processed by the NHS CFA and passed to ABUHB Head of Counter Fraud via the CLUE system.
6. What is management's communication, if any, to those charged with governance regarding their processes for identifying and responding to risks of fraud?	ABHUB's Head of Counter Fraud reports regularly (as a standing agenda item) to the Public and Private session of the Health Board's Audit, Risk and Assurance Committee. Reports from the Audit, Risk and Assurance Committee are submitted to the Board. Should a fraud matter require urgent escalation then this is carried out via the Director of Finance and reported to the Audit Committee Chair. The Head of Counter Fraud also has ongoing independent access to the Audit Committee Chair outside of the Executive Board.

Question	2024-25 Response
	If there is a clear conflict of interest for ABUHB or if it involved a very senior staff member the likelihood would be the matter would be referred to NHS CFS Wales.
7. What is management's communication, if any, to employees regarding their views on business practices and ethical behaviour?	As previously stated, ABUHB has an agreed Values and Behaviours Framework and Business Conduct Policy. The staff values and behaviour are reinforced via the appraisal process which is linked now to pay progression. Declarations of Interests are sought annually with the expectation that as staff are aware of their duty to disclose this will be done as and when this need arises. All Board members are provided with a direct request regarding completing a Declaration of Interest and are made aware of their continuing duty to declare as and when required to do so.
8. For service organisations, have you reported any fraud to the user entity?	As previously stated, any alleged fraud that is suspected to have occurred within NWSSP is reported directly to their LCFS. Any alleged fraud in

Question	2024-25 Response
	NWSSP is reported to the appointed LCFS for NWSSP. They in turn would investigate any instances of fraud against NWSSP unless the loser was specifically a Health Board and report those matters to their own Audit, Risk and Assurance Committee. The Counter Fraud Team are required to liaise with internal and external partners on a regular basis. If any fraud is identified by the organisation it is reported to the Counter Fraud Team who would duly investigate it. Should matters arise that concerns other agencies or partners then a close working protocol is adopted in order that all fraud identified is appropriately dealt with. E.g., Overseas Patients and Immigration Services; Taxi Contracts; Universities; nursing and medical staffing agencies. Fraud is regularly reported to other organisations/parties where it has occurred where ABUHB is not necessarily the financial victim of it, such as the DWP, HMRC etc.

Enquiries of management – in relation to laws and regulations

Question	2024-25 Response
9. Is the audited body in compliance with relevant laws and regulations? How have you gained assurance that all relevant laws and regulations have been complied with? Are there any policies or procedures in place?	Compliance with legislation and regulations form part of the scopes of external and internal scrutiny bodies reviews. Compliance with major new or revised legislation and regulation are reported as separate items to various Executive Groups and Board Committees. During the year a series of Welsh Health Circulars and Ministerial Directions were issued to the health board. Compliance with these is monitored by the corporate governance team and a nominated Director is required to oversee implementation. Assurance on compliance is reported to the Audit, Risk & Assurance Committee and disclosed in the Annual Governance Statement.
10. Have there been any instances of non-compliance or suspected non-compliance with relevant laws and regulations in the financial year, or earlier with an ongoing impact on this year's audited financial statements?	The Health Board currently have an open case with the Health and Safety Executive (HSE). The case relates to a fatal patient fall that occurred in 2019. The HSE have completed their investigation into the matter and have identified possible breaches of legislation by the Health Board. Although the HSE have yet to make an enforcement decision, this now looks likely and a provision is therefore possible in the accounts
11. Are there any potential litigations or claims that would affect the financial statements?	See question 10

Question	2024-25 Response
12. Have there been any reports from other regulatory bodies, such as HM Revenues and Customs which indicate non-compliance?	There have been no issues of non-compliance
13. Are you aware of any non-compliance with laws and regulations within NWSPP since 1 April of the financial year?	No issues to report
14. Have there been any changes to laws and regulations that directly impact the entity this year?	There have been no changes to laws and regulations that directly impact the Health Board.
15. Has there been any significant communications with regulators?	The Health Board continues to maintain positive relationships with its regulators, including Healthcare Inspectorate Wales and the Health and Safety Executive as well as professional regulators such as GMC and NMC. There are no significant communications to report. Reports issued by the regulators are presented to the Board's Patient Quality, Safety & Outcomes Committee alongside management actions plans for improvements. These reports are disclosed into the public domain
16. For service organisations, have you reported any non-compliance with laws and regulations?	There have been no matters of non-compliance with laws and regulations reported in 2024/25

Enquiries of management – in relation to related parties

Question	2024-25 Response
17. Have there been any changes to related parties from the prior year? If so, what is the identity of the related parties and the nature of those relationships? Confirm these have been disclosed to the auditor.	This is fully reflected in the accounts which includes any changes along with prior period information.
18. What transactions have been entered into with related parties during the period? What is the purpose of these transactions? Confirm these have been disclosed to the auditor.	These will be provided as part of the annual accounts and associated statements.
19. What controls are in place to identify, account for and disclose related party transactions and relationships?	There will be provided as part of the annual accounts and associated statements
20. What controls are in place to authorise and approve significant transactions and arrangements: • with related parties, and • outside the normal course of business?	There is an Annual Declarations of Interest process that is completed for all Board Members, standard agenda item on all meetings for disclosure of any Declarations of Interest. Business Conduct Policy in operation

Enquiries of management – in relation to regularity

Question	2024-25 Response
21. What is your assessment of the risk of material irregularity?	There are no known issues in respect of non-compliance with laws or regulations for reporting, as previously stated. The Health Board also has confidence in its preparation of the financial statements and the data used to inform this. The level of risk of irregularity is therefore deemed very low.
22. What is the process for responding to the risk of irregularity?	A robust process is in place through a comprehensive Internal Audit Plan and annual fraud workplan, both of which are approved and monitored/responded to through the Audit Committee.
23. What is your knowledge of actual, suspected or alleged irregularity?	We are not aware of any
24. Where service organisations are used by the entity, have any irregularities been reported to the user entity?	We are not aware of any

Enquiries of management – in relation to the control environment & IT systems

Question	2024-25 Response
25. If internal control deficiencies were reported in the prior year, please comment on the status of these.	The facilities audit classified as limited assurance last year has been followed up and has now been given a “reasonable assurance” classification. For the estates condition, the recommendation tracker is showing as actions complete, with a presentation given to the Finance & Performance Committee. This year the audit on records management received a limited assurance rating.
26. Have there been any changes to significant IT systems or applications in the period?	None that affect the accounts process. The move from Qlik Sense to Qlik View was completed successfully

Enquiries of management – in relation to financial reporting

Question	2024-25 Response
27. Are you aware of significant transactions that are outside the normal trading activities of the business?	None
28. Are you aware of any transactions, events or changes in circumstances that would cause impairments of non-current assets?	Impairments are shown in full the financial statements.
29. Are you aware of any transactions, events and conditions (or changes in these) that may give rise to recognition or disclosure of significant accounting estimates that require significant judgement?	The HSE enforcement order issue is being assessed with current information available regarding the requirement for a provision in the final accounts. This has been discussed in audit planning meetings and full details will be provided during the audit.
30. Have there been any changes in accounting policies in relation to significant estimates?	As above

Question	2024-25 Response
31. Have you used any experts in the preparation of the accounts?	No experts are used in the preparation of the accounts themselves – that is done by the in-house financial accounts team. However, as usual, a range of experts are used to provide information for the accounts in the normal way e.g. District Valuer, the solicitors in NWSSP Legal Services who provide a quantum report which includes estimated settlements/costs used to calculate a provision.
32. Have there been any issues that may impact the preparation of the accounts identified so far?	None
33. Do you have knowledge of events or conditions beyond the period of the going concern assessment that may cast significant doubt on the entity's ability to continue as a going concern?	No issues in this regard

Appendix 2: Enquiries of those charged with governance

Enquiries of those charged with governance – in relation to fraud

Question	2024-25 Response
1. Do you have any knowledge of actual, suspected or alleged fraud affecting the audited body?	Throughout 2024/25 there have been numerous fraud referrals (52) that have affected ABUHB. Some of these cases have resulted in criminal action by way of Police Caution but the majority have been dealt with by way of internal disciplinary processes or have been NFA'd (No further action) as a result of investigation findings. Where appropriate all matters of suspected fraud are referred on to relevant professional bodies for their consideration to carry out their own independent enquiry. The outcome of their standards and conduct hearings are then awaited. The LCFS assists in both these processes.
2. What is your assessment of the risk of fraud within the audited body, including those risks that are specific to the audited body's business sector?	The level of fraud risk is identified in the Fraud Risk Profile that is maintained by the Head of Counter Fraud. This profile lists those Fraud Risks that are, inherent to all NHS Organisations as identified by the NHS Counter Fraud Authority; and, those that are emerging and specific to ABUHB identified as a result of proactive work, intelligence sharing or as the result of investigation work carried out. The Fraud Risk work carried out is prioritised against the accepted methodology of Impact/likelihood. It is aligned with the Government Functional Standards and forms part of the Counter Fraud Annual Workplan. All risk work undertaken is reported to the Director of Finance and the Audit Risk and Assurance Committee. The ABUHB Risk Management Policy is strictly followed in relation to assessments made and all risks are recorded accordingly on the Datix

	system that the organisation uses for this purpose. Should a risk score highly then the matter is escalated to the relevant level i.e. Corporate/Divisional/Directorate/Local. All risk identified that are subject to assessment work remain live and are reviewed at intervals appropriate to their risk level.
3. How do you exercise oversight of: • management's processes for identifying and responding to the risk of fraud in the audited body, and • the controls that management has established to mitigate these risks?	Counter Fraud throughout NHS Wales and NHS CFA allows for the immediate sharing of information of new and emerging fraud trends. These fraud risks can then be actioned, and processes altered or put in place to minimise the loses via this type of fraud. The Post Payment Verification team is itself a process to minimise the risk of fraud from NHS contractors. This service is offered as a control measure NHS Wales wide, provided by NWSSP. They identify and investigate anomalies with GP and Opticians payments. They will take the appropriate action as and when required to recoup monies and if required legal action. The very existence of this team is a deterrent. They work closely with LCFS teams and have regular meetings to discuss emerging fraud issues. They also regularly update the Audit, Risk and Assurance Committee. The Audit, Risk and Assurance Committee are themselves duty bound to report any potential Risk of Fraud within ABUHB. They are reported to by External Audit, Internal Audit and Counter Fraud Services. The Counter Fraud service have an "in confidence" session during the year with the Independent Members of the Audit, Risk & Assurance Committee and Director of Corporate Governance. The Audit Risk and Assurance Committee is appraised of identified risks, work undertaken to assess those risks and remedial actions that have been recommended

Enquiries of those charged with governance – in relation to laws and regulations

Question	2024-25 Response
4. Are you aware of any non-compliance with laws and regulations that may be expected to have a fundamental effect on the operations of the entity?	There are no issues to report
5. How does the Audit Committee in your role as those charged with governance, obtain assurance that all relevant laws and regulations have been complied with?	As the Board itself is charged with governance, including those elements delegated to the Audit, Risk & Assurance Committee, a range of mechanisms are in place across the breadth of the Board and its committees to seek assurance that all relevant laws and regulations have been complied with. These include an integrated risk and assurance reporting arrangements, scrutiny arrangements, internal and external Audit. The Audit, Risk & Assurance Committee itself maintains focus on the effectiveness of the health board's risk and assurance framework, to ensure matters of compliance are focussed on across the spectrum of the Board committees.

Enquiries of those charged with governance – in relation to related parties

Question	2024-25 Response
6. How does the Audit Committee, in its role as those charged with governance, exercise oversight of management's processes to identify, authorise, approve, account for and disclose related party transactions and relationships?	There is an Annual Declarations of Interest process and Business Conduct Policy in operation. The Financial statements include a dedicated section in regard to related party relationships where disclosures are made for related party transactions/relationships. Arrangements for declarations of interest are also disclosed in the Annual Governance, reviewed by the Committee.

Enquiries of those charged with governance – supplementary queries

Question	2024-25 Response
7. Are you aware of any actual, suspected or alleged irregularity affecting the entity?	There are none known for reporting.

Question	2024-25 Response
8. Are there any matters which those charged with governance consider require particular attention during the audit?	All issues regarding the financial statements have been raised throughout the year and fully disclosed to the auditors. These are described in earlier answers.
9. Are those charged with governance aware of any significant communications with regulators?	Yes. Reports issued by regulators are presented to the Board's Patient Quality, Safety & Outcomes Committee alongside management actions plans for improvements. These reports are disclosed into the public domain. A report from each meeting of the Patient Quality, Safety & Outcomes Committee is reported to the Board.

Appendix 3: Background information

Matters in relation to fraud

International Standard for Auditing (UK) 240 covers auditors' responsibilities relating to fraud in an audit of financial statements. This standard has been revised for 2022-23 audits.

The primary responsibility to prevent and detect fraud rests with both management and 'those charged with governance', which for the Health Board is the Board. Management, with the oversight of those charged with governance, should ensure there is a strong emphasis on fraud prevention and deterrence and create a culture of honest and ethical behaviour, reinforced by active oversight by those charged with governance.

As external auditors, we are responsible for obtaining reasonable assurance that the financial statements are free from material misstatement due to fraud or error. We are required to maintain professional scepticism throughout the audit, considering the potential for management override of controls.

What are we required to do?

As part of our risk assessment procedures we are required to consider the risks of material misstatement due to fraud. This includes understanding the arrangements management has put in place in respect of fraud risks. The ISA views fraud as either:

- The intentional misappropriation of assets (cash, property, etc); or
- The intentional manipulation or misstatement of the financial statements.

We also need to understand how those charged with governance exercises oversight of management's processes. We are also required to make enquiries of both management and those charged with governance as to their knowledge of any actual, suspected or alleged fraud, management's process for identifying and responding to the risks and the internal controls established to mitigate them.

Matters in relation to laws and regulations

International Standard for Auditing (UK and Ireland) 250 covers auditors' responsibilities to consider the impact of laws and regulations in an audit of financial statements.

Management, with the oversight of those charged with governance, is responsible for ensuring that the Health Board ‘s operations are conducted in accordance with laws and regulations, including compliance with those that determine the reported amounts and disclosures in the financial statements.

As external auditors, we are responsible for obtaining reasonable assurance that the financial statements are free from material misstatement due to fraud or error, taking into account the appropriate legal and regulatory framework. The ISA distinguishes two different categories of laws and regulations:

- laws and regulations that have a direct effect on determining material amounts and disclosures in the financial statements;
- other laws and regulations where compliance may be fundamental to the continuance of operations, or to avoid material penalties.

What are we required to do?

As part of our risk assessment procedures we are required to make enquiries of management and those charged with governance as to whether the Health Board is in compliance with relevant laws and regulations. Where we become aware of information of non-compliance or suspected non-compliance we need to gain an understanding of the non-compliance and the possible effect on the financial statements

Matters in relation to related parties

International Standard for Auditing (UK) 550 covers auditors’ responsibilities relating to related party relationships and transactions.

The nature of related party relationships and transactions may, in some circumstances, give rise to higher risks of material misstatement of the financial statements than transactions with unrelated parties.

Because related parties are not independent of each other, many financial reporting frameworks establish specific accounting and disclosure requirements for related party relationships, transactions and balances to enable users of the financial statements to understand their nature and actual or potential effects on the financial statements. An understanding of the entity's related party relationships and transactions is relevant to the auditor's evaluation of whether one or more fraud risk factors are present as required by ISA (UK and Ireland) 240, because fraud may be more easily committed through related parties.

What are we required to do?

As part of our risk assessment procedures, we are required to perform audit procedures to identify, assess and respond to the risks of material misstatement arising from the entity's failure to appropriately account for or disclose related party relationships, transactions or balances in accordance with the requirements of the framework.

Matters in relation to regularity

International Standard for Auditing (UK and Ireland) 250 covers auditors' responsibilities to consider the regularity of the organisation's transactions.

Regularity is the concept that transactions that are reflected in the financial statements of an audited entity must be in accordance with the relevant framework of authorities.

Frameworks of authorities are external frameworks, specific to an audited entity, with which the audited entity's transactions must conform. These frameworks are set up by bodies able to issue and/or enforce the authorities for that entity and might include, for example:

- authorising legislation;
- regulations issued under governing legislation;
- parliamentary authorities; and
- government or related authorities (for example Managing Welsh Public Money, issued by the Welsh Government).

Further information is available in Practice Note 10.

What are we required to do?

The Practice Note includes an overview, from page 56 of the Practice Note, of what we are required to do.

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	22 April 2025
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Terms of Reference: Review
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Rani Dash, Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Bryony Codd, Head of Corporate Governance

Pwrpas yr Adroddiad
Purpose of the Report

Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

Aneurin Bevan University Health Board's Standing Orders state that: "*The Board may and, where directed by the Welsh Ministers must, appoint Committees of ABUHB either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board shall establish a Committee structure that it determines best meets its own needs, taking account of any regulatory or Welsh Government requirements. As a minimum, it must establish Committees which cover the following aspects of Board business: Quality and Safety; Audit; Information governance; Charitable Funds; Remuneration and Terms of Service; and Mental Health Act requirements*."

In line with the above, the Health Board has established The Audit, Risk and Assurance Committee with the purpose of supporting 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.

Asesiad / Assessment

The current Terms of Reference were approved by the Board in March 2022. The Terms of Reference were reviewed, with minor amendments to dates and titles

proposed, and circulated to members during January 2025. No further comments were received.

The Committee is therefore requested to review and provide any further comment on the Terms of Reference (Attachment One), prior to submission to the Board for approval in May 2025.

Argymhelliad / Recommendation

The Committee is asked to **ENDORSE** the revised Terms of Reference for the Audit, Risk and Assurance Committee.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Enabler
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. Not applicable to this report

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	None
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol:	None

Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. Choose an item. Not applicable to this report

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Terms of Reference & Operating Arrangements

Version: Approved

Date: March 2022

Document Title:	Audit, Risk & Assurance Committee Terms of Reference – ~~2022/23~~2025/26
Date of Document:	March ~~2022~~2025
Current version:	~~Approved~~Draft
Previous version:	~~May 2021~~March 2022
Approved by:	Board
Review date:	~~March 2023~~March 2026

1. INTRODUCTION

1.1 Section 2 of Aneurin Bevan University Health Board's Standing Orders (referred to in this document as 'ABUHB or the 'Health Board') Standing Orders provides that "*The Board may and, where directed by the Welsh Government must, appoint Committees of the THB either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees*".

1.2 The Board has established a committee to be known as the **Audit, Risk and Assurance Committee** (referred to throughout this document as 'the Committee'). The Committee has been established in order 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.

1.3 The detailed Terms of Reference and operating arrangements approved by the Board for this Committee are detailed below.

2. PURPOSE

2.1 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'.

3. DELEGATED POWERS AND AUTHORITY

3.1 The Audit, Risk and Assurance Committee will advise the Board and Accountable Officer on:

- the design, operation and effectiveness of strategic processes for risk management, internal control and corporate governance across the whole of the organisations activities;
- the Annual Accountability Report, which includes the Annual Governance Statement;
- the accounting policies, the accounts, and the annual report of the organisation, including the process for review of the accounts prior to submission for audit, levels of error identified, and management's letter of representation to the external auditors;
- the planned activity and results of internal and external audit;
- adequacy of management response to issues identified by audit activity, including external audit's management letter;
- assurances relating to the management of risk and corporate governance requirements for the organisation;
- systems for financial reporting to the Board (including those of budgetary control);
- proposals for tendering for the purchase of audit and non-audit services from contractors who provide audit services; and
- anti-fraud policies, whistle-blowing processes, and arrangements for special investigations.

The Audit, Risk and Assurance Committee will also periodically review its own effectiveness and report the results of that review to the Board.

3.2 The Committee's workplan will include:

- a report summarising any significant changes to the organisation's strategic risks and a copy of the strategic/corporate Risk Register;

- a progress report from the Head of Internal Audit summarising:

  ✓ work performed (and a comparison with work planned);
  ✓ key issues emerging from the work of internal audit;
  ✓ management response to audit recommendations;
  ✓ changes to the agreed internal audit plan; and
  ✓ any resourcing issues affecting the delivery of the objectives of internal audit;

- a progress report (written/verbal) from the External Audit representative summarising work done and emerging findings (this may include, where relevant to the organisation, aspects of the wider work carried out by the Wales Audit Office, for example, Value for Money reports and good practice findings);

- management assurance reports;

- reports (where appropriate) on action taken within the Board's Scheme of Delegation as regards:
  - use of single tender waivers;
  - extensions of contracts:
  - writing off of losses; or
  - the making of special payments;

- A report summarising progress in the implementation of audit recommendations, together with a copy of the Audit Recommendations Tracker;

and when appropriate the Committee will be provided with:

- proposals for the terms of reference of internal audit / the internal audit charter;

- the internal audit strategy;

- the Head of Internal Audit's Annual Opinion and Report;

- quality assurance reports on the internal audit function;
- the draft accounts of the organisation;
- the draft Annual Accountability Report which includes the Annual Governance Statement;
- a report on any changes to accounting policies;
- external Audit's management letter;
- a report on any proposals to tender for audit functions;
- a report on co-operation between internal and external audit;
- the organisation's Risk Management strategy;
- periodic reporting on Post Payment Verification Audits, and arrangements for managing declarations of interest and gifts and hospitality; and
- annual review of the Board's Standing Orders and Standing Financial Instructions, monitoring compliance and reporting any proposed changes to the Board for consideration and approval.

3.3 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of good governance, risk management and internal control, together with indicators of their effectiveness.

3.4 The Committee's programme of work will also be designed to provide assurance that:

- there is an effective internal audit function that meets the standards set for the provision of internal audit in the NHS in Wales and provides appropriate independent assurance to the Board and the Accountable Officer through the Committee;
- there is an effective counter fraud service that meets the standards set for the provision of counter fraud in the NHS in

Wales and provides appropriate assurance to the Board and the Accountable Officer through the Committee;

- there is an effective clinical audit and quality improvement function that meets the standards set for the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Experience, Quality & Safety Committee;

- there are effective arrangements in place to secure active, ongoing assurance from management with regard to their responsibilities and accountabilities, whether directly to the Board and the Accountable Officer or through the work of the Board's committees;

- the work carried out by key sources of external assurance, in particular, but not limited to the health board's external auditors, is appropriately planned and co-ordinated and that the results of external assurance activity complements and informs (but does not replace) internal assurance activity;

- the work carried out by the whole range of external review bodies is brought to the attention of the Board, and that the organisation is aware of the need to comply with related standards and recommendations of these review bodies, and the risks of failing to comply; and

- the results of audit and assurance work specific to the health boards, and the implications of the findings of wider audit and assurance activity relevant to the HB's operations, are appropriately considered and acted upon to secure the ongoing development and improvement of the organisations governance arrangements.

Authority

3.5 The Committee is authorised by the Board to investigate or have investigated any activity within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the health board relevant to the Committee's remit and ensuring patient/client and staff confidentiality, as appropriate. It may seek any relevant information from any:

- employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and

- any other committee, subcommittee or group set up by the Board to assist it in the delivery of its functions.

3.6 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

Access

3.7 The Head of Internal Audit and the Engagement Partner/Audit Manager of External Audit shall have unrestricted and confidential access to the Chair of the Audit, Risk & Assurance Committee.

3.8 The Committee will meet with Internal and External Auditors and the nominated Local Counter Fraud Specialist without the presence of officials on at least one occasion each year.

3.9 The Chair of the Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

3.10 The Committee may, subject to the approval of the LHB Board, establish sub committees or task and finish groups to carry out on its behalf specific aspects of Committee business.

4. MEMBERSHIP

Members

4.1 Membership will comprise a minimum of four (4) members, comprising:

Chair	Independent Member of the Board
Vice Chair	Independent Member of the Board
Members	Independent Member of the Board x 2
	The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

Attendees

4.2 In attendance: The following members of the Executive Team will be regular attendees:

- The Accountable Officer
- Director of Finance, Procurement and VBHC
- Director of Corporate Governance

Other attendees will be:

- Head of Internal Audit
- Local Counter Fraud Specialist
- Representative of the Auditor General/External Audit

4.3 By invitation: The Committee Chair may extend invitations to attend committee meetings to the following:

- other Executive Directors; and
- other officials from within or outside the organisation to attend all or part of a meeting to assist it with its discussions on any particular matter.

Secretariat

4.4 The secretariat for the Committee will be provided by the Office of the Director of Corporate Governance.

Member Appointments

4.5 The membership of the Committee shall be determined by the Board, based on the recommendation of the Chair of ABUHB - taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

4.6 Members shall be appointed to hold office for a period of one year at a time, up to a maximum of their term of office. During this time a member may resign or be removed by the Board.

4.7 Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the Board, based upon the recommendation of the Chair of ABUHB.

Support to Committee Members

4.8 The Director of Corporate Governance, on behalf of the Committee Chair, shall:

- arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and
- ensure the provision of a programme of development for committee members as part of the Board's overall Development Programme.

5. COMMITTEE MEETINGS

Quorum

5.1 At least three members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or Vice Chair.

5.2 Where members notify the Committee Chair or Committee Secretariat that they are unable to attend a meeting, and there is a danger that the Committee will not be quorate, the Chair can invite another independent member to become a temporary member of the Committee.

Frequency of Meetings

5.3 The Chair of the Committee, in agreement with Committee Members, shall determine the timing and frequency of meetings. However, meetings shall be held as a minimum on a **Bi-Monthly basis** (six times per year) and in line with the health board's annual plan of Board Business. However, additional meetings will be called, in agreement with the Chair of the Committee, if urgent business is required to be taken forward between scheduled meetings.

Openness and Transparency

5.4 Section 3.1 of ABUHB Standings Orders confirms the Board's commitment to openness and transparency in the conduct of all its business and extends equally to the work carried out on its behalf by Committees. The Board requires, wherever possible, meetings to be held in public. The Committee will:

- hold meetings in public, other than where a matter is required to be discussed in private (see point 5.6);
- issue an annual programme of meetings (including timings and venues) and its annual programme of business;
- publish agendas and papers on the Health Board's website in advance of meetings;

- ensure the provision of agendas and minutes in English and Welsh and upon request in accessible formats, such as Braille, large print, and easy read; and
- through ABUHB's website, promote information on how attendees can notify the Health Board of any access needs sufficiently in advance of a proposed meeting, e.g. interpretation or translation arrangements, in accordance with legislative requirements such as the Equality Act 2010 and Welsh Language Standards 2018.

Withdrawal of individuals in attendance

5.5 There may be circumstances where it would not be in the public interest to discuss a matter in public, e.g., business that relates to a confidential matter. In such cases the Chair (advised by the Director of Corporate Governance where appropriate) shall schedule these issues accordingly and require that any observers withdraw from the meeting. In doing so, the Committee shall resolve:

That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960 (c.67).

In these circumstances, when the Committee is not meeting in public session it shall operate in private session, formally reporting any decisions taken to the next meeting of the Committee in public session.

6. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for the audit and assurance. The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.2 The Committee, through its Chair and members, shall work closely with the Board's other committees, joint and sub committees and groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business;

- sharing of appropriate information; and
- appropriate escalation of concerns.

In doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

6.3 The Committee shall embed the health board's corporate standards, priorities and requirements, e.g., equality and human rights through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity, and the submission of Committee minutes and written reports;

- bring to the Board's specific attention any significant matters under consideration by the Committee;

- ensure appropriate escalation arrangements are in place to alert the Chair of ABUHB, Chief Executive or Chairs of other relevant committees/groups of any urgent/critical matters that may affect the operation and/or reputation of the health board.

7.2 The Board may also require the Committee Chair to report upon the Committee's activities at public meetings, e.g. Annual General Meeting, or to community partners and other stakeholders, where this is considered appropriate, e.g. where the committee's assurance role relates to a joint or shared responsibility.

7.3 The Director of Corporate Governance, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of further committees established.

7.4 The Committee shall provide a written annual report to the Board on its activities. The report will also record the results of the Committee's self-assessment and evaluation.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

The requirements for the conduct of business as set out in ABUHB's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum
- Issue of Committee papers

The Board and Board Committee Handbook provides detailed guidance on the conduct of the Committees business.

9. CHAIR'S ACTION ON URGENT MATTERS

9.1 There may, occasionally, be circumstances where decisions which would normally be made by the Committee need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Committee. In these circumstances, the Chair of the Committee, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Committee - after first consulting with at least two other Independent Members of the Committee. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

9.2 Chair's action may not be taken where the Chair has a personal or business interest in the urgent matter requiring a decision.

10. REVIEW

10.1 These Terms of Reference shall be reviewed annually by the Committee. The Committee Chair will report any changes to the Board for ratification.

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	22 April 2025
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Audit, Risk and Assurance Committee Annual Report 2024 - 25
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Head of Corporate Risk and Assurance

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This paper presents the Audit, Risk and Assurance Committee Annual Report 2024-25, referred to as the Annual Report throughout this paper.

The Annual Report included as Appendix A is provided for endorsement prior to submission to the Board May 2025.

Cefndir / Background

Section 2 of Aneurin Bevan University Health Board's Standing Orders states that "*The Board may and, where directed by the Welsh Government must, appoint Committees of the Health Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees*".

Asesiad / Assessment

The Audit, Risk and Assurance Committee has been established by the Board with the purpose of supporting 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'.

Each Committee is responsible for developing an annual report for submission to the Board via the Chair within 6 weeks of the end of the reporting year, setting out its activities during the year and including the review of its performance.

The Board shall use the information from this evaluation activity to inform:

- The ongoing development of its governance arrangements, including its structures and processes;

- Its Board Development Programme, as part of an overall Organisation Development framework; and

- The Board's report of its alignment with the Welsh Government's Citizen Centred Governance Principles *"putting the citizen at the heart of everything and focusing on their needs and experiences; making the organisation's purpose the delivery of a high-quality service*."

The Annual Report seeks to provide a comprehensive evaluation of the business undertaken by the Committee throughout the 2024-25 financial year including any issues, and gaps in assurance that have required escalation to the Board.

The Committee should note that the Annual Report does not include the closing position of the Audit Recommendations Tracker for 2024/25. This omission is due to the timing of the Committee meeting and the time required to update and validate the tracker before it can be submitted for approval.

The closing position of the tracker, along with any other requested amendments from today's meeting (22 April 2025) will be incorporated into the final version. The Committee Secretariat will then circulate the final document electronically to the Committee for endorsement before its submission to the Board in May.

Argymhelliad / Recommendation

The Committee is asked to:

- **CONSIDER** and **ENDORSE** its Annual Report 2024-25 prior to submission to the Board May 2025.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	Failure to agree the reports would mean that the Health Board would not comply with Welsh Government and HM Treasury requirements.
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 objectives will be referenced to the IMTP.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

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

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans;

	investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• **Workforce**	Not Applicable
• **Service Activity & Performance**	Not Applicable
• **Financial**	Not Applicable
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. Choose an item. Not applicable to the report, however, considerations will be included in considering how the business of the Committee aligns to the Well Being of Future Generations Act.



DRAFT

AUDIT, RISK AND ASSURANCE COMMITTEE

ANNUAL REPORT FOR 2024-25

March 2025

Approved by: Audit Risk & Assurance Committee Date Approved: 00/00/0000

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FOREWORD

I am pleased to present the Audit, Risk and Assurance Committee's (the Committee's) Annual Report for the year ended 31 March 2025.

In this report we provide an overview of the work of the Committee and describe the steps taken to strengthen audit, risk management and assurance arrangements in the last 12 months.

The Committee has welcomed the main conclusion of the Auditor General for Wales' in the Structured Assessment for 2024 which concluded that Aneurin Bevan University Health Board:

'Board and committee governance arrangements are stable and generally effective. However, given its financial and performance challenges, the Health Board's development of a new long-term strategy and delivery of its three-year route map are crucial to enabling the organisation to transform services to meet current and future demand.' The report highlighted further opportunities for improvement in key areas, which will be monitored by the Committee.

The Committee has also acknowledged its role in overseeing the important work that is still being carried out in several areas to improve governance and assurance arrangements. This remains a key focus of the Committee's work in the year ahead.

I would like to take the opportunity to acknowledge and welcome both Dafydd Vaughn and Neil Patrick, who joined the Committee in 2024, and express my personal thanks to all who contributed to the audit, risk, and assurance agenda over the last 12-months.

Diolch yn Fawr / Thank you.

Iwan Jones
Chair, Audit, Risk and Assurance Committee

INTRODUCTION

The Standing Orders[1] of Aneurin Bevan University Health Board (referred to throughout this document as 'ABUHB' or the 'Health Board') state that: "*The Board may and, where directed by the Welsh Government must, appoint Committees either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees*". [Section 3]

The Term of Reference of the Audit & Assurance Committee (referred to throughout this report as 'the Committee') that applied in 2024/25 were approved by the Board in March 2022 (see **Appendix 2**). These were not changed during the reporting year, 2024/25.

The Committee formally adopted its Terms of Reference, following the Board's approval, on 23 March 2022.

The purpose of the Committee is to undertake scrutiny and review of matters related to audit, financial accounting, assurance, and risk management. In doing so, the Committee will support the Board and the Accountable Officer by reviewing the comprehensiveness and reliability of assurances on governance, risk management, the control environment and the integrity of financial statements and the annual report.

The remainder of this report describes how the Committee complied with and satisfied the requirements set out within its Terms of Reference during the period 1 April 2024 to 31 March 2025.

2024-25 WORK PROGRAMME

ABUHB Standing Orders require the Director of Corporate Governance to produce an Annual Plan of Board business. This should incorporate formal Board meetings, regular Board Development sessions and, as appropriate, planned activities of the Board's Committees and Advisory Groups.

When the Committee's Work Programme (see **Appendix 3**) was agreed care was taken to ensure that this was aligned to its Terms of Reference and the requirement for the Committee to 'proactively seek information to gain assurance for itself and/or on behalf of the Board'.

[1] abuhb-model-standing-orders-reservation-and-delegation-of-powers-september-2023

The Work Programme is, however, a framework rather than a prescriptive agenda. This gives the Committee flexibility to identify changing priorities or any need for further assurance or information.

FREQUENCY OF COMMITTEE MEETINGS AND MEMBERSHIP

The Terms of Reference state that the committee should meet at least bi-monthly. During 2024-25, the Committee met eight times virtually via Microsoft Teams

- 16 April 2024
- 21 May 2024 (draft annual accounts)
- 09 July 2024 (final annual accounts)
- 12 September 2024
- 12 November 2024
- 18 February 2025

The Terms of Reference state that the Committee should have four members; at the time of writing this report, the Committee consisted of the following Independent Members:

- Iwan Jones - Chair
- Richard Clark – Vice Chair
- Dafydd Vaughn *(Joined April 2024)*
- Neil Patrick (*Joined May 2024)*

Detail of the members and executive directors who attended these meetings is provided at **Appendix 4**.

Committee meetings were regularly attended by representatives from:

- Audit Wales; the Health Board's external auditor;
- Audit & Assurance Services NHS Wales Shared Services Partnership (Internal Audit) and;
- Local Counter Fraud Services

In 2024-25, the Committee received private briefings (without officers' present) from auditors and the local counter-fraud lead as below:

- Internal Audit (May *2024 and November 2024*)
- External Audit (*July 2024 and February 2025)*
- Counter Fraud (April 2024 and September 2024)

COMMITTEE REPORTING ARRANGEMENTS

The minutes of Committee meetings are routinely submitted to the Board by way of an Assurance Report, these are included in an overarching Committee Assurance Report.

All Board papers can be accessed via the following link:
Audit Risk and Assurance Committee

COMPLIANCE WITH THE COMMITTEE'S WORK PROGRAMME

Among the key issues considered by the Committee during 2024-25, as outlined in the Committee's Work Programme, the following were also considered:

- Update Report on the Clinical Audit Activity
- Update Report on Consultant Job Planning
- Update Report on the Implementation of the Actions from the Audit Wales Community Pharmacy Data Matching Report.
- Receive Private Practice Policy.
- Chairs of Audit Committees Operating Arrangements.
- National KPI Template for Capital Projects.
- Receive Responses from Welsh Government on the Questions set out in the Audit Wales Community Pharmacy Data Matching Report.
- Review Audit Recommendation Tracking Process.
- Receive Standards of Behaviour Policy.
- Review Audit Enquires to those charged with Governance and Management

ASSURANCE AND IMPROVEMENT

The Committee reviewed and approved the audit strategies and plans for the auditors as listed below and received audit reports produced in support of them during 2024-25: -

- External Auditors, Audit Wales
- Internal Auditors, NWSSP Audit & Assurance Services

In approving the strategies and plans, the Committee ensured that they were robust and linked to the health board's risk profile.

Where reports received a less than reasonable assurance audit rating or where there were specific areas of concern, the appropriate Executive Directors were requested to attend Committee meetings. This process provided opportunities to discuss the reports more fully, and for the Committee to satisfy itself that the findings and recommendations raised in the reports were being addressed in a timely manner and implemented to address control weaknesses or compliance issues.

Certain reports were referred to other Committees of the Board for ongoing monitoring, for example reports relating to clinical governance issues were referred for further consideration by the Patient Quality Safety and Outcomes Committee.

EXTERNAL AUDIT – AUDIT WALES (AW)

The Auditor General for Wales is the statutory external auditor for the NHS in Wales. Audit Wales (AW) undertakes the external auditor role for the Health Board on behalf of the Auditor General.

The Audit Wales 2024 Structured Assessment work reviewed the Health Board's corporate governance and financial management arrangements, particularly the progress made in addressing the previous year's recommendations. Findings from the 2024 review were reported to the Committee in February 2025, prior to submission to the Board in March 2025.

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

The report went on to say that:

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

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

- **Corporate approach to planning** – *"the Health Board has generally effective arrangements for developing strategic plans built on good engagement.*

  Developing a new long-term strategy is a clear priority for the Health Board. However, it needs to ensure clinical services plans are developed in consultation with all relevant stakeholders and fully reflects the changes needed to further deliver sustainable clinical service models."

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

Audit Wales was pleased to hear from Committee Members that they fully recognised the conclusions drawn and the key issues that required further improvement in the year ahead.

Copies of reports produced by Audit Wales can be accessed via the following link: Audit Wales Publications.

Each meeting of the Committee received a progress report from Audit Wales and during 2024-25 the Committee received two External Audit reports, relating to the Health Board's External Audit Plan.

- Audit of Financial Statements report
- Opinion on the Financial Statements
- Audit of Accounts Report Addendum
- Audit of Charitable Funds Audit of Financial Statements Report and Opinion of the Financial Statements
- Structured Assessment 2024
- Review of Cost Savings Arrangements
- Unscheduled Care: Flow out of Hospital
- Discharge Planning Progress Update
- Audit Wales Community Pharmacy Matching Data

The following reports from 2024/25 plan are expected to be received in Quarters 1 and 2 of the 2025-26 financial year: -

- Review of Quality Governance
- Review of Planned Care Services Recovery
- Eye Care Services
- Urgent and Emergency Care – Arrangements for Managing demand
- Review of Digital Transformation

INTERNAL AUDIT - NHS WALES SHARED SERVICES PARTNERSHIP (NWSSP)

During the first quarter of 2024-25, the Committee received Internal Audit reports from the schedule for 2023-24 as well as reports from the 2024-25 schedule, including management responses from the relevant Executive Director.

At the time of writing this report, **29** audit reviews have been reported to the Committee. These are detailed in the assurance rating sections.

The Committee will receive the following **eight** final reports from the 2024-25 Internal Audit Plan at its April meeting.

- Embedding of Policies

- Divisional Governance Arrangements
- Directorate Review – Mental Health and Learning Disabilities
- Maternity Services Improvement Plan
- Process of Reallocating Vacant Practices
- Job Planning
- Staff Culture
- The Grange A&E Expansion

The one review listed below from the 2024 -2025 plan has been deferred.

- Partnership Arrangements

The following **13** reports form the 2024-25 audit scheduled will be presented at Committee meetings during Quarters 1 and 2 of the 2025-26.

- Financial Sustainability
- Contract Management
- Performance Framework
- Health and Safety Part 1 and 2
- Waiting List Management
- Medical Equipment and Devices
- Medical E-Rostering
- Follow-up of High Priority Recommendations
- Welsh Intensive Care System
- Technical Continuity
- Electronic document and records management solution
- Capital Systems/Major Project Provisions (not separately provided)
- NHH Regional Satellite Centre

The assurance sections that follow provide a summary of the scope of the Internal Audit Reviews that have been completed and received by the Committee during the financial year, April 2024 to March 2025.

Substantial Assurance

In the following review areas, it was reported that the Board could take **substantial assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. The few matters that required attention were compliance or advisory in nature with low impact on residual risk exposure.

- **Unified Breast Unit at Ysbyty Ystrad Fawr (2023/24)**
  Executive Lead: Chief Operating Officer
  The audit sought to review the management arrangements in place to progress the Ysbyty Ystrad Fawr Unified Breast Unit – in the period after the prior audit which

was completed in December 2022.

- **Financial Controls (2023/24)**
  Executive Lead: Director of Finance and Procurement
  This internal audit has been undertaken to provide an opinion over the effectiveness of the Health Board's treasury financial controls.

- **Early Supported Discharge – Stroke (2023/24)**
  Executive Lead: Director of Allied Health Professionals and Support Services.
  During September 2022, a GIRFT (Getting It Right First Time) report was published, following the completion of a review of stroke services that was requested by Aneurin Bevan University

  Health Board (the 'Health Board'). A range of recommendations were raised, but this audit focusses on the implementation of the early supported discharge (ESD) pathway. The overall objective of the audit was to assess whether the arrangements in place for the early supported discharge of stroke patients are operating effectively.

- **Maternity Action Plan (2023/24)**
  Executive Lead: Director of Nursing
  The Purpose of the audit was to review the governance arrangements in place and examine the tracking and progress of maternity related actions from key recent external reviews.

- **Declarations of Interest (2024/25)**
  Executive Lead: Director of Corporate Governance
  The purpose of this audit was to review the arrangements for registering and managing potential conflicts cause by the receipt of gifts, hospitality and external interests.

Reasonable Assurance

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

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

- **Asset Management (2023/24)**
  Executive Lead: Director of Finance and Procurement
  This internal audit has been undertaken to provide an opinion over the effectiveness of the Health Board's processes to create and maintain accurate and up-to-date records of its equipment assets.

- **Risk Management and Assurance (2023/24)**
  Executive Lead: Director of Corporate Governance
  The audit sought to access on the effectiveness of the risk management and assurance arrangements in pace within the Health Board in order to ensure that strategic objectives are received.

- **Long-Term Sickness Absence Management (2023/24)**
  Executive Lead: Director of Workforce and OD
  The purpose of the audit was to review the compliance with the NHS Wales Managing Absence at Work Policy. This was not an audit on the number of sickness absence episodes but whether the Health Board is acting promptly and managing the interests of all parties
  within the process of managing long term sickness absence.

- **Savings Programmes (2023/24)**
  Executive Lead: Director of Finance and Procurement
  The overall objective of the audit is to provide assurance that the Health Boards savings programmes are specific, realistic and measurable and that monitoring arrangements are effective. This audit did not assess the overall 2023/24 deficit position, including additional cost pressures/funding allocation received, but rather focussed on the delivery and management of savings programmes.

- **Medical Equipment and Devices (2023/24)**
  Executive Lead: Director of Allied Health Professionals and Support Services.
  This internal audit has been undertaken to provide an opinion over the management and tracking of ultrasound devices throughout the Health Board.

- **Waiting List Management (2023/24)**
  Executive Lead: Chief Operating Officer
  To establish whether all patients on the waiting list have been assessed and assigned an appropriate priority rating in line with the Royal College of Surgeons guidance and that suitable arrangements are in place to communicate and support those patients, where applicable, at Aneurin Bevan University Health Board (the 'Health Board').

- **Directorate Review – Theatre Stock (2023/24)**
  Executive lead: Chief Operating Officer
  This internal audit has been undertaken to provide an opinion over
  the effectiveness of the Health Board's processes to manage and monitor theatre stock.

- **Intra-site Patient Transfers (2023/24)**
  Executive Lead: Chief Operating Officer

This internal audit has been undertaken to provide an opinion over the management of intra-site patient transfers within Aneurin Bevan University Health Board (the 'Health Board').

- **LINC Programme (2023/24)**
  Executive Lead: Director of Digital
  To review the arrangements in place for the mitigation of risk associated with the non or late delivery of the LINC programme of work.

- **NHH Satellite Radiotherapy (2023/24)**
  Executive Lead: Director of Strategy, Planning and Partnerships.
  The audit was undertaken to review the delivery and management arrangements in place to progress the development of a Regional Radiotherapy Satellite Centre (RSC) at Nevill Hall Hospital, and the performance to date against its key delivery objectives i.e. time, cost, and quality. This was the second audit of the RSC project.

- **IMTP – Service Delivery Plans (2024/25)**
  Executive Lead: Director of Strategy, Planning and Partnerships.
  This internal audit has been undertaken to provide an opinion over the controls to ensure the delivery of IMPT/ Strategic Objectives.

- **Facilities Stock (2024/25)**
  Executive Lead: Chief Operating Officer
  A dedicated follow-up review over the implementation progress of the Facilities stock recommendations raised within the 2023/24 audit.

- **End of Life Care (2024/25)**
  Executive Lead: Director of Nursing
  To determine if care arrangements for end-of-life care (EoL) patients are planned sufficiently in advance to enable their care to be provided in the community and to avoid unnecessary hospital admission.

- **Providing Care to Asylum Seekers and Refugees (2024/25)**
  Executive Lead: Chief Operating Officer
  To provide an opinion over the arrangements in place within Aneurin Bevan University Health Board (the "Health Board") for providing care to asylum seekers and refugees, including that applicable guidance is being adhered to.

- **Intelligence Led Organisation (2024/25)**
  Executive Lead: Director of Digital
  To evaluate and determine the processes in place to deliver information products to staff and maximise the use of analytics in
  an appropriate and secure manner.

- **Nevill Hall RAAC (2024/25)**
  Executive Lead: Chief Operating Officer

Reinforced Autoclaves Aerated Concrete (RAAC) is a form of lightweight concrete used in construction in many buildings between the 1950s and 1990s and has only recently been identified as posing a significant risk to the structural integrity of buildings. The audit sought to evaluate the arrangements in place to manage/mitigate the risks associated with the presence of RAAC found within Nevill Hall Hospital (NHH).

- **Estates Assurance – Energy Management (2024/25)**
  Executive Lead: Chief Operating Officer
  Noting rising costs of energy, effective management and control of energy costs has been risk assessed as an area of potential benefit for audit.

- **Newport East HWBC (2024/25)**
  Executive Lead: Director of Public Health
  The audit was undertaken to review the delivery and management arrangements in place to progress the Newport East Health and Wellbeing Centre project, and the performance to date against its key delivery objectives. This was the second audit of the project and covered the period from the last review in January 2023 to April 2024.

Limited Assurance

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

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

- **Decarbonisation (2023/24)**
  Executive Lead: Director of Finance and Procurement
  To consider progress against the NHS Wales Decarbonisation Strategic Delivery Plan. Following on from the advisory review delivered in 2022/23, the scope included governance, strategy progress and implementation.

- **Regional Partnership Board (2023/24)**
  Executive Lead: Director of Finance and Procurement
  This internal audit has been undertaken to provide an opinion over compliance with the Model Standing Orders Reservation and Delegation of Power/ Standing Financial Instructions (SFIs) / Financial Control Procedures (FCPs) of Aneurin Bevan University Health Board (the "Health Board"), regarding Regional Partnership Board (RPB) Payments made on behalf of the RPB, by the Health Board.

- **Bevan Health and Wellbeing Centre (2023/24)**
  Executive Lead: Director of Public Health
  The audit sought to review the delivery and management arrangements in place to progress the Bevan Health and Wellbeing Centre.

- **Records Management (2024/25)**
  Executive Lead: Director of digital
  The purpose of this audit was to assess the implementation of the recommendations raised within the 2022/23 internal audit and to retest the agreed objectives.

No Assurance

There were no audited areas that reported **no assurance.**

Assurance Rating Not Applicable

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

- **Follow-up of High Priority Recommendations (2023/24)**
  Executive Lead: Director of Corporate Governance
  To assess whether high priority internal audit recommendations have been implemented and the completeness and accuracy of the updates provided to the Audit, Risk and Assurance Committee via the Audit Recommendation Tracking Tool ("the Tracker")

- **Flexible Working (Advisory) (2023/24)**
  Executive Lead: Director of Workforce and OD
  The purpose of this review was to determine if the requirements of the Flexible Working Policy and Guidance are being applied consistently across the organisation. This is an advisory review and so, although management actions have been raised the review has not been given an assurance rating.

MONITORING AND IMPLEMENTATION OF AUDIT RECOMMENDATIONS

Following the April 2024 Follow-up of High Priority Recommendations Audit, comprehensive tracking of all high priority recommendations was implemented.

Regular reviews were conducted to verify the inclusion and accuracy of all recommendations, allowing identification and rectification of any clerical errors. The Tracker was updated with the status of each action, including progress and justifications for any deadline extensions. Many actions were completed within their designated closure periods, and any necessary extensions were justified and approved by the Committee, with new deadlines clearly communicated and documented.

The measures implemented maintain the integrity of the Tracker and ensure that the Committee receives an enhanced level of assurance surrounding implementation and monitoring of audit recommendations.

In addition, the development of comprehensive process for Audit and strengthened relationships with service leads and executive directors has resulted in improvements in the implementation of recommendations.

At each meeting, the Committee received an update on the status of internal and external audit recommendations. At the final meeting of the 2024/25 financial year the closing position of the Audit Recommendations Tracker is set out below:

ADD THE POSITION

RISK MANAGEMENT

RISK MANAGEMENT FRAMEWORK

The Risk Management Framework, Policy, and Appetite Statement provide assurance that the Health Board has robust risk management processes in place, with a clear structure for risk escalation via hierarchical risk registers and assurance meetings to ensure the delivery of operational and strategic objectives.

Since the refreshed approach and the establishment of the Strategic Risk Register, there has been a gradual shift in the organisation's outlook and approach to risk. This shift is evidenced by an increase in requests for training, support in the development of directorate and divisional risk registers, and a greater emphasis on risk as a driver for agendas.

Moving into 2025/26, there will be a greater emphasis on assurance mapping across the Three Lines Model to demonstrate assurance sources and provide a clearer line of sight of risks linked to the Health Board’s Strategic Objectives and Ministerial Priorities.
Furthermore, reporting of the Corporate Risk Register will commence in 2025 to provide a holistic view of strategic and corporate risks (high-level operational risks).

To strengthen the internal control system, a system-wide assurance mapping exercise linked to the Quality Assurance and Performance Management Frameworks will be carried out to provide the Committee with the assurances it requires regarding its delegated responsibilities.

In late 2025, the Committee will receive an updated report on risk management that includes an assessment of the Health Board's risk management maturity.

FREQUENCY OF RISK REVIEWS AND REPORTING

At each meeting of the Committee, an overview of the Strategic Risk Register is provided with detailed risk assessments of the risks. The Board then receives the overview of the Strategic Risk Register, and any areas of concern are highlighted, as appropriate.

At the end of the 2024/25 financial year, the Strategic Risk Register holds nine principal risks and 21 sub risks, shown below.

Risk Scoring Matrix					
Likelihood/ Frequency (Over 2 years)	**Consequence/Impact**				
	1. Negligible	**2. Minor**	**3. Moderate**	**4. Major**	**5. Catastrophic**
5. Almost Certain (>75%)				**1 x (Extreme)** *SRR 001G	
4. Likely (41-75%)					
3. Possible (11-40%)			**1 x (High)** SRR 007 B	**13 x (High)** SRR 001 A - D, F, *I, *SRR 002 B *SRR 004 B, SRR 005 A SRR 006 A, B, C *SRR 010	**2 x (Extreme)** *SRR 002A SRR 011A
2. Unlikely (1-10%)				**4 x (Moderate)** SRR 001 E SRR 004 A SRR 007 A SRR 008 A	
1. Rare (<1%)					

COMMUNITY OF PRACTICE – RISK MANAGEMENT

The Risk Management Community of Practice (CoP) will be refreshed in 2025 to enhance its value, promote risk maturity, and share best practices for risk management and organisational learning.

SELF ASSESSMENT & EVALUATION

As part of the Health Board's statutory requirements, each Committee of the Board is required to conduct an annual self-evaluation of committee effectiveness. All Board Members are required to complete a self-assessment for each Committee on which they are a member, to determine its effectiveness and ability to carry out its responsibilities.

The outcome of the assessment will enable the Committee to identify areas of development and focus for the coming year, such as any training and development, as well as changes to processes and procedures.

The self-assessment for the Audit, Risk and Assurance Committee was shared throughout January and February 2025 with both Committee members and lead Executive Directors. Five responses were received to the questionnaire. Members are requested to score their responses from 1-3, as per the table below.

Score	Measure	Description
1	**Room for improvement**	The Committee is falling short of requirements and should consider how it can work towards becoming more effective in this area
2	**Meeting standards**	The Committee is performing to the required standard in this area. There may be room for improvement, but the Committee can be seen to be discharging its responsibilities effectively.
3	**Excelling**	This is an area where the Committee is performing beyond the standard expectations and is a real area of strength when it comes to exercising its responsibilities.

Following completion of the self-assessments, the sections were analysed to provide an overall score for the section and recommendation for improvements for each section. A summary of the results is provided below. Further detail on the responses can be found at **Appendix One.**

Audit, Risk & Assurance	Areas for Improvement based on comments received	Action
Committee Processes: Composition, Establishment, and Ways of Working (Q 1-27)	Development of tailored training and induction to support new Independent Members to undertake their role effectively	• Revised local Induction Programme being developed for the Health Board • National Induction Programme launched by HEIW
	Quality of reports: Ensure reports are clear, concise and accessible for all members to support effective decision making. Reports should also be in an accessible format (not large excel spreadsheets)	• Report writing included within Development programme being developed with the Good Governance Institute • New board book software being developed
Internal Control and Risk Management (Q 28-35)	No Comments Received	N/A
Annual Report and Accounts and Disclosure	* All areas highlighted were confirmed as reviewed by this Committee	N/A

Statements (Q36-39)		
Internal Audit (Q40-49)	No Comments Received	N/A
External Audit (Q50-56)	No Comments Received	N/A
Clinical Audit (Q57-58)	No Comments Received	N/A
Counter Fraud (Q59-66)	No Comments Received	N/A
Overall Assessment	**MEETING STANDARDS**	

The findings from the self-assessment will be used to inform a comprehensive annual assessment of the Board's effectiveness. The effectiveness of the Board's Business function is reported through the Annual Governance Statement, enabling a focus on the work undertaken with the Board's Committees, interconnectedness of the committees and escalation to the Board, as well as the culture between the Health Board and its auditors, regulators, and partners.

KEY AREAS OF FOCUS IN 2025-26

In the year ahead the Committee will continue to focus on those matters that will strengthen audit, risk, and assurance arrangements. The Committee Work Programme has been designed to ensure that in relation to all aspects of audit:

1.0.1 internal financial control matters, such as safeguarding of assets, the maintenance of proper accounting records and the reliability of financial information;

1.0.2 adequacy of disclosure statements (Governance Statement) which are supported by the Head of Internal Audit Opinion and other opinions;

1.0.3 internal and external audit recommendations continue to be monitored, reviewed, and evaluated to ensure compliance and where compliance is not evidenced, clear, agreed rationale is provided;

1.0.4 the policies and procedures related to fraud and corruption, and;

1.0.5 that the system for risk management is robust in identifying and mitigating risks.

Thus, enabling the Committee to provide the Board with assurance that the risks impacting on the delivery of the Health Board's objectives are being appropriately

managed.

The annual Committee Programme of Business will be reported to each meeting for discussion.

Hardcopies of the Work Programme can be obtained from the Director of Corporate Governance, Headquarters, St Cadoc's Hospital, Lodge Road, Caerleon, NP18 3ZQ.

CONCLUSION

This report provides a summary of the work undertaken by the Committee over the past 12 months and demonstrates how the Committee has complied with the Terms of Reference.

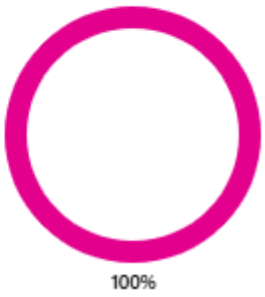
APPENDICES

- Appendix 1 – Audit, Risk & Assurance Self-Assessment response detail.
- Appendix 2 – Audit, Risk & Assurance Committee Terms of Reference 2023/24
- Appendix 3 - Audit, Risk & Assurance Committee 2023/24 Work Plan
- Appendix 4 - Independent Members and Lead Executives Attendance at the Audit, Risk & Assurance Committee Meetings 2023/24

Appendix 1:

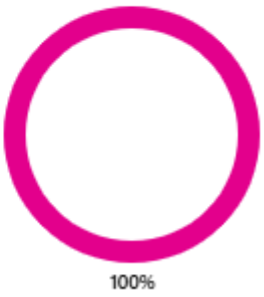
1. Does the Committee have written terms of reference, and have they been approved by the Board?

1 - Room for Improvement	0
2 - Meeting Standards	5
3 - Excelling	0



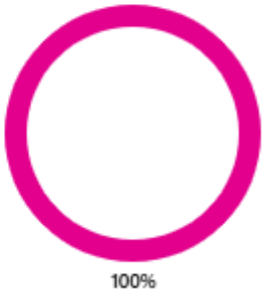
2. Are the terms of reference reviewed annually?

1 - Room for Improvement	0
2 - Meeting Standards	5
3 - Excelling	0



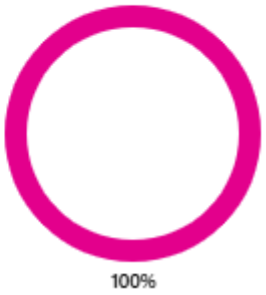
3. The number of meetings held during the year is sufficient to allow the Committee to perform as effectively as possible?

1 - Room for Improvement	0
2 - Meeting Standards	5
3 - Excelling	0



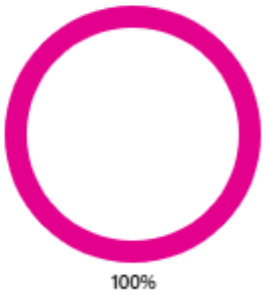
4. Has the Committee been quorate for each meeting this year?

1 - Room for Improvement	0
2 - Meeting Standards	5
3 - Excelling	0



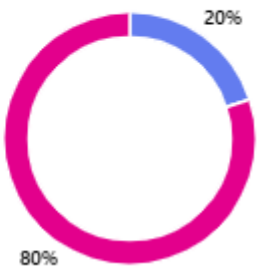
5. In terms of numbers, membership of the Committee is sufficient to discharge its responsibilities?

1 - Room for Improvement	0
2 - Meeting Standards	5
3 - Excelling	0



6. Members who have recently joined the ARAC have been provided with induction training to help them understand their role and the organisation?

1 - Room for Improvement	1
2 - Meeting Standards	4
3 - Excelling	0



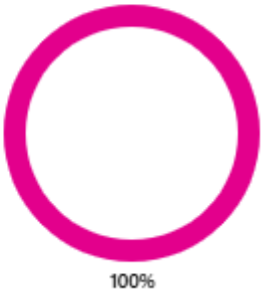
7. The Committee is clear about its role in relationship to other Committees that play a role in relations to clinical go vernance quality and risk management?

1 - Room for Improvement	2
2 - Meeting Standards	3
3 - Excelling	0



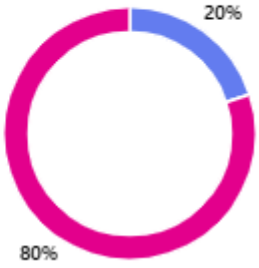
. 8. Committee members understand their responsibilities regarding identifying, declaring, and resolving conflicts of in terest?

1 - Room for Improvement	0
2 - Meeting Standards	5
3 - Excelling	0



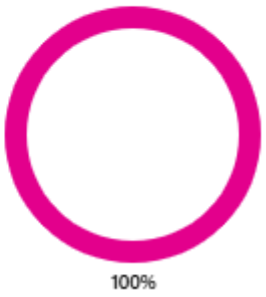
9. The Committee uses assurance mapping to identify where assurance is required and identify any key gaps where n o assurance is provided, or where the quality of the assurance is poor?

1 - Room for Improvement	1
2 - Meeting Standards	4
3 - Excelling	0



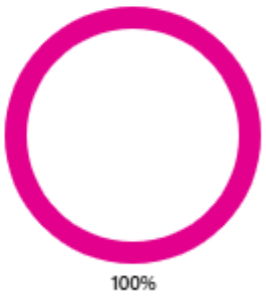
10. The Committee has an established a plan of matters to be dealt with across the year?

1 - Room for Improvement	0
2 - Meeting Standards	5
3 - Excelling	0



11. Does the Committee consider issues at the right time and in the right level of detail?

1 - Room for Improvement	0
2 - Meeting Standards	5
3 - Excelling	0



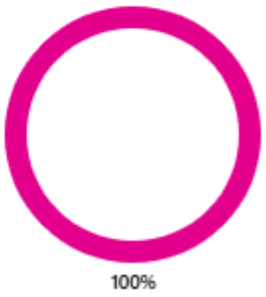
12. The Committee ensure that the relevant executive director attends meetings to enable it to understand the reports and information it receives?

1 - Room for Improvement	2
2 - Meeting Standards	3
3 - Excelling	0



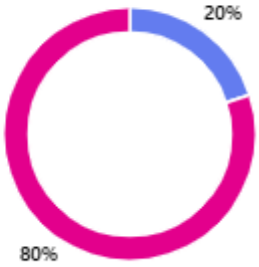
13. Are the Committee's papers distributed in sufficient time for members to give them due consideration?

1 - Room for Improvement	0
2 - Meeting Standards	5
3 - Excelling	0



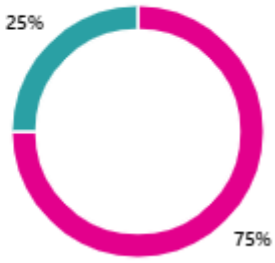
14. The quality of the Committee's papers received allows Committee members to perform their roles effectively?

1 - Room for Improvement	1
2 - Meeting Standards	4
3 - Excelling	0



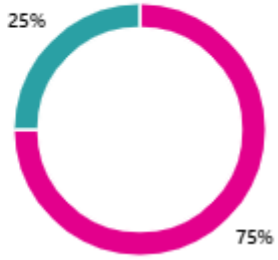
15. Committee meetings are chaired effectively?

1 - Room for Improvement	0
2 - Meeting Standards	3
3 - Excelling	1



. 16. The Committee chair allows debate to flow freely and does not assert his/her own view too strongly?

1 - Room for Improvement	0
2 - Meeting Standards	3
3 - Excelling	1



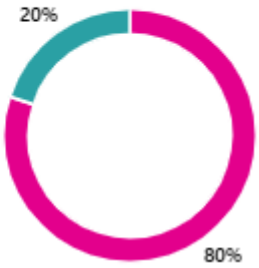
17. The Committee environment enables people to express their views, doubts, and opinions?

1 - Room for Improvement	0
2 - Meeting Standards	2
3 - Excelling	2



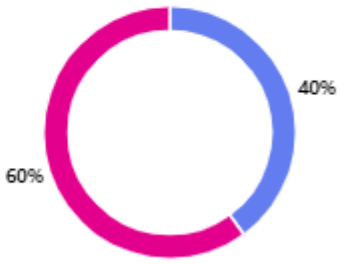
18. The Committee challenges management and other assurance providers to gain a clear understanding of their fin dings?

1 - Room for Improvement	0
2 - Meeting Standards	4
3 - Excelling	1



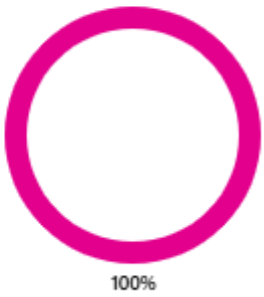
. 19. Members hold their assurance providers (management) to account for late or missing assurance?

1 - Room for Improvement	2
2 - Meeting Standards	3
3 - Excelling	0



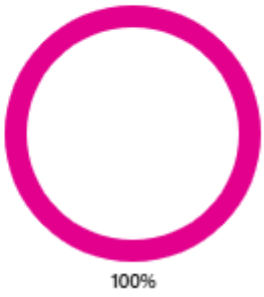
20. Internal and External Audit contributes to the debate across the range of the agenda?

1 - Room for Improvement	0
2 - Meeting Standards	5
3 - Excelling	0



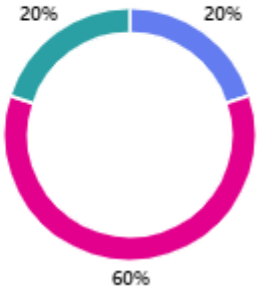
21. Each agenda item is 'closed off' appropriately so that the Committee is clear on the conclusion; who is doing wha t, when and how and how it is being monitored?

1 - Room for Improvement	0
2 - Meeting Standards	4
3 - Excelling	0



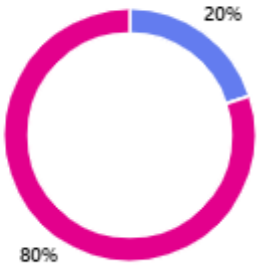
22. At the end of each meeting the Committee discuss the outcomes and reflect on decisions made and what worke d well, not so well etc?

1 - Room for Improvement	1
2 - Meeting Standards	3
3 - Excelling	1



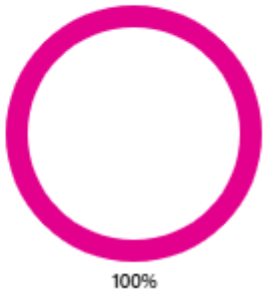
23. Decisions and actions are implemented in line with the timescale set down?

1 - Room for Improvement	1
2 - Meeting Standards	4
3 - Excelling	0



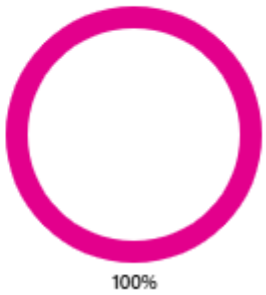
. 24. Are the outcomes of each meeting and any internal control issues reported to the next Board meeting?

1 - Room for Improvement	0
2 - Meeting Standards	5
3 - Excelling	0



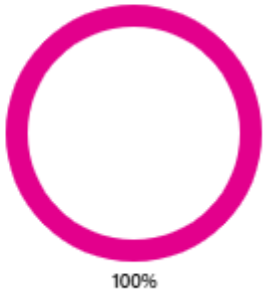
. 25. Does the Committee prepare an annual report on its work and performance for the Board?

1 - Room for Improvement	0
2 - Meeting Standards	5
3 - Excelling	0



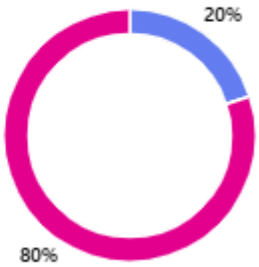
26. The results of the annual self-assessment are used to inform and influence succession planning and improve effe ctiveness.

1 - Room for Improvement	0
2 - Meeting Standards	5
3 - Excelling	0



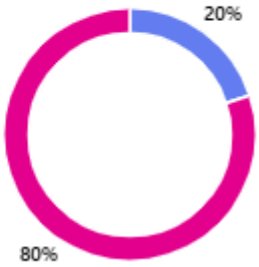
27. The self-assessment is objective and rigorous enough for meaningful conclusions to be drawn?

1 - Room for Improvement	1
2 - Meeting Standards	4
3 - Excelling	0



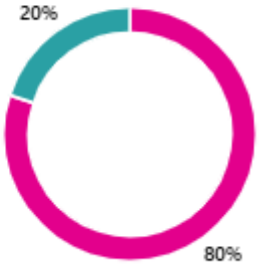
28. Has the Committee reviewed the effectiveness of the organisation's assurance framework?

1 - Room for Improvement	1
2 - Meeting Standards	4
3 - Excelling	0



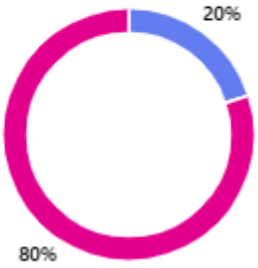
29. The Committee has an effective system for monitoring management's progress with recommendations from internal and external sources?

1 - Room for Improvement	0
2 - Meeting Standards	4
3 -- Excelling	1



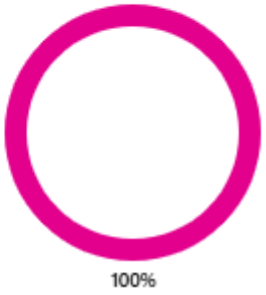
30. Does the Committee receive and review the evidence required to demonstrate compliance with regulatory requirements – for example, as set by the Health Inspectorate Wales, Audit Wales, HSE etc?

1 - Room for Improvement	1
2 - Meeting Standards	4
3 - Excelling	0



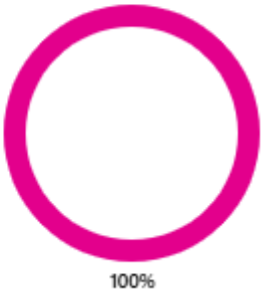
31. The Committee challenges management on whether there is a comprehensive process for identifying and evaluating risk, and for deciding what levels of risk are tolerable?

1 - Room for Improvement	0
2 - Meeting Standards	5
3 - Excelling	0



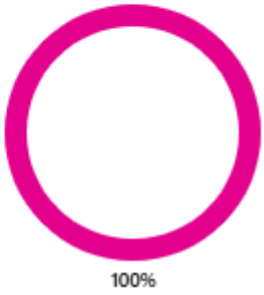
32. The Committee critically challenges and reviews the adequacy and effectiveness of control processes in responding to risks?

1 - Room for Improvement	0
2 - Meeting Standards	5
3 - Excelling	0



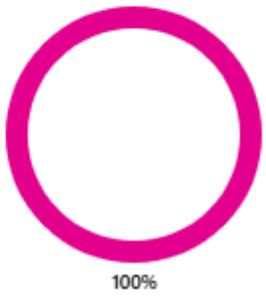
33. The Committee has a good understanding of how the organisation develops, operates, and monitors the system of internal control.

1 - Room for Improvement	0
2 - Meeting Standards	5
3 - Excelling	0



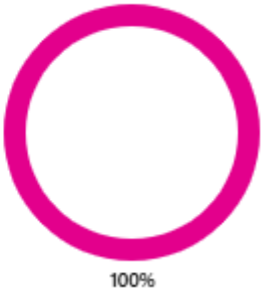
34. When any significant failings or weaknesses in internal control arise, the Committee reviews management's analysis of the root cause and subsequent action plan.

1 - Room for Improvement	0
2 - Meeting Standards	5
3 - Excelling	0



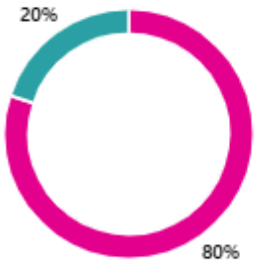
35. Has the Committee reviewed the accuracy of the draft annual governance statement?

1 - Room for Improvement	0
2 - Meeting Standards	5
3 - Excelling	0



36. Does the Committee receive and review a draft of the organisation's annual report and accounts?

1 - Room for Improvement	0
2 - Meeting Standards	4
3 - Excelling	1



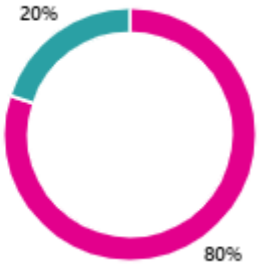
37. Does the Committee specifically review?

a. Changes in accounting policies?	5
b. Changes in accounting practice due to changes in accounting standards?	5
c. Changes in estimation techniques?	5
d. Significant judgements made in preparing the accounts?	5
e. Significant adjustments resulting from the audit?	5
f. Explanations of any significant variances?	5



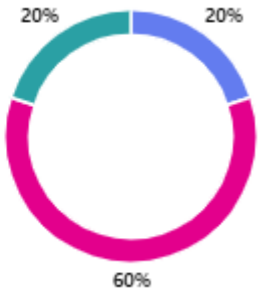
38. Is a meeting of the Committee scheduled to discuss any proposed adjustments to the accounts and audit issue s?

1 - Room for Improvement	0
2 - Meeting Standards	4
3 - Excelling	1



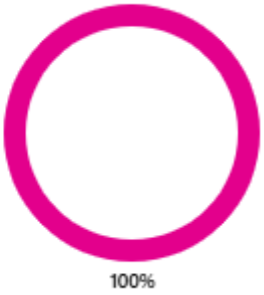
39. Does the Committee ensure it receives explanations for any unadjusted errors in the accounts found by the exte rnal auditors?

1 - Room for Improvement	1
2 - Meeting Standards	3
3 - Excelling	1



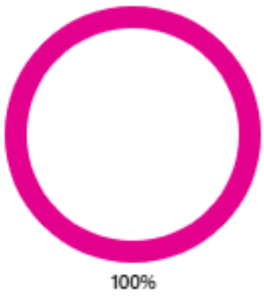
40. Is there a formal 'internal audit charter' which includes terms of reference, defining internal audit's objectives an d responsibilities?

1 - Room for Improvement	0
2 - Meeting Standards	5
3 - Excelling	0



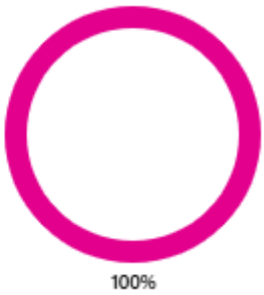
41. Does the Committee review and approve the internal audit plan and any changes to the plan?

1 - Room for Improvement	0
2 - Meeting Standards	5
3 - Excelling	0



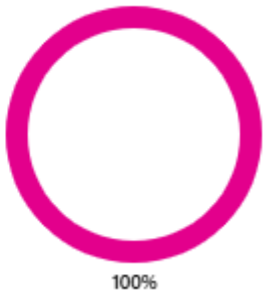
42. Is the Committee confident that the audit plan is derived from a clear risk assessment process?

1 - Room for Improvement	0
2 - Meeting Standards	5
3 - Excelling	0



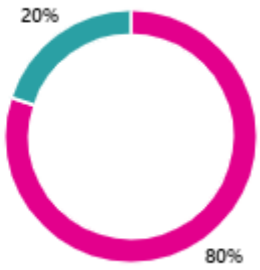
43. Does the Committee receive periodic progress reports from the Head of Internal Audit?

1 - Room for Improvement	0
2 - Meeting Standards	5
3 - Excelling	0



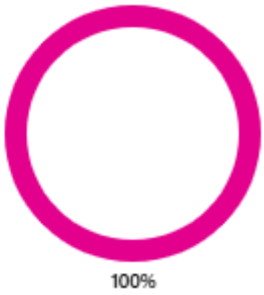
44. Does the Committee effectively monitor the implementation of management actions arising from internal audit reports?

1 - Room for Improvement	0
2 - Meeting Standards	4
3 - Excelling	1



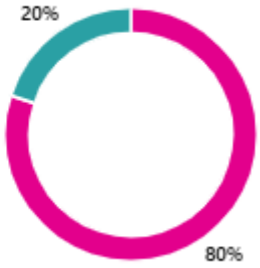
45. Does the Head of Internal Audit have a right of access to the Committee and its chair at any time?

1 - Room for Improvement	0
2 - Meeting Standards	5
3 - Excelling	0



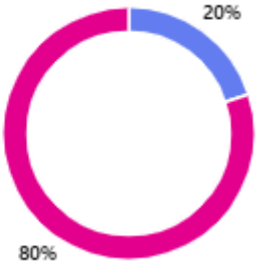
46. Is the Committee confident that Internal Audit is free of any scope restrictions, or operational responsibilities?

1 - Room for Improvement	0
2 - Meeting Standards	4
3 - Excelling	1



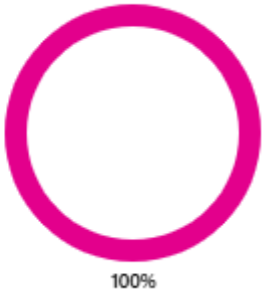
47. Has the Committee evaluated whether Internal Audit complies with the Public Sector Internal Audit Standards?

1 - Room for Improvement	1
2 - Meeting Standards	4
3 - Excelling	0



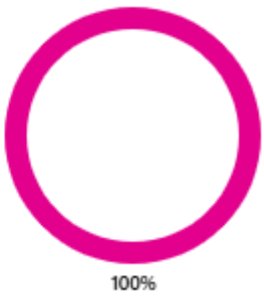
48. Does the Committee receive and review the Head of Internal Audit's Annual Opinion Report?

1 - Room for Improvement	0
2 - Meeting Standards	5
3 - Excelling	0



. 49. Does the Committee hold periodic private discussions with external auditors?

1 - Room for Improvement	0
2 - Meeting Standards	5
3 - Excelling	0



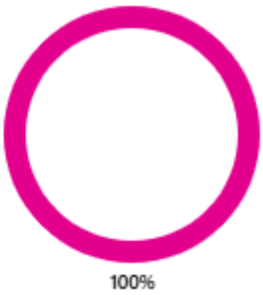
50. Do the external auditor's present their audit plan to the Committee for agreement and approval?

1 - Room for Improvement	2
2 - Meeting Standards	3
3 - Excelling	0



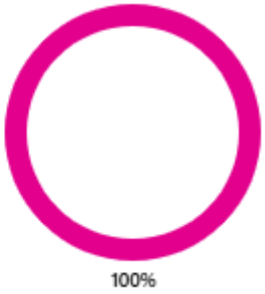
51. Does the Committee review the external auditor's ISA 260 report (the report to those charged with governanc e)?

1 - Room for Improvement	0
2 - Meeting Standards	5
3 - Excelling	0



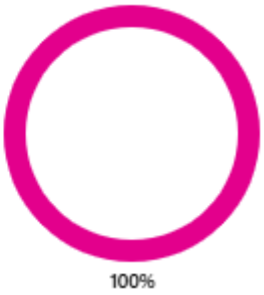
52. Does the Committee review the external auditor's value for money conclusion?

1 - Room for Improvement	0
2 - Meeting Standards	5
3 - Excelling	0



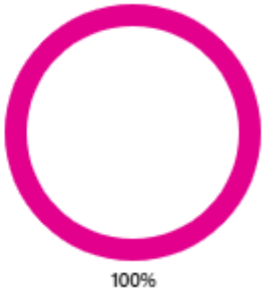
53. Does the Committee review the external auditor's opinion on the quality account when necessary?

1 - Room for Improvement	0
2 - Meeting Standards	5
3 - Excelling	0



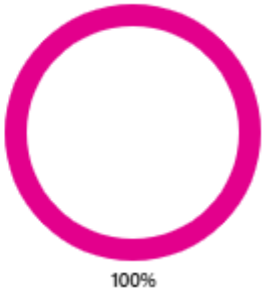
54. Does the Committee hold periodic private discussions with external auditors?

1 - Room for Improvement	0
2 - Meeting Standards	5
3 - Excelling	0



55. Does the Committee require assurance from External Audit about its policies for ensuring independence?

1 - Room for Improvement	0
2 - Meeting Standards	4
3 - Excelling	0



56. Has the Committee approved a policy to govern the value and nature of non-audit work carried out by the external auditors?

1 - Room for Improvement	2
2 - Meeting Standards	2
3 - Excelling	0



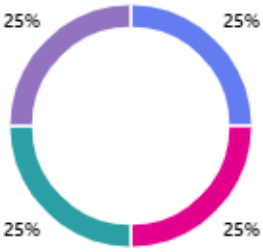
57. If the Committee is NOT responsible for monitoring clinical audit, does it receive appropriate assurance from the relevant Committee?

1 - Room for Improvement	2
2 - Meeting Standards	2
3 - Excelling	0



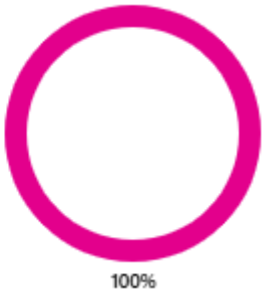
58. If the Committee is responsible for monitoring clinical audit, has it:

a. Reviewed an annual clinical audit plan?	1
b. Received regular progress reports?	1
c. Monitored the implementation of management of actions?	1
d. Received a report over the quality assurance processes covered by clinical audit activity	1



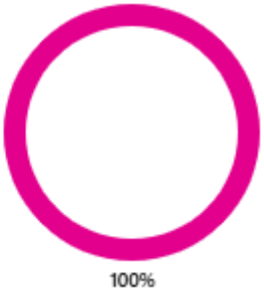
59. Does the Committee review and approve the counter fraud work plans, and any changes to the plans?

1 - Room for Improvement	0
2 - Meeting Standards	5
3 - Excelling	0



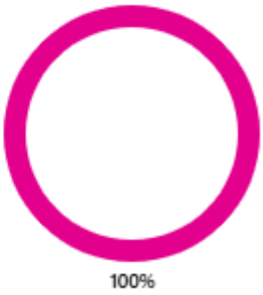
60. Is the Committee satisfied that the work plan is derived from an appropriate risk assessment and that coverage i s adequate?

1 - Room for Improvement	0
2 - Meeting Standards	5
3 - Excelling	0



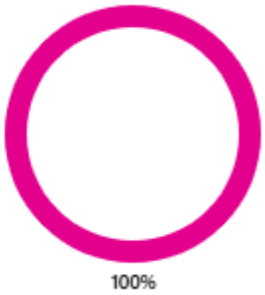
61. Does the audit Committee receive periodic reports about counter fraud activity?

1 - Room for Improvement	0
2 - Meeting Standards	5
3 - Excelling	0



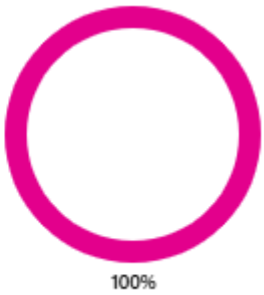
62. Does the Committee effectively monitor the implementation of management actions arising from counter fraud reports?

1 - Room for Improvement	0
2 - Meeting Standards	5
3 - Excelling	0



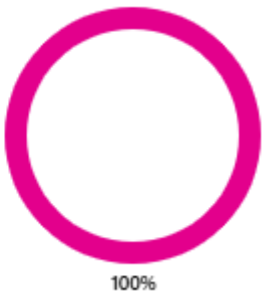
63. Do those working on counter fraud activity have a right of direct access to the Committee and its chair?

1 - Room for Improvement	0
2 - Meeting Standards	5
3 - Excelling	0



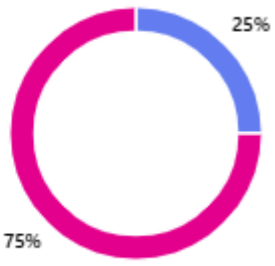
64. Does the Committee receive and review an annual report on counter fraud activity?

1 - Room for Improvement	0
2 - Meeting Standards	5
3 - Excelling	0



65. Does the Committee receive and discuss reports arising from quality inspections by NHSCFA?

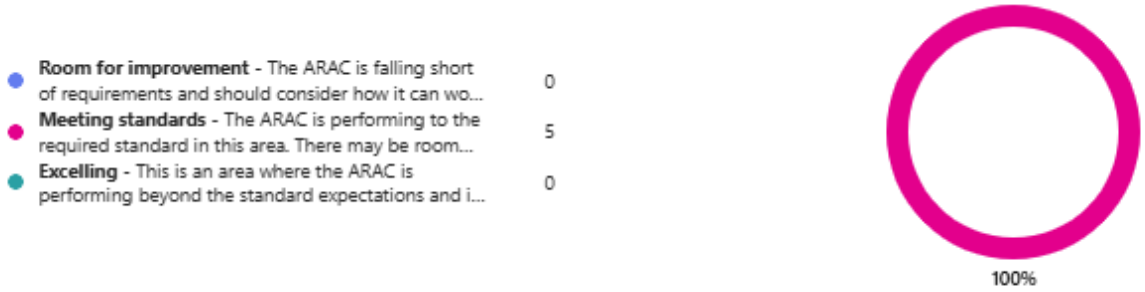
1 - Room for Improvement	1
2 - Meeting Standards	3
3 - Excelling	0



66. Does the Committee hold periodic private discussions with external auditors?



Overall



Appendix 2

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Terms of Reference & Operating Arrangements

Version: Approved
Date: March 2022

Document Title:	Audit, Risk & Assurance Committee Terms of Reference – 2022/23
Date of Document:	March 2022
Current version:	Approved
Previous version:	May 2021
Approved by:	Board
Review date:	March 2023

1. INTRODUCTION

1.1 Section 2 of Aneurin Bevan University Health Board's Standing Orders (referred to in this document as 'ABUHB or the 'Health Board') Standing Orders provides that "*The Board may and, where directed by the Welsh Government must, appoint Committees of the THB either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees*".

1.2 The Board has established a committee to be known as the **Audit, Risk and Assurance Committee** (referred to throughout this

document as 'the Committee'). The Committee has been established in order 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.

1.3 The detailed Terms of Reference and operating arrangements approved by the Board for this Committee are detailed below.

2. PURPOSE

2.1 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'.

3. DELEGATED POWERS AND AUTHORITY

3.1 The Audit, Risk and Assurance Committee will advise the Board and Accountable Officer on:

- the design, operation and effectiveness of strategic processes for risk management, internal control and corporate governance across the whole of the organisations activities;

- the Annual Accountability Report, which includes the Annual Governance Statement;

- the accounting policies, the accounts, and the annual report of the organisation, including the process for review of the accounts prior to submission for audit, levels of error identified, and management's letter of representation to the external auditors;

- the planned activity and results of internal and external audit;

- adequacy of management response to issues identified by audit activity, including external audit's management letter;

- assurances relating to the management of risk and corporate governance requirements for the organisation;

- systems for financial reporting to the Board (including those of budgetary control);

- proposals for tendering for the purchase of audit and non-audit services from contractors who provide audit services; and

- anti-fraud policies, whistle-blowing processes, and arrangements for special investigations.

The Audit, Risk and Assurance Committee will also periodically review its own effectiveness and report the results of that review to the Board.

3.2 The Committee's workplan will include:

- a report summarising any significant changes to the organisation's strategic risks and a copy of the strategic/corporate Risk Register;

- a progress report from the Head of Internal Audit summarising:

  - ✓ work performed (and a comparison with work planned);
  - ✓ key issues emerging from the work of internal audit;
  - ✓ management response to audit recommendations;
  - ✓ changes to the agreed internal audit plan; and
  - ✓ any resourcing issues affecting the delivery of the objectives of internal audit;

- a progress report (written/verbal) from the External Audit representative summarising work done and emerging findings (this may include, where relevant to the organisation, aspects of the wider work carried out by the Wales Audit Office, for example, Value for Money reports and good practice findings);

- management assurance reports;

- reports (where appropriate) on action taken within the Board's Scheme of Delegation as regards:
  - ➓ use of single tender waivers;
  - ➓ extensions of contracts:
  - ➓ writing off of losses; or
  - ➓ the making of special payments;

- A report summarising progress in the implementation of audit recommendations, together with a copy of the Audit Recommendations Tracker;

and when appropriate the Committee will be provided with:

- proposals for the terms of reference of internal audit / the internal audit charter;
- the internal audit strategy;
- the Head of Internal Audit's Annual Opinion and Report;
- quality assurance reports on the internal audit function;
- the draft accounts of the organisation;
- the draft Annual Accountability Report which includes the Annual Governance Statement;
- a report on any changes to accounting policies;
- external Audit's management letter;
- a report on any proposals to tender for audit functions;
- a report on co-operation between internal and external audit;
- the organisation's Risk Management strategy;
- periodic reporting on Post Payment Verification Audits, and arrangements for managing declarations of interest and gifts and hospitality; and
- annual review of the Board's Standing Orders and Standing Financial Instructions, monitoring compliance and reporting any proposed changes to the Board for consideration and approval.

3.3 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance

functions, but will not be limited to these. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of good governance, risk management and internal control, together with indicators of their effectiveness.

3.4 The Committee's programme of work will also be designed to provide assurance that:

- ♣ there is an effective internal audit function that meets the standards set for the provision of internal audit in the NHS in Wales and provides appropriate independent assurance to the Board and the Accountable Officer through the Committee;

- ♣ there is an effective counter fraud service that meets the standards set for the provision of counter fraud in the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Committee;

- ♣ there is an effective clinical audit and quality improvement function that meets the standards set for the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Experience, Quality & Safety Committee;

- ♣ there are effective arrangements in place to secure active, ongoing assurance from management with regard to their responsibilities and accountabilities, whether directly to the Board and the Accountable Officer or through the work of the Board's committees;

- ♣ the work carried out by key sources of external assurance, in particular, but not limited to the health board's external auditors, is appropriately planned and co-ordinated and that the results of external assurance activity complements and informs (but does not replace) internal assurance activity;

- the work carried out by the whole range of external review bodies is brought to the attention of the Board, and that the organisation is aware of the need to comply with related

standards and recommendations of these review bodies, and the risks of failing to comply; and

- ♣ the results of audit and assurance work specific to the health boards, and the implications of the findings of wider audit and assurance activity relevant to the HB's operations, are appropriately considered and acted upon to secure the ongoing development and improvement of the organisations governance arrangements.

Authority

3.5 The Committee is authorised by the Board to investigate or have investigated any activity within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the health board relevant to the Committee's remit and ensuring patient/client and staff confidentiality, as appropriate. It may seek any relevant information from any:

- employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and

- any other committee, subcommittee or group set up by the Board to assist it in the delivery of its functions.

3.6 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

Access

3.7 The Head of Internal Audit and the Engagement Partner/Audit Manager of External Audit shall have unrestricted and confidential access to the Chair of the Audit, Risk & Assurance Committee.

3.8 The Committee will meet with Internal and External Auditors and the nominated Local Counter Fraud Specialist without the presence of officials on at least one occasion each year.

3.9 The Chair of the Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

1.10 The Committee may, subject to the approval of the LHB Board, establish sub committees or task and finish groups to carry out on its behalf specific aspects of Committee business.

4. MEMBERSHIP

Members

1.1 Membership will comprise a minimum of four (4) members, comprising:

Chair	Independent Member of the Board
Vice Chair	Independent Member of the Board
Members	Independent Member of the Board x 2

The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

Attendees

1.2 In attendance: The following members of the Executive Team will be regular attendees:

- The Accountable Officer
- Director of Finance, Procurement and VBHC
- Director of Corporate Governance

Other attendees will be:

- Head of Internal Audit
- Local Counter Fraud Specialist
- Representative of the Auditor General/External Audit

1.3 By invitation: The Committee Chair may extend invitations to attend committee meetings to the following:

- other Executive Directors; and

- other officials from within or outside the organisation to attend all or part of a meeting to assist it with its discussions on any particular matter.

Secretariat

1.4 The secretariat for the Committee will be provided by the Office of the Director of Corporate Governance.

Member Appointments

1.5 The membership of the Committee shall be determined by the Board, based on the recommendation of the Chair of ABUHB - taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

1.6 Members shall be appointed to hold office for a period of one year at a time, up to a maximum of their term of office. During this time a member may resign or be removed by the Board.

1.7 Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the Board, based upon the recommendation of the Chair of ABUHB.

Support to Committee Members

1.8 The Director of Corporate Governance, on behalf of the Committee Chair, shall:

- arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and
- ensure the provision of a programme of development for committee members as part of the Board's overall Development Programme.

5. COMMITTEE MEETINGS

Quorum

1.1 At least three members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or Vice Chair.

1.2 Where members notify the Committee Chair or Committee Secretariat that they are unable to attend a meeting, and there is a danger that the Committee will not be quorate, the Chair can invite another independent member to become a temporary member of the Committee.

Frequency of Meetings

1.3 The Chair of the Committee, in agreement with Committee Members, shall determine the timing and frequency of meetings. However, meetings shall be held as a minimum on a **Bi-Monthly basis** (six times per year) and in line with the health board's annual plan of Board Business. However, additional meetings will be called, in agreement with the Chair of the Committee, if urgent business is required to be taken forward between scheduled meetings.

Openness and Transparency

1.4 Section 3.1 of ABUHB Standings Orders confirms the Board's commitment to openness and transparency in the conduct of all its business and extends equally to the work carried out on its behalf by Committees. The Board requires, wherever possible, meetings to

be held in public. The Committee will:

- hold meetings in public, other than where a matter is required to be discussed in private (see point 5.6);
- issue an annual programme of meetings (including timings and venues) and its annual programme of business;
- publish agendas and papers on the Health Board's website in advance of meetings;
- ensure the provision of agendas and minutes in English and Welsh and upon request in accessible formats, such as Braille, large print, and easy read; and
- through ABUHB's website, promote information on how attendees can notify the Health Board of any access needs sufficiently in advance of a proposed meeting, e.g. interpretation or translation arrangements, in accordance with legislative requirements such as the Equality Act 2010 and Welsh Language Standards 2018.

Withdrawal of individuals in attendance

5.5 There may be circumstances where it would not be in the public interest to discuss a matter in public, e.g., business that relates to a confidential matter. In such cases the Chair (advised by the Director of Corporate Governance where appropriate) shall schedule these issues accordingly and require that any observers withdraw from the meeting. In doing so, the Committee shall resolve:

That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960 (c.67).

In these circumstances, when the Committee is not meeting in public session it shall operate in private session, formally reporting any decisions taken to the next meeting of the Committee in public session.

6. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for the audit and assurance. The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.2 The Committee, through its Chair and members, shall work closely with the Board's other committees, joint and sub committees and groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business;
- sharing of appropriate information; and
- appropriate escalation of concerns.

In doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

6.3 The Committee shall embed the health board's corporate standards, priorities and requirements, e.g., equality and human rights through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity, and the submission of Committee minutes and written reports;

- bring to the Board's specific attention any significant matters under consideration by the Committee;

- ensure appropriate escalation arrangements are in place to alert the Chair of ABUHB, Chief Executive or Chairs of other relevant

committees/groups of any urgent/critical matters that may affect the operation and/or reputation of the health board.

7.2 The Board may also require the Committee Chair to report upon the Committee's activities at public meetings, e.g. Annual General Meeting, or to community partners and other stakeholders, where this is considered appropriate, e.g. where the committee's assurance role relates to a joint or shared responsibility.

7.3 The Director of Corporate Governance, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of further committees established.

7.4 The Committee shall provide a written annual report to the Board on its activities. The report will also record the results of the Committee's self-assessment and evaluation.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

The requirements for the conduct of business as set out in ABUHB's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum
- Issue of Committee papers

The Board and Board Committee Handbook provides detailed guidance on the conduct of the Committees business.

9. CHAIR'S ACTION ON URGENT MATTERS

9.1 There may, occasionally, be circumstances where decisions which would normally be made by the Committee need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Committee. In these circumstances, the Chair of the Committee, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Committee - after first consulting with at least two other Independent Members of the Committee. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

9.2 Chair's action may not be taken where the Chair has a personal or business interest in the urgent matter requiring a decision.

10. **REVIEW**

1.1 These Terms of Reference shall be reviewed annually by the Committee. The Committee Chair will report any changes to the Board for ratification.

Appendix 3

ANNUAL PROGRAMME OF BUSINESS 2025/26

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 2024 and the Structured Assessment 2024 recommendations
- The Board's Assurance Framework and Corporate Risk Register; and
- Key statutory, national, and best practice requirements and reporting arrangements.

Area of Focus as per Standing Orders:
The Audit, Risk and Assurance Committee will provide assurance to the Board of the effectiveness of its arrangements for handling reservations and delegations.

The Committee has been established to enable the scrutiny and review of matters related to audit, financial accounting, assurance, and risk management, to a level of depth and detail not possible in Board meetings.

The purpose of the Committee is to support the Board and Accounting Officer by reviewing the comprehensiveness and reliability of assurances on governance, risk management, the control environment and the integrity of financial statements and the annual report by:

- independently monitoring, reviewing, and reporting to the Board on the processes of governance, risk management and internal control in accordance with the standards of good governance determined for the NHS in Wales;
- advising the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further;
- Maintaining an appropriate financial focus demonstrated through robust financial reporting and maintenance of sound systems of internal control; and
- Working with the other committees of the Board to provide assurance that governance and risk management arrangements are adequate and part of an embedded Board Assurance Framework that is ‘fit for purpose’.

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2025/26						
			Quarter 1			Quarter 2	Quarter 3		Quarter 4
			22nd April 2025	20th May *Draft Accounts*	24th June *Final Accounts*	4th Sept 2025	21st Oct 2025	16th Dec 2025	12th Feb 2026
Preliminary Matters									
Attendance and Apologies	**SI**	Chair	√	√	√	√	√	√	√
Declarations of Interest		All Members	√	√	√	√	√	√	√
Minutes of the Previous Meeting		Chair	√	√	√	√	√	√	√
Action Log and Matters Arising		Chair	√	√	√	√	√	√	√
Committee Requirements as set out in Standing Orders									
Development of Committee Annual Programme of Business 2025/26	**An**	Chair & DofCG	√						√
Review of Committee Programme of Business	**SI**	Chair		√	√	√	√	√	
Annual Review of Committee Effectiveness 2024/25 to include a review of the Terms of Reference	**An**	Chair & DofCG	√						
Committee Annual Report 204/25	**An**	Chair & DofCG			√				
Corporate Governance, Risk & Assurance									
Review and report upon the adequacy of arrangements for declaring, registering, and handling interests	**An**	DofCG					√	√	
Receive full report of all offers of gifts and hospitality as declared	**An**	DofCG	√					√	
Compliance with Ministerial Directions	**BI**	DofCG	√					√	
Compliance with Welsh Health Circulars (WHCs)	**BI**	DofCG	√					√	
Review of Standing Orders, Standing Financial Instructions, and Scheme of Delegation	**An**	DofCG							√

Compliance with regulatory requirements	**An**	DofCG							√
Audit Recommendations Tracking Report	**Qu**	DofCG		√		√			√
Annual Review of Risk Management Framework	**An**	DofCG	√						
Report on the Implementation of the Risk Management Framework	**BI**	DofCG					√		√
Committee Risk & Assurance Report	**SI**	DofCG	√		√	√	√	√	
Financial Governance and Control									
Report of the use of Single Tender Action	**SI**	DofF&P	√			√	√	√	
Report of Losses and Special Payments *(May report will be included in the Accounts)*	**BI**	DofF&P		√			√		
To Approve Reviewed and Updated Financial Control Procedures	**Ad hoc**	DofF&P	√		√	√	√	√	
Annual Report and Accounts									
To consider the approach and timelines for the Annual Report and Accounts	**An**	DofF&P & DofCG						√	
Review the Health Board's Annual Report (Overview & Performance Section) **(Part 1)**	**An**	DofCG		√	√				
Review Draft/Final Accountability Report, including Annual Governance Statement **(Part 2)**	**An**	DofCG		√	√				
Review Draft/Final Annual Accounts and Financial Statements **(Part 3)**	**An**	DofF&P		√	√				
Audit Enquiries to those charged with Governance and Management	**An**	DofF&P		√					
Audit Wales, Audit of Accounts (ISA 260) including Letter of Representation	**An**	AW			√				
Final Annual Accounts Memorandum	**An**	AW					√		
Receive the Annual Head of Internal Audit Opinion (including Specialised)	**An**	HofIA			√				

Agree a recommendation to the Board in respect of the audited annual report and accounts	**An**	Chair			√				
Counter-Fraud									
Review of the Counter Fraud, Bribery and Corruption Policy *(Feb 2026)*	**3-Yearly**	DofF&P	-	-	-	-	-	-	-
Receive the Counter Fraud Annual Report	**An**	HofCF		√					
Agree the Counter Fraud Annual Workplan	**An**	HofCF	√						
Receive a Quarterly Report on Counter Fraud Activity	**Quarterly**	HofCF				√		√	
Agree the Counter Fraud Functional Standard Return Declaration	**An**	HofCF			√				
Receive the Post Payment Verification Annual Report, including, the Annual Workplan for 2025-26	**An**	PPV Manager			√				
Receive a Mid-Year update in respect of Post-Payment Verification Activity	**An**	PPV Manager					√		
Clinical Audit									
Receive the Clinical Audit Activity Annual Report 2024 - 2025	**An**	Medical Director			√				
Agree the Clinical Audit Plan 2025 - 2026	**An**	Medical Director			√				
Mid-year Report on the delivery of the Clinical Audit Plan	**An**	Medical Director					√		
Internal Audit (Including Specialised Audit) – NWSSP Audit & Assurance Services									
Agree the Internal Audit Annual Workplan	**An**	HofIA	√						
Receive Internal Audit Progress Reports	**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		√					

External Audit – Audit Wales									
Receive the External Audit Annual Audit Report	**An**	AW		√					
Agree the External Audit Annual Plan	**An**	AW		√					
Receive the draft external auditor's opinion on the quality account	**An**	AW						√	
Receive the 2025 Structured Assessment	**An**	AW					√		
Receive External Audit Progress Report 2025-26	**SI**	AW	√	√	√	√	√	√	√
Review of External Audit Reports including results & the adequacy of executive & management responses to any issues identified, ensuring that they are acted upon	**Ad hoc**	AW							
Consider any Audit Wales National Value for Money Examinations & Performance Reports	**Ad hoc**	AW							
Total Items Scheduled (excluding preliminary items) -to be updated prior to each meeting			**13**	**13**	**17**	**12**	**16**	**14**	**8**
Audit, Risk and Assurance Committee Members to meet Independently with:									
External Audit Team	**BI**	Chair			√			√	
Internal Audit Team	**BI**	Chair		√			√		
Local Counter Fraud Team	**BI**	Chair	√			√			√

Lead Officer Key	
DofCG	Director of Corporate Governance
DofF&P	Director of Finance and Procurement
HofCF	Head of Counter Fraud
PPV	Post Payment Verification
HofIA	Head of Internal Audit
AW	Audit Wales
Chair	Chair

Frequency of Inclusion Key	
SI	Standing Item
AN	Annually
BI	Biannually
Quarterly	Quarterly

Schedule of Meetings Key	
√	Scheduled agenda item in FWP
√R	Received at the Scheduled meeting
D	Deferred from this agenda
√ D	Deferred Scheduled agenda item Received
W	Withdrawn from FWP
T	Transferred to another Committee
IC	Matter discussed In Committee

Appendix 4

Attendance at 2024-25 Audit, Risk and Assurance Committee Meetings: Independent Members and Lead Executives

Meeting Dates	16 April 2024	21 May 2024	09 July 2024	12 September 2024	12 November 2024	18 February 2025
MEMBERS						
Iwan Jones (Chair)	√	√	√	√	√	√
Richard Clark (Vice Chair)	Apologies	√	Apologies	√	Apologies	Apologies
Dafydd Vaughn	√	√	√	Apologies	√	√
Neil Patrick	Not yet a member of the committee	√	√	√	√	√
OFFICERS						
Chief Executive	√	Apologies	√	√	Apologies	Apologies
Director of Finance & Procurement	√	√	√	√	√	√
Director of Corporate Governance	√	√	√	√	√	Apologies *(Representative attended)*

Agenda Item:

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	22 April 2025
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.

The report also provides the Register of Interests and Register of Gifts and Hospitality declared during 2024/25.

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.

In support of the revised policy, work has been undertaken to develop a new sharepoint site which includes support and guidance for implementing the policy, and utilises Microsoft forms for completing declarations, which automatically populate the relevant register.

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.

It should be noted that the onus is on the individual to inform the corporate governance team of any changes in their declarations. As previously reported to the Committee, there was no feedback when a member of staff left the organisation for their interest to be removed. Therefore, it was not possible to validate the previous Register. The DoI Register in place up to the end of September 2024, when the revised policy and process for making declarations was introduced will be held as an archive document.

Following the introduction of the revised Policy, a new register is being populated (Attachment 1). In order to ensure that this remains as up to date as possible, the Corporate Governance Team now receive the 'leavers list' on a weekly basis which will be used to remove any staff on the register who have left the Health Board.

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 2).

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.

Internal Audit Review

Internal Audit reviewed the arrangements for registering and managing potential conflicts caused by the receipt of gifts, hospitality and external interests during January 2025 and concluded substantial assurance in this area.

Two medium priority recommendations were identified in the report.

Finding	Agreed Action
Whilst the policy allows, in some instances, gifts to be received (e.g. where it may cause offence to the donor), the declarations should be made (and approved) prior to the acceptance of the gifts. Furthermore, any cash, vouchers etc. should be donated to a charitable fund instead.	As set out within the Standards of Business Conduct Policy (section 14), awareness sessions will be held with managers to set out the requirements of the Policy and ensure these are further cascaded to staff. The Policy also sets out that the importance of continued compliance will be referenced in induction programmes. **Target Date: March 2026**
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.	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. **Target Date: March 2026**

Argymhelliad / Recommendation

The Audit, Risk and Assurance Committee is asked to note the current note the arrangements in place and the current Register of Interests and Register of Gifts and Hospitality.

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.

Full name	Position held in health Board	Division	For 'nil declaration' please select this box	Declaration	D. Financial Transactions or benefits in kind	I confirm a nil declaration	I confirm that the list accurately reflects my interests and those of my close family and understand that these declarations will be included in the register available public inspection
Leanne Watkins	Chief Operating Officer	Executive Board	Nil Declaration			Agree	Agree
Neil Patrick	Independent Member	N/A		Innovation Evolution Credit PLC NED from Dec 2023-present MRAL UK Ltd Director from Nov 2024 to present MRAL UK Group Ltd Director from November 2024 to present Vigorate Ltd. Director/Partner from August 2022 to present Neil Patrick Associates Ltd. Director from July 2020 to present			Agree
Iwan Jones	Independent Member	Corporate	Nil Declaration			Agree	Agree

Penelope Anne Jones	Independent Member	Community		The Palmer Centre, Chepstow Trustee - 2years Daughter - Laura Anne Jones MS - The Senedd - 2023-2007 and 2020- present day.	Paid County Councillor Penny Jones Monmouthshire County Council - from 2012		Agree
Sarah Simmonds	Executive Director of Workforce and OD	Chief Executive	Nil Declaration			Agree	Agree
Prof Helen M Sweetland	Independent Member (Uni)	Corporate	Nil Declaration			Agree	
Dr James Calvert	Executive Medical Director & Deputy Chief Executive	Corporate		Personal - Calvert Services Ltd - Director. Does not function in health sector therefore no attributable conflict In the past 12 months I have been sponsored to attend respiratory educational meetings by Astra-Zeneca and GSK. Astra-Zeneca has also provided support via a donation of goods and services contract to ABUHB to support pathway redesign for the Severe Asthma	I undertake writing of medico-legal reports on behalf of claimants and defendants in the area of occupational lung injury. I do not undertake this work for patients in ABUHB		Agree

Jennifer Winslade	Executive Director of Nursing	Executive Nursing	Nil Declaration			Agree	
Hannah Evans	Executive Director of Strategy, Planning and Partnerships	Chief Executive	Nil Declaration			Agree	Agree
Paul Deneen	Board Member	Headquarters	Nil Declaration			Agree	
Nicola Prygodzicz	CEO	Corporate				Agree	Agree
Peter Carr	Executive Director of Allied Health Professions and Health Science	Corporate		Digital Health & Care Wales, since July 2023 as Chair of the LIMS 2.0 Programme	Paid 0.1 WTE at current Executive pay scale		Agree
Richard Clark	Independent Member (Local Authority)	Board	Nil Declaration			Agree	Agree
Rob Holcombe	Director of Finance and Procurement	Finance	Nil Declaration			Agree	
Rani Dash	Director of Corporate Governance	Corporate	Nil Declaration			Agree	Agree

Tracy Daszkiewicz	Exec Director of Public Health	Public Health		Swindon Womens Aid, Swindon, June 2020 - present Faculty of Public Health - Vice President, June 2022- June 2025 I will then take over as President June 2025- 2028	None		Agree
Ann Judith Lloyd	Chair ABUHB	Welsh Government	Nil Declaration			Agree	Agree
Paul Solloway	Director of Digital	Executive Team	Nil Declaration			Agree	Agree

Designation	Role	Organisation		Paid/Unpaid	Self or Family Member	Date
Executive Directors						
Nicola Prygodzicz	Chief Executive	Sister works in Velindre as a Senior Nurse in Corporate Nursing				29/2/2024
		Social connection with Rhian Mannings, CEO of 2 Wish Upon a Star Charity				
James Calvert	Medical Director / Deputy Chief Executive	Director	I am a co-Director with my spouse of Calvert Services Ltd. I do not contract for any NHS Services and don't believe that this directorship constitutes a conflict of interest	Unpaid	Self	19/12/2023
		Pharmaceutical Company Activity	Following consultation with Astra-Zeneca, ABUHB in receipt of donation of goods and services to support development of Severe Asthma Team. Payments received for conference attendance and South Wales Severe Asthma meeting	Paid (<£5000)	Self	
			During 2023-2024 I have received sponsorship to attend medical educational meetings from GSK (for a GSK organized meeting) and Astra Zeneca (to attend the European Thoracic Society Meeting). The standard of the educational content of the GSK meeting met ABPI standards and was not product related. The ERS is the largest respiratory CPD meeting in Europe and attendance was discussed as part of my PADR. I work as a respiratory consultant in the Severe Asthma Service in ABUHB. The Severe Asthma Service has benefitted			

Designation	Role	Organisation		Paid/Unpaid	Self or Family Member	Date
			from a "joint working agreement" with Astra Zeneca who have provided project management support for a process improvement project run in the department. I do not make formulary decisions about drugs marketed by these companies. I therefore do not believe this presents a material conflict but I am aware of my duty to declare an interest if I find myself in a situation where this is relevant.			
			I write a small number of medico-legal reports each year. I undertake these on behalf of HM Coroner, NHS Services and private legal firms. This work is done in my own time and I do not make use of any NHS facilities to do this work. In the past I have either recused myself or declared an interest where ABUHB patients or clinicians are mentioned. I do not do private medical work	<£10k annually		
			Network lead for the All Wales Neonatal Network		Spouse	
Sarah Simmonds	Director of Workforce and OD	Nil Declaration				20/12/2023
Leanne Watkins	Director of Operations	Terence Watkins – Separated husband working in planning as Senior Programme Manager				20/02/2024
Rani Dash	Director of Corporate Governance	Nil Declaration				10/2/2022 (confirmed no change 19.12.23)
Robert Holcombe	Director of Finance and Procurement	Member of Torfaen CBC L.A.F 23/24 Son worked for JK Bowkett ltd for part of 23/24				04/04/24

Designation	Role	Organisation		Paid/Unpaid	Self or Family Member	Date
Peter Carr	Director of Therapies and Health Science	Chair of the national LIMS 2.0 Programme Board, appointed by Welsh Government		Paid	Self	22/02/2024
Jennifer Winslade	Director of Nursing	Trustee	Hospice Care Devon	Unpaid	Self	16/01/2024
Hannah Evans	Director of Strategy, Planning and Partnerships	Nil Declaration				28/12/2023
Paul Solloway	Director of Digital	Nil Declaration				19/12/2023
Tracy Daszkiewicz	Director of Public Health	Board of Trustee for Swinon Domestic Abuse Support Charity				13/01/2024
Dr Chris O'Connor	Interim Director of Primary, Community and Mental Health Services (until 30/04/2023)	Nil Declaration				07/03/2022 (confirmed no changes 22/12/22)
Independent Members						
Ann Lloyd	Chair	Nil Declaration				21/12/2023
Pippa Britton	Vice Chair	Non- executive director/trustee	British Paralympic Association	Unpaid	Self	02/01/2024
		Board Member	Charity Commission	Paid	Self	
		Ambassador	Healthy Weight (Welsh Government)	Paid	Self	

Designation	Role	Organisation		Paid/Unpaid	Self or Family Member	Date
Shelley Bosson	Independent Member (Community)	Director	Howards Furnishers (EV) Limited	Unpaid	Self	28/12/2023
		Vice Chair	Tai Tarian Limited	Paid	Self	
Louise Wright	Independent Member (Trade Union)	Director/Owner	Coleg QS	Paid	Husband	02/01/2024 (confirmed no changes 28/12/22)
Richard G Clark	Independent Board Member	Director	Shared Resources Services (SRS)	Unpaid	Self	24/01/2024
		Director	CSC Foundry	Unpaid	Self	
		Company Secretary and Trustee	Torfaen Voluntary Alliance	Unpaid	Self	
			Torfaen Museum Trust			
			Monmouthshire & Torfaen YOS Local Management Board			
			Monmouthshire Farm School Endowment Trust			
			Cwmbran Centre for Young People Management Board			
		Elected Member, Deputy Leader & Exec Member	Children Families and Education, Torfaen County Borough Council	Paid	Self	

Designation	Role	Organisation		Paid/Unpaid	Self or Family Member	Date
Paul Deneen	Independent Member	Trustee	Walter Scott Educational Charitable Trust – Ross-on-Wye	Unpaid	Self	13/01/2024
		Trustee	Pashley Trust – Educational – Walford Primary School, Walford, Ross-on-Wye	Unpaid	Self	
		District Secretary	National Education in Union in Herefordshire	Paid	Self	
		Member	Employment Tribunals (West Midlands and Cardiff)	Paid	Self	
		Deputy Lieutenant of Herefordshire	Life Member of Magistrates Association, Chair of Governors at Walford Nursery and Primary Schools	Unpaid	Self	
Penny Jones	Independent Member	Volunteer Trustee	The Palmer Centre, Chepstow		Self	13/03/2024
			County Councillor for Monmouthshire		Self	
Phil Robson	Special Advisor to the Board	Trustee	Hospice of the Valleys	Unpaid	Self	10/2/2022
Prof. Helen Sweetland	Independent Member (University)	Nil Declaration				03/01/2024
Iwan Jones	Independent Member (Finance)					14/03/2024
		Golf Union of Wales Ltd			Self	

Designation	Role	Organisation		Paid/Unpaid	Self or Family Member	Date
Dafydd Vaughan	Independent Member (Digital)	Director and Shareholder	Cedyrn Ltd	Paid	Self	25/01/2024
		Director and Shareholder	Mimulus HQ Ltd	Paid	Wife	
		Member	Member of Advisory Panel, Centre for Digital Public Services (Welsh Gov Body)	Unpaid	Self	
		Senior Partner (Major Projects)	TPX Impact Ltd	Paid	Wife	
		Chief Technology Officer	Consulting Practice, Public Digital Ltd	Paid	Self	
Katija Dew	Independent Member (Third Sector) (until 01.04.23)	Trustee	Newport Live	Unpaid	Self	13/01/2022
		Director of Services	The Care Collective de Cymru Ltd	Paid	Self	17/05/2022

Title	Declaration (Nil/Paid/Unpaid)
Counsellor – Mental Health	Director of non-profit organisation Torfaen Talks CIC
Head Of Systems and Governance	Nil Declaration
R&D Director	South East Wales Academic Health Science Partnership (Director - Paid Secondment 1 day a week
	European Wound Management Association (Unpaid)
	Innovation Advisory Council Wales (Unpaid)
	Respiratory Innovation Wales (Unpaid)
Assistant Director of Workforce & OD	Member of St Marks Church Parochial Church Council (Unpaid)
Business Partner Accountant	Nil Declaration
Head of Procurement	Nil Declaration
Tech 3 - Physio	Nil Declaration
111 National Programme Director	Nil Declaration
Physiotherapist	Director, B4 Physiotherapy Ltd
Assistant Director of Performance & Information	Nil Declaration
Senior Planning and Service Development Manager	Nil Declaration
Senior Business Partner - Head of Workforce Planning	Nil Declaration
Admin Officer Physio	Nil Declaration
Associate Director Value-Based Health Care	Nil Declaration
Operational Lead, MH&LD	Board Trustee – Wales Mindfulness Charity
Head of Corporate Governance	Spouse - Consultant Colorectal & General Surgeon
B7 Physiotherapist Clinical Specialist	Nil Declaration
Assistant Director Strategy, Planning & Partnerships	Newydd Housing Association – paid (self)
Admin - Physio	Self employed PA to grandfather - paid
MSK Physiotherapist	Self-employed private practice

Title	Declaration (Nil/Paid/Unpaid)
Organisational Development Manager	Trustee and the Chair of the Gwent Cardiac Rehabilitation Trust Fund. This is a registered charity that raises funds to support Cardiac Rehabilitation services in the locality - Not paid)
CT/MRI Radiographer	Part time role with Njord medical as Applications Specialist
Head of Financial Planning and Performance	Nil Declaration
Dietetic Assistant Practitioner	Private Secretary (Paid)
Finance Manager - Clinical Futures	Volunteer - St Johns Ambulance (Review of area accounts)
Head of Management Accounting and Costing	Nil Declaration
Physiotherapist	Bank physiotherapist – Nuffield Hospital Vale
Consultant Old Age Psychiatrist	Interest declared
Head of Midwifery and Associate Director of Nursing	Interest declared
Assistant Director - Innovation	Nil Declaration
Clinical Pharmacist	Provide educational sessions on behalf of Astra Zeneca on diabetes optimisation and ABUHB SGLT2i project. Morph consultancy meeting to discuss the use of CGM in Wales
Assistant Finance Director	Nil Declaration
Head of Strategic Finance & Innovation	Nil Declaration
Psychological Therapist	Trustee RCT People First, Trustee Mental Health Matters, Private Practice – Systemic Supervisor and educator
Senior Manager Legal Services	Nil Declaration
Mental Health and Learning Disabilities Partnership Manager	Chair of Trustees/Directors - Cymryd Rhan Unpaid
Divisional Nurse	Nil Declaration
National Clinical Lead for Value Based and Prudent Healthcare	Consultancy for Sprink Ltd (research) – paid (Sept 2020 to Sept 2021)
Physiotherapist	Paid TV work

Title	Declaration (Nil/Paid/Unpaid)
Divisional Director for Primary and Community Services	Nil Declaration
Physiotherapist	Owner and Physiotherapist JLM Performance
Senior Planning Managers	Nil Declaration
Divisional Nurse/Clinical Futures Transformational Manager	Nil Declaration
	Nil Declaration
Deputy Director of Planning	Nil Declaration
Physiotherapy Administration	Private Counselling
Family and Therapies	Consultant in a monthly advisory board conducted by Nutricia Ltd
Divisional Nurse	Nil Declaration
Consultant Antimicrobial Pharmacist	Father in receipt of Pfizer pension
Directorate Manager of Pathology	Nil Declaration
Head of Complex HR / Senior Workforce Business Partner	Nil Declaration
Assistant Finance Director	Nil Declaration
Physiotherapist	Bank Work, Spire Hospital
General Manager, Mental Health Learning Disabilities	Nil Declaration
Senior Pharmacist Primary Care	Nil Declaration
Clinical Psychologist	Husband director of Rogue & Bard since 2022 – dividends only Personal involvement in Psychologists for Social Change Cymru 2023 onwards
Procurement	Nil Declaration
Consultant in Public Health	Nil Declaration
Physiotherapy Technician	Nil Declaration
Paediatric Physiotherapist	Self employed physio at private practice
Service Performance and Delivery manager	Voluntary member of St John Cymru Wales Parent is a Voluntary Commissioner for Gwent St John Cymru Wales
Head of Transformation	Nil Declaration

Title	Declaration (Nil/Paid/Unpaid)
Assistant Divisional Director Family & Therapies	Children in Wales Trustee (Not paid)
Head of Information Architecture, Informatics Directorate	Nil Declaration
Physiotherapist	Work as a physio at private clinic
Estates Manager	Nil Declaration
Service Improvement Manager - Workforce, Facilities	Nil Declaration
Energy and Carbon Manager, Works and Estates	Nil Declaration
Haematology	Nil Declaration
Engineer, Works and Estates	Skenrith Mews Management Company (No financial gain)
Senior Estates Manager, Works and Estates	Son is managing partner at JK Bowkett who are measured term contractors for the Health Board
Estates officer, Works and Estates	Nil Declaration
Laundry Manager, Green Vale Linen Services	Nil Declaration
Senior Programme Manager, Project Management Office - Planning	Relief work for Newport City Councils childrens care homes – occasional weekend work several times a year to help with emergency placements. Paid hourly

Division	Directorate	Declaration
Family & Therapies	Paediatrics	Nil Declaration
Scheduled Care	Pathology	Nil Declaration
Scheduled Care	Ear, Nose and Throat	Director - St Josephs Hospital (Private Practice - Paid)
Scheduled Care	Dermatology	Nil Declaration
Family & Therapies	CAMHS	Harebell Investments Ltd (director)
Scheduled Care	Trauma and Orthopaedics	Director of Phillip Alderman Ltd (Private Practice)
		Director/Governor Haberdashers Monmouth School
		Shareholder St Joseph's Hospital Ltd (Private Practice)
Family & Therapies	Paediatrics	Nil Declaration
Scheduled Care	Anaesthetics	Provides sedation in Private Dental Practice (Paid)
Unscheduled Care	Neurology	Nil Declaration
Family & Therapies	Obstetrics and Gynaecology	Practice at St. Josephs Hospital as Consultant O&G
Unscheduled Care	Gastroenterology	Nil Declaration
Scheduled Care	Rheumatology	Private Practice - St Josephs Hospital
Consultant - Anaesthetics	Anaesthetics	Nil Declaration
Mental Health & Learning Disabilities	Forensic Psychiatry	Nil Declaration
Unscheduled Care	Cardiology	Nil Declaration
Family & Therapies	CAMHS	Nil Declaration
Mental Health & Learning Disabilities	Psychiatry	Nil Declaration
Scheduled Care	Pathology	Private Practice - St Josephs Hospital
Family & Therapies	Paediatrics	Nil Declaration
Mental Health & Learning Disabilities	Adult Mental Health	Nil Declaration
Mental Health & Learning Disabilities	Older Adult Mental Health	Nil Declaration

Division	Directorate	Declaration
Family & Therapies	Obstetrics and Gynaecology	Spouse has partial shares in St Josephs Hospital
Scheduled Care	Pathology	Director of Pvt company (Sandeep & Nidhika Berry Pvt Ltd)
		Spouse – Consultant ENT surgeon (Cardiff and Vale UHB)
		Spouse- Consultant, Spire Hospital and Vale Clinic/ Hospital
Family & Therapies	Sexual and Reproductive Health	Nil Declaration
Family & Therapies	Physiotherapy	Private work with Nuffield Health and The Pap Effect - Caerphilly
Scheduled Care	Medicine	Director of Maple and Spice - e-book company
Unscheduled Care	Acute	Nil Declaration
Scheduled Care	Orthodontics	Specialist in NHS Care and Private Contracts
Scheduled Care	Anaesthetics	Working with Intelligent Ultrasound as a Clinical Consultant - Research occurring in ABUHB in line with FDA Standards, local research team and monitored by Prof Peter Wall
Family & Therapies	CAMHS	Nil Declaration
Scheduled Care	Anaesthetics	Nil Declaration
Scheduled Care	Rheumatology	South Wales Rheumatology Services Limited (Private Practice)
Unscheduled Care	Cardiology	Philip Campbell Consultancy Limited
		Shares - St Josephs Hospital
Family & Therapies	Physiotherapy	Founder & Owner of 'The Good Leader Academy' Since March 2024
Scheduled Care	Urology	Nil Declaration
Mental Health & Learning Disabilities	Older Adult Mental Health	Nil Declaration
Scheduled Care	Dermatology	Director of Ty Bryn & Village Medical Services Ltd
Family & Therapies	Physiotherapy	Self-Employed private Physiotherapist in Monmouth since 2011
Family & Therapies	Physiotherapy	Severn Area Rescue Association – Volunteer (6 Months)
Family & Therapies	Physiotherapy	Nil Declaration

Division	Directorate	Declaration
Scheduled Care	Ear, Nose and Throat	Nil Declaration
Scheduled Care	Radiology	Spouse - Psychologist at CAVUHB
Family & Therapies	Child Health	Nil Declaration
Family & Therapies	Physiotherapy	Nothing on form
Scheduled Care	Dermatology	Secretary of Welsh Dermatology Forum (audit group in Wales for all the Dermatologists) - No expenses received
Family & Therapies	Physiotherapy	Nil Return
Unscheduled Care	Acute	Council Member of Welsh Acute Physicians Society (WAPS) Education and pastoral care
Scheduled Care	Anaesthetics	Nil Declaration
Scheduled Care	Pathology	Private Practice - St Josephs Hospital
Scheduled Care	Trauma & Orthopaedics	The Director of Corporate Governance Rani Mallison is son's partner and soon to be my daughter-in-law.
Family & Therapies	Physiotherapy	Nil Return
Family & Therapies	Physiotherapy	Nil Declaration
Community	Frailty	Nil Declaration
Unscheduled Care	Neurology	Dr Kenneth Dawson Neurological Services Limited
		Private Practice - St Josephs Hospital and Glan Usk Suite
Unscheduled Care	Care of the Elderly	Nil Declaration
Scheduled Care	Anaesthetics	Nil Declaration
TEC Cymru	Informatics	Board Member with Social Care Wales. This is a four-year term and a remunerated post. Social Care Wales are the regulator of the social care sector in Wales, and are funded/sponsored by Welsh Government. 4 years from April 1st. £282 per day – 2 days a month on average
Family & Therapies	Obstetrics and Gynaecology	Private Practice
Unscheduled Care	Emergency Department	Nil Declaration
Scheduled Care	Surgery	Charitable Fund within ABUHB
		Honorary Senior Lecturer Cardiff University Medical School
		Visiting Professor University of South Wales
Family & Therapies	Physio	Nil Declaration

Division	Directorate	Declaration
Scheduled Care	Anaesthetics	Nil Declaration
Scheduled Care	Pathology	Undertakes private sessions at St. Josephs Hospital on a case by case basis
Scheduled Care	Haematology	Nil Declaration
Mental Health & Learning Disabilities	Community Mental Health	Nil Declaration
Scheduled Care	Pathology	Spouse has private sector practice as dietician trading as 'The Abergavenny Dietician'
Scheduled Care	Radiology	TREASURER OF THE SOUTH EAST WALES RADIOLOGY GROUP WHICH RECEIVES ANNUAL SPONSORSHIP FROM CANNON MEDICAL FOR ITS BIANNUAL EDUCATIONAL MEETING
Scheduled Care	ITU	Nil Declaration
Unscheduled Care	Emergency Department	Nil Declaration
Family & Therapies	Physio	Nil declaration
Unscheduled Care	Respiratory Medicine	Private practice at St Joseph's Hospital, Newport and at Spire Hospital Cardiff
Family & Therapies	Physiotherapy	Self employed as a mediclegal expert physiotherapy witness since 2018 – paid self-employment
Scheduled Care	General Surgery	Nil Declaration
Scheduled Care	Pathology	Provide microbiology and Infection Control advice to Spire Hospital Cardiff
Unscheduled Care	Gastroenterology	Nil Declaration
Scheduled Care	Anaesthetics	Nil Declaration
Scheduled Care	Trauma and Orthopaedics	Director South Wales Knee Clinic Ltd
		Private practice at St Josephs Hospital, Newport and at Spire Hospital Cardiff
Community	Palliative Care	Gleeson Coaching and Consulting Limited
Family & Therapies	Obstetrics and Gynaecology	Nil Declaration
Family & Therapies	Obstetrics and Gynaecology	Vice President of British Gynaecological Imaging (No payment)
Scheduled Care	Surgery	Bearsden Consulting - Private Company
Scheduled Care	Radiology	Director - NM Medical Services

Division	Directorate	Declaration
		Private practice at St Josephs Hospital, Newport and at Spire Hospital Cardiff
Family & Therapies	Child Health	Nil Declaration
Scheduled Care	Anaesthetics	Nil Declaration
Family & Therapies	Weight Management	Private secretarial work for medical consultant (Prof Haboubi) - Approximately 3 hours per week. £300 per month
Family & Therapies	Child Health	Nil Declaration
Unscheduled Care	Emergency Department	Spouse - Former Area Manager AstraZeneca
Unscheduled Care	Care of the Elderly	Nil Declaration
Unscheduled Care	Respiratory Medicine	Honorary President Welsh Sleep Apnoea Society
Scheduled Care	Anaesthetics	Nil Declaration
Family & Therapies	Paediatrics	Nil Declaration
Scheduled Care	Pathology	Private practice at St Josephs Hospital, Newport and at Spire Hospital Cardiff
Scheduled Care (moving to Clinical Support Services)	Pathology Directorate Manager	Common Law partner is Pathology manager for Spire Hospital Cardiff. We provide Pathology services for Spire Cardiff covered by an SLA .The SLA includes prices for services. She is not a director or shareholder in Spire Healthcare.
Unscheduled Care	Acute	Nil Declaration
Scheduled Care	General Surgery	Nil Declaration
Scheduled Care	Radiology	Occasionally take part in studies at Cardiff Uni
Unscheduled Care	Cardiology	Nil Declaration
Scheduled Care	Histopathology	Private Practice - St Josephs Hospital
Unscheduled Care	Respiratory Medicine	Private Practice - St Josephs Hospital
Mental Health & Learning Disabilities	Mental Health	Attended Advisory Board - Edinburgh to provide expert advice (Paid)
Scheduled Care	Radiology	Private Practice - St Josephs Hospital
		Medica Reporting Limited

Division	Directorate	Declaration
Family & Therapies	Physiotherapy	Nil Declaration
Scheduled Care	Haemotology	Preparing and delivering two presentations on managing chronic lymphocytic leukaemia and follicular lymphoma at an evening educational meeting for haematology nursing staff in South Wales Meeting (Paid)
		Sponsorship from Janssen pharmaceuticals to attend British Society for Haematology annual scientific meeting in Glasgow April 2019
		Received sponsorship from Janssen pharmaceuticals to attend British Society for Haematology annual scientific meeting in Glasgow April 2019
AMS	Pharmacy	Nil
Unscheduled Care	Emergency Department	Nil Declaration
Mental Health & Learning Disabilities	Adult Mental Health	Consultant Psychiatrist - Elysium Healthcare, CAVUHB
Family & Therapies	Anaesthetics	Nil Declaration
Scheduled Care	Pain Management	Nil Declaration
Scheduled Care	Pathology	Nil Declaration
Community	Palliative Care	Nil Declaration
Scheduled Care	Anaesthetics	Nil Declaration
Scheduled Care	Anaesthetics	Nil Declaration
Mental Health & Learning Disabilities	General Adult	Member of ATSAC - professional certificate in Sex Addicition - no private clients at present
Family & Therapies	Physio	In business with partner – Parent & Baby sensory massage & yoga (Little Rainbows Play)
Unscheduled Care	Emergency Department	Nil Declaration
Primary Care	Dental	Nil Declaration
Unscheduled Care	Emergency Department	Nil Declaration
Scheduled Care	Anaesthetics	Speaker at Educational presentations organised by Grunenthal Ltd and previously Pfizer
Scheduled Care	Trauma and Orthopaedics	Nil Declaration

Division	Directorate	Declaration
Family & Therapies	Paediatrics	Nil Declaration
Family & Therapies	Neonatology	Nil Declaration
Scheduled Care	Trauma and Orthopaedics	Nil Declaration
Unscheduled Care	Care of the Elderly	Nil Declaration
Family & Therapies	Sexual and Reproductive Health	Nil Declaration
Family & Therapies	Physio	Nil
Family & Therapies	Physio	Nil Declaration
Unscheduled Care	Neurology	Private company Lawthom Medical Limited – dissolved April 2018. Never active and no transactions.
Scheduled Care	General Surgery	Private Practice
Scheduled Care	General Surgery	Private Practice - **** Vascular Specialist Services ltd
Family & Therapies	Paediatrics	Nil Declaration
Scheduled Care	Trauma and Orthopaedics	Private Practice - St Josephs Hospital
Scheduled Care	General Surgery	Nil Declaration
Estates & Facilities	Minor Works	On call firefighter SW Fire & Rescue £4848.75 per annum
Scheduled Care	Haemotology	Speaker fees from meetings/presentations inc travel and accommodation
Family & Therapies	Physio	Nil declaration
Scheduled Care	Radiology	Director of Lim Perkins Healthcare Ltd
		Private Practice - St Josephs Hospital
Family & Therapies	Sexual and Reproductive Health	Previous role a Medical Examiner for Heddlu Gwent Police
Scheduled Care	Medicine	Nil Declaration
Scheduled Care	Trauma and Orthopaedics	Shares - St Josephs Hospital
Family & Therapies	Physiotherapy	Nil return
Mental Health & Learning Disabilities	Adult Psychiatry	Nil Declaration

Division	Directorate	Declaration
Scheduled Care	Trauma and Orthopaedics	Private Practice - Glan Usk Suite, Nevill Hall Hospital (Spouse acts as Private Secretary)
Family & Therapies	Physio	Race equality First – Trustee Volunteer Magistrate in Gwent Community Councillor in Cwmbran Trade Union Rep - Unison
Unscheduled Care	Medicine	Nil Declaration
Scheduled Care	Anaesthetics	Chair of Trustees - IPPG (UK Reg. Charity 1143221 (Reimbursement of Travel Costs)
Family & Therapies	Sexual and Reproductive Health	Spouse - Architectural Business
		Occasional honorary work for Bayer (Paid)
Scheduled Care	Anaesthetics	Joint Director of Masters medical services with spouse. Limited company providing private medical services
Scheduled Care	General Surgery	Private Practice - St Josephs Hospital
Scheduled Care	General Surgery	Consultancy agreements with 2 medical device companies, Cook Medical and LeMaitre Vascular.
Scheduled Care	Trauma and Orthopaedics	Nil Declaration
Scheduled Care	Dermatology	Nil Declaration
Unscheduled Care	Emergency Department	Nil Declaration
Corporate	Primary Care	Nil Declaration
Scheduled Care	Anaesthetics	Nil Declaration
Scheduled Care	Anaesthetics	Nil Declaration
Scheduled Care	Anaesthetics	Ceased practice at St Josephs Hospital in 2019
Community	Palliative Care	Medical Director Thrombosis UK
Community	Palliative Care	Trustee - Hospice of the Valleys
Scheduled Care	Trauma and Orthopaedics	Nil Declaration
Mental Health & Learning Disabilities	Psychiatry	Nil Declaration
Family & Therapies	Obstetrics and Gynaecology	Nil Declaration
Family & Therapies	Neonatology	Nil Declaration

Division	Directorate	Declaration
Family & Therapies	Physio	Nil
Scheduled Care	Maxillofacial	Nil Declaration
Scheduled Care	Haemotology	Secretary of UKCLL forum (registered charity 1104229)
Scheduled Care	Trauma and Orthopaedics	Nil Declaration
Family & Therapies	Obstetrics and Gynaecology	Nil Declaration
Scheduled Care	Ear, Nose and Throat	Private Practice - St Joseph's Hospital
Family & Therapies	Child Health	Nil Declaration
Family & Therapies	Physiotherapy	Nil Declaration
Scheduled Care	Medicine	Nil Declaration
Family & Therapies	Child Health	Undertakes sponsored educational talks to primary care which are sponsored and educationally overseen by pharma, currently specifically Astra Zeneca
Family & Therapies	Obstetrics and Gynaecology	Nil Declaration
Unscheduled Care	Diabetes and Endocrinology	Nil Declaration
Family & Therapies	Child Health	Nil Declaration
Family & Therapies	Paediatrics	Nil Declaration
Scheduled Care	Trauma and Orthopaedics	Shares - St Joseph's Hospital
		Private Practice - St Josephs and Nuffield
Scheduled Care	Dermatology	Nil Declaration
Unscheduled Care	Care of the Elderly	Nil Declaration
Scheduled Care	Pathology	Private Practice - St Josephs and Spire
Scheduled Care	Ear, Nose and Throat	Shares - St Joseph's Hospital
Scheduled Care	Ear, Nose and Throat	Private Practice - St Josephs
Family & Therapies	Physiotherapy	Nil Declaration
Family & Therapies	Neonatology	Locum Shifts (Honorary Contract - NEST, Bristol)
Scheduled Care	Trauma and Orthopaedics	Nil Declaration

Division	Directorate	Declaration
Scheduled Care	Anaesthetics	Nil Declaration
Family & Therapies	Physiotherapy	Nil
Scheduled Care	Haemotology	Nil Declaration
Scheduled Care	Pathology	Nil Declaration
Scheduled Care	Radiology	Director of Rholben Radiology - spouse provides secretarial support
Scheduled Care	Radiology	Private Practice - St Josephs
Scheduled Care	Trauma and Orthopaedics	Private Practice - St Josephs (Director) and Nuffield
Primary Care & Community Services	Education & Training	Part Owner and Director of R&W Training Academy Limited since 23 March 2024 – details on form
Mental Health & Learning Disabilities	Older Adult Mental Health	Nil Declaration
Unscheduled Care	Acute	Nil Declaration
Family & Therapies	Child Health	Nil Declaration
Family & Therapies	Neonatology	Nil Declaration
Family & Therapies	Physiotherapy	Abergavenny RFC Physiotherapist
Family & Therapies	Physiotherapy	
Scheduled Care	Pathology	Private Practice - St Josephs
Unscheduled Care	Care of the Elderly	Nil Declaration
Family & Therapies	Obstetrics and Gynaecology	Nil Declaration
Scheduled Care	Radiology	Director of RSG Radiology Limited
Scheduled Care	Radiology	Private Practice - St Josephs and Spire
Scheduled Care	General Surgery	Private Practice - Glan Usk Suite, Nevill Hall Hospital
Scheduled Care	General Surgery	Private Practice - St Josephs
Scheduled Care	Anaesthetics	Nil Declaration
Scheduled Care	Dermatology	Private Practice - St Josephs and Glan Usk Suite, Nevill Hall Hospital

Division	Directorate	Declaration
Family & Therapies	Physio	Nil
Unscheduled Care	Cardiology	Nil Declaration
Unscheduled Care	Emergency Department	Nil Declaration
Mental Health & Learning Disabilities	Psychiatry	Nil Declaration
Critical Care	Critical Care	Director – I am your Gasman ltd Trustee – Intensive Care National Audit and Research Centre
Scheduled Care	Radiology	Nil Declaration
Scheduled Care	Trauma and Orthopaedics	Chairman of the Education and Revalidation Committee (not paid) British Orthopaedic Association
Scheduled Care	Radiology	Nil Declaration
Family & Therapies	Physiotherapy	Swansea City Football Club – Match Day Physiotherapist
Family & Therapies	Dietetics	Nil Declaration
Scheduled Care	Pathology	Private Practice - St Josephs
F&T	Maternity	Private work as an International Board certified Lactation Consultant – from June 2024
Unscheduled Care	Cardiology	Nil Declaration
Scheduled Care	Ophthalmology	Private work in Dublin on the weekend
Scheduled Care	Anaesthetics	Nil Declaration
Scheduled Care	Anaesthetics	Private practice – Nuffield and St Joseph's
Unscheduled Care	Emergency Department	Medical Director for Great Western Air Ambulance Charity
Unscheduled Care	Emergency Department	Work occasional trauma team leader shifts at Southmead Hospital in Bristol (North Bristol Hospitals NHS Trust)
Scheduled Care	Trauma and Orthopaedics	Nil Declaration
	Physio	Private patients
Unscheduled Care	Care of the Elderly	Nil Declaration
Family & Therapies	Paediatrics	Nil Declaration
Unscheduled Care	Respiratory Medicine	Nil Declaration

Division	Directorate	Declaration
Family & Therapies	Physiotherapy	Nil Return
Scheduled Care	Trauma and Orthopaedics	Nil Declaration
Scheduled Care	Anaesthetics	Nil Declaration
Scheduled Care	Anaesthetics	Nil Declaration
Scheduled Care	Anaesthetics	Nil Declaration
Scheduled Care	Anaesthetics	Private Practice - St Josephs
Scheduled Care	Anaesthetics	Secondment from ABUHB to WAST and EMRTS Wales for a number of sessions per week (paid per session)
Scheduled Care	Maxillofacial	Part of Medical Team for Dragons and Newport Rugby Club (Paid per match)
Scheduled Care	Surgery	Nil Declaration
Scheduled Care	Anaesthetics	Nil Declaration
Unscheduled Care	Respiratory Medicine	Reansa Medical Services Limited
Unscheduled Care	Respiratory Medicine	Private limited company providing medical legal reports
Scheduled Care	Radiology	Nil Declaration
Family & Therapies	Physio	Expert witness on behalf of Somek and Associates
Unscheduled Care	Acute	Locum Shifts undertaken at NHH
Primary Care & Community Services	Education & Training	Part Owner & Director of R&W Training Academy Limited since 23 March 2024 – details on form
Unscheduled Care	Gastroenterology	Nil Declaration
Mental Health & Learning Disabilities	Older Adult Mental Health	Nil Declaration

Date of Disclosure	Department	Nature of Gift	Company	Accepted/Declined
08/05/2024	Macmillan Lung Cancer	Funding to attend Lung Cancer UK Annual Conference in Glasgow (Conference fees, travel & Accomodation) - Total £550	Hugh James And Irwin Mitchell Solicitors	Accepted
08/05/2024	Macmillan Lung Cancer	Funding to attend Lung Cancer UK Annual Conference in Glasgow (Conference fees, travel & Accomodation) - Total £550	Hugh James And Irwin Mitchell Solicitors	Accepted
13/06/2024	Employee wellbeing Service	Royalties for authorship of book	Bristol University Press	Accepted
17/06/2024	Neurological Rehab	2 tickets to a fundraising ball raising funds for Headway Brain Charity	Cari Snowden Taylor on behalf of Hugh James Law	Accepted
17/06/2024	Employee wellbeing Service	Overnight accommodation at university based hotel and evening meal - estimated at £160	Brunel University London	Accepted
24/09/2024		8 PC Monitors		Declined
07/11/2024		6 Lead coats	Mermaid Medical	Accepted
04/11/2024	Cariology	Sponsorship to attend conferences in Manchester & Switzerland		Accepted
09/10/2024	Planning Strategy and partnerships	Train tickets and ticket to an awards event that the Health Board was invited to	Kier Construction	Accepted
30/10/2024	Planning	Travel & Lunch for Awards Ceremony	Arcadis	Accepted
25/11/2024	Planning	Meal at an event	Gleeds Management	Accepted
26/11/2024	Unknown	6 Lead Coats	Mermaid Medical	Accepted
27/11/2024	G-PIMHS	Garden Centre voucher from a mother		Accepted
28/11/2024	Gwent Parent Infant Mental Health Service	Garden Centre voucher from a mother		Accepted
29/11/2024	Digital Data and Technology	Laptop Cart	Kinetic ID	Accepted
29/11/2024	G-PIMHS (gwent parent infant mental health service)	Garden Centre voucher from a mother		Accepted
08/01/2025	Urgent Care	Hotel gift card - internal gift from colleagues		Accepted
31/01/2025	Colorectal Nurses	£100 to support a training/study day for team	Nutricia	Accepted
31/01/2025	Colorectal Nurses	£100 to support a training/study day for team	iMEDicare	Accepted

31/01/2025	Colorectal Nurses	£100 to support a training/study day for team	Pennamed Ltd	Accepted
31/01/2025	Colorectal Nurses	£100 to support a training/study day for team	Viatris UK	Accepted
31/01/2025	Colorectal Nurses	£100 to support a training/study day for team	Marja Cross	Accepted
31/01/2025	Colorectal Nurses	£100 to support a training/study day for team	Norgine.com	Accepted
04/03/2025	Obstetric & Gynaecology	Funding for transport, hotel & meals to attend symposium	Smith & Nephew UK	Accepted

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	22 April 2025
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Committee Risk and Assurance Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Head of Corporate Risk and Assurance

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report presents the Audit, Risk and Assurance Committee (the Committee) with an assessment of the strategic risks related to the Board's strategic objectives and provides assurance that these risks are being effectively managed.

Cefndir / Background

The Strategic Risk Report, last presented to the Committee on 18 February 2025, included **nine** principal risks and **21** sub-risks.

Between February and April, the Board met once, on 26 March 2025. During this meeting, the Board approved the 2024/25 closing position of the Strategic Risk Register and reaffirmed its delegation of risk oversight responsibilities to various committees.

This approach aligns with the Board's Risk Management Framework, enhancing governance and ensuing appropriate scrutiny and assurance of all potential risks that could threaten the delivery of the 2025-28 Integrated Medium-Term Plan (IMTP).

Asesiad / Assessment

Strategic Risk Register

In accordance with best practices, all strategic risks undergo regular review to ensure that the control environment remains robust and adequate for managing identified risks. Where existing controls are deemed insufficient, additional mitigation measures are documented, and action taken to address these gaps. Similarly, assurances are continuously evaluated across the Three Lines Model to assess the effectiveness and reliability of existing controls.

If gaps in assurance are identified, the control environment is reassessed, and appropriate measures are put in place to strengthen risk management. Conversely, when gaps in assurance are found, it is essential to develop and implement effective assurance mechanisms to transition from reassurance to robust, evidence-based assurance. This ensures that risks are actively managed and mitigated with the appropriate oversight and verification processes in place.

A high-level summary of the **nine** principal strategic risks is presented in Table 1, with further details provided in **Appendix A** (Risk Dashboard and individual risk assessments for the 21 sub-risks).

It is important to note that **SRR 001H, SRR 003**, and **SRR 009** have been previously de-escalated to corporate or divisional risk levels and are therefore excluded from Table 1.

Additionally, **SRR 001E, SRR 004A, SRR 007A**, and **SRR 008A** have a risk score of 8 (Moderate Risk) and are not included in the risk level columns of Table 1.

Only the number of 'High' and 'Extreme' risks are provided.

Table 1

Overarching Strategic Risk Description	Sub-Risks	Risk Level		Sub-Risk Theme	Delegated Committee
		High (9 – 12)	Extreme (15 – 25)		
SRR 001 - There is a risk that the Health Board will be unable to deliver and maintain high quality safe and sustainable services which meet the changing needs of the population.	**A, B, C & D**	3	1	People	People and Culture Committee
	***E & F**	-	1	Service Delivery	Partnerships, Public Health & Planning Committee
	G	-	1	Financial Sustainability	Finance and Performance Committee
	I	-	1	Compliance and Safety	Finance and Performance Committee
SRR 002 - There is a risk that there will be significant failure of the Health Board's estate.	**A & B**	1	1	Compliance and Safety	Partnerships, Public Health & Planning Committee

SRR 004 - There is a risk that the Health Board is unable to respond in a timely, efficient, and effective way to a major incident, business continuity incident or critical incident.	***A & B**	1	-	Compliance and Safety	Partnerships, Public Health & Planning Committee
SRR 005 - There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system.	**A**	1	-	Service Delivery	Patient Quality, Safety & Outcomes Committee
SRR 006 - There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.	**A, B & C**	2	1	Service Delivery	Finance and Performance Committee
SRR 007 - There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population	***A & B**	1	-	Transformation & Partnership Working	Partnerships, Public Health & Planning Committee
SRR 008 - There is a risk that the Health Board fails to build positive relationships with patients, staff, and the public.	***A**	-	-	Transformation & Partnership Working	Patient Quality, Safety & Outcomes Committee
SRR 010 - The Health Board will fail to protect the Health and Safety of staff, patients, and visitors in line with its duties under the Health and Safety at Work Act 1974	**A**	-	1	Compliance and Safety	Patient Quality, Safety & Outcomes Committee
SRR 011 - The Health Board is at risk of failing to meet the Welsh Government's Public Sector emissions reduction targets of 16% by 2025 and 34% by 2030.	**A**	-	1	Service Delivery	Finance & Performance Committee
TOTAL	**21**	**9**	**8**		

**-represents the moderate risks not included in the table*

Reduction in Risk score

SRR 001G: Failure to deliver a sustainable financial position and longer-term financial plan

Since the Committee's last meeting in February and the subsequent report to the Board, the Director of Finance has reviewed the strategic risk outlined above. In light of the improved year-end financial forecast and a stronger financial footing entering the 2025/26 financial year, the likelihood of the risk materialising has been revised from 'Almost Certain' (5) to 'Certain' (4), reducing the overall risk score from 20 to 16. While the risk remains categorised as 'Extreme,' it now falls within the Health Board's threshold and appetite for financial risk.

As of the end of Month 11, the Health Board reported a year-to-date deficit of £7.240m, with a projected year-end deficit of £7.356m. This marked improvement in the financial position follows the Welsh Government's allocation of £40.5m in additional funding, confirmed in a letter dated 02 December 2024. This includes £9.5m in recurrent funding to address operational pressures and £31m in recurrent funding, conditional upon meeting specific performance objectives. This funding has been reflected in both the Health Board's year-to-date forecast positions.

The Director of Finance and the wider Executive Team fully recognise that the IMTP 2025–28 and the associated annual plan continue to carry a significant level of financial risk. However, the implementation of strengthened controls and enhanced assurance mechanisms has enabled the Executive Team to take a more proactive approach in safeguarding the Health Board's financial position, while also responding more effectively to instances of poor financial management.

Risk Appetite and Exposure

Risk Appetite

The Committee should note that while **five** sub-risks remain outside the acceptable risk threshold for their respective domains, they are being actively managed. The residual risk is subject to continuous assessment, ensuring that emerging threats and vulnerabilities are identified and addressed. To further mitigate these risks, targeted controls and interventions are continually implemented and refined, with a specific focus on reducing the likelihood, impact, or both.

Risk ID	Theme	Appetite	Threshold	Current Score
SRR 001I	Compliance & Safety	Minimal	8 and below	12
SRR 002A	Compliance & Safety	Minimal	8 and below	15
SRR 002B	Compliance & Safety	Minimal	8 and below	12
SRR 004B	Compliance & Safety	Minimal	8 and below	12
SRR 010	Compliance & Safety	Minimal	8 and below	12

Risk Exposure

In terms of the Health Board's current risk exposure to the **21** strategic sub-risks, the infographic below illustrates that the majority of strategic risks are concentrated in the central line of the risk matrix.

This positioning reflects a high level of risk exposure, reinforcing the need for continued monitoring, robust controls, and proactive mitigation strategies to manage and reduce these risks effectively.

Risk Scoring Matrix					
Likelihood/ Frequency (Over 5 years)	**Consequence/Impact**				
	1. Negligible	**2. Minor**	**3. Moderate**	**4. Major**	**5. Catastrophic**
5. Almost Certain (>75%)					
4. Likely (41-75%)				**1 x (Extreme)** SRR 001G	
3. Possible (11-40%)			**1 x (High)** SRR 007 B	**13 x (High)** SRR 001 A - D, F, *I, *SRR 002 B *SRR 004 B, SRR 005 A SRR 006 A, B, C *SRR 010	**2 x (Extreme)** *SRR 002A SRR 011A
2. Unlikely (1-10%)				**4 x (Moderate)** SRR 001 E SRR 004 A SRR 007 A SRR 008 A	
1. Rare (<1%)					

*Risks outside of appetite

Closing Position

The closing position reported to the Committee confirms that the Strategic Risk Register currently includes **nine** high-level strategic risks and **21** sub-risks, with **five** of these sub-risks managed outside of their predefined risk appetite level. These risks continue to be actively managed to ensure appropriate mitigation and oversight

Annual Review of the Risk Management Framework

In accordance with statutory requirements, the Risk Management Framework is to be reviewed annually to ensure continued effectiveness and alignment with current regulations and best practices. This regular evaluation is essential for maintaining a proactive approach to identifying, assessing, and mitigating risks within the healthcare environment.

The latest review confirms that the Risk Management Framework remains robust, with no significant material changes required. However, several updates have been implemented to enhance its applicability and efficiency, as detailed in **Appendix B**.

The areas where changes have been made are listed below and highlighted in yellow within Appendix B for ease of review.

Improved Risk Assessment Templates: Refinements have been made to the templates used for risk assessment to facilitate more comprehensive and standardised evaluations. These improvements aim to enhance usability and effectiveness for staff conducting risk assessments.

Inclusion of Thematic Risk Registers: Thematic Risk Registers have been added to the Risk Management Framework to enhance risk identification, analysis, and mitigation. By categorising risks under specific themes, detailed analyses can be undertaken, targeted mitigation strategies developed, and ensure proactive management of emerging risks. This structured approach will improve the clarity and effectiveness of risk reporting, ensuring risks are escalated to the right level for management.

In addition, the integration of thematic risk registers represents a significant step towards a more robust and resilient risk management process.

Management of Risks at the Originating Level: Risks that can be effectively managed within their originating area, regardless of their risk score, should not be unnecessarily escalated to a higher-level risk register. This ensures that risk management remains proportionate, with only those risks requiring senior oversight being escalated.

Guidance on Moving Project Risks to the Organisational Risk Register: Greater detail has been included on when risks related to projects should be escalated to the organisational risk register. This ensures that project-specific risks are appropriately managed within the project governance structure, with only those that have broader service/ departmental or organisational implications being escalated**.**

Inclusion of Malicious and Non-Malicious Intent: Insights from external training sessions have led to the inclusion of considerations related to the intent behind risks, distinguishing between malicious and non-malicious origins. Recognising intent is essential for tailoring appropriate mitigation strategies and responses.

These updates reflect an ongoing commitment to strengthening risk management practices. Regular reviews and refinements ensure the framework remains resilient and responsive to an evolving healthcare landscape.

Argymhelliad / Recommendation

The Audit, Risk and Assurance Committee is requested to:

- **NOTE** the Strategic Risk Register and the Risk Assessments for the 21 sub-risks, acknowledging the comprehensive review and ongoing management of these risks;

- **ENDORSE** for onward approval by the Board the reduction in likelihood for SRR 001G

- **CONSIDER** whether it has sufficient assurance that the strategic risks are being assessed, managed, and reviewed appropriately and effectively, considering the detailed analysis and ongoing mitigation efforts outlined in this report;

- **NOTE** the risks that remain outside of the agreed-upon appetite for their respective risk domains, recognising the ongoing efforts to mitigate these risks and bring them within acceptable levels.

- **AGREE** whether the changes to the Risk Management Framework can be **APPROVED** by this Committee, with the Board informed via the Committee Assurance Report, or whether onward submission to the Board for formal **APPROVAL** is required.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	The Strategic Risk Report is informed by Datix, ensuring a bottom-up approach to risk escalation.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Choose an item. The Strategic Risk Register assesses risk that could impact achievement of all strategic priorities.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	N/A
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	At each meeting, the relevant Committee will monitor the risk theme relevant to its responsibilities.

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive

	Committee, including policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• **Workforce**	Not Applicable
• **Service Activity & Performance**	Not Applicable
• **Financial**	Not Applicable
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives Choose an item.

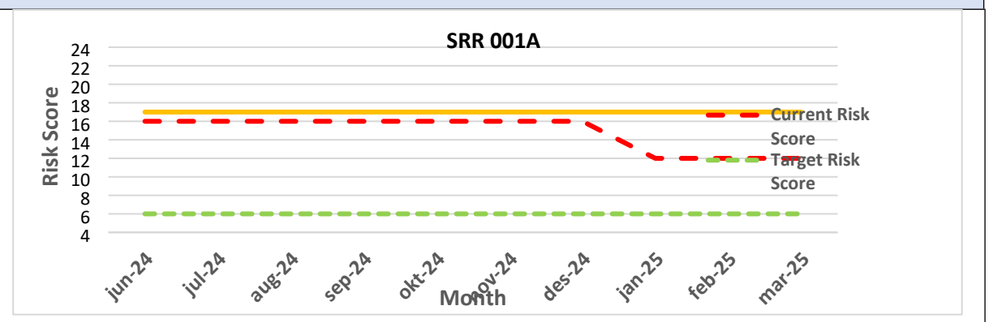
			Risk Description	Risk Score Matrix
				2 | 4 | 5 | 6 | 8 | 9 | 10 | 12 | 15 | 16 | 20 | 25
SRR 001	Director of workforce and OD	There is a risk that the Health Board will be unable to deliver and maintain high quality safe and sustainable services which meet the changing needs of the population	a)Due to an inability to recruit and retain staff across all disciplines and specialities.	
			b) Due to a deterioration in, and a failure to improve, the well-being of our staff	
			c) Due to insufficient and ineffective leadership levels throughout the organisation.	
			d) Due to the threat of Industrial Action during ongoing disputes and negotiations at a national level	
	Director of Strategy, Planning and Partnerships.		e) Due to inadequate strategic plans which respond to population health and socio-economic needs	
			f) Due to unsustainable service models	
	Director of Finance and Procurement		g) Due to the failure to deliver a sustainable financial position and longer-term financial plan	
	Director of Strategy, Planning and Partnerships.		l) Due to a failure to implement the required performance improvements in some areas of the organisation in line with the Health Board's Performance Management Framework domains of Quality and Safety, Operational Delivery, and Finance.	
SRR 002	Chief Operating Officer	There is a risk that there will be significant failure of the Health Board's estate	a) Due to the presence of Reinforced Autoclaved Aeriated Concrete (RAAC) within structures	
			b) Due to significant levels of backlog maintenance	
SRR 004	Director of Strategy, Planning and Partnerships.	There is a risk that the Health Board is unable to respond in a timely, efficient and effective way to a major incident, business continuity incident or critical incident	a) Due to emergency planning arrangements at both the corporate and operational level not being sufficiently robust to respond to a Major Incident	
			b) Due to ineffective and insufficient arrangements across all service areas to respond to a Business Continuity or Critical Incident.	
SRR 005	Chief Operating Officer	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system	a) Due to inadequate arrangements to support system-wide patient flow	
SRR 006	Director of Digital	There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery	a) Due to the full or partial failure of existing digital infrastructure and systems	
			b) Due to an adverse impact on service delivery in the implementation of new digital systems	
			c) Due to a failure to develop digital solutions that are sustainable and fit for the future	
SRR 007	Director of Strategy, Planning and Partnerships.	There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population	a) Due to the likelihood of further austerity measures impacting effective collaboration with strategic partners across the Health Board footprint.	
			b) Due to the impact of fragile services across the regional and supra regional geography	
SRR 008	Director Of Nursing	There is a risk that the Health Board fails to build positive relationships with patients, staff and the public	a) Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement	
SRR 010	Director of Allied Health Professions and Health Science	There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in-line with its duties under the Health and Safety at Work Act 1974	a) Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.	
SRR 011	Director of Finance and Procurement	There is a risk that the Health Board will not meet the carbon reduction target set by Welsh Government (16% reduction by 2025 and a 34% reduction by 2030) . This is common to all Health Bodies across the country.	a) The effect of a failure to meet this target is on the wider environment due to the limitations to change estate and structural operations and available funds to implement strategic changes at scale to fully meet the target expected	

Key	
Current Score	●
Target Score	×
Appetite Threshold	◊
Current to target	◄ –

Assessment of adequacy of assurances	
	POSITIVE = Identified assurances are deemed robust in telling us that the controls in place are working effectively.
	REASONABLE = Identified assurances are deemed adequate in telling us that the controls in place are working effecively, however some gaps have been identified which need to be addressed.
	NEGATIVE = Identified assurances are deemed insufficent in telling us that the conrols in place are working effectively with substantial gaps identified which need to be addressed.

RISK THEME	PEOPLE		
LINK TO IMTP	SECTION 4: ENABLER – WORKFORCE AND CULTURE		
Strategic - SRR 001 A	**There is a risk The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**	**Publication Status**	**Public**
Threat *(As a result of)*	**Due to an inability to recruit and retain staff across all disciplines and specialties.**	**Risk Appetite Level – Open** Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.	
Impact *(Consequences of the threat)*	**Patient** • Adverse impacts on delivery of care to patients across acute and non-acute settings **Staff** • Non-compliance with safe staffing principles and standards. • Increased Workload **Organisation** • Operational Disruptions • Quality of Services • Reputational Damage • Financial strain – use of agency and bank staff	**Risk Appetite Threshold - Score 17 and below.** Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing. **SUMMARY** The current risk level is **OUTSIDE** of target level but **WITHIN** the appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	

Lead Director	Director of Workforce & Organisational Development	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee / Group	People & Culture Committee	**Likelihood**	3 *(Possible)*	3 *(Possible)*
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Major)*	2 *(Minor)*
Last Reviewed	01 April 2024	**Risk rating**	**12** *(High)*	**= 6** *(Moderate)*
Next Review (Quarterly based on risk score)	01 July 2025			



Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	Plans to Improve Control ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Monitoring Framework to support roll-out of the People Plan. • Workforce Dashboard to track activity – recruitment, turnover, sickness absence. • Supply and demand tracker (Nursing and HCSW). • People Plan tracker to support delivery of actions within the People Plan 2022-25. • Variable Pay Reduction Plan approved June 2022 and supported by the Programme Board. • Management of attendance through All Wales Management Attendance at Work Policy. • Duty of Quality - Section 6.8.2 Workforce and Section 6.8.3 Culture. • Nurse Staffing Levels (Wales) Act 201625b/25c. • Review of staffing and recruitment plan internally in line with Royal College Guidance, i.e., RCP. • Workforce planning supported by Compendium of new roles to support innovative workforce models. • Recruitment KPI's. • IMTP (Integrated Medium-Term Plan) Educational Commissioning. • Workforce Establishment controls national working group has been instigated. • Value and Sustainability Board. • Implementation of the Collective Agreement (Non-Pay Deal) 2022/24. • **Recruitment** • Engagement with national recruitment campaigns such as BAPIO, M&D Kerela Initiatives, Train, Work, Live and Student Streamlining for Registered Nurses, Physician's Associates, Midwives, and therapy staff and with HEIW (Health Education and Improvement Wales) for Junior Doctor. • Annual programme of Apprentice recruitment • Overseas Nursing (All Wales Recruitment programme) • Nursing Workforce Strategy agreed. • Streamlining and improving recruitment timescales through recruitment modernisation programme (started Oct 2022) • Partnerships with employability schemes and FE/HE to widen access. • Actively working with Local Authorities to promote joint recruitment activities via Gwent Workforce Board.	**Retention** • Development of career pathways (e.g., non-clinical to clinical). • NHS Wales Nurse Retention Plan quarterly updates being reviewed for submission 09 Sept 2024 ongoing reviews taking place. • HCSW retention plan developed in collaboration with Nursing focusing on areas of high turnover • Short project in progress with an MSc student to develop a retention dashboard, using a regression model to better understand and predict retention. Data analysis is underway with a 5 year past dataset shared. **Variable Pay Reduction** • Development of action plan based on WHC to support the reduction in bank and agency usage. **E- Systems** • Utilise benefits of roll out Safe Care staffing to support effective and efficient staff deployment within adult ward areas. • Roll out of medical rostering to predict junior doctor gaps and look for alternative ways to fill. • Ensure compliance increase in e-job planning to optimise current resources and identify any gaps in provision. • Review and analyse the electronic Bank & Agency data from Patchwork to identify areas with high usage, reasons for use and potentially convert to substantive roles. **Development of alternative and new roles** • Continued implementation of new roles such as Physician Associates, CAAPs, Enhanced and Advanced roles to support workforce skills gaps in line with IMTP. • Establishment of Mental Health Workforce Planning through HEIW leadership of Mental Strategic Workforce Plan and allocation of workforce planning resources and training programme currently being delivered to Health Boards. • Updating of compendium of new roles and benchmarking is available via workforce planning intranet site and HEIW portal. • Looking to increase Assistant band 4 in Community/Mental Health and areas such as Cardiology Physiology

- Working with partners to improve visibility and attraction
- DBS Policy in place with DBS risk assessment form
- Introduced centralised HCSW talent pools from September 2023.
- Future Nurse Academy introduced in January 2024.

Retention
- Retention lead appointed with programme action plan in place for the next two years.
- Engagement chat cafes providing information and support for key topics such as Agile Working, Learning and Development, Wellbeing Activity, Occupational Health, and Complex HR.
- Week of events planned to support retention agenda in 2025. This will include a mixed method of online webinars, videos and retention materials.
- Internal Retention group has been established with a view to 1) interrogating data from multiple sources to fully understand the issues 2) Turn the data into intelligence so that we can understand and respond to organisational and local level impacts.
- Changes in pension regulation and flexile retirement options from October 2023 and reduced break in service required following retire and return.
- Development of HCSW skills matrix and career framework has commenced.
- Talent management and succession planning framework and resources now live and available on SharePoint. Framework signed off by Executive Committee.
- Career conversations and succession planning resources designed; Talent management succession planning workshop dates available with spaces for 120 people (with monthly training sessions available). Sessions are nearly fully booked with 114/120 places booked**.** Further workshops planned until the end of the year.
- All Wales self-assessment retention tool completed and submitted to HEIW with assessment at organisational level for Nursing and Midwifery to provide a baseline.

Variable pay reduction
- Plan in place to monitor and review all agency, bank pay incentives supply and demand reporting to Value and Sustainability Board.

E- Systems
- Effective deployment of current staff - Programme Plan implemented to introduce Workforce Medical E-Systems to support effective deployment of medical staff. E-Locum Bank, E-Job Planning, E-Agency systems are all 'live' and rolled out within the Health Board.
- E-Rostering is planned to go live shortly following ESR interface testing and following increase in e-job planning compliance, provisionally scheduled for the end of July 2025.

Development of Alternative and New Roles
- Development of alternative and new roles.
- A Gwent Strategic Workforce Action plan has been developed through co-production with our partners across Gwent and now forms the basis of the Gwent Workforce Board programme of work and agenda. The Action plan has been developed around the 7 key principles of A Healthier Wales: Our Workforce Strategy for Health and Social Care.
- The NCN (Neighbourhood Care Networks) Workforce Planning programme commenced in Autumn 2023, with all initial workforce planning workshops with all 11 NCN areas completed. The programme is now moving into the next stage of the programme with a comprehensive workforce planning assessment of Blaenau Gwent as an initial project. Programme plan led by WOD developed in conjunction with NCN leads and Divisional Senior Management.

Training
- The HEIW Education & Training Plan continues the investment in education and training in Wales that has been increasing over past years. In the HEIW Education Training Plan 22/23 there were increases in - Adult Nursing (36%) and Mental Health Nursing (20%), Healthcare science, Allied Health Professionals Clinical Psychology (11%- 43%). This will increase the number of graduates coming out of training in 2025 and beyond which are required to support turnover and existing vacancies in addition to external recruitment and internal training developmental programmes.
- The 2024/25 education training plan demonstrated very few increases on previous years for students graduating in 2027 and beyond. The draft 2025/26 education and training plan proposes further increases in Wales training numbers in all branches of Nursing, health care science, medical speciality training junior doctors, pharmacy and continued increase in HCSW investment and increased placements in adult nursing in General Practice.
- HEIW have increased Health Care Support Workforce Development funding and there have been further changes for accelerated training pathways in some areas so support entry graduate level qualifications. Improved HCSW funding has enabled clinical induction to be delivered in house from April 2024 to accelerate time to effectiveness and improve employee experience.
- RCN Connect Programme has been established in connection with HEIW and higher education providers to support candidates enter registered nursing training (12 supported so far this year, with 3 more to interview) – We don't get involved with regards to the interview process.
- Cadet Nursing programme in place – 16 candidates attended for the 2024 induction and work is ongoing to support all 16 to achieve accreditations. - 16 RCN cadets attending All Wales HCSW Clinical Skills Induction, currently 12 active.
- Continue to extend scope of Advanced Clinical Practitioners to undertake new procedures, reporting etc reducing medical capacity.
- Increasing consultant therapy and nurse practitioners.
- RCN introduction of Registered Nursing Associate role to help build the capacity of the nursing workforce – students to start from September 2025 with placements from September 2027.
- Development of new roles and career pathways to support hard to fill roles in Health Visiting.
- Re-design of the Health Board's work experience programme with 246 applicants since March 2024 and 75 placements confirmed

Training
- HEIW are increasing the capacity of training through creating more spaces for training the future Primary Care workforce, including Primary Care Academy
- Workforce planning training prospectus of local and online training launched September 2024
- Development opportunity being scoped for Business support staff.
- Suite of learning masterclasses launched with 5 topics now available to book, including influencing skills, setting up teams for success, giving feedback, having courageous conversations, having a meaningful PADR. 236 attendees in July 2024.
- Recruitment training for managers to streamline campaigns as much as possible to reduce time to hire.
- Development of training doctor fill rate dashboard to monitor and improve fill rate or to inform alternative recruitment strategies.
- A review and action plan underway to consider how to address instances where nurse streamlining preferences for specific posts exceed the number of vacancies available, to promote recruitment and retention.
- 31 staff enrolled on workforce planning online training modules level 1. 15 managers enrolled on level 2 training delivered locally March 2025. A capacity and capability workforce planning action plan are being developed to support 25/26 programme of activity.

• K102 bridging model now being offered to support HCSW pathways into registered nursing. • Development of Leadership Development programmes for key roles such as the Clinical Director post (CDx). Similar program for Directorate Managers (DMx) a 10-month leadership development program to support the capability of this key group commenced 23 April 2024 with cohort 2 launching June 2025. Nursing and Midwifery Academy for senior level nurses and midwifes, Leadership Development program (entry level) and Leading People (advanced Level) programmes fully booked. Core Leadership programme currently delivering to 200 staff per year. • Delivery of workforce planning training **Vacancy Numbers and establishment control** • Quarterly reporting of vacancy numbers to WG as of March 2025 was 629 WTE, an increase of 44 WTE since September 2024. • Development of ESR establishments commenced on a national basis in September 2023. Local delivery action plan has been developed and project workstream established and work commenced. National work programme proposal is also in development to assess digital solutions **Staff attendance** • Support for staff who are absent in line with Managing Attendance at Work Policy, including those on long term absence with a view to signposting to self-help support, and adapting/adjusting roles to enable a safe return to work. • "Hot spot" areas identified and plans in place to support	

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*		**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*			
• Workforce reports to the Nurse Strategic Workforce Group. • Monthly sickness monitoring reports. • Weekly filled and unfilled shift reports (RN) and reports of agency for HCSW/RN. • Medical Staffing Co-ordinator review of medical rotas. • Cross site operational calls.	• Occupational Health and Wellbeing dashboards report KPIs. • Recruitment KPIs • Medical & Dental and Student Streamlining fill rate reports		
Level 2 Organisational *(Executed by risk management and compliance functions)*			
• Reports to the People and Culture Committee and the Board on the progress of the People Plan 2022-25 • Workforce Dashboard presented to the Executive Committee, P&CC Committee, and the Board. • Workforce and OD (Organisational Development) group established to support delivery and implementation of workforce plans to support Clinical Futures Service transformation. • Measurements of Wellbeing through the ABUHB	• (Aneurin Bevan University Health Board) Staff Survey • Routine Reporting against nurse staffing levels. • Variable Pay Programme Board reporting to Value and Sustainability Board		
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*			
• Internal Audit Reviews 2023 -24 • Long Term Sickness Absence Management (Q4) • Flexible Working (Q4) • External quarterly vacancy reporting to WG • National Workforce Implementation Plan: Addressing NHS Wales Workforce Challenges. The Strategic Workforce Implementation Board will report to the Minister for Health and Social Services with a collective view from a range of key partners including policy and professional leads in WG, and representatives of NHS employers, staff organisations and professional representative.	• External reporting on Nursing Staffing Levels • National Acuity Audits (Nursing) • Workforce planning external audit action plan 2024	• Latest local survey saw a reduction in staff wellbeing	• Internal Audit Staff Culture Q3 2024/25

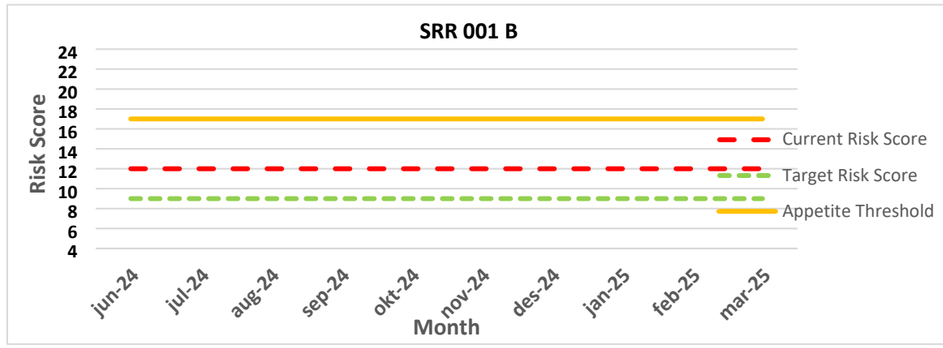
Assurance Rating (*Overall Assessment of controls and assurances*) *Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**POSITIVE**

RISK THEME	PEOPLE				
LINK TO IMTP	**SECTION 4: ENABLER – WORKFORCE AND CULTURE**				
Strategic - SRR 001 B	**There is a risk The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**			**Publication Status**	**Public**
Threat *(As a result of)*	**Due to a deterioration in, and a failure to improve, the well-being of staff.**				
Impact *(Consequences of the threat)*	**Patient** • Adverse impacts on delivery of care to patients across acute and non-acute settings	**Staff** • High absence levels, with some sustained long periods • Non-compliance with safe staffing principles and standards	**Organisation** • Reputational damage to the health board as an employer • Work-related claims • Financial Implications		
Lead Director	Director of Workforce & Organisational Development	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee / Group	People & Culture Committee	**Likelihood**	**3** *(Possible)* *x*	**3** *(Possible)* x	
Initial Date of Assessment	01 June 2023	**Impact**	**4** *(Major)*	**3** *(Moderate)*	
Last Reviewed	01 April 2024	**Risk rating**	**= 12** *(High)*	**= 9** *(High)*	
Next Review (Quarterly based on risk score)	01 July 2025				

Risk Appetite Level – Open
Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.

Risk Appetite Threshold - Score 17 and below. Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.

SUMMARY
The current risk level is **OUTSIDE** of target level but **WITHIN** the appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.



Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
General • Monitoring of absence, reasons for absence and trends in referrals to Occupational Health and Employee Well-being Service through Workforce Performance Dashboard. • Dashboard reported to Executive Team, TUPF and LNC colleagues and People and Culture Committee with regular summary of Well-being and Occupational Health activity. • Regular meetings with divisions to ensure staff are well supported and staff wellbeing is a priority. • Strategic Equality plan • Rest and Facilities charter – monitoring and compliance. • Staff related policies. • National Staff Survey and Health Board Employee Experience Survey • External Employee Assistance Programme • Speaking up Safely action plan • Race/LGBT groups. • Wellbeing resources • Staff diversity networks • Regular Schwartz rounds arranged across the Health Board • Taking Care giving care Rounds integrated into our leadership offers and available for teams to undertake either with support or on their own. • Close links with the Arts in Health programme • Chaplaincy service for staff • Establishment of new bilingual Health and Well-being AB Pulse page on the intranet with library of resources for staff well-being Support offered to Trade Union Representatives and their members to ensure a positive experience of work and rapid escalation when appropriate. • Support availability of "Safe Space" conversations for senior medical leaders from Faculty of Medical Leadership & Management. • The Avoidable Employee Harm Programme, launched on 05 July 2022 initially focusing on HR processes has resulted in a 70% reduction in investigations and a wide range of other organisational benefits	**General** • Increase wellbeing initiatives. • Identify, training and develop Respect and Resolution advocates (like Mental Health first aiders). • Work with Professional Nurse Advocates (PNA) to explore ways to offer high quality support to nursing colleagues. • Trained mediators so there is team and organisational resilience and network. • Scope, design and deliver a programme of research 'Healthy Working Day'. • Enhanced our financial well-being offer. • Support offered to Trade Union Representatives and their members to ensure a positive experience of work and rapid escalation when appropriate. • Support availability of "Safe Space" conversations for senior medical leaders from Faculty of Medical Leadership & Management. • The Avoidable Employee Harm Programme, launched on 05 July 2022 initially focusing on HR processes has resulted in a 70% reduction in investigations and a wide range of other organisational benefits. The programme has now won six awards including two from NHS Wales. • Implementation of the Speaking up Safely process in line with the Welsh Government Framework. • We are planning a series of events to celebrate 10 Years of Schwartz Rounds within ABUHB. **Occupational Health.** • Reviewed Occupational Health provision and consider options to improve sustainability within the service, paper drafted. Current Demand and Capacity review underway with support from planning • Submission of response to All Wales KPI delivery and ongoing data analysis review in place. • Recently appointed 8a role to provide further clinical leadership and key priority for M1-3 is to undertake training needs analysis to develop OH team. Training needs analysis completed. Recently appointed Band 7 and Band 5 to stabilise nursing workforce currently advertising Band 6. Band 8a recently resigned and in the process of advertising for a replacement, • Support equality and diversity of workforce. • Review of staff diversity networks. • Review of National Staff survey s to understand variations within diverse workforce demographic profile.

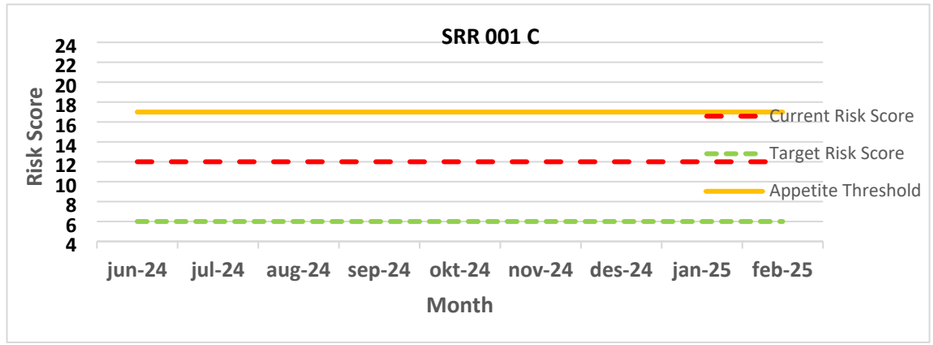
• The Avoidable Employee Harm Programme model will be used to underpin our approach to the Speaking up Safely (SUS) initiative within ABUHB. • an externally commissioned SUS hotline will be piloted in September 2024. • An external Employee Assistance Programme (Vivup) has been commissioned for a further 12 months to offer additional psychosocial wellbeing support to staff, including a waiting list initiative. **Occupational Health** • Additional occupational health resources secured to reduce waiting times. • Occupational Health and NWSSP are working in partnership to implement a new Occupational Health Software system across Wales called OPASG2. OPASG2 provides benefits to employment and recruitment processes. • Occupational Health and the Well-being Service continue to work with Therapies colleagues on support for staff experiencing Long Covid-19. • Support equality and diversity of workforce. • A part time Disability Inclusion Officer has been seconded to the EDI Team and made permanent in December 2024. • Band 5 EDI Officer appointed and commenced in post at the end of March 2024. • Inclusive Leadership sessions embedded in the Leading People Programme from January 2024 onwards. • Reverse Mentorship Programme launched February 2024. **Other** • Assessment of compliance against BMA Rest and Facilities charter complete with action plan developed, reporting to LNC • Reducing fatigue poster developed.	• Development of a buddy system to assist international medical staff with induction and orientation and support values and current norms. • Development of an empowerment passport to support disabled staff and reasonable adjustments and wellbeing. **Staff Survey Action Plan** • Findings from the staff survey 24/25 indicate improvements with culture and diversity. • An ABUHB action plan is in development to address staff engagement, work related stress and to improve retention of staff.

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Dashboard reporting • Reporting to monitor the rollout of the People Plan 22-25 Reporting to monitor of demand on wellbeing services	• Understand if support is reaching all staff	• Meetings with Divisions ongoing to ensure all areas are aware of what's available.
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• People and Culture Committee reports (People Plan 22-25) • Local wellbeing surveys • LNC – reporting of compliance of BMA Rest and Facilities		
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
• National workforce surveys • Monitoring and compliance of BMA Rest and Facilities via NHS Employers • Staff Welfare Charter Sickness Absence Audit 2023/24 – Outcome: Reasonable Assurance	• Latest local survey saw a reduction in staff wellbeing	• Internal Audit Staff Culture Q3 2024/25

Assurance Rating (*Overall Assessment of controls and assurances*) *Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**POSITIVE**

RISK THEME	PEOPLE				
LINK TO IMTP	SECTION 4: ENABLER – WORKFORCE AND CULTURE				
Strategic - SRR 001 C	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**			**Publication Status**	**Public**
Threat *(As a result of)*	**Due to insufficient and ineffective leadership levels throughout the organisation**			**Risk Appetite Level – Open** Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.	
Impact *(Consequences of the threat)*	**Patient** • Adverse impacts on delivery of care to patients across acute and non-acute settings;	**Staff** • Adverse impacts on staff recruitment and retention	**Organisation** • Failure to deliver health board priorities, required improvements and achieve sustainability; • Poor levels of accountability and delivery; • Reputational damage to the health board as an employer;	**Risk Appetite Threshold - Score 17 and below.** Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.	
				SUMMARY The current risk level is **OUTSIDE** of target level but **WITHIN** the appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	

Lead Director	Director of Workforce & Organisational Development	Risk Exposure	**Current Level**	**Target Level**
Monitoring Committee / Group	People & Culture Committee	**Likelihood**	**3** *(Possible)* *x*	3 *(Possible)* x
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Major)*	2 *(Minor)*
Last Reviewed	01 April 2024	**Risk rating**	**= 12** *(High)*	**= 6** *(Moderate)*
Next Review (Quarterly based on risk score)	01 July 2025			

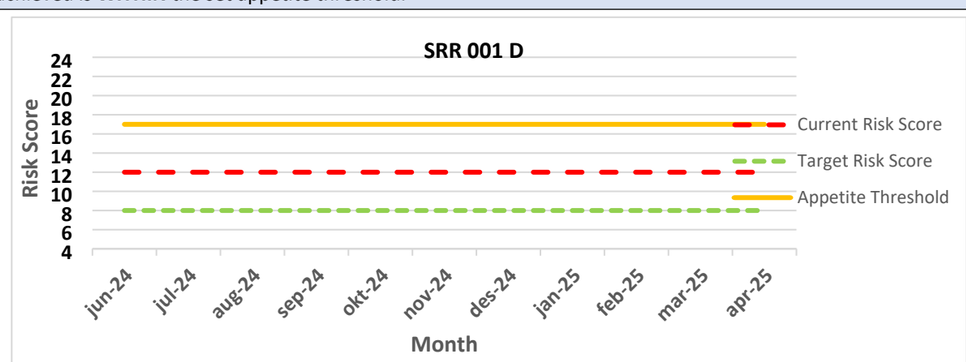


Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Talent and Succession Planning framework published • Monitoring Framework to support roll out of the People Plan – Focus on Talent and Succession Planning. • Monitoring Frameworks with HEIW • Lead appointed July 2023 on secondment funded by HEIW to create organisational talent management framework to enable to organisation to be deliberate and consistently attract, identify and develop talent for critical roles across ABUHB. • HEIW schemes • 1 x HEIW funded graduate managements trainee successfully appointed August 2023 following additional recruitment process. • Develop Leadership Capabilities • Leadership journey and programmes mapped, and 1 pager flyer designed and on intranet. Leadership development offer now available for entry level leaders and mangers, clinical directors, directorate managers (DMx), senior nurses and multi-disciplinary teams. • Learning masterclasses have been designed and developed for the organisation addressing ley themes such as giving feedback, developing team and having courageous conversations. • Leading People Programme (starting cohort 9 May 2025) • 2022/2024 Academi Wales scheme the Health Board are sharing a graduate with Monmouthshire council; our graduate joined the health board in March 2023 and is supporting the decarbonisation agenda.	Talent and Succession Planning • Pilot planned for Finance, Occupational Health and divisional managers focusing on how to identify critical roles, development sessions on holding career conversations and culminating in a Talent Management Strategy. Development leadership capabilities • Currently exploring leadership funding options with USW to maximise Governmental Grants and utilisation of the apprentice levy. • Continued commitment to NHS graduate schemes. • Continued bespoke development and support for senior management teams in clinical and non-clinical settings focusing on leadership, team dynamics and thriving. • Working with HEIW to inform a national development programme for managers • Engagement with the management competency framework which will be adopted in Wales (following implementation in NHS England).

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• WOD Divisional reporting Evaluation of internal leadership programmes and regular review of our internal offer		
Level 2 Organisational *(Executed by risk management and compliance functions)*		
Reporting to People and Culture Committee - progress against People Plan 22-25		
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
• Internal Audit Review Talent and Succession Board		

Assurance Rating (*Overall Assessment of controls and assurances*) *Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**POSITIVE**

RISK THEME	**PEOPLE** This risk score will be reviewed following the confirmation of the 25/26 pay scales, at which point the likelihood of industrial action may change.				
LINK TO IMTP	**SECTION 4: ENABLER – WORKFORCE AND CULTURE**				
Strategic - SRR 001 D	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**			**Publication Status**	**Public**
Threat *(As a result of)*	**Due to the threat of Industrial Action during ongoing disputes and negotiations at a national level**			**Risk Appetite Level – Open** Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.	
Impact *(Consequences of the threat)*	**Patient** • Adverse impacts on delivery of care to patients across acute and non-acute settings	**Staff** • Non-compliance with safe staffing principles and standards	**Organisation** • Litigation & Financial Penalties • Reputational damage to the health board and loss of public confidence	**Risk Appetite Threshold - Score 17 and below.** Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.	
				SUMMARY The current risk level is **OUTSIDE** of target level but **WITHIN** the appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	
Lead Director	Director of Workforce & Organisational Development	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee / Group	People & Culture Committee	**Likelihood**	**3** *(Possible)* *x*	2 *(unlikely)* x	
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Major)*	**4** *(Major)*	
Last Reviewed	01 April 2024	**Risk rating**	**= 12** *(High)*	**= 8** *(Moderate)*	
Next Review (Quarterly based on risk score)	01 July 2025				

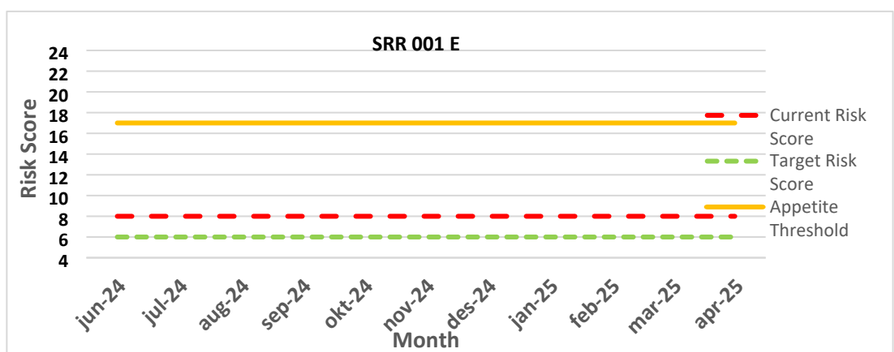


Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• All Wales Industrial Action Planning Group • Local Health Board planning arrangements • Section 234A of the Trade Union and Labour Relations (Consolidation) Act 1992; and • CODE OF PRACTICE Industrial Action Ballots and Notice to Employers • Business Continuity Processes - Redeployment Principles and Risk Assessment agreed. • Duty of Quality - Section 6.8.2 Workforce and Section 6.8.3 Culture • Effective derogation processes including Christmas Day cover definition. • Local Negotiating Committee (LNC) • Services Business continuity plans in place. • Terms and conditions agreements in place for medical cover supported by NHS Wales Employer guidance. • Command and control structure and leads established. • Derogation test completed. • Executive and Senior Manager leads established links with national planning cells. • All Wales training sessions provide by legal and risk to support industrial action. • Reducing impact on patients - Support for early supported discharge prior to industrial action. • Picketing guidance supported and agreed.	• Agreement reached in England for Medical & Dental Staff – re-commencement of negotiations in Wales for Medical & Dental Staff. • Issue of WHC AFC non pay elements of collective agreement 2022-24. Response to WG on immediate assurance by end May 2024 • Review of rotas for junior doctor industrial action (minimum staffing levels based on safety assessment). • Communication plans- public, stakeholders and partners • Establish working mechanisms with NWSSP to consider derogations for junior doctors (who are the employer) and pay application. • Consideration of further additional national legal advice

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Local Staff re-deployments assessment • Divisional engagement and service planning arrangements in place • Local Negotiating Committee (LNC) Trade Union Partnership meetings		Further industrial action
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Reporting to Executive team • Business Continuity groups Command and control structure in place to be implemented as required.		
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
• All Wales IA group and Welsh Government planning group. Debriefing session planned to reflect and capture learning for any potential future action		

Assurance Rating (*Overall Assessment of controls and assurances)* *Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE**

RISK THEME	SERVICE DELIVERY				
LINK TO IMTP	**SECTION 3: SYSTEM CHANGE**				
Strategic/ Corporate Risk SRR 001 E	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**			**Publication Status**	**Public**
Threat *(As a result of)*	**Due to inadequate strategic plans which respond to population health and socio-economic needs.**			**Risk Appetite Level – OPEN** Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.	
Impact *(Consequences of the threat)*	**Patient** • Increased patient acuity levels • Worsening of health inequalities • Worsening of health outcomes	**Staff**	**Organisation** • Failure to train teams in multi-morbidity management • Failure to comply with the Wellbeing of Future Generations Act (Wales) • Reputational damage and loss of public confidence • Increased demand	**Risk Appetite Threshold – SCORE 17 AND BELOW** Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.	
				SUMMARY The current risk level is **OUTSIDE** of target level but **WITHIN** the appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	
Lead Director	Director of Strategy, Planning and Partnerships	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee / Group	Partnerships, Public Health and Planning Committee	**Likelihood**	2 (*Unlikely*) x	2 (*Unlikely*) x	
Initial Date of Assessment	01 June 2023	**Impact**	*4 (Major)*	3 (*Moderate*)	
Last Reviewed	01 October 2024	**Risk rating**	**= 8 (Moderate)**	**= 6 (Moderate)**	
Next Review (Six monthly based on risk score)	01 April 2025				



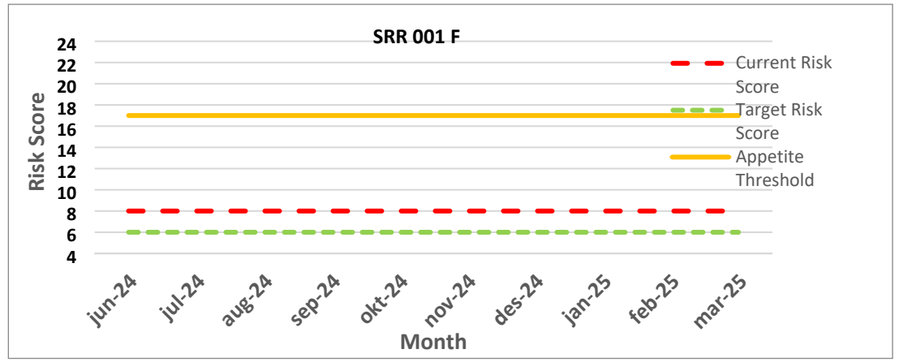
Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Health Board IMTP and associated KPIs • Public Health Wales surveillance data • Qliksense – performance dashboard • Population Needs Assessment and Area Plan • Marmot Region Programme	• Area plan is being refreshed through the RPB • Marmot Region Implementation Plan • Population health management – test and learn using segmentation and risk satisfaction using linked data to target resource. • Refresh organisational strategy with a central focus on population health and wellbeing. • Action through SEW Regional Collaborative to identify additional service areas where collaboration and networking would support sustainability.

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Qliksense – performance information • SFN – performance information		• Effectiveness of the plans in delivering improvements
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• IMTP Delivery and Outcomes Reporting to Board • Marmot Region Programme • Regional Planning reporting to Population Health, Planning and Partnerships Committee		

• RPB reporting to Board and Population Health, Planning and Partnerships Committee	• Clinical Futures Programme Reporting to Population Health, Planning and Partnerships Committee		
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*			
Internal Audit Reviews 2023-24 • IMTP Planning (Q1) Outcome – Reasonable Assurance **Internal Audit Reviews 2024-25** • Internal Audit Partnership Arrangements – **Limited Assurance**		• Outcome of the Internal Audit Partnership Arrangements 2024/25 Plan – **LIMITED**	• Implementation of the recommendations of the Partnership Arrangements Audit

Assurance Rating (*Overall Assessment of controls and assurances) Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE**

RISK THEME	**SERVICE DELIVERY**				
LINK TO IMTP	**SECTION 3: SYSTEM CHANGE**				
Strategic Risk **SRR 001 F**	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**			**Publication Status**	**Public**
Threat *(As a result of)*	**Due to unsustainable Service Models**			**Risk Appetite Level – OPEN** Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.	
Impact *(Consequences of the threat)*	**Patient** • Increased demand • Increased patient acuity levels • Worsening of health inequalities • Worsening of health outcomes	**Staff**	**Organisation** • Failure to train teams in multi-morbidity management • Failure to comply with the Wellbeing of Future Generations Act (Wales) • Reputational damage and loss of public confidence	**Risk Appetite Threshold – SCORE 17 AND BELOW** Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.	
				SUMMARY The current risk level is **OUTSIDE** of target level but **WITHIN** the appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	
Lead Director	Director of Strategy, Planning and Partnerships.	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee / Group	Partnerships, Public Health & Planning Committee	**Likelihood**	2 (Unlikely) x	2 (Unlikely) x	
Initial Date of Assessment	01 June 2023	**Impact**	*4 (Major)*	3 (Moderate)	
Last Reviewed	01 October 2024	**Risk rating**	**= 8** (Moderate)	***= 6*** *(Moderate)*	
Next Review (Quarterly based on risk score)	01 April 2025				



Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• The Health Board IMPT and associated KPIs • Clinical Futures Transformation programmes. • Public Health Wales surveillance data – Covid, flu and other communicable diseases. • Qliksense – performance information. • Population needs assessment and area plan development by the RPB. • Southeast Wales Plan for fragile services.	• Area plan is being refreshed through the RPB. • Population health management – test and learn using segmentation and risk satisfaction using linked data to target resource. • Review of enhanced local general hospital service models to ensure sustainable quality services. • Development of SEW plan for fragile. • Review of organisational strategy

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Public Health Wales surveillance data – COVID, flu and other communicable diseases. • Qliksense – performance information		• Evidence of individual arrangements in place to deliver service plans.

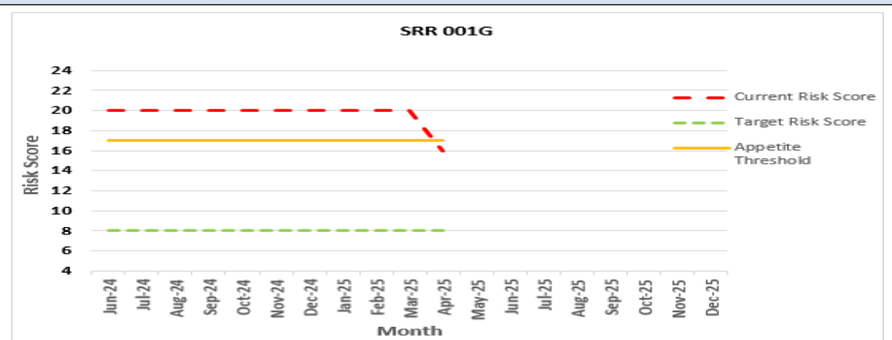
Level 2 Organisational *(Executed by risk management and compliance functions)*			
• IMTP delivery and outcomes reporting to Board. • RPB reporting to Board and Population Health, Planning and Partnerships Committee. • Clinical Futures Programme Reporting to Population Health, Planning and Partnerships Committee.	• Regional Planning reporting to Population Health, Planning and Partnerships Committee.		
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*			
Internal Audit Reviews 2023-24 • IMTP planning Q1. Outcome – Reasonable Assurance. **Internal Audit Reviews 2024-25** • IMTP – Service Plans (Q2) – Outcome - Reasonable Assurance Partnership Arrangements. Outcome – Limited Assurance	• Recommendations identified in the Limited and Reasonable Assurance Internal Audit Reports from the 2024/25 Audit Plan	• Implementation of the management responses to close off recommendations	
Assurance Rating (*Overall Assessment of controls and assurances) Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE**

RISK THEME	**FINANCIAL SUSTAINABILITY**			
LINK TO IMTP	**SECTION 4: ENABLER - FINANCE**			
Strategic - SRR 001 G	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**		**Publication Status**	**Public**
Threat *(As a result of)*	**Due to the failure to deliver a sustainable financial position and longer-term financial plan.**			
Impact *(Consequences of the threat)*	**Organisation** • Breach of statutory duty to breakeven over 3 years. • Instigation of NHS Wales Escalation & Intervention Arrangements. • Non–delivery of health board priorities, required improvements, and achieving longer-term sustainability. • Prioritisation and possible disinvestment in service delivery. • Reputational damage and loss of public confidence.			
Lead Director	Director of Finance and Procurement	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee / Group	Finance and Performance Committee	**Likelihood**	4 (Likely) x	2 (Unlikely) x
Initial Date of Assessment	01 June 2023	**Impact**	*4 (Major)*	4 (Major)
Last Reviewed	01 April 2025	**Risk rating**	**= 16** (Extreme)	***= 8*** (Moderate)
Next Review (Monthly based on risk score)	01 May 2025			

Risk Appetite Level – OPEN
Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.

Risk Appetite Threshold – Score 17 and Below
Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.

SUMMARY
The current risk level is **OUTSIDE** of target level but **WITHIN** the appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.



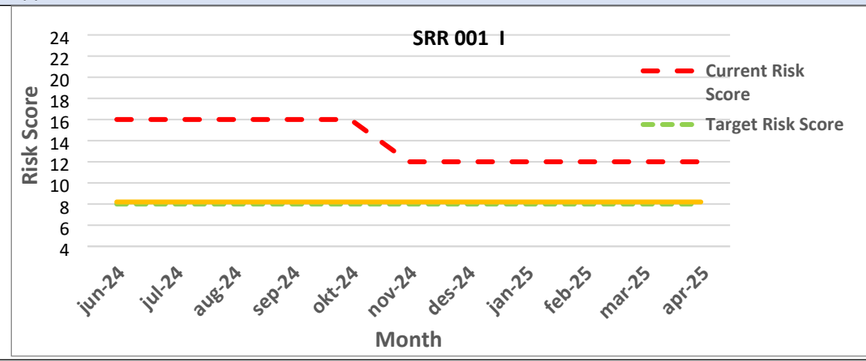
Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• IMTP 25/26-27/28 • IMTP Delivery Framework • Sustainability Route Map revision • Accountability Framework • Performance Framework • 3-year route map to sustainable recovery developed and approved by Board July 24. • Scheme of Delegation • Standing Financial Instructions (SFIs) • Standing Orders (SOs) • Final budget delegation • Financial Control Procedure (FCP) Budgetary control • Financial Budget Intelligence (FBI) • Appropriately trained Finance Team (capacity & capability) • Budget holder training & other business training tools • Cost intervention procedures • 25/26 savings plans & opportunities. • Health Board financial escalation processes. • Health Board Pre-Investment Panel (PIP) process. • Financial assessment and review to incorporate the financial impact of COVID-19 and other key costs. • Executive groups and structures established to deliver statutory duties. • Assessment of financial control environment within divisions and corporate teams. • Financial Escalation Meetings • Regular organisational Recovery plan meetings and briefings • Value & Sustainability Board established. • Revised accountability arrangements part of Executive governance.	• Revised V&SB approach for 2025/26 to help drive financial recovery, separating thematic and divisional scrutiny. • Service Redesign disaggregated as a V&SB theme • Review of programme structures to match V&SB thematic areas • Updated Route Map development • Focus on future opportunity development to deliver 3-year financial plan – through programmes under the VS&B structure.

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Assurance *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	Actions to Address Gaps *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Adherence to SO/SFI/FCPs • Regular AFD meetings to discuss position and performance. • Day 5 comprehensive financial performance review – DoF led. Divisional Assurance meetings are in place to implement savings plans and deliver service and workforce plans within available resources – part of Chief Operating Officer governance		• Greater focus is required on service, workforce, and financial plans all balancing to achieve financial sustainability. • Development of detailed 3-year recovery plan.
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Regular monitoring at the Executive Team reviewing the level of deliverable recurrent savings along with assessing cost avoidance and deferred investments. • Performance escalation meetings established. • Financial assessment and review report to the Board and Finance & Performance Committee • Financial Governance and Accounting reports to the Audit, Risk and Assurance Committee. • Board Briefing sessions on the financial position.		• 2025/26 – 27/28 IMTP plans focussed on 'living within' budget levels. • 2025/26 savings plan to be delivered. • Detailed delivery plans will be a constant development over next 3 years.
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
Internal Audit • Annual Report • 2025/26 Audit Reviews **External Audit Reports** • 2024 -25 – Annual Report • 2025/26 - Audit Reviews **Welsh Government** • Financial assessment and review reports to Welsh Government – monthly • Enhanced monitoring T.I. meetings with Welsh Government monthly • IMTP plan to WG end of March 2025	• Recommendations from audits	• Implement management actions to complete the recommendations from audit reports

Assurance Rating (*Overall Assessment of controls and assurances*) *Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE**

RISK THEME	COMPLIANCE AND SAFETY			
LINK TO IMTP	SECTION 2: DRIVERS – PERFORMANCE EXPECTATIONS		SECTION 4: ENABLERS – WORKFORCE & CULTURE	
Strategic Risk **SRR 001 I**	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, sustainable services that meet the needs of the population.**		**Publication Status**	**Public**
Threat *(As a result of)*	**Due to a failure to implement the required performance improvements in some areas of the organisation in line with the Health Board's Performance Management Framework domains of Quality and Safety, Operational Delivery, and Finance.**		**Risk Appetite Level – MINIMAL** Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurrence of the risk after application of controls.	
Impact *(Consequences of the threat)*	**Patient** • Unintended Patient Harm. • Negative Public/Patient Experience.	**Staff** • Reduced Staff Morale leading to potential absence from work.	**Organisation** • Loss of patient/public trust and confidence. • Scrutiny from external organisations. • Adverse publicity. • Punitive Actions. • Financial implications.	**Risk Appetite Threshold – SCORE 8 AND BELOW** Risks relating to all aspects of patient safety but also including safeguarding, staff & public security in addition to risks relating to compliance and/or legal implications.
				SUMMARY The current risk level is **OUTSIDE** of target and the appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.

		Risk Exposure	Current Level	Target Level
Lead Director	Director of Strategy, Planning and Partnerships.			
Monitoring Committee	Finance and Performance Committee.	**Likelihood**	3 (Possible) x	2 (Unlikely x
Initial Date of Assessment	19 April 2024.	**Impact**	*4 (Major)*	4 (Major)
Last Reviewed	01 November 2024.	**Risk rating**	**= 12** **(High)**	***= 8*** ***(Moderate)***
Next Review (Quarterly based on risk score)	01 June 2025			

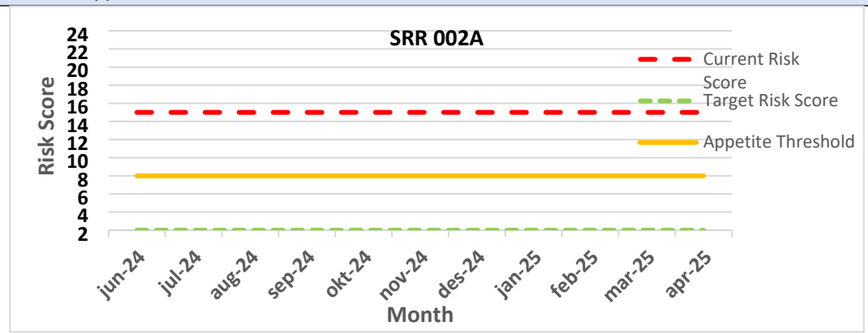


Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	Plans to Improve Control ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Performance Management and Assurance Framework • Executive Accountability letters • Divisional Directors Accountability letters • Monthly Assurance meetings with fortnightly meetings for Urgent Care and MH&LD Divisions in place • Escalation processes triggered for Divisions in escalation – including improvement plans and fortnightly oversight (as above) with agendas that focus on priority areas. Reviewed post End of Year and proposed adjustments awaiting sign off • Reporting through to Finance and Performance Committee via Executives • Specific areas of focus are discussed at Value and Sustainability Board • System wide way of working to progress an operational framework, develop winter plans, escalation processes, etc. • External scrutiny via Welsh Government and NHS Executive • Capacity to run the performance framework and reporting requirements has been strengthened with the appointment of the Head of Systems Planning and Performance and analytical team who will fully be in place by January 2025 alongside the Business Partnering Support	• 6-month review of Performance Management and Assurance • Alignment of internal mechanisms to national escalation • Focussed agendas targeting specific areas of concern and areas for improvement – working with the Business Partners to ensure a joined-up approach. • Standardised Divisional Assurance Templates (pre-populated) • Commission external reviews to support improvements where required. • Appropriate Business Partnering Support and analytical support • Realign capacity and/or redefine roles to provide explicit support

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• DMTs in place for all Divisions • Divisional oversight arrangements – monthly/fortnightly meetings • Divisional plans in place and focussed agendas • Cross Divisional meeting monthly – progress the wider system way of working. • System Leadership Team for awareness and updates	• 12-month Performance Management Framework review in the Autumn	
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Established reporting to the Executive Committee • Established reporting to the Finance and Performance and Patient, Quality and Safety Committee • Established reporting to the Board • Routine reporting through the IQPD process		
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
Internal Audit 2024/25 Plan • Directorate Review - Mental Health and Learning Disabilities (Q2) • Divisional Governance Arrangements (Q2) HIW Inspections Llais for feedback	• Internal Audit 2024/25 Plan • Findings and recommendations from the Divisional Governance Arrangements (Q2) • Findings and recommendations from the Directorate Review - Mental Health and Learning Disabilities (Q2)	

Assurance Rating (*Overall Assessment of controls and assurances)* *Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE**

RISK THEME	COMPLIANCE AND SAFETY				
LINK TO IMTP	**SECTION 4: ENABLERS - ESTATES**				
Strategic Risk SRR 002 A	**There is a risk that there will be significant failure of the Health Boards Estates.**			**Publication Status**	**Public**
Threat *(As a result of)*	**Due to the presence of Reinforced Autoclaved Aeriated Concrete (RAAC) within structures.**			**Risk Appetite Level – MINIMUM** Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurrence of the risk after application of controls.	
Impact *(Consequences of the threat)*	**Patient** • Harm or injury to patients • Adverse impacts on delivery of care to patients across acute and non-acute settings	**Staff** • Harm or injury to staff	**Organisation** • Litigation & Financial Penalties • Loss of estate	**Risk Appetite Threshold –** Score 8 and below Risks relating to all aspects of patient safety but also including safeguarding, staff & public security in addition to risks relating to compliance and/or legal implications.	
				SUMMARY The current risk level is **OUTSIDE** of the target level and appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold	
Lead Director	Chief Operating Officer	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee / Group	Partnerships, Public Health and Planning Committee	**Likelihood**	3 (Possible) x	1 (Rare) x	
Initial Date of Assessment	01 June 2023	**Impact**	*5 (Catastrophic)*	2 (Minor)	
Last Reviewed	01 March 2024	**Risk rating**	**= 15 (Extreme)**	**= 2 *(Low)***	
Next Review (Quarterly based on risk score)	01 April 2025				



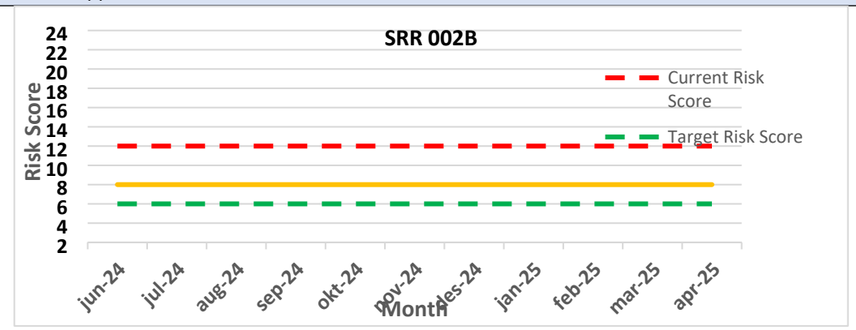
Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Work to assess the risk has been undertaken with expert external surveyor advice. Repeat surveys undertaken on 6 monthly intervals (most recent June/July2024 with report detailing recommendations received in October 2024). Recent surveys completed over December and January and any recommended additional actions being scoped up in conjunction with external experts • Current measures including props and additional support have been put in place in line with the latest guidance and learning from other organisations working through RAAC issues. Plans will be modified in line with any further guidance • Remediation work to areas of high-risk areas undertaken • Controlled access to roof areas • Implemented toolbox talks for awareness for estate teams and contractors to work in area where RAAC is present. • Ongoing engagement with expert surveyor • Estates and Facilities Divisional Compliance team engaged in supporting the estate's function response to the ongoing management • Risk assessments completed by the Health and Safety function in departments with props to manage any consequences of the presence of props. Note: H&S assessments are around the location of props not of RAAC itself and they flagged no issues or alterations • Links with NHS England and other Health Boards in Wales for shared learning. • Regular dialogue with Welsh Government and Shared Services Estates.	• Additional Surveys continue to take place with expert surveyors to inform the next steps relating to further remediation of the issues and monitor existing issues • Management Strategy and the Management Plan are completed and scheduled for approval at the March Health & Safety Committee meeting on 9th April.

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Fortnightly checks in place for the props in place • Outcome of surveys continuing, and reinspection of conditions (a regular 6 monthly inspection) Review of existing arrangements in place supported by external body	• Ongoing management of the issues.	
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Health Board Fire and Health and Safety function engaged in fortnightly governance group to monitor • risks and issues associated with any remedial measures implemented. • Outcome of H&S risk assessment • Formal reporting to the Board/Committees in place Formal update to the PPHPC in July and SOC being developed, led by Planning team for Q1 to Q2 2025/26		
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
• Internal Audit 2024/25 Plan – report received as Reasonable Assurance (albeit Substantial Assurance on the process relating to surveys. Report submitted to Audit Committee November 2024. • Management Action Plan agreed following Internal Audit including the development of a Management Strategy. this document has been drafted and will be submitted to the ABUHB Health and Safety 'Committee' in March 2025 • Internal Audit also commented that the risk appetite needs to reflect the current position of monitoring and managing the RAAC pending SOC and FBC hence appetite of 15 should be considered by Board.	• Recommendations identified in the Reasonable Assurance Internal Audit Reports from the 2024/25 Audit Plan	• Repeat surveys have been completed and once the latest report from these surveys is received any necessary additional actions will be implements **Internal Audit 2024/25 Plan** • Implementation of the management responses to close off recommendations

Assurance Rating (*Overall Assessment of controls and assurances)* *Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE**

RISK THEME	COMPLIANCE AND SAFETY				
LINK TO IMTP	**SECTION 4: ENABLERS - ESTATES**				
Strategic Risk SRR 002 B	**There is a risk that there will be significant failure of the Health Boards Estates.**			**Publication Status**	**Public**
Threat *(As a result of)*	**Due to significant levels of backlog maintenance and structural impairment.**			**Risk Appetite Level – MINIMAL** Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurrence of the risk after application of controls.	
Impact *(Consequences of the threat)*	**Patient** • Harm or injury to patients. • Adverse impacts on the delivery of care to patients across acute and non-acute settings.	**Staff** • Harm or injury to staff.	**Organisation** • Non-compliance with health and safety legislation. • Litigation and financial penalties. • Loss of estate	**Risk Appetite Threshold – SCORE 8 AND BELOW** Risks relating to all aspects of patient safety but also including safeguarding, staff & public security in addition to risks relating to compliance and/or legal implications.	
				SUMMARY The current risk level is **OUTSIDE** of the target level and appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	

		Risk Exposure	Current Level	Target Level
Lead Director	Chief Operating Officer			
Monitoring Committee / Group	Partnerships, Health Protection & Planning Committee	**Likelihood**	3 (Possible) x	3 (Possible) x
Initial Date of Assessment	01 June 2023	**Impact**	*4 (Major)*	2 (Minor)
Last Reviewed	01 January 2025	**Risk rating**	**= 12 (High)**	**= 6 (Moderate)**
Next Review (Quarterly based on risk score)	01 April 2025			



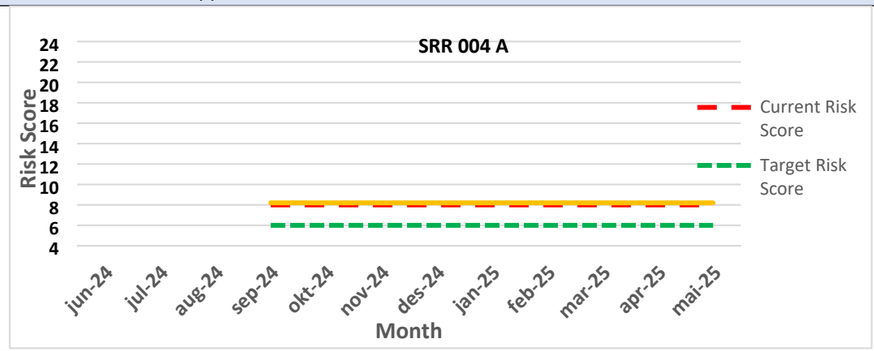
Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Health Board Estates Rationalisation Strategy • Health Board Estates Strategy • Health Board policies and procedures related to the maintenance of Health Board estate. • 6 Facet survey completed in 2019. • Divisional Risk Register • Multiple policies and SOPs published and communicated to staff. • A robust internal training programme in place covering all aspects of estate management including food hygiene. • Improved statutory compliance processes and forum led by Designated Person - DP (Divisional Director) • Asbestos reinspection programme (over the next 3 years) • Additional capital allocation to Estates and Facilities for backlog maintenance reduction of £500k from discretionary allocation • HB-wide groups on compliance (such as Ventilation and water) are widened in membership to ensure clinical services are active participants • A clear approach to compliance monitoring and escalation of AE reports has been implemented.	• Active estate rationalisation (including leases) is required to reduce estate demands and help prioritise capital spend to reduce backlog maintenance. • A water/ventilation engineer to enable all critical ventilation systems to undergo annual validation in accordance with HTM 04/01. • Ongoing attempts to recruit to workforce gaps and a new model of Estate Officer also being developed to assist with recruitment and retention of staff in the workforce. • Planning function leading a review of capital priorities which may help identify additional funding priority given to backlog maintenance. • Policies being reviewed and priority given to out-of-date policies, but all policies will be reviewed for effectiveness and compliance with HTM. • Drive clinical service engagement in compliance meetings where engagement is low. • Additional escalation for capital funding by the Division Estates and Facilities to support the prevention of seasonal issues and plant failure if possible. • Continuation of the additional £500k backlog maintenance allocation by the Board to the Estates and Facilities Division in 2025/26 • Informed by the risk assessment processes of the Estates and Facilities Division, the Health Board has secured significant investment in estate during 2025/26 and 2026/27 from the All Wales Targeted Estates Fund (TEF)

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Assurance *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	Actions to Address Gaps *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Divisional reporting of Statutory and Mandatory training of staff • Staff training levels are monitored and reported regularly. If areas of non-compliance are noted, targeted training can be resourced to ensure compliance. Outcome of the Asbestos reinspection programme	• If the revised approach for monitoring and escalation of AE reports is effective in reducing the level of a deterioration.	• Performance reporting
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• The divisional risk register is reviewed quarterly by the Senior Management Board this is reported to the Quality & Patient Safety Operational Group Regular reporting on estate condition to the Executive Committee and Partnerships, Health Protection & Planning Committee		
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
Internal Audit Reviews 2023- 24 • Estates Assurance - Estate Condition. Audit completed and been shared with Audit Committee and • Finance and Performance Committee Internal Audit Plan 2024-25 • Estates Assurance – Energy Management (Q2) Outcome = Reasonable Assurance. Reported to the November ARAC • Authorising Engineer (Shared Service Estates) reports in line with normal timelines, but active engagement with AEs through compliance processes. • Health Board contributes to annual Estates Facilities and Performance Managements (EFPMS) at all Wales level	• Recommendations identified in the Reasonable Assurance Internal Audit Reports from the 2024/25 Audit Plan	**Internal Audit 2024/25 Plan** • Implementation of the management responses to close off recommendations

Assurance Rating (*Overall Assessment of controls and assurances)* *Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE**

RISK THEME	COMPLIANCE AND SAFETY				
LINK TO IMTP	**SECTION 3: SYSTEM CHANGE**				
Strategic Risk SRR 004 A	**There is a risk that the Health Board is unable to respond in a timely, efficient and effective way to a business continuity incident or critical incident**			**Publication Status**	**Public**
Threat *(As a result of)*	**Due to emergency planning arrangements at both the corporate and operational level not being sufficiently robust to respond to a major incident.**			**Risk Appetite Level – MINIMAL** Ultra-safe leading to only minimum risk exposure as far as practicably possible; a negligible/ low likelihood of occurrence of the risk after application controls.	
Impact *(Consequences of the threat)*	**Patient** • Adverse impacts on delivery of care to patients across acute and non-acute settings • Harm or injury to patients	**Staff** • Inability to respond to a major incident to meet needs of those affected • Harm or injury to staff	**Organisation** • Health Board breaches statutory duties under the Civil Contingencies Act 2004 • Litigation & Financial Penalties • Reputational damage and loss of public confidence	**Risk Appetite Threshold – SCORE 8 AND BELOW** Risks relating to all aspects of patient safety but also including safeguarding, staff and public security in addition risks relating to compliance and/or legal implications.	
				SUMMARY The current risk level is **OUTSIDE** of target level but **WITHIN** the appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	

		Risk Exposure	Current Level	Target Level
Lead Director	Director of Strategy, Planning and Partnerships			
Monitoring Committee / Group	Partnerships, Public Health & Planning Committee	**Likelihood**	2 (Unlikely) x	2 (Unlikely) x
Initial Date of Assessment	01 June 2023	**Impact**	*4 (Major)*	3 (Moderate)
Last Reviewed	01 November 2024	**Risk rating**	**= 8 (Moderate)**	**= 6 *(Moderate)***
Next Review (Quarterly based on risk score)	01 May 2025			



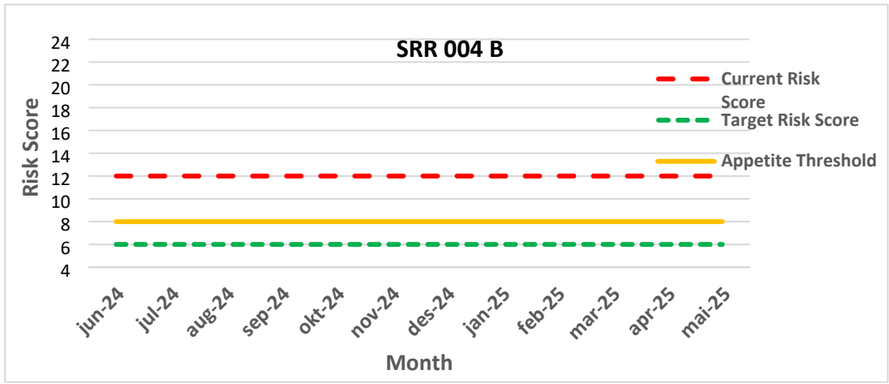
Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Local/Divisional action cards are in place in key areas • Training undertaken service-specific relating to local response. • Major incident exercise 'Euclid' undertaken 20 June 24. Approx. 100 participants and external observers, demonstrated that the Health Board was able to successfully respond to an incident. As a result of the exercise action cards refreshed and renewed with teams to incorporate learning • Internal strategic on call training • Executive Team attending 2-day strategic training. • Loggist training is provided and accessed regularly • New all Wales logbooks are in place for use • Regular liaison with Gwent Local Resilience Forum (Strategic and tactical) • Joint Planning and Training with LRF and across Wales. • Ongoing Participation in exercises UK, Wales, LRF and HB. • Provide quarterly training sessions for on call gold and silver managers, to maintain skills in incident management, update knowledge in relation to risks and learning from local and national incidents. Test and exercise using the multiagency Joint decision model and the principles of joint working (JESIP) • Continuing to work with the communication team to improve incident cascade during an event to ensure Health Board wide awareness in a timely manner • LRF Pandemic Solaris undertaken	• Continue to deliver training programmes to support staff preparedness to response to an incident. • Additional 'local' team and intra team exercises to take place for areas to practice and embed their response to a major incident together • Embed an alert, activation and escalation pathway that follows the Health Board predefined C3 (Command, control, and Coordination) structure of strategic, tactical, and Operational. • BCPs in place across all services • National pandemic exercise Pegasus Autumn 2025 • Development of a pan plan to support pandemic pathways (HCIDs e.g., MPOX)

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Departmental debrief following an incident to inform learning and enhance controls. • Training records • Plans and action cards in place and up to date • Debrief with key stakeholders following an incident to inform learning and enhance controls.		
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Report to the EPRR Group from debrief of incidents • Reports to the PPHP Committee on Emergency Planning Preparedness		
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
Internal Audit Review(s) • Business Continuity Planning 2023-24 (Q2) outcome report published – included MI response - **Reasonable Assurance** Outcome and feedback from national exercises		

Assurance Rating (*Overall Assessment of controls and assurances)* *Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE**

RISK THEME	COMPLIANCE AND SAFETY				
LINK TO IMTP	**SECTION 3: SYSTEM CHANGE**				
Strategic Risk SRR 004 B	**There is a risk that the Health Board is unable to respond in a timely, efficient, and effective way to a major incident.**			**Publication Status**	**Public**
Threat *(As a result of)*	**Due to ineffective and insufficient arrangements across all service areas to respond to a Business Continuity or Critical Incident**			**Risk Appetite Level – MINIMAL** Ultra-safe leading to only minimum risk exposure as far as practicably possible; a negligible/ low likelihood of occurrence of the risk after application controls.	
Impact *(Consequences of the threat)*	**Patient** • Harm or injury to patients • Adverse impacts on delivery of care to patients across acute and non-acute settings	**Staff** • Staff absence (injury, wellbeing) • Harm or injury to staff	**Organisation** • Operational flow if services fail to prepare BCPs against the 5 key themes • Loss of infrastructure; • Financial implications due to staff absence • Health Board breaches statutory duties under the Civil Contingencies Act 2004; • Litigation & Financial Penalties; • Reputational damage and loss of public confidence	**Risk Appetite Threshold – SCORE 8 AND BELOW** Risks relating to all aspects of patient safety but also including safeguarding, staff and public security in addition risks relating to compliance and/or legal implications.	
				SUMMARY The current risk level is **OUTSIDE** of target level but **WITHIN** the appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	

Lead Director	Director of Strategy, Planning and Partnerships	Risk Exposure	**Current Level**	**Target Level**
Monitoring Committee / Group	Partnerships, Public Health & Planning Committee	**Likelihood**	3 (Likely) x	2 (Unlikely) x
Initial Date of Assessment	01 June 2023	**Impact**	*4 (Major)*	3 (Moderate)
Last Reviewed	01 February 2025	**Risk rating**	**= 12 (High)**	**= 6 (Moderate)**
Next Review (Quarterly based on risk score)	01 May 2025			



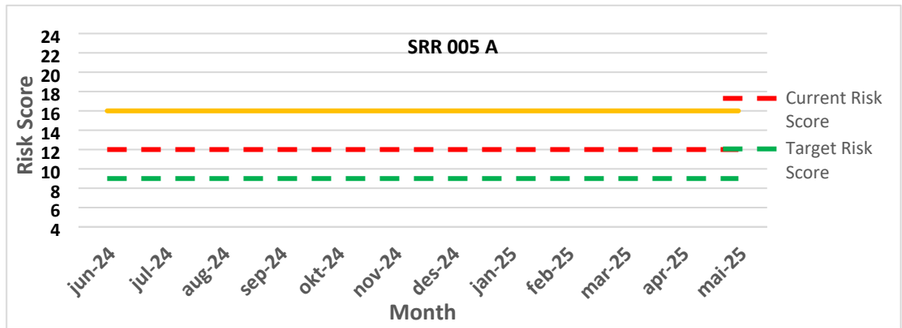
Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• BC Policy • BC Response Guidance • BC Template • BC Exercise • BC debrief learning. • HB and LRF Plans. • 3C (Command/Control, Communication) structure in place to respond to incidents. • 1-2-1 graining with Divisional BC leads and BC plan workshops for services • EPRR Group Established. • Repository on intranet for BC plans to be added to by areas for audit, maintenance, and review of interdependencies. • Awareness raising of the requirement for BC across the Health Board through various training programmes • Infectious Diseases • Joint plan with PH in response to infectious diseases and public health incidence response overall • Internal strategic on call training • Executive Team attending 2-day strategic training. • Regular liaison with Gwent Local Resilience Forum (Strategic and tactical) • Joint Planning and Training with LRF and across Wales. • Ongoing Participation in exercises UK, Wales, LRF and HB. • Provide quarterly training sessions for on call gold and silver managers, to maintain skills in incident management, update • knowledge in relation to risks and learning from local and national incidents. Test and exercise using the multiagency Joint • decision model and the principles of joint working (JESIP).	• Ongoing support to develop business continuity plans. • Developing a Health Board service BC supporting plan – to provide a generic response framework if they have no specific plans in place • Continued engagement with Divisions, Directorates, and service areas to embed contingency planning in the culture of the • organisation, Conduct BIAs develop plans, Exercise, review, to mitigate the risks and threats to service delivery. • Develop further training programmes to support staff preparedness to response to an incident. • Embed an alert, activation and escalation pathway that follows the Health Board predefined C3 (Command, control, and Coordination) structure of strategic, tactical, and Operational. • Work with the communication team to improve incident cascade during an event to ensure Health Board wide awareness in a timely manner. • Working with ICT to scope how to maintain critical communications during loss of IT linked telephone systems or national power outages. (As this is not fully implemented, it is still being worked through thus would make it additional control until in place) • Each Division to identify on their risk register outstanding business continuity planning for their areas.

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Departmental debrief following an incident to inform learning and enhance controls. • Training records • Plans and action cards in place and up to date • Debrief with key stakeholders following an incident to inform learning and enhance controls.		
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Report to the EPRR Group from debrief of incidents • Reports to the PPHP Committee on Emergency Planning Preparedness		
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
Internal Audit Review(s) Business Continuity Planning 2023-24 (Q2) outcome report published – included MI response – **Reasonable Assurance** • Outcome and feedback from national exercise		

Assurance Rating (*Overall Assessment of controls and assurances)* *Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE**

RISK THEME	SERVICE DELIVERY				
LINK TO IMTP	**SECTION 3: SYSTEM CHANGE**				
Strategic Risk SRR 005 A	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system**			**Publication Status**	**Public**
Threat *(As a result of)*	**Due to inadequate arrangements to support system-wide patient flow**			**Risk Appetite Level – OPEN** Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.	
Impact *(Consequences of the threat)*	**Patient** • Avoidable deaths and significant harm. • Delayed discharges from acute and non-acute settings resulting. in deteriorating patients. • Delays in releasing ambulances from hospital sites back into the community.	**Staff** • Increased workload • Fatigue & burnout	**Organisation** • Litigation & Financial Penalties • Reputational damage and loss of public confidence	**Risk Appetite Threshold – OPEN SCORE 17 AND BELOW** Risk related to all aspects of our ability to deliver, manage, and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.	
				SUMMARY The current risk level is **OUTSIDE** of target level but WITHIN appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	

Lead Director	Chief Operating Officer	Risk Exposure	**Current Level**	**Target Level**
Monitoring Committee / Group	Patient Quality, Safety and Outcomes Committee	**Likelihood**	3 (Possible) x	3 (Possible) x
Initial Date of Assessment	01 June 2023	**Impact**	*4 (Catastrophic)*	3 (Major)
Last Reviewed	01 February 2024	**Risk rating**	**= 12 (High)**	***= 9 (High)***
Next Review (Quarterly based on risk score)	01 May 2025			



Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Escalation Policy. • Performance and Accountability Framework • Operational Framework • Major incident Procedures • Daily X-site flow meetings - Twice daily flow calls to receive updates from all acute sites as well as community services. Allowing opportunity for escalation of risks. • Escalation communications – ambulance focussed email escalation when congestion begins to build up on the GUH forecourt. Aim to escalate to senior management to aid in quick risk-based decision making. Includes members of the Executive team. • fortnightly safety flow forum – Cross divisional focused forum to look at priority areas to improve flow from across the system. Action focussed and task driven. • Enhanced monitoring in place for U&EC • Range of performance measures/metrics in place • Repatriation mechanism with neighbouring Health boards – Daily repatriation calls between head of operations and counterparts in south Wales to ensure regular dialogue to repeat patients between hospitals and health boards. • Maximum Capacity Plan – Executive team agreed maximum capacity plan to ensure there is clear description ad guide for where extra capacity can be accessed to ensure patient flow is maintained. • Planned care recovery meetings with the NHS execs. • Regular Dialogue with WAST regarding flow across the patch/regional and attending national calls. • • WG – IQPD meetings to review areas of focus	• New developments and pathways coming online into FY25/26 • New expanded transfer lounge o New ED extension and reconfiguration • Additional ED consultants coming onboard • Safety Flow agenda delivering wider developments and improvements

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Assurance *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	Actions to Address Gaps *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• The Escalation Framework has been enacted and ineffective in mitigating threats and impact to services. • Performance report against measures/metrics	• Evidence that the Escalation Framework is delivering improvements across all areas of patient flow e.g., ambulance handovers. Now working to KPI WG plan. • The impact of the Performance and Accountability framework in improving patient flow	• Close monitoring and reporting of the frameworks in practice to support learning and improvements.
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Divisional Assurance reviews. • Performance against measures/metrics reported to the Executive Committee	• Effectiveness of the Operational Framework	• Operational framework coming into place in November / December 2024 and will be tested as part of a deep dive exercise.
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
Internal Audit Reviews • Intra-site Patient Transfers – Reasonable Assurance accepted by the ARAC on 9th July 2024. External inspections/visits.		

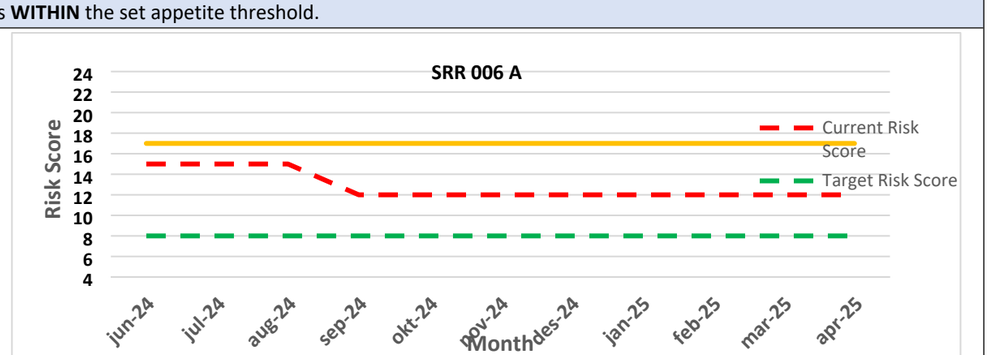
Assurance Rating (*Overall Assessment of controls and assurances)* *Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE**

RISK THEME	**SERVICE DELIVERY**			
LINK TO IMTP	**SECTION 4: ENABLER – DIGITAL, DATA & TECHNOLOGY**			
Strategic Risk **SRR 006 A**	**There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.**		**Publication Status**	**Public**
Threat *(As a result of)*	**Due to the full or partial failure of existing digital infrastructure and systems.**			
Impact *(Consequences of the threat)*	**Patient** • Unintended harm or Injury to Patients.	**Staff** • Unintended harm or injury to staff	**Organisation** • Data Breaches • Litigation and Financial Penalties. • Reputational damage and loss of public confidence.	
Lead Director	Director of Digital	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee / Group	Finance and Performance Committee	**Likelihood**	3 (Possible) x	2 (Unlikely) x
Initial Date of Assessment	01 June 2023	**Impact**	*4 (Major)*	4 (Major)
Last Reviewed	01 January 2024	**Risk rating**	**= 12** **(High)**	***= 8*** ***(Moderate)***
Next Review (Quarterly based on risk score)	01 April 2025			

Risk Appetite Level – OPEN
Willing to consider all potential options, subject continued application and /or establishment of controls; recognising that there could be a high-risk exposure.

Risk Appetite Threshold – Score 17 and Below
Risk related to all aspects of our ability to deliver, manage and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.

SUMMARY
The current risk level is **OUTSIDE** of target level but WITHIN appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.



Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Remedial Action Plan revised and updated to capture further recommendations against NIS CAF assessment in Jan 2024. This Action Plan has also supported ABUHB risk remediation responses to ABUHB's NIS CAF Risk Register which by CRU to address risks identified during the NIS CAF assessment. The remedial actions proposed have been accepted by CRU and progress will be reviewed annually. • Director of Digital (SIRO) and Chief Information Officer (Deputy SIRO) SIRO trained. • New Information Governance and Cyber Security governance and assurance processes reviewed and implemented. • Governance group terms of reference agreed. Meetings started in November 2023. • Cyber is fully engaged with IG colleagues to implement the recommendations of the Templar report. Cyber now supports all the Governance and Assurance Groups intending to increase cyber security awareness and build cyberculture amongst non-ICT staff • Scheduled monthly vulnerability scans of all ABUHB-managed servers to include third-party servers. The results of these scans will now be reported in the Monthly Cyber Report. • Working with Business Systems and Desktop Teams to ensure that patching compliance for internally managed systems and third-party systems is monitored and reported monthly. Monthly review meetings are held between Cyber, and the Teams review compliance levels against policy. Results are captured within the monthly Cyber Report. • Implement the recommendations from Templar report: • Work with Information Governance around implementing the controls required to achieve ISO27001 accreditation. • Battle tested OUR cyber incident response, communication cascade and reporting to Cyber Resilience Unit. This will be incorporated into the overall action plan. • Working with ICT Support Teams and the Log4j version 2 vulnerability has been resolved within the Health Board. The least important service impacting Version 1 is being managed through ICT Departmental risk management process. · Risk impact reduced as recent loss of power at key sites, incorporating our data Centre allowed is to failover in a seamless fashion from one DC to the other with no service impact. · • Maintained the use of Trust ware for all emails Trustwave provides inspection and protection from malicious links embedded within emails. · • Begun the roll out simulated phishing campaigns. The initial phishing has been tested on the ICT Department and reported within the Cyber Report. Cyber will continue campaigns during 2023 to increase email security awareness among staff. • ·Introduced scenario-based incident response exercising using National Cyber Security Centre developed 'Exercise in a box' the aim is to assess our current skills in responding to real-life cyber security incident scenarios and to identify improvements. Cyber plans to run several more exercises during 2023.	• Work with Information Governance around implementing the controls required to achieve ISO27001 accreditation. • A recent cyber incident at several London Hospitals presented an opportunity for ABUHB to battle test its cyber response, communication cascade and reporting to Cyber Resilience Unit. This will be incorporated into the overall action plan. • Updated audit from Cyber Resilience Unit to be undertake in Q2 2025. • Internal Audit review on Shadow IT scheduled for 2025/2026. • Improvements in mandatory training compliance for Information Governance and Cyber Security.

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Internal directorate meetings setup monthly to monitor risks to regularly update and to provide assurance over outstanding action plans. • Single directorate risk registers now in place.	• None	• Not Applicable
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Regular reporting on progress to the Finance & Performance Committee on the cyber security action plan. • Annual Senior Information Risk Owner report.	• None	• Not Applicable
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
• Cyber security Audit in April 2023 provided Digital with a substantial audit for its cyber security improvement plan, reporting and backup systems. • Oversight from NHS Wales Cyber Resilience Unit. **Internal Audit 2024/25** • Intelligence Led Organisation – **Reasonable Assurance Outcome** reported to ARAC • Technical Continuity - **WIP**	• None	• Not Applicable

Assurance Rating (*Overall Assessment of controls and assurances*) *Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE**

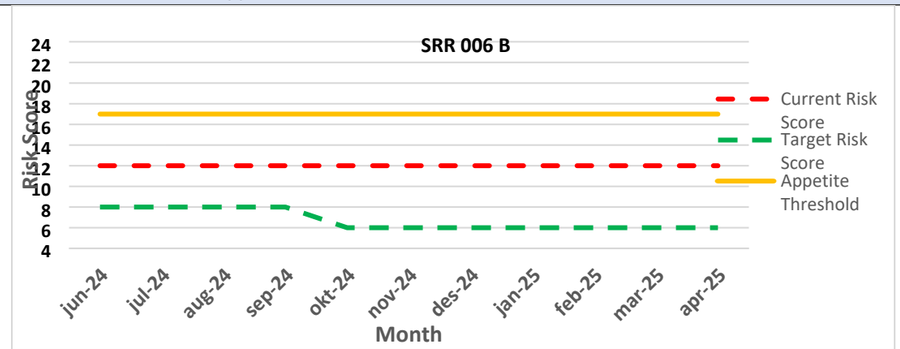
RISK THEME	**SERVICE DELIVERY**			
LINK TO IMTP	**SECTION 4: ENABLER – DIGITAL, DATA & TECHNOLOGY**			
Strategic Risk **SRR 006 B**	**There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.**		**Publication Status**	**Public**
Threat *(As a result of)*	**Due to an adverse impact on service delivery in the implementation of new digital systems.**			
Impact *(Consequences of the threat)*	**Patient** • Unintended harm or Injury to Patients. • Adverse impacts on delivery of care to patients across acute and non-acute settings.	**Staff** • Unintended harm or injury to staff	**Organisation** • Data Breaches • Litigation and Financial Penalties. • Reputational damage and loss of public confidence.	

Risk Appetite Level – OPEN
Willing to consider all potential options, subject continued application and /or establishment of controls; recognising that there could be a high-risk exposure.

Risk Appetite Threshold – Score 17 and Below
Risk related to all aspects of our ability to deliver, manage and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.

SUMMARY
The current risk level is **OUTSIDE** of target level but **WITHIN** appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.

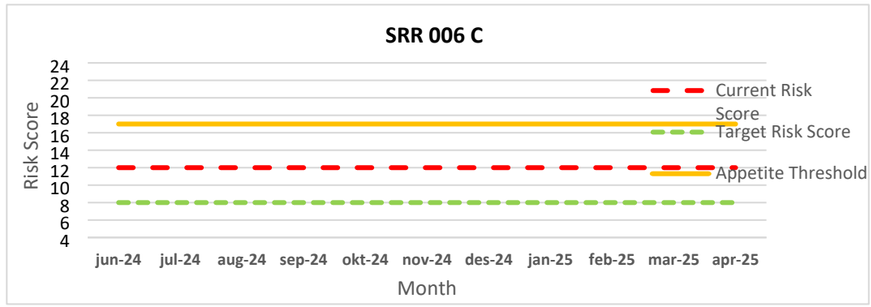
		Risk Exposure	Current Level	Target Level
Lead Director	Director of Digital			
Monitoring Committee / Group	Finance and Performance Committee	**Likelihood**	3 (Possible) x	2 (Unlikely) x
Initial Date of Assessment	01 June 2023	**Impact**	*4 (Major)*	3 (Moderate)
Last Reviewed	01 January 2024	**Risk rating**	**= 12** **(High)**	***= 6*** ***(Moderate)***
Next Review (Quarterly based on risk score)	01 April 2025			



Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Adoption of formal project management methodologies PRINCE 2 to ensure project plans are developed in conjunction with services. • Formal governance arrangements in place through project boards and programme boards where risks and issues are managed and mitigated. • Each project has a senior responsible officer from the service who can provide challenge and assurance over the delivery of the project work packages. • Each clinical project has a clinical lead who would advise and support potential impacts on service delivery caused by the implementation of new digital services. • Business change team in place to support services in improvement of clinical and administrative processes. • Benefits team in place who identify, track, and ensure any benefits are realised which will ultimately improve service delivery. • Projects support backfilling of clinical time where required. • Assurance activities included in project framework including clinical safety, information governance, health records and cyber security. • An overarching Digital Portfolio Progress Group is in place to receive programme updates, manage risk and issue escalations and provide multi-disciplinary assurance over digital projects. • Business change work includes a service readiness impact assessment to enable the project team to develop a realistic plan that incorporates service change requirements. • Aggregated view of risks and issues available to pick up common themes and impact for early intervention or escalation. • Aggregated view of digital Lessons Learned available, and lessons are reviewed during project initiation for best chance of success. • Formal divisional engagement meetings in place monthly to discuss new programmes of work and provide update on critical programmes/projects	• Additional governance being put in place with the Digital, Data and Technology Sub-Committee which will report to the Finance & Performance Committee. • Terms of reference developed, and meeting will be put in place during Q2 2025. • Digital benefits Board development session planned for 2025. • Digital transformation development programme to be provided to the Board in 2025/2026.

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Assurance *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	Actions to Address Gaps *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
○ Project Boards meet monthly and report into the bi-monthly Digital Portfolio Progress Group (DPPG) ○ Digital Directorate meetings being held monthly to monitor risks to regularly update and to provide assurance over outstanding action plans.	• Escalation of risks and issues done on an Ad hoc basis to Director of Digital and Executive Committee in the absence of DDaT Sub-committee.	• Additional governance being put in place with the Digital, Data and Technology Sub-Committee which will report to the Finance & Performance Committee
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Regular Reporting to the Finance & Performance Committee • Risk management approach and escalation processes in place in line with the Health Board's Risk Framework	• None	• Not Applicable
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
Internal Audit 2023/24 • Benefits Management review – Outcome Substantial Assurance • Stakeholder Engagement on IT Projects 2023/24 Q3 – Outcome Substantial Assurance **Internal Audit 2024/25** • Intelligence Led Organisation – **Reasonable Assurance Outcome** reported to ARAC • Technical Continuity - **WIP**	• Recommendations identified through audit work	• Recommendations identified through audit work

Assurance Rating (*Overall Assessment of controls and assurances*) *Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE**

RISK THEME	SERVICE DELIVERY					
LINK TO IMTP	SECTION 4: ENABLER – DIGITAL, DATA & TECHNOLOGY					
Strategic Risk **SRR 006 C**	**There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.**				**Publication Status**	**Public**
Threat *(As a result of)*	**Due to failure to develop digital solutions that are sustainable and fit for the future.**				**Risk Appetite Level – OPEN** Willing to consider all potential options, subject continued application and /or establishment of controls; recognising that there could be a high-risk exposure.	
Impact *(Consequences of the threat)*	**Patient** • Unintended harm or injury to patients. • Adverse impacts on delivery of care to patients across acute and non-acute settings	**Staff** • Unintended harm or injury to staff.	**Organisation** • Data breaches • Litigation & Financial Penalties • Reputational damage and loss of public confidence		**Risk Appetite Threshold – Score 17 and Below** Risk related to all aspects of our ability to deliver, manage and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.	
					SUMMARY The current risk level is **OUTSIDE** of target level but **WITHIN** appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	
Lead Director	Director of Digital	Risk Exposure	**Current Level**	**Target Level**		
Monitoring Committee / Group	Finance and Performance Committee	**Likelihood**	3 (Possible) x	2 (Unlikely) x		
Initial Date of Assessment	01 June 2023	**Impact**	*4 (Major)*	4 (Major)		
Last Reviewed	01 January 2024	**Risk rating**	**= 12** **(High)**	***= 8*** ***(Moderate)***		
Next Review (Quarterly based on risk score)	01 April 2025					

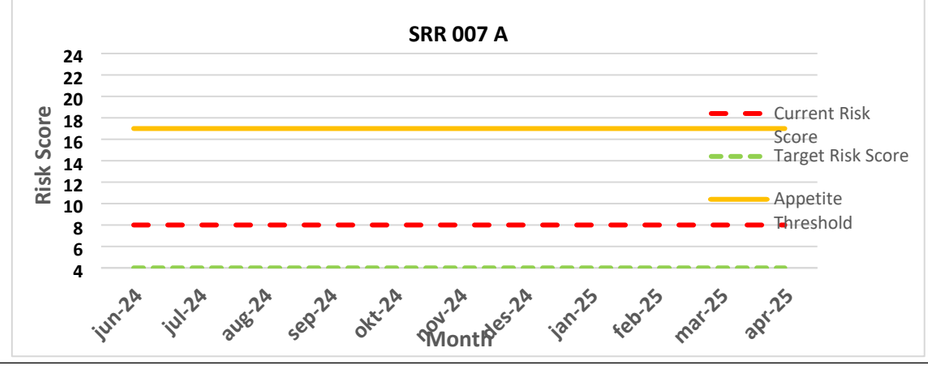
Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
○ New Digital Service Request process in place which provides governance in several key areas: ○ Automation of request process via 'Seren' the ICT Portal ○ Information Governance – ensuring new services have appropriate controls to keep patient information safe. ○ Cyber Security – ensuring new services adopted or developed meet the requirements of the cyber assessment framework. ○ Patient Safety – ensuring services do not introduce any patient safety risks. ○ Records – ensuring new systems comply with the requirements of records management. ○ Strong business analysis function in operation which ensures the "as-is" and "to-be" process mapping is undertaken which provides assurance that new services implemented are fit for purpose and delivery what stakeholders require. ○ Business change function which ensures implemented systems are effective and deliver the benefits required. ○ Formal framework in place for the adoption of new digital services and best practice guidance followed. ○ Annual planning processes include formal DDAT Annual Operational Plan aligned with service priorities identified in IMTP process ○ New Digital Request processes include fortnightly senior leadership scrutiny of requests, ○ New prioritisation framework & tool Monthly/quarterly Operational delivery aligned to ITIL standards ○ Annual operational plan completed and aligned with IMTP ○ Divisional Digital Oversight meetings with senior Digital & Divisional staff to support identification of digital alignment with service priorities for Urgent Care, MH & LD, CSS, Division of Surgery & PCCS in place ○ Software Development uses an agile product management methodology using DevOps software for managing its backlog, delivery plan and sprints.	• Monthly/quarterly Divisional Digital Oversight meetings with senior Digital & Divisional staff to support identification of digital alignment with service priorities to be arranged for Division of Medicine, • Portfolio optimisation to ensure the resources of the service are aligned to key priorities • New Digital Request quarterly reporting to DDAT sub-committee • New governance structures to be put in place further to directorate restructuring • Development of product management approach to delivery of core software applications and extending use of agile processes to ICT • Development of digital strategies including Electronic Health & Care Record

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Assurance *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	Actions to Address Gaps *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
Quarterly reporting to DDAT sub-committee	• If the NDSR process delivers anticipated improvements • The outcome of the EDRMS audit	• Monitor the performance of the NDSR process • Audit into the effectiveness and appropriateness of the electronic document and records management solution (EDRMS) in use for the management of digital health records and the provision of scanning services.
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Regular Reporting to the Finance & Performance Committee	• None	• Not Applicable
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
Internal Audit 2023/24 • LINC Programme– **Outcome Reasonable assurance** • Network Infrastructure (VPN) - **Outcome Reasonable assurance** **Internal Audit 2024/25** • Electronic document and records management solution – **WIP** • Technical Continuity - **WIP**	• Recommendations identified through audit work	• Regular Reporting to the Finance & Performance Committee

Assurance Rating (*Overall Assessment of controls and assurances*) *Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE**

RISK THEME	**TRANSFORMATION AND PARTNERSHIP WORKING**			
LINK TO IMTP	**SECTION 3: SYSTEM CHANGE**		**SECTION 4: ENABLERS - REGIONAL PLANS**	
Strategic Risk: SRR 007A	**There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population.**		**Publication Status**	**Public**
Threat *(As a result of)*	**Due to the likelihood of further austerity measures impacting effective collaboration with strategic partners across the Health Board footprint.**		**Risk Appetite Level – OPEN** Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.	
Impact *(Consequences of the threat)*	**Patient** • Unmet patient need resulting in harm	**Staff**	**Organisation** • Ineffective use of combined resource Delayed decision making • Adverse impacts on delivery of care to patients across acute and non-acute settings • Failure to deliver health board priorities, required improvements and achieve longer-term sustainability • Reputational damage and loss of public confidence	**Risk Appetite Threshold – SCORE 17 AND BELOW** All risks relating to our ability to engage effectively with other organisations including development of collaborations and partnerships along with all risks associated with innovation, transformation, and strategic change.
				SUMMARY The current risk level is **OUTSIDE** of target level but **WITHIN** appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.

Lead Director	Director of Strategy, Planning, and Partnerships.	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Partnerships, Public Health & Planning Committee	**Likelihood**	2 (Unlikely) x	2 (Unlikely) x
Initial Date of Assessment	01 June 2023	**Impact**	4 (Major)	2 (Minor)
Last Reviewed	01 October 2024	**Risk rating**	**= 8 (Moderate)**	***= 4 (Moderate)***
Next Review (Six Months based on risk score)	01 April 2025			



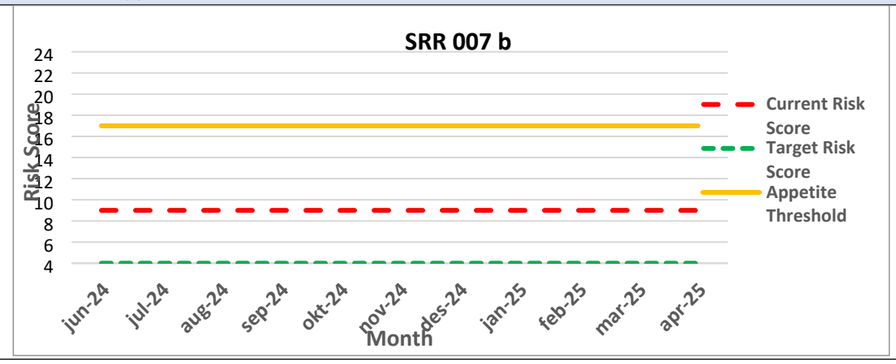
Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
The Health Board plays an active role in a range of formal partnership arrangements to enable integrated working for the population including: • The Gwent Public Services Board (Gwent PSB) brings public bodies together to work to improve the economic, social, environmental, and cultural well-being in Gwent. They are responsible, under the Wellbeing of Future Generations (Wales) Act, for overseeing the development of the new Local Wellbeing Plan which is a long-term vision for the area. • The Gwent Regional Partnership Board As set out in the Partnership Arrangements (Wales) Regulations 2015, local authorities and local health boards (RPB) manage and develop services to secure strategic planning and partnership working. RPBs also need to ensure effective services and care, and support is in place to best meet the needs of their respective population. Through these statutory forums formal partnership arrangements take place. • In addition to these statutory forums the Health Board has a range of interfaces with key stakeholder bodies, including regular liaison with local authorities, neighbouring Health Boards, housing associations, and third-sector partners. • Joint working between operational teams including integrated operational arrangements and combined multidisciplinary teams, for example, Community Resource Teams	• Governance review of Regional Partnership Board undertaken in August 2023. • Renewed Strategy for strategic partnership Capital in place and revised governance processes. • New Long-Term Strategy for Health Board to focus on Partnership approach.

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• PMO reporting to the Director of Strategy, Planning and Partnerships. • Regional Leadership Group Reporting	• Systematic reporting of outcomes • Systematic evaluation of schemes • Governance of financial control arrangements	• Implementation plan to be developed following RPB governance review. • Health Board strategy development approach to focus on partnership approach
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Assurance reporting to the Population Health, Partnerships, and Planning Committee. Assurance reporting to the Board.		
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
Internal Audit Plan 2024/25 • RPB Governance Review (Q4) – **Outcome = Limited Assurance.** Reported to ARAC September 2024 Partnership Arrangements Review (Q1) Deferred	• Recommendations identified in the Limited Assurance RPB Governance Revie	• Implementation of the management responses to close off recommendations

Assurance Rating (*Overall Assessment of controls and assurances)* *Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable** - adequate evidence that the controls in place are working effectively.	**Positive** - robust evidence that the controls in place are working effectively.	**REASONABLE**

RISK THEME	TRANSFORMATION AND PARTNERSHIP WORKING				
LINK TO IMTP	**SECTION 3: SYSTEM CHANGE**			**SECTION 4: ENABLERS – REGIONAL PLANS**	
Strategic Risk SRR 007 B	**There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population.**			**Publication Status**	**Public**
Threat *(As a result of)*	**Due to the impact of fragile services across the regional and supra regional geography**			**Risk Appetite Level – OPEN** Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.	
Impact *(Consequences of the threat)*	**Patient** • Unmet patient need resulting in harm • Adverse impacts on delivery of care to patients across acute and non-acute settings	**Staff**	**Organisation** • Failure to deliver health board priorities, required improvements and achieve longer-term sustainability • Reputational damage and loss of public confidence • Ineffective use of combined resources • Delayed decision making	**Risk Appetite Threshold – SCORE 17 AND BELOW** All risks relating to our ability to engage effectively with other organisations including development of collaborations and partnerships along with all risks associated with innovation, transformation, and strategic change.	
				SUMMARY The current risk level is **OUTSIDE** of target level but **WITHIN** appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	

		Risk Exposure	Current Level	Target Level
Lead Director	Director of Strategy Planning and Partnerships			
Monitoring Committee	Partnerships, Public Health & Planning Committee	**Likelihood**	3 (Possible) x	2 (Unlikely) x
Initial Date of Assessment	04 January 2024	**Impact**	*3 (Moderate)*	2 (Minor)
Last Reviewed	01 January 2024	**Risk rating**	**= 9 (High)**	***= 4 (Low)***
Next Review (Quarterly based on risk score)	01 April 2025			

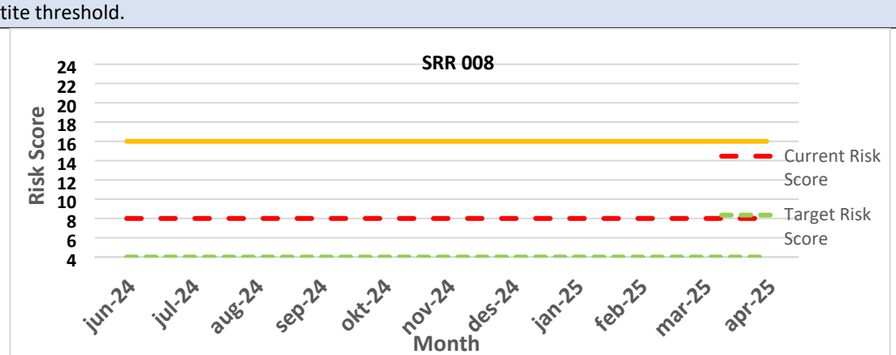


Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
A robust Southeast Wales regional planning infrastructure has been established with clear governance mechanisms in place with attendance from CEO, DoP and COO. • The Regional Portfolio Delivery Board brings the participating health boards together to review all regional service projects, to assess progress against agreed timelines and to agree additional measures / escalations in the event of identified issues and risks. This Board then reports to an Oversight Board with Chief Executive membership. • Four workstreams are established (Orthopaedics, Ophthalmology, Diagnostics and Cancer) and the UHB is well represented and engaged on all. • Where appropriate workstreams are underpinned by a Memorandum of Understanding between the participating health board, setting out their respective commitment to collaborative regional planning where this can enhance service sustainability, quality, and efficiency. • When service issues span regions, arrangements are set up on a bespoke basis, for example the Vascular Project Board and the Interventional Radiology (IR) project. In addition to these formal arrangements, the Health Board has a range of informal planning networks and communication channels, with an ongoing commitment to communication, sharing best practice and advising of anticipated service issues and risks.	The southeast Wales health boards have agreed revised joint priorities and working arrangements for regional planning in 2024, following a review workshop attended by Chief Executives. The revised priorities / forward work plan includes the following: - • An absolute commitment to delivering on the existing regional programmes of work but with these 're-baselined' for 2024/25 to ensure there is a continued regional consensus on objectives, outcomes, and planning assumptions. • The need to review the current regional working governance arrangements, to ensure these remain fit for purpose. • The need to further review the indicative list of fragile services for the Southeast region and begin considering the regions response to these. • The need to develop a regional clinical service plan that can articulate what a long-term sustainable secondary care system looks like for Southeast Wales that can then inform local decisions (collaborative work has been undertaken in March with a parallel WG review of fragile services across south Wales, to ensure alignment of assumptions and priorities) • A further workshop (to include Chairs, Executives and clinicians) has been arranged for June Discussion ongoing at all Wales NHS CEOs and NHE Executive on governance and infrastructure to take forward cross regional planning to be reviewed considering IR and Neonatal work

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
Service Divisions reporting to the Chief Operational Officer	• Alignment and effectiveness of partners to deliver integrated services	
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Assurance reporting to the Population Health, Partnerships, and Planning Committee. • Assurance reporting to the Board. • Regular touchpoint meetings of all key players to review progress and issues arising		
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		

Assurance Rating (*Overall Assessment of controls and assurances*) *Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE**

RISK THEME	**TRANSFORMATION AND PARTNERSHIP WORKING**				
LINK TO IMTP	**SECTION 4: ENABLER - QUALITY**				
Strategic Risk SRR 008	**There is a risk that the Health Board fails to build positive relationships with patients, staff and the public.**			**Publication Status**	**Public**
Threat *(As a result of)*	**Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement.**			**Risk Appetite Level – OPEN** Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.	
Impact *(Consequences of the threat)*	**Patient** • Unmet patient needs resulting in patient harm. • Ineffective use of combined resources • Delayed decision making • Adverse impacts on delivery of care to patients across acute and non-acute settings	**Staff**	**Organisation** • Failure to deliver health board priorities, required improvements and achieve longer-term sustainability • Reputational damage and loss of public confidence	**Risk Appetite Threshold – OPEN SCORE 17 and Below** All risks relating to our ability to engage effectively with other organisations including development of collaborations and partnerships along with all risks associated with innovation, transformation, and strategic change.	
				SUMMARY The current risk level is **OUTSIDE** of target but **WITHIN** the appetite threshold. Target level is **WITHIN** the set appetite threshold.	
Lead Director	Director of Nursing	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee	Patient Quality, Safety and Outcomes Committee	**Likelihood**	2 (Unlikely) x	2 (Unlikely) x	
Initial Date of Assessment	01 June 2023	**Impact**	*4 (Major)*	2 (Minor)	
Last Reviewed	01 January 2025	**Risk rating**	**= 8 (Moderate)**	**= 4 (Low)**	
Next Review (Six monthly based on risk score)	01 July 2025				



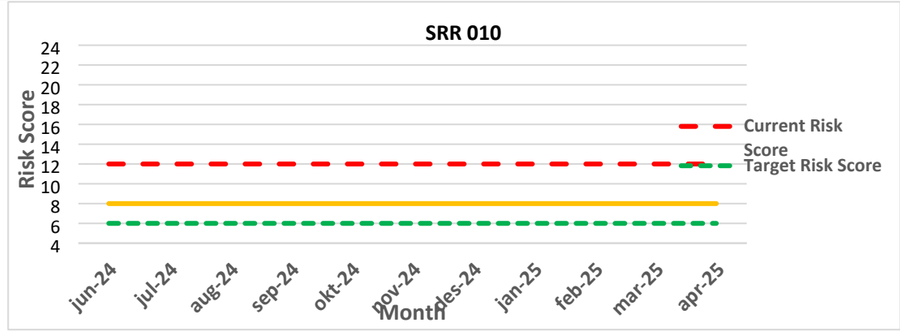
Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Corporate Engagement Team • Patient Experience and Involvement Strategy- organisational ownership • Person Centred Care (PCC) Surveys and National surveys via CIVICA • PCC KPI's (support PCC Quality pillar) • 'You said…… we did' public facing information for service areas. • PLO service at GUH • Introduction of PALS Service (Oct 23) • Volunteer Patient Experience Feedback • Collaboration to recruit community listeners to support Dementia Awareness • Digital patient stories to support listening and learning. • Patient Experience and Involvement Strategy • DATIX • Oversight of Medical Examiner reports to determine patient experience actions • Public Engagement- Big Conversation Bereavement held 20th March 2024 • People Participation Panel ED in Progress • Patient Experience and Involvement Team oversee patient experience through dedicated work programme and link in with divisional teams.	• Structured graduated approach to roll out of Civica to ensure divisional teams can use and access data. This will ensure sustainable progress. • PCCT staff training to support Civica data entry and retrieval. • Programme Manager for Dementia working regionally to improve public engagement and promote the role of Community Listeners. • Employment of dedicated PALS team who will have a key role in gaining feedback from patients, staff, and relatives. Monthly reporting in place and quarterly updates to QPSOG • Completion of surveys limited to QR code access or physical presence of PCCT to manually ask and in-put data. SMS provision to be implemented in Feb 2025 across ED and all MIU's. • National directives around new national surveys that need to be managed additional to internal roll out programme. • Volunteer feedback to be reviewed to identify themes. • Need to develop bereavement model and improve bereavement offer to meet Bereavement Standards. Resources being scoped.

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Concerns are fed back to divisional teams when identified. • Outcome of the volunteer feedback to drive improvements. • Patient Experience and Involvement Team undertaking Culturally Competent Accreditation, receiving a silver distinction award in Oct 2024 • Immediate feedback and escalation to clinical teams following PALS queries and concerns • Civica patient feedback in in the process of being rolled out across all – all divisional leaders receive reports for their live areas monthly.	• Currently there is no SMS provision to increase the number of surveys. • No single point of contact or 'drop in' provision for patients/families/staff to raise initial patient experience concerns. • Survey of bereaved people needs to be developed and rolled out to meet Bereavement Standards. • • CIVICA team have the ability to pull and view feedback that has been left by patients/family. The listening and learning from the feedback to be shared by each department/directorate/division i.e., / 'you said, we did' / quality improvement projects.	• SMS provision for patient experience feedback will be launching in ED and all MIU's in February 2025. • PALS Single point of contact is established. PALS officers have key role in patient experience and involvement- including establishing 'drop in' clinics on hospital sites should patients/staff/relatives wish to discuss concerns. Need to have discussions with facilities around rooms. • Patient experience KPI's and common themes by department/directorate/division need to be identified and pulled from the civica system left on surveys feedback. These will be added to a template patient experience report and CIVICA surveys will be built into ward accreditation. • Development of a ABUHB bereavement survey has been built within CIVICA and tested. Launch date likely early 2025.
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Regular reporting to the Patient Quality, Safety & Outcomes Committee (PQSCO) • Listening and Learning reported through QPSOG/ Outcomes Committee Implemented PALS DATIX Module		
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
• Bi-monthly LLais Reports • HIW inspections Advocacy reports		

Assurance Rating (*Overall Assessment of controls and assurances)* *Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE**

RISK THEME	COMPLIANCE AND SAFETY				
LINK TO IMTP	SECTION 4: ENABLER – WORKFORCE & CULTURE				
Strategic Risk **SRR 010 A**	**There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in line with its duties under the Health and Safety at Work Act 1974**			**Publication Status**	**Public**
Threat *(As a result of)*	**Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.**			**Risk Appetite Level – MINIMAL** Any risk that has a MINIMAL risk appetite level should be managed to a Score of 8 or below.	
Impact *(Consequences of the threat)*	**Patient** • Unintended physical harm to patients • Psychological trauma	**Staff** • Unintended physical harm to staff • Psychological trauma • Increased levels of staff sickness	**Organisation** • Punitive actions from the Health and Safety Executive (HSE) • Loss of estates due to unsafe environments • Financial implications • Adverse publicity • Reputational damage.	**Risk Appetite Threshold – SCORE OF 8 or Below** Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible / low likelihood of occurrence of the risk after application of controls.	
				SUMMARY The current risk level is **OUTSIDE** of target level and appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	

Lead Director	Director of Allied Health Professions and Health Science	Risk Exposure	**Current Level**	**Target Level**
Monitoring Committee	Patient Quality, Safety and Outcomes Committee	**Likelihood**	3 (Possible) x	2 (Unlikely) x
Initial Date of Assessment	01 December 2023	**Impact**	*4 (Major)*	3 (Moderate)
Last Reviewed	01 February 2025	**Risk rating**	**= 12** **(High)**	**= 6** **(Moderate)**
Next Review (Quarterly based on risk score)	01 May 2025			

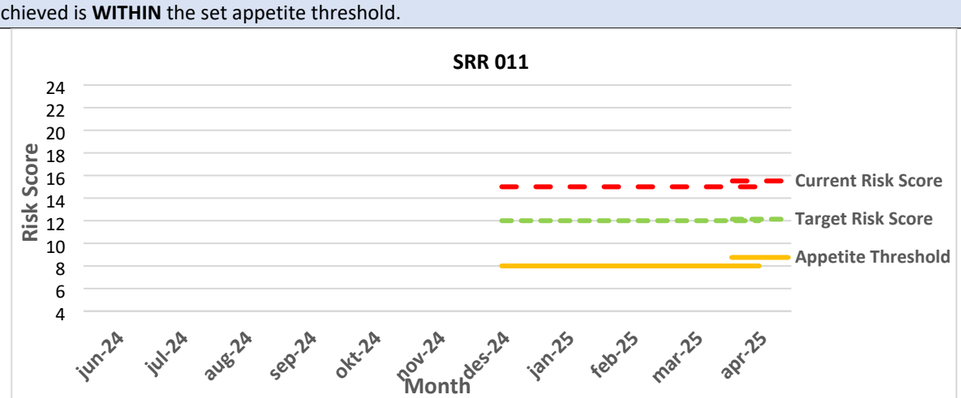


Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Attendance at Divisional Quality & Patient Safety meetings provides a forum to discuss Health and Safety concerns/best practices. • Health and Safety Policies and Procedures • Dedicated Health and Safety site on ABPULSE • Provision of dedicated health and safety expertise and advice to meet the requirements of the Management of Health and Safety at Work Regulations 1999, Regulation 7 'Health and Safety Assistance'. • Health and Safety training for all staff (include general H&S, fire safety, manual handling, violence & aggression) • Partial Programme of Health and Safety Monitoring (Active & Reactive) • Corporate and Directorate Health and Safety Risk Register established. • Board Training /development (Completed 24 April 2024) • Implementation of Health, Safety, and Fire Improvement Plan for 2023/24 to address 7 risk areas of concern. • Health and Safety Governance and reporting arrangements (Health and Safety Committee)	• Develop and implement a 3-year health and safety culture plan, including the implementation of a new Health and Safety Management System • Suitable and Sufficient Risk assessments (including local risk assessments, specific fire risk assessments, and fire risk assessments) • Consultation and communication with the workforce regarding compliance with the Act • New ways of working with Divisions to ensure accountability for health and safety is recognised. • Implement key performance indicators to monitor health and safety compliance. • Review the governance arrangements for the Health & Safety Committee • Health and Safety Policies and Procedures to be reviewed. • Onboard further Manual Handling trainers across the organisation to improve compliance. • Scope for training non-Health Board staff • Learning from events to be documented and communicated to the organisation.

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Assurance *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	Actions to Address Gaps *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
Health and Safety compliance data extracted from ESR and Datix and reported	• Implementation of a health and safety performance report • Health and Safety Committee Membership and governance to be reviewed to ensure there is robust scrutiny and challenge on compliance with the Act • Compliance on completion of risk assessments and mitigating actions	• Revise accountability arrangements for Health and Safety being progressed as part of the organisational Health & Safety Governance Framework. • Review the membership and ToRs of the Health and Safety Committee • Risk assessments and mitigating actions to be documented and reported regularly to demonstrate progress against the Improvement Plan
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Established monitoring of H&S at the Executive Committee • Corporate H&S report risk and assurance to the Health and Safety Committee Established monitoring of H&S at the PQSO Committee	• Thematic Risk Register	• Development of a thematic risk register to be discussed at the Health and Safety Committee
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
Internal Audit 2024/25 Plan • Health and Safety Internal Audit – TBR • Performance reviews at All Wales Health and Safety Management Steering Group • South Wales Fire & Rescue Service fire safety audit programme. Health and Safety Executive reviews/inspections.		

Assurance Rating (*Overall Assessment of controls and assurances)* *Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE**

RISK THEME	SERVICE DELIVERY			
LINK TO IMTP	**SECTION 4: ENABLER – GREEN HEALTH**			
Strategic Risk **SRR 011**	**There is a risk that the Health Board will not meet the carbon reduction target set by Welsh Government (16% reduction by 2025 and a 34% reduction by 2030)** *This is common to all Health Bodies across the country.*		**Publication Status**	**Public**
Threat *(As a result of)*	**Due to the limitations to change estate and structural operations and available funds to implement strategic changes at scale to fully meet the target expected.** *(The effect of a failure to meet this target is on the wider environment.)*		**Risk Appetite Level** **OPEN** - Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure	
Impact *(Consequences of the threat)*	**Organisation** • Failure to meet the target set on Welsh Health bodies for reducing carbon output • Non–delivery of health board priority in this regard, required improvements, and achieving longer-term sustainability for the Health Board and nationally. • Reputational damage and loss of public confidence. • Opportunity cost of reduced energy costs		**Risk Appetite Threshold – SCORE 17 AND BELOW.** Risk driven by the likelihood of the HB missing this target with some cause for optimism regarding making some progress towards reducing carbon emissions in some areas such as ReFit and changes in clinical practice. The impact locally is relatively small.	
			SUMMARY The current risk level is **OUTSIDE** of target level and **WITHIN** the appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	
Lead Director	Director of Finance and Procurement	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee / Group	Finance and Performance Committee	**Likelihood**	5 (Almost Certain) x	4 (Likely) x
Initial Date of Assessment	30 October 2024	**Impact**	*3 (Moderate)*	*3 (Moderate)*
Last Reviewed	01 April 2025	**Risk rating**	**= 15** **(Extreme)**	***= 12*** ***(Moderate)***
Next Review (Monthly based on risk score)	01 May 2025			



Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Quarterly review of projects and workstreams at the Decarbonisation Programme Board • The project structure has 5 key workstreams each with a Health Board Lead covering clinical, communications, resources, • waste and facilities and estates • Regular reporting of financial data available • Significant work already with the ReFit programme and Investment Grade Proposal (IGP) which aims to secure funding for • projects of £7.4m, to reduce carbon emissions by 995 tonnes Co2 with a 10-year payback on investment. • Refreshed Decarbonisation Action Plans for 2024-25. The DAPs are integrated with other sustainability plans and were approved at the Decarbonisation Project Board in July 24. • Annual net zero return submitted to Welsh Government • Regular reporting of success stories in this area communicated across the Health Board (e.g., “Gloves R off”) • Decarbonisation Action Plans reported annually Executive lead and publicised on the green health website • SUS Qi training • Met office training • Carbon literacy training HEIW • 4 modules on carbon reduction and net zero ESR • Spread & Scale academy training sessions	• Project structure regularly reviewed should action be needed. • Controls will be implemented further as part of the ReFit programme when it progresses following approval of the Investment Grade Proposal.

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Regular meetings of the subgroups to discuss position, monitor and new ideas • Bi-annual ISO14001 audit to be undertaken in October 2024. Estates operational meetings	• Detailed level metrics and measures are limited due to data capture equipment.	• All opportunities for funding will be optimised • Training opportunities will be maximised.
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Six monthly updates to the Board • Executive Committee (Clinical Futures Board) updates – Quarterly • Six monthly updates to the Finance & Performance Committee Decarbonisation Programme Board – Quarterly reporting		• The annual reporting to Welsh Government via the net zero return is the main source of information for carbon output by the Health Board. However, it provides a relatively simplistic picture of output of total tonnes per carbon and so its value is limited. • Funding is the greatest limitation on achieving targets. All opportunities for funding will be optimised • Training opportunities will be maximised.
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
Internal Audit Report in July 24. • Received "limited assurance" but not because of controls – the issues were largely around funding limitations. **External Audit Reports 2023 -24** Periodic reports from Audit Wales – considered by the Audit and Risk Assurance committee	• Funding for a comprehensive ABUHB decarbonisation strategy is not available.	• As above - REFIT invest to Save capital opportunities being progressed.

Assurance Rating (*Overall Assessment of controls and assurances)* *Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**NEGATIVE**

Aneurin Bevan University Health Board

Risk Management Framework

V2 DRAFT

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. Refer to ABPULSE for the current version.

Status: Issue 2 | Issue date: TBC 2025
Approved by: Aneurin Bevan UHB Board | Review by date: TBC 2026
Owner: Corporate Governance Directorate | Ref No: ABUHB_Corporate_0277

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V2 DRAFT

1 INTRODUCTION

Aneurin Bevan University Health Board (the Health Board) is committed to the principles of good governance and recognises the importance of effective risk management as a fundamental element of the health board's governance framework and system of internal control. Risk management is essential, not only for providing a safe environment and improved quality of care for service users and staff, but also for the achievement of the organisation's strategic goals, corporate and clinical objectives.

The Health Board views risk management as an integral part of the overall management process, rather than as a separate arrangement, and is committed to working in partnership with staff to make risk management a core organisational process and to ensure that it becomes an integral part of the Health Board's thinking and activities.

This Framework sets out the Health Board's approach to embedding a risk management culture that underpins and supports the business of the Health Board; delivering and securing high quality care in a safe environment, that is complying with legal and regulatory requirements; meeting objectives; and, promoting its values.

This Framework has been developed to ensure that the latest guidance, best practice and recommendations from independent reviews and assessments are considered in the systems and processes that are in place to manage risk and strengthen assurance arrangements throughout the Health Board.

2 PURPOSE

This Framework sets out the Health Board's vision for managing risk. Through the management of risk, the Health Board seeks to minimise, although not necessarily eliminate, threats, and maximise opportunities.

This Frameworks sets out the overarching processes that will allow the Health Board to effectively manage risk while maintaining high-risk governance and assurance standards. It explains how the Health Board's risk management activities interact with other governance and assurance arrangements to create an integrated system of internal control.

It also includes the Health Board's risk appetite statement, which articulates the levels and types of risk the Health Board is willing to accept to achieve its objectives.

V2 DRAFT

3 PRINCIPLES

This Risk Management Framework is informed by a set of principles, presented below.

The Health Board:

- Recognises that, as a healthcare organisation, risk is inherent and will exist at all levels of the organisation;
- Believes that risk management is everybody's business, and its risk management and assurance arrangements apply to all directly employed staff and those engaged in work or other activities on behalf of the Health Board;
- Seeks to control risks in a proportionate and cost-effective manner such that exposures are mitigated to an acceptable level (in accordance with agreed risk appetite) or are eliminated as far as it is reasonably possible;
- Acknowledges that some risks can never be eliminated entirely;
- Seeks to mitigate and control its identified risk exposure;
- Recognises that good risk management practice facilitates the opportunities to innovate and improve;
- Encourages considered and controlled risk-taking within authorised limits in order to develop and transform its services and functions;
- Applies its risk management and assurance framework to all categories of risk;
- Will adopt and adapt instances of good practice in established risk management and assurance methodologies, but where appropriate will develop bespoke risk management arrangements where required;
- Will ensure that its risk management and assurance arrangements support transparency, accountability, and wider public interest regarding the activities of the organisation.

4 OBJECTIVES

The Health Board recognises that implementing an effective risk management framework is key to delivering its overarching strategy and developing a positive learning environment and risk-aware culture.

4.1 The objectives of risk management across the Health Board are to:

- Minimise the potential for harm to patients, staff and those who engage with the Health Board to levels that are as low as is reasonably practical;
- Protect Health Board assets;

- Enable the Health Board to anticipate, respond to, and remain resilient in changing strategic and operational circumstances;
- Ensure that risk management forms an integral part of the organisation's thinking, performance management, and business planning;
- Ensure that the Health Board achieves and sustains compliance with statutory, policy, and legal frameworks;
- Ensure that a consistent and integrated approach to risk management is embedded in the day-to-day working practices of the organisation at all levels.

4.2 To achieve these objectives the Health Board will consider risk when:

- Developing, approving, and implementing strategies, plans, and polices;
- Developing and approving business cases or investment proposals;
- Scenario planning for exceptional circumstances such as major incidents and business continuity planning;
- Planning and delivering transformation and change projects;
- Implementing cost improvement or other efficiency programmes;
- Entering into contractual relationships or other partnership agreements.

4.3 To enable the Health Board to deliver these objectives it will:

- Clearly define risk management roles, responsibilities, and reporting lines within the organisation, aligned to the organisation's Performance Management and Accountability Framework;
- Reinforce the importance of effective risk management;
- Ensure that the importance of effective risk management and assurance is reflected in the roles and responsibilities of the internal governance structure;
- Maintain timely, accurate, and comprehensive intelligence about identified risks on a single management information system (Datix) and use this to produce corporate and local risk registers and other forms of risk analysis and reporting;
- Ensure that appropriate actions and controls are in place to mitigate risks and that these are well understood by those expected to apply them;
- Ensure that gaps in control are identified and implemented in a timely manner;
- Provide training and engagement activities to strengthen risk management capacity and capability within the workforce and to

generate and sustain a good level of awareness and understanding of risk management;
- Monitor, review, and seek continuous improvement in risk management arrangements across the organisation.

5 SCOPE

This Framework applies to all Health Board employees, regardless of grade or role. This includes those with whom we contract, those who are seconded to work in the organisation, and any volunteers who work in partnership with the organisation.

Therefore, accountability and responsibility for active risk management is shared at all levels within the organisation and across our partnerships, ensuring that risk management is an integral part of the overall approach to health, partnership governance, and service delivery.

The framework overarches both clinical and non-clinical risk management and is aligned to and supports the delivery of the Health Board's:

- Quality Strategy
- Performance Management & Accountability Framework
- Regulatory Requirements
- Strategies and Strategic Plans

6 RISK MANAGEMENT AND ASSURANCE ARRANGEMENTS

Key components of the Health Board's risk management arrangements include:

- Risk Appetite
- Risk Assessment Process
- Roles and Responsibilities
- Risk Management System and tools
- Reporting and Escalation
- Governance and risk assurance

6.1 Risk Appetite

For an organisation to truly have an effective risk management system in place, it must first understand its risk appetite, which is defined as **'the amount and type of risk that an organisation is willing to seek, accept, or tolerate**.' It is an agreed level of risk that the Health Board is prepared to accept or be exposed to in pursuit of its strategic objectives.

Risk appetite is a way of expressing the Health Board's attitude to different types of risk and the nature of the risks the Health Board is prepared to

take. The Health Board's appetite for risk can vary depending on the nature of the risk and the prevailing operating conditions or circumstances.

The Health Board has developed an approach to defining its risk appetite. The risk appetite is not prescriptive but instead provides several underlying component parts that encourage structured thinking. The aim of the risk appetite is to allow the Health Board to reach an informed conclusion as to whether the risk can be accepted and to what extent.

The benefits of adopting a risk appetite include:

- Supporting informed decision-making;
- Reducing uncertainty;
- Improving consistency across governance mechanisms and decision-making;
- Supporting performance improvement;
- Focusing on priority areas within an organisation;
- Informing spending review and resource prioritisation processes.

The Health Board has identified a number of risk appetite themes against which it has assigned a risk appetite. Therefore, in the instances where risks are associated with the theme and dependent on the risk score assigned, the Health Board will be more easily able to determine how to respond and so make best use of mitigation resources.

Safety, quality, and the Health Board's staff are key considerations in any risk-based decisions. The following risk appetite themes and descriptions have been determined after considering key negative and positive events that might affect the achievement of the Health Board's objectives.

- **People:** Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of the Health Board's People Strategy which would include culture & wellbeing.

- **Health Board Activities (Compliance and Safety):** Risks relating to all aspects of patient safety but also including safeguarding, staff & public security as well as risks relating to compliance and/or legal implications.

- **Health Board Activities (Service Delivery):** Risks related to all aspects of the Health Board's ability to deliver, manage, and improve service quality and performance, along with all risks relating to the current performance of its infrastructure such as IM&T and Estates, including our ability to deliver associated strategy.

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- **Financial Sustainability:** Risks relating to all aspects of the Health Board's financial performance and its ability to manage cost and efficiencies.

- **Transformation and Partnership Working:** All risks relating to the Health Board's ability to engage effectively with other organisations including development of collaborations and partnerships along with all risks associated with innovation, transformation, and strategic change.

- **Confidence & Trust:** All risks relating to confidence and trust in the Health Board, including risks relating to key stakeholders, communities and adapting to external challenges.

Risks throughout the organisation will be managed within the Board's risk appetite, or where this is exceeded, action will be taken to reduce the risk.

The Health Board's Risk Appetite Statement, which is included at **Appendix A**, sets out the Board's strategic approach to risk-taking by defining its risk appetite thresholds. It is a live document that will be regularly reviewed and modified, so that any changes to the organisation's strategy, objectives, or, its capacity to manage risk, are properly reflected.

6.2 Risk Assessment Process

Risk Management is the systematic application of management policies, practices and procedures to the task of identifying, analysing, assessing, treating and monitoring risk in a way that will enable organisations to minimise losses and maximise opportunities.

The aim of risk management is not to remove risk altogether, but to manage risk to an acceptable level, considering the cost of minimising the risk and reducing risk exposure (the level of risk that the organisation is exposed to, either in regard to an individual risk or the cumulative exposure to the risks faced by the organisation).

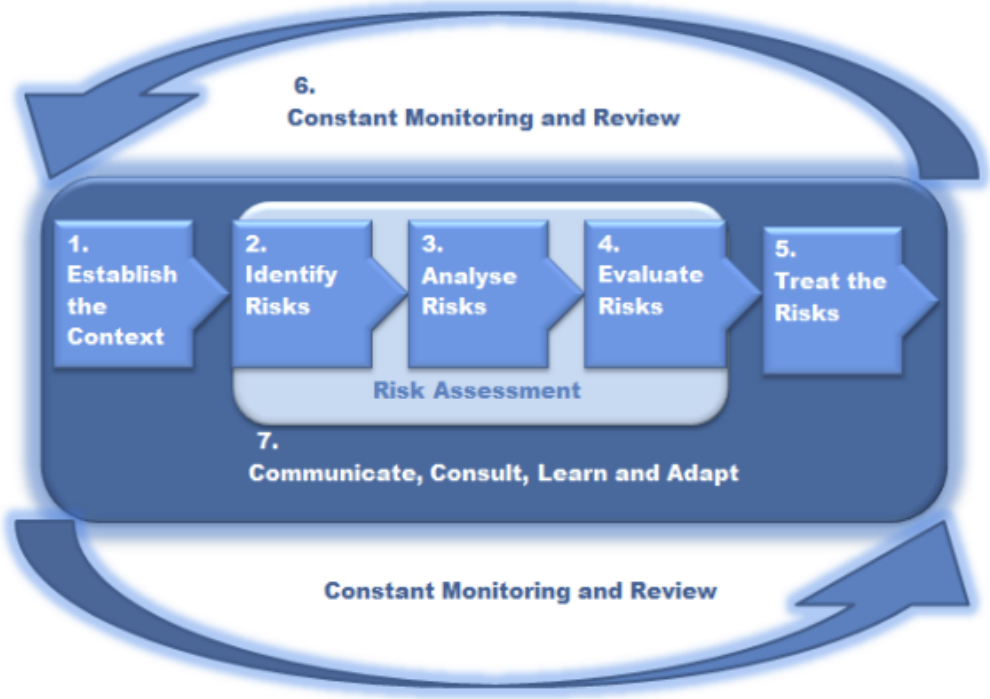
The Health Board has adopted a structured approach to risk management, whereby risks are identified, assessed and controlled, and if appropriate, escalated or de-escalated through the governance mechanisms of the organisation.

When assessing a risk, understanding whether a risk is malicious or non-malicious in nature is vital for determining the appropriate response and mitigation strategy.

Malicious risks, such as cyber-attacks or fraud, require a different approach compared to non-malicious risks, such as human error or natural disasters. By being cognisant of the intention behind risks, we can tailor our risk management efforts to address the specific nature of each threat, ensuring a more effective and comprehensive risk management process.

The process is defined in seven key steps, which are detailed within the supporting **Risk Management Policy and Procedure** (**Appendix B**).

Figure 1: The risk management process as defined in ISO 31000



6.3 Roles and Responsibilities

The Risk Management Framework applies to all Health Board employees, those with whom we contract, those who are seconded to work in the organisation and any volunteers who work in partnership with the organisation.

This framework also identifies certain designated roles with specific responsibilities to risk management and assurance. These roles are:

- The Board
- Chief Executive Officer (Health Board's Accountable Officer)
- Director of Corporate Governance
- Executive Directors
- Head of Corporate Risk and Assurance
- Risk Owner
- Risk Leads (for individual services and functions)
- All Staff

The supporting **Risk Management Policy and Procedure** (**Appendix B**) presents more information about these roles and the specific responsibilities relating to risk management.

6.4 Risk Management System

The Health Board maintains an organisation-wide information management system to support a standard approach to risk management. The system used is the risk management module of the Datix suite of applications.

Any newly identified risk must undergo a comprehensive risk assessment which must be recorded on the Health Board's risk management system, Datix. To ensure that the risk reflects the current operating environment, all risks must be monitored and updated on a regular basis.

The supporting **Risk Management Policy and Procedure** (**Appendix B**) describes further the role of Datix in effectively supporting risk management.

6.5 Risk Registers

Risk registers support day-to-day risk management and facilitate the monitoring of risk information, including changes to risk exposure and the delivery of mitigating actions.

Risk registers must be created and maintained on the Health Board's risk management framework, Datix. This includes the Strategic and Corporate Risk Registers as well as risk registers for divisions, directorates and at a local level (ward/service).

The Health Board will establish a risk register hierarchy to aid in the escalation process. This ensures that the potential risk is managed and monitored at the appropriate level. The risk register hierarchy is detailed below.

Strategic Risk Register - will hold all potential risks that has the potential to hinder achievement of one or more of the health board's strategic priorities as outlined in the Integrated Medium-Term Plan (IMTP). The Strategic Risk Register will act as the Board Assurance Framework. The term 'Board Assurance Framework' is used to refer to a document that brings together in one place all the relevant information on the risks relating to the Board's Strategic Objectives.

The Board Assurance Framework provides a structure and process that enables the Health Board to focus on the key control gaps, assurance gaps and risks that may compromise the delivery of its strategic and annual objectives. It ensures that the assurance mechanisms operating across the

Health Board are fully aligned to support the Chief Executive as the Accountable Officer, and the Board, to deliver the organisation's objectives.

Corporate Risk Register – will hold all significant operational risks that require higher-level ownership, exceed the division's capacity or resources to manage, or pose large-scale patient safety, regulatory, or legal concerns. These risks typically have a score of 15 or higher.

There will be close alignment between the Corporate Risk Register and the Strategic Risk Register to ensure the Board is sighted on key operational risks.

Divisional Risk Register - will hold all potential operational risks that necessitate a higher level of ownership than an individual Directorate can provide. Such risks necessitate plans and resources that are beyond the Directorate's capability or capacity to implement. These risks typically have a score between 8 – 12.

Local / Directorate Risk Register - Local Risk Registers will typically have a higher number of Health and Safety risks than other risk registers given the need for local mitigation.

Directorate Risk Registers will hold all potential operational risks that necessitate a higher level of ownership than an individual ward/service can provide. Such risks typically necessitate plans and resources that have a score between 1 and 6.

Thematic Risk Registers (e.g., Health and Safety, Quality & Patient Safety and Emergency Planning) - will be managed by a specialist Committee / Group.

Any risk with a score of 15 or above should be considered for escalation to the Corporate Risk Register so that the Executive Team is aware of the potential risks to service delivery.

Project Risk Registers will be managed by the appropriate project boards, with reporting and escalation managed by the Project Group.

Any risk with a score of 9 or above should be considered for escalation to the appropriate directorate risk register so that the directorate is aware of the potential risks to service delivery.

Key Caveat:
If a risk can be effectively managed within its originating area, regardless of its score, it should remain on that risk register and not be escalated

unnecessarily. Escalation should only occur when the risk can no longer be managed at that level.

Risks should be monitored regularly to ensure that control measures remain effective, and escalation should occur if the risk worsens or remains unresolved.

The only instance where project risks should be added to an organisational risk register, is when a project risk increases in score (9 and above) and poses a significant threat to delivery of services. This escalation allows for a holistic view of all risks and ensures that there is proactive management in addressing risks that could impact service delivery and overall organisational performance.

6.6 Risk Evaluation Matrix

The Health Board provides an approved methodology and supporting matrix to guide the evaluation of risks. Each risk is evaluated by calculating the likelihood and consequence of it materialising by using the NHS Wales Risk Scoring Matrix (5x5 Model) and then determining its overall risk rating of 'low',' moderate', 'high', or 'extreme'.

The Risk Scoring Matrix can be found in the **Risk Management Policy and Procedure** (**Appendix B**).

6.7 Reporting and Escalation

One of the Health Board's key management and assurance reports is the Strategic Risk Report. At each meeting respectively, the entire Strategic Risk Register will be reviewed by the:

- Board
- Audit, Risk, and Assurance Committee

At each meeting, the Board's Committees listed below will receive the Strategic Risk Report and the strategic risks delegated to them by the Board for detailed scrutiny and focus, as outlined in the **Risk Management Policy and Procedure** (Appendix B). These reports will be aligned with the Committee's agenda.

- Patient Quality, Safety, and Outcomes Committee
- Finance and Performance Committee
- People and Culture Committee
- Partnerships, Population Health, and Planning Committee

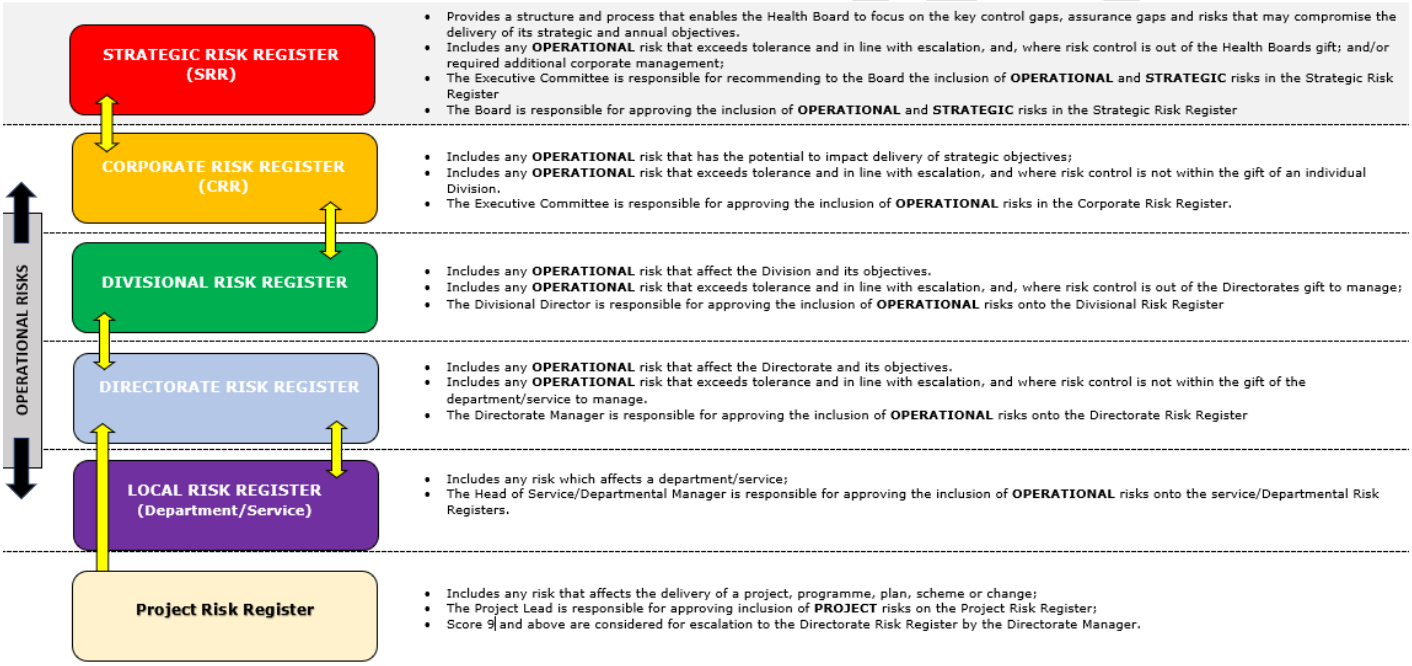
In addition, at each meeting, the Committee will receive an overview of the relevant corporate risks that are being monitored by the Executive

Committee for assurance. These will be aligned with the Committee's agenda.

In the interests of transparency and accountability and the wider public interest, unless exceptional circumstances apply, the Strategic Risk Report is discussed by the Board and sub-committees during the public session of its formal meeting.
The risk escalation framework is determined by the risk score or the significance of the risk to the delivery of patient safety, service delivery, or organisational objectives.

If the capability or capacity to manage a potential directorate, divisional, or corporate risk is exceeded, or if current controls are not mitigating the risk that is now present, the risk must be escalated through the appropriate governance arrangements, as presented in Figure 3, below.

Figure 3



Further detail on the escalation process, is set out within the **Risk Management Policy and Procedure** (**Appendix B**).

7 IMPLEMENTATION OF THE FRAMEWORK

Led by the Director of Corporate Governance, the Corporate Governance Directorate will plan and deliver the implementation of the Risk Management Framework along with a programme of training and other developmental activities to raise awareness and understanding of risk management to strengthen the maturity, capacity, and capability for risk management across the Health Board.

Activities to support implementation of this Framework will include:

- working with teams, services, directorates and functions to develop their risk management capability and ensure risk management is dynamic and part of the everyday;
- embedding risk management in quality and governance processes at all levels of the Health Board;
- using data in a risk-focused way (what does this tell us about the service and where are these risks and vulnerability);
- ensuring risk registers interact appropriately at different levels of the Health Board to ensure risks are appropriately escalated and that there is oversight of risks as appropriate; and
- ensuring staff are aware of the options for managing a risk – whether to tolerate (accept), treat (reduce or remove), transfer (responsibility), terminate (suspend the risk situation/activity) or take the opportunity.

8 TRAINING

All new staff are required to attend an Induction Programme which includes risk management training. Additional training will be available through ESR.

Board members will receive risk management training, both individually and collectively, to enable them to discharge their responsibilities effectively. This will be delivered at a minimum through Board Member Induction, with formal training delivered to the collective Board every two years.

The Corporate Governance Directorate will deliver training, and ongoing support and advice to all staff and Board Members. This will ensure that the Health Board incorporates risk management as a core function of all programmes of work associated with the delivery of organisational objectives and will aid in the identification of risks to objectives at the outset of planning processes.

9 SUPPORTING DOCUMENTS

This Framework should be read in conjunction with the:

- Risk Management Policy and Procedure
- ABUHB Risk Appetite Statement
- Guidance Note for Risk Assessment and Management
- Guidance for Using the Risk Management System – Datix

10 MONITORING EFFECTIVENESS

Compliance with the standards set out in the Risk Management and Assurance Framework will be assessed routinely by the Audit, Risk & Assurance Committee, and by the Board.

The Framework will be reviewed and updated annually or sooner if a change in obligations requires it.

The Annual Governance Statement is signed by the Chief Executive Officer and sets out the organisational approach to internal control. This is produced at the end of the financial year and is scrutinised as part of the annual accounts process and presented to the Board with the accounts, as part of the Annual Accountability Report.

The Head of Internal Audit will also provide an opinion together with the summarised results of the internal audit work performed during the year. The Health Board's risk management arrangements are also subject to audit review annually.

11 REFERENCES

- International Organisation for Standardisation, ISO 31000 Standard: Risk Management Principles and Guidance, 2018
- Good Governance Institute, Risk Appetite for NHS Organisations, 2019
- NHS National Patient Safety Agency, Risk Model Matrix
- HM Treasury, Management of Risk: Principles and Concepts (The Orange Book), 2019
- HM Treasury, Management of Risk: Risk Appetite Guidance Note, 2021
- NHS Providers, Aneurin Bevan University Health Board Risk Appetite, 2023
- National Security Risk Assessment (NSRA)

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Aneurin Bevan University Health Board

Risk Appetite Statement

January 2024

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12 INTRODUCTION

Risk is the effect of uncertainty on Aneurin Bevan University Health Board's (the Health Board's) ability to achieve its objectives.

Risk itself is neither positive nor negative, but the outcome of taking risks can be to realise an opportunity or a threat. Only in extreme circumstances is the risk unforeseen. Therefore, through careful consideration and based on information available, the Health Board should be able to determine when it can take more risk and when it should not.

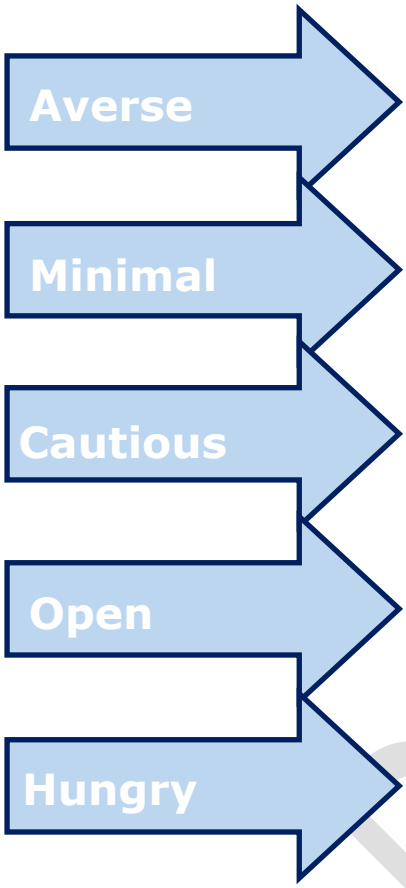
Risk appetite is a way of expressing the Health Board's attitude to different types of risk and the nature of the risks the Health Board is prepared to take. The Health Board's appetite for risk can vary dependent on the nature of the risk and the prevailing operating conditions or circumstances.

The Health Board's Risk Appetite Statement is not prescriptive but instead provides several underlying component parts that encourage structured thinking. The aim of the risk appetite is to enable the Health Board to reach an informed conclusion as to whether a risk can be accepted and to what extent.

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13 RISK APPETITE DESCRIPTION

The Board has agreed the following levels of risk appetite.



Avoidance of any risk exposure

Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible / low likelihood of occurrence of the risk after application of controls.

Preference for safe, though accept there will be some risk exposure. medium likelihood of occurrence of the risk after application of controls.

Willing to consider all potential options, subject to continued application and / or establishment of controls: recognising that there could be a high -risk exposure.

Eager to be innovative and take on a very high level of risk but only in the right circumstances.

14 RISK APPETITE BOUNDARIES

To enable translation of the risk appetite into Aneurin Bevan University Health Board's risk scoring methodology, the tolerance for each risk appetite has been plotted on the matrix below i.e., at what point a risk is acceptable (within tolerance) and when it is not (outside tolerance).

There may at times be risks which exceed appetite thresholds and the Health Board will therefore need to actively consider and agree to any risks managed outside tolerance in line with escalation levels.

Risk Appetite Level	Risk Appetite Threshold
Averse	**Score 5 and below**
Minimal	**Score 8 and below**
Cautious	**Score 13 and below**
Open	**Score 17 and below**
Hungry	**Score 21 and below**

15 RISK APPETITE THEMES

All risks should be considered in the context of the Health Board's risk appetite. To assist this a number of risk appetite themes have been developed, against which they have assigned a risk appetite. Therefore, in the instances where risks are associated with the theme and dependent on the risk score assigned, the Health Board will be more easily able to determine how to respond and so make best use of mitigation resources.

Safety, quality and the Health Board's staff are key considerations in any risk-based decisions and so with that in mind, the following risk appetite themes and descriptions below have been determined by the Board after considering key negative and positive events that might affect the achievement of the Health Board's objectives.

15.1 People

Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of the Health Board's People Strategy which would include culture & wellbeing.

The Health Board will continue to provide and review creative opportunities to develop and grow its workforce, building the operational capability and skills needed to deliver its strategic priorities. To do this the Health Board recognises that its risk appetite will need to be **open**, exploring new innovative workforce models, innovative ways of working and recruitment while always being aligned to positive culture and promoting wellbeing.

15.2 Aneurin Bevan University Health Board Activities (Compliance & Safety)

Risks relating to all aspects of patient safety but also including safeguarding, staff & public security, in addition risks relating to compliance and/or legal implications.

Compliance, safety & security is of the upmost importance. To reflect this the Health Board has a **minimal** risk appetite when making decisions about any matter or risk that may influence compliance, legality, patient harm & safety including safeguarding.

Aneurin Bevan University Health Board Activities (Service Delivery)

Risks relating to all aspects of the Health Board's ability to deliver, manage, and improve service quality and performance along with all risks relating to the current performance of the organisation's infrastructure such as IM&T and Estates, including the Health Board's ability to deliver its associated strategy.

The Health Board will have an **open** risk appetite to service delivery. This openness will be reflected in decisions that increase the likelihood of creative, innovative, and positive outcomes but also encompass wider improvements to service delivery models, including the use of IT and new technology, acknowledging that investment of resource needed to purchase equipment or deliver successful projects can be significant and must be managed appropriately.

Financial Sustainability

Risks relating to all aspects of the Health Board's financial performance and its ability to manage cost and efficiencies.

The Health Board's risk appetite for effective financial management is **cautious** as making sure there is sound financial management whilst maximising opportunities and cost effectiveness is vital to ensure future success. While the Health Board is more receptive in its approach to risk, it shall remain vigilant to those risks that could have quality, resource, reputational and safety implications that outweigh any perceived financial benefits.

Transformation & Partnership Working

All risks relating to the Health Board's ability to engage effectively with other organisations, including development of collaborations and partnerships, along with all risks associated with innovation, transformation, and strategic change.

The Health Board will be **open** in its risk appetite to transformation and when working with local authorities, healthcare partners and other agencies to improve the health of the population. It is acknowledged that risk exposure may exist in decisions to transform and work with others, so the Health Board shall be conscious of those risks that could have quality, reputational and safety implications for patients and/or the organisation.

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Confidence & Trust

All risks relating to confidence and trust in the Health Board, including risks relating to key stakeholders, communities and adapting to external challenges.

The Health Board's natural position is to not tolerate risks that breakdown or impact confidence & trust. Building on and maintaining the confidence and trust of all stakeholders, including staff is vital, so to highlight both the complexity and importance of transparency, the Health Board shall be **cautious** to any risk or opportunity that may influence that confidence and/or trust.

16 RISK APPETITE REVIEW

The Health Board will review its risk appetite on an annual basis, fully recognising that this may be subject to change due to various factors both internal and external that could shape the nature and extent of the risks the Health Board is prepared to take.

The Health Board's Risk Appetite Statement will remain an integral part of its Risk Management Framework and will be embedded into the organisation's risk management system.

17 MONITORING AND REPORTING

The Health Board will align existing risks with risk appetite themes. In addition, the Health Board will report the volume (including an approximation of cumulative exposure/risk clusters) of risks by risk theme vs risk appetite and develop a set of Key Risk Indicators, as appropriate, to help measure/inform risk appetite.

In order that the Health Board can understand its risk exposure in connection with the risk appetite themes and ensure an effective response, reporting will be undertaken in-line with the **Risk Management Policy and Procedure**. Risk register entries will be categorised by the risk appetite theme to enable the Health Board to understand the type, nature, and volume of risk attributable to each risk appetite theme.

18 APPENDIX 1 – Risk Appetite Summary Table

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

Aneurin Bevan University Health Board

Risk Management Policy and Procedure

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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. Refer to ABPULSE for the current version

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1 INTRODUCTION

Aneurin Bevan University Health Board (the Health Board) is committed to the principles of good governance and recognises the importance of effective risk management as a fundamental element of the health board's governance framework and system of internal control. Risk management is essential, not only for providing a safe environment and improved quality of care for service users and staff, but also for the achievement of the organisation's strategic goals, corporate and clinical objectives.

The Health Board views risk management as an integral part of the overall management process, rather than as a separate arrangement, and is committed to working in partnership with staff to make risk management a core organisational process and to ensure that it becomes an integral part of the Health Board's thinking and activities.

This Policy sets out the Health Board's approach to embedding a risk management culture that underpins and supports the business of the Health Board; delivering and securing high quality care in a safe environment, that is complying with legal and regulatory requirements; meeting objectives; and promoting its values.

2 AIMS

The aim of this Risk Management Policy and Procedure is to underpin the Health Board's Risk Management Framework that ensures:

- integration of risk management into activities across the organisation as well as planning and decision-making processes;
- chances of adverse incidents, risks and complaints are minimised by effective risk identification, prioritisation, treatment, and management;
- a risk management framework is maintained, which provides assurance to the Board that strategic and operational risks are being managed;
- risk management is an integral part of Health Board's culture and encourages learning from incidents; and
- employees, reputation, finances, and business continuity are protected through the process of risk identification, assessment, control and mitigation.

This Policy should be read in the context of the Health Board's Risk Management Framework which describes the Health Board's key principles and objectives to ensure an effective risk management system is in place across the organisation.

3 SCOPE

This Risk Management Policy and Procedure applies to all Health Board employees, regardless of grade or role. This includes those with whom we contract, those who are seconded to work in the organisation, and any volunteers who work in partnership with the organisation.

Therefore, accountability and responsibility for active risk management is shared at all levels within the organisation and across our partnerships, ensuring that risk management is an integral part of the overall approach to health, partnership governance, and service delivery.

4 ROLES AND RESPONSIBILITIES

Employees in all positions are responsible for maintaining risk awareness by identifying and reporting risks to their line manager and/or directors as appropriate. All areas must conduct ongoing robust risk assessments and escalate risks through the Health Board's governance and escalation route, as outlined below in the Risk Management Process section.

Although risk management is everyone's responsibility, certain roles bear more responsibility and ownership for implementing risk management systems and processes and ensuring risks are managed effectively.

The Board is made up of Executive Directors and Independent Members that share equal responsibility for the success of the organisation, including the effective management of risk and compliance with relevant legislation. In relation to risk management the Board is responsible for:

- articulating the strategic objectives and success measures for the organisation;
- protecting the reputation of the organisation;
- providing leadership on the management of risk;
- determining the risk appetite for the organisation;
- ensuring the approach to risk management is consistently applied;
- ensuring that assurances demonstrate that risk has been identified, assessed and all reasonable steps taken to manage it effectively and appropriately;
- considering any risks that are outside of appetite.

The Audit, Risk and Assurance Committee is responsible, on behalf of the Board, for reviewing the adequacy and effectiveness of:

- all risk and control related disclosure statements (the Annual Governance Statement), prior to endorsement by the Board;

- the effectiveness of the organisational risk management system;
- the underlying assurance processes that indicate the degree of achievement of strategic objectives and the effectiveness of the management of risks;
- reviewing risk related documents, policies, and procedures;
- reviewing on a regular basis the strategic risks, controls, and treatment plans and, in relation to those risks which are outside the risk appetite of the organisation, recommend appropriate action to the Board; and
- escalating to the Board any matters of significance which require Board attention or approval.

The Chief Executive (CEO) is the Accountable Officer of the Health Board and has overall accountability and responsibility for ensuring it meets its statutory and legal requirements and adheres to guidance issued by the Welsh Government in respect of Governance. This responsibility encompasses risk management, health and safety, financial and organisational controls, and governance.

In respect of risk management, the CEO has overall accountability and responsibility for:

- ensuring the Health Board maintains an up-to-date Risk Management Framework endorsed by the Board;
- promoting a risk management culture throughout the Health Board;
- ensuring that there is a framework in place, which provides assurance to the Board in relation to the management of risk and internal control;
- ensuring that risk issues are considered at each level of business planning, from the corporate planning process to the setting of staff objectives;
- setting out their commitment to the risk management principles, which is a legal requirement under the Health and Safety at Work Act 1974.

The Welsh Government requires the Chief Executive to sign a Governance Statement annually in their capacity as Accountable officer. This outlines how risks are identified, evaluated and controlled, together with confirmation that the effectiveness of the system of internal control has been reviewed.

Executive Directors are accountable and responsible for ensuring that their respective areas of responsibility are implementing this Framework, and related policies/procedures. Each Director is accountable for the

delivery of their particular area of responsibility, and will therefore ensure that the systems, policies and people are in place to manage, eliminate or transfer the key risks related to the Health Board's strategic objectives.

Specifically, they will:

- support the embedding of an effective risk management culture throughout the Health Board;
- communicate to their teams, the Board's strategic objectives; and ensure that directorate, service and individual objectives and risk reporting are aligned to these;
- ensure that a forum for discussing risk and risk management is maintained within their area, which will encourage integration of risk management;
- lead the risk management process within respective areas which includes risk assessments; incident reporting; the investigation of incidents/near misses; and the management of the risk register;
- ensure there is a system for monitoring the application of risk management within their area, and that risks are treated as required;
- provide reports to the appropriate committee of the Board that will contribute to the monitoring and auditing of risk;
- ensure staff attend relevant mandatory and local training programmes;
- ensure a system is maintained to facilitate feedback to staff on risk management issues and the outcome of reporting; and
- ensure the specific responsibilities of managers and staff in relation to risk management are identified within the job description for the post, and that those key objectives are reflected in the individual performance review/staff appraisal process.

In addition, Clinical Executive Directors (Medical Director, Director of Nursing and the Director of Allied Health Professionals and Health Science) have collective responsibility for clinical quality governance, which will include patient safety, incident management and patient experience, and will therefore have a responsibility to ensure that clinical risks are appropriately managed in-line with this Framework and the Board's Quality Strategy.

Director of Corporate Governance is the delegated Director lead for risk management in the Health Board, and is accountable for leading on the design, development and implementation of the Board Assurance Framework and Risk Management Framework. The Director of Corporate Governance will:

- lead the embedding of an effective risk management culture throughout the Health Board;
- work closely with the Chair; Chief Executive; Chair of the Audit, Risk and Assurance Committee; and Executive Directors, to implement and maintain an appropriate Risk Management Framework and related processes, ensuring that effective governance systems are in place;
- develop and communicate the Board's risk awareness, appetite, and tolerance;
- lead and participate in risk management oversight at the highest level, covering all risks across the organisation on a Health Board basis;
- work closely with the Chief Executive and Executive Directors to support the development and maintenance of Corporate and Divisional level risk registers;
- develop and oversee the effective execution of the Health Board's assurance arrangements;
- develop and implement the Health Board's Risk Management Framework; and
- produce the health board's Annual Governance Statement.

Head of Corporate Risk and Assurance is accountable to the Director of Corporate Governance, and in relation to risk management will specifically:

- provide specialist advice in relation to controls and assurances for a range of functions at all levels in the organisation to support the effective management of clinical and non-clinical risk and governance;
- ensure a central system is in place to collate risk registers across the Health Board, which link to the Health Board's assurance arrangements;
- support the management and development of the Health Board's assurance arrangements and Risk Management Framework;
- work with Divisions, Directorates, Functions and Heads of Service to ensure risks are escalated in accordance with the Risk Management Framework;
- compile the Strategic Risk Register and Corporate Risk Register for reporting to Board and its Committees; and

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- provide training, information and advice to operational staff, teams functions on risk management and risk registers, ensuring alignment to risk management reporting and escalation arrangements.

Risk Leads and Risk Owners are the responsible point of contacts for an identified risk, who coordinates efforts to mitigate and manage the risk with various individuals who may also own parts of the risk.

These responsibilities include:

- taking responsibility for managing risk;
- ensuring that risks are assessed where they are:
    - identified within the working activities carried out within their management control;
    - identified within the environment within their control;
    - reported from the staff within their management control.
- identifying and managing risks that cut across delivery areas;
- ensuring all incidents/accidents and near misses are reported;
- monitoring mitigating actions and ensuring action owners are clear about their roles, and what they need to achieve;
- discussing risks on a regular basis with staff, and through discussions at meetings to help improve knowledge about the risks faced; increasing the visibility of risk management and moving towards an action focussed approach; and
- ensuring risks are updated regularly and acted upon.

Line Managers are expected to take an active lead to ensure that risk management is embedded into the way their service/team/ward operates. Managers must ensure that their staff understand and implement the Framework and supporting processes, ensuring that staff are provided with the education and training to enable them to do so.

Managers must be fully conversant with the Health Board's approach to risk management and governance. They will support the application of this Framework and its related processes and participate in the monitoring and auditing process where required.

All Staff are responsible for ensuring that identified risks are reported to their immediate line manager so that effective controls can be considered and implemented as needed. All staff have a general responsibility for overall risk management issues and must adhere to Health Board procedures in their work.

5 RISK MANAGEMENT

The Health Board, like all organisations, faces actual and theoretical risks ranging from trivial to existential. ISO 31000, Risk Management, recommends that risk management be based on three core elements:

- a set of principles that describes the essential attributes of good risk management;
- a risk management framework that provides a structure for risk management; and
- a risk management process that prescribes a tailored, structured approach to understanding, communicating, and managing risk in practice.

Implementation of the principles will support staff to:

- Seek to control risks in a proportionate and cost-effective manner such that exposures are mitigated to an acceptable level (in accordance with agreed risk appetite) or are eliminated as far as it is reasonably possible;
- Acknowledge that some risks can never be eliminated entirely;
- Seek to mitigate and control its identified risk exposure;
- Encourages considered and controlled risk-taking within authorised limits in order to develop and transform its services and functions;
- Apply risk management and assurance framework to all categories of risk;
- Will adopt and adapt instances of good practice in established risk management and assurance methodologies, but where appropriate will develop bespoke risk management arrangements where required;
- Will ensure that risk management and assurance arrangements support transparency, accountability, and wider public interest regarding the activities of the organisation.

The Health Board recognises that there are significant benefits to managing risk, these include:

- Supports achievement of Health Board objectives;
- Avoids or mitigates the impact of failure;
- Supports cost efficiency and value for money;
- Compliance with legal and regulatory framework;
- Management of external impacts and changes; and
- Exploit opportunities encouraging innovation

The Health Board's Risk Management system is supported by the Risk Management Framework which can be found here. The Framework sets out the Health Board's approach to embedding a risk management culture that underpins and supports the business of the Health Board; delivering and securing high quality care in a safe environment, that is complying with legal and regulatory requirements; meeting objectives; and, promoting its values.

Risks are linked to objectives and strategic aims, which exist at different levels:

- **Strategic risks** – risks that affect the Heath Board's ability to deliver its strategic priorities or to function as an organisation as a whole;
- **Corporate risks** – risks that have an impact on the delivery of the Health Board's business objectives or common risks that necessitate a corporate response;
- **Divisional risks –** risks that have an impact on the delivery of divisional objectives or common risks that necessitate a co-ordinated response;
- **Thematic risks -** risks that are specific to risk domains and cut across multiple divisions and directorates;
- **Directorate / Team risks** - risks that are related to the delivery of departmental operations and objectives;
- **Programmes/Projects -** risks associated with, usually, time limited activities and medium- to long-term delivery of benefits.

Strategic risk, corporate, operational, and local team risk registers should not typically include project risks. Project risks will be managed through the appropriate project boards with reporting and escalation through the change management governance process.

The only instance where project risks should be added to an organisational risk register, is when a project risk increases in score (9 and above) and poses a significant threat to delivery of services. This escalation allows for a holistic view of all risks and ensures that there is proactive management in addressing risks that could impact service delivery and overall organisational performance.

It is crucial for our organisation to recognise and manage all potential risks to ensure the continuity and quality of our services. Risks should be identified and managed at the appropriate level, whether at the project or

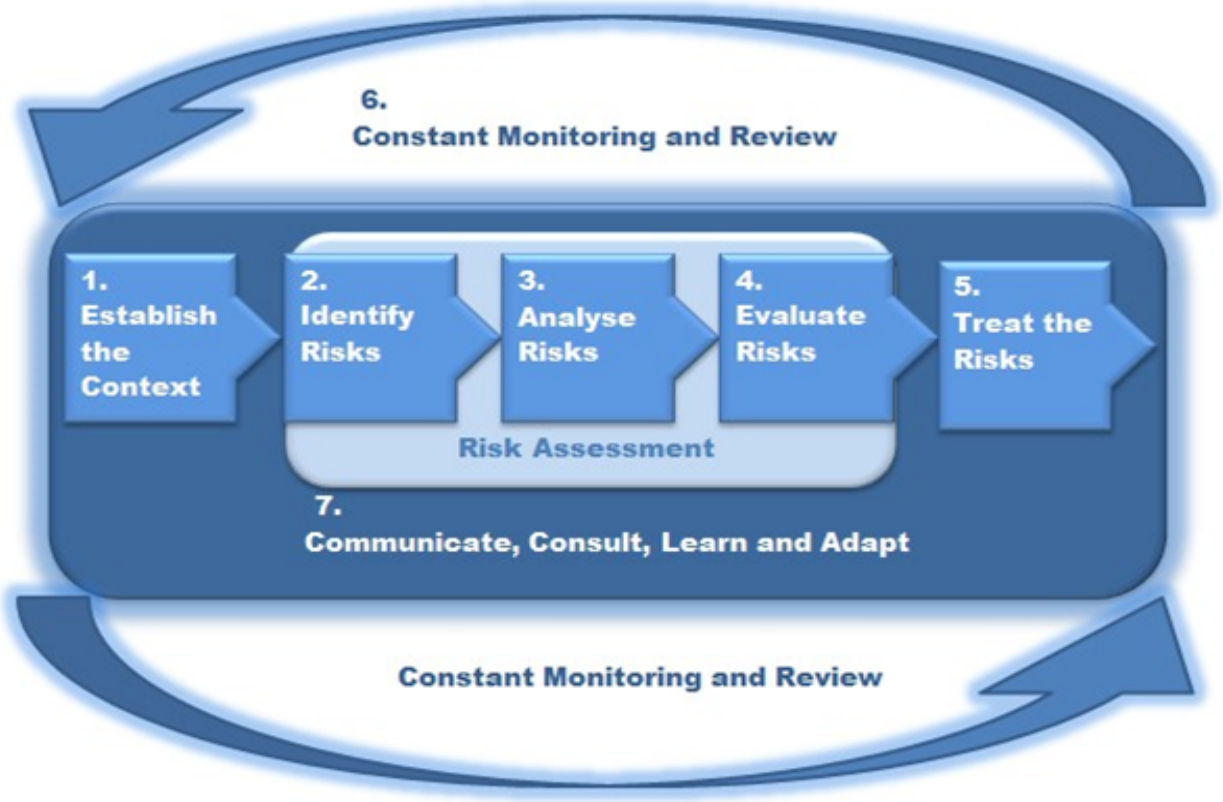
organisational level, to ensure effective mitigation and response. However, it is equally important for staff to be aware of the intention behind each risk. Understanding whether a risk is malicious or non-malicious in nature is vital for determining the appropriate response and mitigation strategy.

Malicious risks, such as cyber-attacks or fraud, require a different approach compared to non-malicious risks, such as human error or natural disasters. By being cognisant of the intention behind risks, tailored risk management efforts can be implemented to address the specific nature of each threat, ensuring a more effective and comprehensive risk management process.

5.1 Risk Management Process

The risk management process is illustrated in Figure 1 and each step in the process is explained in greater detail.

Figure 1



Before identifying risks, first decide on the scope of the activity, including your objectives, and develop an understanding of your operating environment.

Identify your stakeholders (internal and external) to determine whether they could potentially expose the Health Board to risk, could be exposed to risk, or could assist with risk management.
There are three other elements that are important to consider when establishing the context for a risk assessment:

- **The external context** - the environment in which we operate and seek to achieve objectives including, operational, cultural, political, people, environmental, legal, regulatory, financial, technological, and economic factors.

- **The internal context** - includes factors that are relevant to the risk assessment. This is important as risk assessments will be most effective when they are linked to the objectives of the organisation or activity under assessment. Factors typically considered in the internal context include the organisation's strategic objectives, organisational capabilities, and culture.

- **The risk management context** - this defines the goals and objectives of the risks.

The aim of this step is to develop a comprehensive list of future events which could be uncertain but are likely to have an impact (either positively or negatively) on the achievement of the objectives - these are the risks.
It is important to understand the difference between a Risk and an Issue, as these can often get confused. A useful way of remembering the difference is;

- Risks are things that **might** happen and stop us achieving objectives, or otherwise impact on the success of the Health Board.

- Issues are things that **have h**appened or are **currently** happening, that are being actively managed.

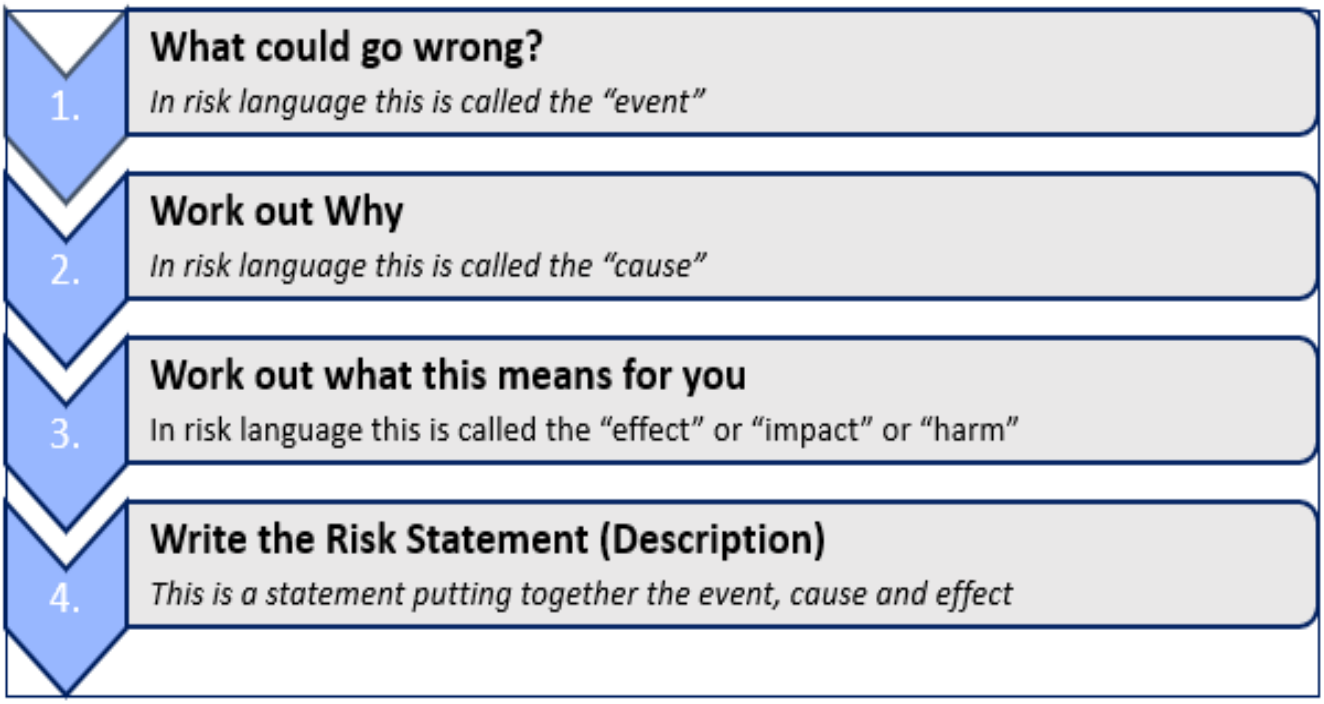
An Issue or a Risk can be determined by the temporal proximity of the event as outlined in the table below.

Temporal Proximity	Risk or Issue
Has happened or is currently happening	**Issue**
Potential to materialise in this financial year	**Risk**
Potential to materialise in the next financial year	**Risk**
Potential to materialise in the next 2 -5 years *(dependant if the risk is malicious (2y) or non-malicious (5y)*	**Risk**

Common techniques for identifying risks are the use of risk categories or linking risks to each objective identified in the context setting phase. Another method is to consider threats and opportunities the Health Board faces and use these to identify relevant risks.

For each risk identified ensure that its source or cause is well understood and documented, including key elements such as the risk event, the potential cause and the potential impact should the risk be realised. A clear risk description is important to ensure corresponding actions for treatment are effective.

The steps below will guide the development of a risk description, examples of this process are included at **Appendix 1.**



5.1.3 Step 3: Analyse Risks

Risk analysis establishes the potential impact of each risk and its likelihood of occurrence. The combination of these two factors determines the severity of the risk, which may be positive or negative. Before considering how to manage a risk, you need to assess its seriousness. This is done by measuring the risk's **LIKELIHOOD** and **IMPACT**.

Although there are many ways to achieve this, a common approach is to use a matrix or 'risk heat map'. Consequence and likelihood are plotted on the two axes of the matrix, with each corresponding cell assigned a level of severity.

Risks should be measured at the following three stages.

- **INITIAL –** This will be the score when the risk is first identified – this will not change.
- **CURRENT** - This should reflect the latest level of risk each time that the risk is reviewed.
- **TARGET**- The desired level of risk that we are working to reduce the risk to, with the effective implementation of controls and mitigating actions.

The NHS 5 X 5 Risk Scoring Matrix is presented at **Appendix 2.**

Risk evaluation determines the tolerability of each risk. Tolerability is not the same as severity. Tolerability aids in determining which risks require treatment and their order of priority. This is achieved by comparing the risk severity established in the risk analysis step to the risk criteria found in the defined likelihood and consequence criteria.

The Health Board has defined its risk appetite against six broad themes and agreed on the level at which risks within those themes are considered unacceptable; risks below this level are considered tolerable. The Risk Appetite Statement can be accessed here.

Decisions on tolerability should also consider the risk's broader context, including the risk's impact on other stakeholders.

Financial, legal, regulatory, and other considerations should be factored into treatment decisions. Considered and informed acceptance of risk supports decision making and is essential for organisational performance, including the achievement of objectives.

5.1.5 Step 5: Treat the Risk

Risk treatment is the action taken in response to the risk evaluation when additional mitigation activities are agreed upon.

Risk treatment is a cyclical process in which individual risk treatments (or combinations of treatments) are evaluated to see if they are adequate to reduce residual risk levels to a tolerable or appropriate level. If not, then new risk treatments need to be developed and assessed until a satisfactory level of residual risk is achieved.

There are four strategies to managing a risk, known as the 4T's (Treat, Tolerate, Transfer, Terminate) which consider the factors below:

- Avoiding the risk entirely by not undertaking the activity;
- Removing a source or cause of the risk;
- Sharing the risk with other parties;
- Retaining the risk by informed decision;
- Taking more risk to achieve certain objectives or opportunities;
- Changing the likelihood and/or consequence of the risk through modifying controls in place.

Selecting the most appropriate treatment requires balancing the cost and effort of implementation against the benefits derived from additional risk mitigation. In some cases, further treatment may be unachievable or unaffordable and the residual risk may need to be accepted and communicated.

Consideration should be given to how external stakeholders can provide support when developing treatment options or if treatments can be implemented collaboratively.

Risk treatments are commonly documented in a risk treatment plan. These generally include:

- reasons for treatment selection, including expected benefits and potential concerns;
- accountabilities for approving the plan and its implementation;
- resource requirements;
- reporting, assurance, and monitoring requirements; and
- priorities, timing, and schedules.

5.1.6 Step 6: Communication and Consultation

Communication and consultation are essential attributes of good risk management.

Risk management cannot be done in isolation and is fundamentally communicative and consultative and is a requirement within each element of the risk management process.

Formal risk reporting is only one form of risk communication. Good risk communication generally includes the following attributes:

- encourages stakeholder engagement and accountability;
- maximises the information obtained to reduce uncertainty;
- meets the reporting and assurance needs of stakeholders;
- ensures that relevant expertise is drawn upon to inform each step of the process;

- informs other stakeholder processes such as corporate planning and resource allocation.
-

5.1.7 Step 7: Monitoring and Review

Risks change over time and hence risk management will be most effective where it is dynamic and evolving.

Monitoring and review are integral to successful risk management, it is important to articulate who is responsible for conducting monitoring and review activities.

Key objectives of risk monitoring and review include:

- detecting changes in the internal and external environment, including evolving objectives and strategies;
- identifying new or emerging risks;
- ensuring the continued effectiveness and relevance of controls and the implementation of treatment programs;
- obtaining further information to improve the understanding and management of already identified risks; and
- analysing and learning lessons from events, including near-misses, successes, and failures

Monitoring and review can be periodic or in response to trigger events or changing circumstances.

The table below serves as a guide for conducting periodic risk assessments based on the risk level (severity). The frequency of the review process, however, should be proportional to the rate at which the organisation and its operating environment change.

Risk Score	Risk Level	Review Risk Assessment
1 - 4	Low	12 months
5 - 8	Moderate	6 months
9 - 12	High	3 months
15 - 25	Extreme	1 month

The results and observations from monitoring and review are most useful when well documented and shared. The Health Board Risk Management System, Datix, should be used to record, manage, monitor and review all risks. The information recorded on Datix feeds into the organisation-wide

risk register, giving a holistic view of risks across the entire organisation and can be used to identify themes and ensure the risk is managed and monitored at the most appropriate level.

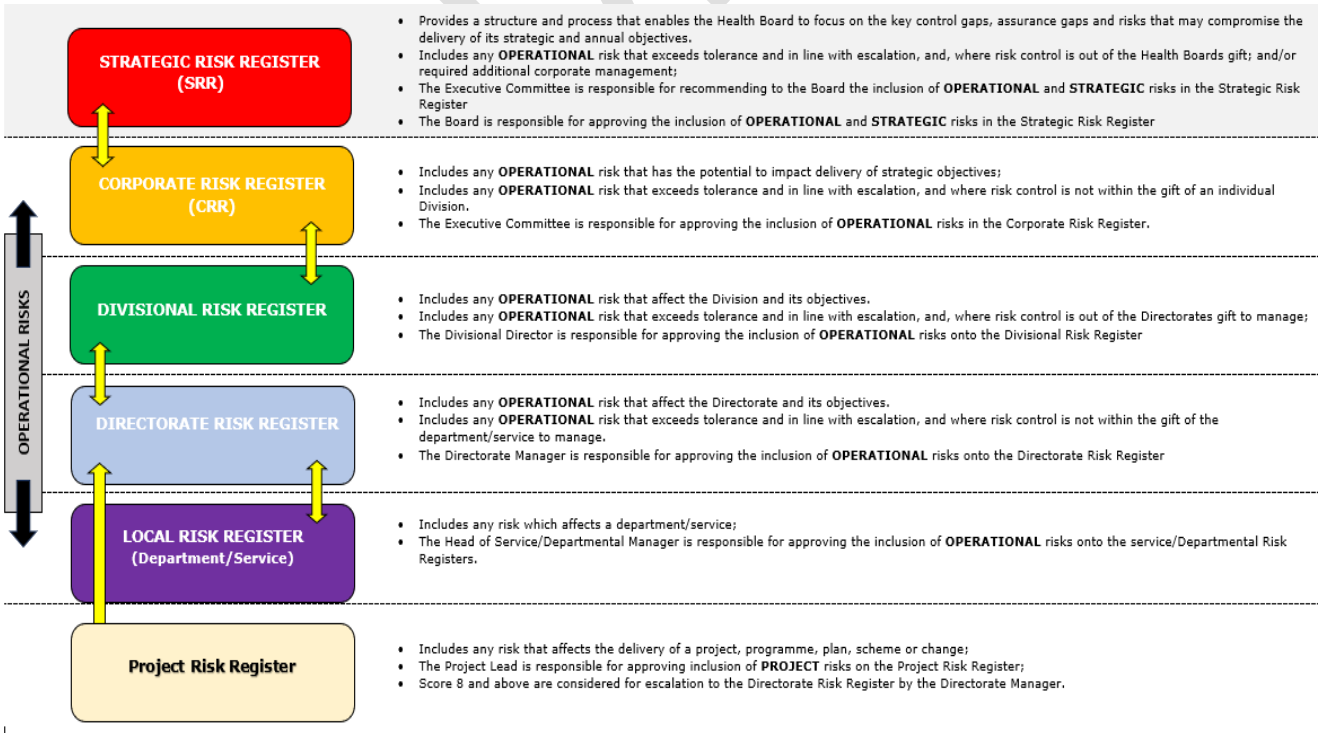
They should be included in formal risk reports, be recorded, and published internally and externally as appropriate.

Risk monitoring should be included as a standing agenda item in assurance meetings for regular discussion and review of risk information. This discussion might identify that the impact of some risks, or the actions required to mitigate them, are such that the risk needs to be escalated to a higher management level.

6 ESCALATION PROCESS

The Health Board uses hierarchical risk registers to ensure that risks are managed, escalated, and reported at the appropriate organisational level. The risk escalation framework is determined by the risk score or the significance of the risk to the delivery of patient safety, service delivery, safeguarding assets, or organisational objectives.

If the capability or capacity to manage a potential directorate, divisional, or corporate risk is exceeded, or if current controls are not mitigating the risk materialising, the risk must be escalated using Datix and communicated to the appropriate person, as illustrated below, and explained in detail in the next section.



Trigger Points for Escalation

Strategic Risk Register holds all risks which present a direct threat to the Board's strategic priorities as outlined in the Integrated Medium-Term Plan (IMTP). Furthermore, any risks identified on the Corporate Risk Register that are deemed significant or have the potential to have a strategic impact will be escalated and monitored through the Strategic Risk Register.

Corporate Risk Register – will hold all significant operational risks that require higher-level ownership, exceed the division's capacity or resources to manage, or pose large-scale patient safety, regulatory, or legal concerns. These risks typically have a score of 15 or higher.

There will be close alignment between the Corporate Risk Register and the Strategic Risk Register to ensure the Board is sighted on key operational risks.

Divisional Risk Register - will hold all potential operational risks that necessitate a higher level of ownership than an individual Directorate can provide. Such risks necessitate plans and resources that are beyond the Directorate's capability or capacity to implement, crosses over two or more directorates or have a score between 9 – 12.

Local / Directorate Risk Register - Local Risk Registers will typically have a higher number of Health and Safety risks than other risk registers given the need for local mitigation.

Directorate Risk Registers will hold all potential operational risks that necessitate a higher level of ownership than an individual ward/service can provide. Such risks typically necessitate plans and resources that have a score between 1 and 8.

Thematic Risk Registers (e.g., Health and Safety, Quality & Patient Safety and Emergency Planning) - will be managed by a specialist Committee / Group.

Any risk with a score of 15 or above should be considered for escalation to the Corporate Risk Register so that the Executive Team is aware of the potential risks to service delivery.

Project Risk Registers will be managed by the appropriate project boards, with reporting and escalation managed by the Project Group. Any risk with a score of 9 or above should be considered for escalation to

the appropriate directorate risk register so that the directorate is aware of the potential risks to service delivery.

Key Caveat:
If a risk can be effectively managed within its originating area, regardless of its score, it should remain on that risk register and not be escalated unnecessarily. Escalation should only occur when the risk can no longer be managed at that level.

Risks should be monitored regularly to ensure that control measures remain effective, and escalation should occur if the risk worsens or remains unresolved.

The only instance where project risks should be added to an organisational risk register, is when a project risk increases in score (9 and above) and poses a significant threat to delivery of services. This escalation allows for a holistic view of all risks and ensures that there is proactive management in addressing risks that could impact service delivery and overall organisational performance.

Risk Assessment Templates are included in **Appendices 3 and 4** for Divisional, Directorate, and Local risks, as well as Corporate and Strategic risks. **Appendix 5** illustrates a flow chart of the escalation process.

DATIX RISK MANAGEMENT SYSTEM

Risks must be recorded on the Health Board's Risk Management System, Datix. The DatixWeb Risk Module Training Guide is a step-by-step guide to recording and managing risks on Datix and can be accessed here.

7 SUPPORTING DOCUMENTS

This document should be read in conjunction with the:

- Risk Management Framework
- Risk Appetite Statement
- DatixWeb Risk Module Training Guide

8 TRAINING AND IMPLEMENTATION

All new staff are required to attend an Induction Programme which includes risk management training. Additional training will be available through ESR.

Board members will receive risk management training, both individually and collectively, to enable them to discharge their responsibilities effectively. This will be delivered at a minimum through Board Member

Induction, with formal training delivered to the collective Board every two years.

The Corporate Governance Directorate will deliver training, and ongoing support and advice to all staff and Board Members. This will ensure that the Health Board incorporates risk management as a core function of all programmes of work associated with the delivery of organisational objectives and will aid in the identification of risks to objectives at the outset of planning processes.

9 AUDIT AND REVIEW

This document will be reviewed annually in line with the Risk Management Framework and will be subject to regular auditing to ensure that risk management practices are effectively embedded across the Health Board

10 APPENDICES

- Appendix 1 - Risk Statement Examples
- Appendix 2 – NHS Wales Risk Scoring Matrix (5x5 Model)
- Appendix 3 - Risk Assessment Template Divisional / Directorate / Local Risk Assessment
- Appendix 4 - Risk Assessment Template Strategic/Corporate Risk
- Appendix 5 - Escalation Process

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APPENDIX 1: Risk Statement Examples

1. What could go wrong?	2. What could be the cause of this?	3. What would be the effect/impact?	4. Risk Statement (Description)
Poor quality care provided to patients	• High staff sickness rate • Inability to recruit sufficient staff. • Inability to release staff for statutory and mandatory training	• Adverse harm to patients • Loss of public confidence in services • Breach of Staffing Levels Act	There is a risk that safe staffing levels are not maintained, compromising patient safety and care.
Staff could fall over storage boxes	• Medical records stored in boxes unsafely in office accommodation	• Staff absence due to injury • Breach of Health & Safety at Work Legislation • Litigation Claims for Injury	There is a risk that the unsafe storage of medical records could cause potential harm to staff and loss to the organisation.
Unable to update electronic patient records	• System downtime • Internet access • IT failure	• Adverse harm to patients • Compliance with record-keeping standards • Litigation claims • Reputational damage	There is a risk that patient records will not be updated with critical information should access to web-based/electronic recording systems be compromised.

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APPENDIX 2: NHS Wales Risk Scoring Matrix (5x5 Model)

X-Axis = Likelihood/Frequency of the risk occurring.

Y-Axis = the level of risk **Consequence/Impact**

Color-coding is crucial for a 5×5 risk assessment matrix to represent the combination level of probability and consequence of the identified risks.

Each risk box represents the rating of a risk that is calculated based on its levels of likelihood and impact using a numeric value.

Calculating Risks Using the 5×5 Risk Matrix

The first step is to assign a numeric value from 1 to 5, 1 being the lowest, for each of the categories under Likelihood and Consequence. Then, use the formula of multiplying the value of the Likelihood by the value of the Consequence to determine the Risk Level.

The likelihood of **malicious risks** should be assessed over a **2-year period**. In contrast, the likelihood of **non-malicious risks** should be evaluated over a **5-year period**.

Definition:

Non-Malicious - A risk arising from **unintentional** errors, system failures, or natural causes, where there is no deliberate intent to harm.

Malicious - A risk arising from **intentional** harmful actions aimed at causing damage, disruption, or financial/reputational harm.

Likelihood x Consequence = Risk Level

Risk Scoring Matrix					
Likelihood/ Frequency	Consequence/Impact				
	1. Negligible	2. Minor	3. Moderate	4. Major	5. Catastrophic
5. Almost Certain (91%)	5 (Moderate)	10 (High)	15 (Extreme)	20 (Extreme)	25 (Extreme)
4. Likely (61-90%)	4 (Low)	8 (Moderate)	12 (High)	16 (Extreme)	20 (Extreme)
3. Possible (41-60%)	3 (Low)	6 (Moderate)	9 (High)	12 (High)	15 (Extreme)
2. Unlikely (11-40%)	2 (Low)	4 (Low)	6 (Moderate)	8 (Moderate)	10 (High)
1. Rare (1-10%)	1 (Low)	2 (Low)	3 (Low)	4 (Low)	5 (Moderate)

The 5 risk rating levels under Likelihood/Frequency are as follows:

	Likelihood/frequency score (severity levels) and examples of descriptors				
Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency **How often might it/does it happen.**	This will probably never happen/recur. May occur once in 10 years or more (e.g., <5%)	Do not expect it to happen/recur but it is possible it may do so. Could occur once every 5 to 10 years (e.g., 5-20%)	Might happen or recur occasionally. Might occur once every 2 to 5 years (e.g,21 – 50%)	Will probably happen/recur but it is not a persisting issue. Expected to occur annually or more (e.g,51 – 80%)	Will undoubtedly happen/recur, possibly frequently. Expected to occur frequently (e.g., monthly+) (e.g.,>80 %)

The 5 risk rating levels under Consequence/Impact are as follows:

	Severity/Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical /psychological harm)	Minimal injury or illness requiring no intervention or treatment. No time off work	Minor injury or illness, requiring. minor intervention e.g., First Aid treatment. Requiring time off work up to 7 days or restricted / modified duties. No permanent effects Increase in length of hospital stay by 1-3 days	Moderate injury or illness requiring professional intervention e.g., Hospital Treatment, Counselling. Specified injury e.g., Bone Fracture, Loss of consciousness, Burn / scalding. Requiring time off work for greater than 7 days. Potential for long term effects Increase in length of hospital stay by 4-15 days.	Major injury or illness leading to long-term incapacity/disability e.g., Amputation, loss of sight or hearing. Chronic and or acute short term high risk ill health effects. Requiring time off work for greater than 28 days Life changing illness or injury Increase in length of hospital stay by >15 days.	Incident leading to death. Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients

			An event which impacts on a small number of persons	Mismanagement of patient care with long-term effects RIDDOR/agency reportable incident or Dangerous Occurrence	
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (Stage 1) Local resolution Single failure to meet internal standards. Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards. Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on. Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training.	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis.

Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required. Zero performance rating Severely critical report
Adverse publicity	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned. (Questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget. Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million

Fraud	Unlikely to result in material loss or reputational damage. (Little or no loss to the organisation, material loss less than £500)	Material loss or reputational damage likely to be minimal. (Some risk to the organisation which may result in minor reduction in service capacity or material loss of up to £5000. Reputational damage likely to be within the organisation which may lead to complaint	Could result in material loss or reputational damage. (Moderate risk to the organisation which may result in reduction of service. Material loss of up to £10000. Reputational damage across NHS with a high potential for complaint or a low risk of litigation	Could result in high material loss or reputational damage. (May result in temporary loss of service or material loss of up to £50000. Reputational damage widespread and outside of NHS with a likelihood of litigation	Could result in high material loss or reputational damage. (May result in temporary loss of service or material loss of up to £50000. Reputational damage widespread and outside of NHS with a likelihood of litigation
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment No damage to equipment or property	Loss/interruption of >8 hours Minor impact on environment Slight / minor damage to equipment or property	Loss/interruption of >1 day Moderate impact on environment Moderate damage to equipment or property	Loss/interruption of >1 week Major impact on environment Major damage to equipment or property	Permanent loss of service or facility. Catastrophic impact on environment Catastrophic damage to equipment or property

The table below outlines the time frame for implementation of actions based on risk score and level.

Risk Score	Overall Risk	Timeframe
1 - 4	Low	Quick, easy measures implemented immediately, and further action planned for when resources permit.
5 - 8	Moderate	Actions implemented as soon as possible but no later than a year.
9 - 12	High	Actions implemented as soon as possible but no later than six months.
15 - 25	Extreme	Requires urgent action. The Health Board is made aware, and it implements immediate corrective action. However, where likelihood is rare or unlikely then potential decision needed on tolerance and action timescales.

V2 DRAFT

Appendix 3: Local Risk Assessment

Local/Directorate/Divisional Risk Assessment - SELECT					
OBJECTIVE / PRIOIRTY	ADD WHICH OBJECTIVE / PRIORITY THE RISK IS LINKED TO				
Risk ID & Description					
Threat					
Impact	Patient	Staff	Organisation		
Risk Handler		Risk Exposure	Current Level	Target	
Monitoring Forum		Likelihood			
Initial Date of Assessment		Impact			
Last Reviewed		Risk rating			
Next Review					

Notes for completion:
When a potential risk threatens the achievement of objectives/priorities or is deemed a high-level operational risk, it should be escalated through the hierarchical structure and a request to the Lead Executive Director for consideration by the Executive Committee for inclusion on the Corporate Risk Register (CRR).

The **Threshold** for escalation to the:
- Directorate Risk Register is set at **8 and above**,
- Divisional Risk Register **12 and above**,
- Corporate Risk Register **15 and above.**

However, risks can be escalated, if they are beyond the scope of the current level to mitigate.

The timeframe for actions to be implemented must be aligned to the risk score/level.

Score	Overall Risk	Timeframe for implementing Actions
1 - 3	Low	Quick, easy measures implemented immediately, and further action planned for when resources permit
4 - 6	Moderate	Actions implemented as soon as possible but no later than a year
8 - 12	High	Actions implemented as soon as possible but no later than six months
15 - 25	Extreme	Requires urgent action

Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Plans to Improve Gaps in Control *(Are further controls possible to reduce risk exposure to target level)*	Implementation Date for further controls	Person Responsible for Implementing further controls	Progress against Actions to Improve Control *(What has been implemented)*

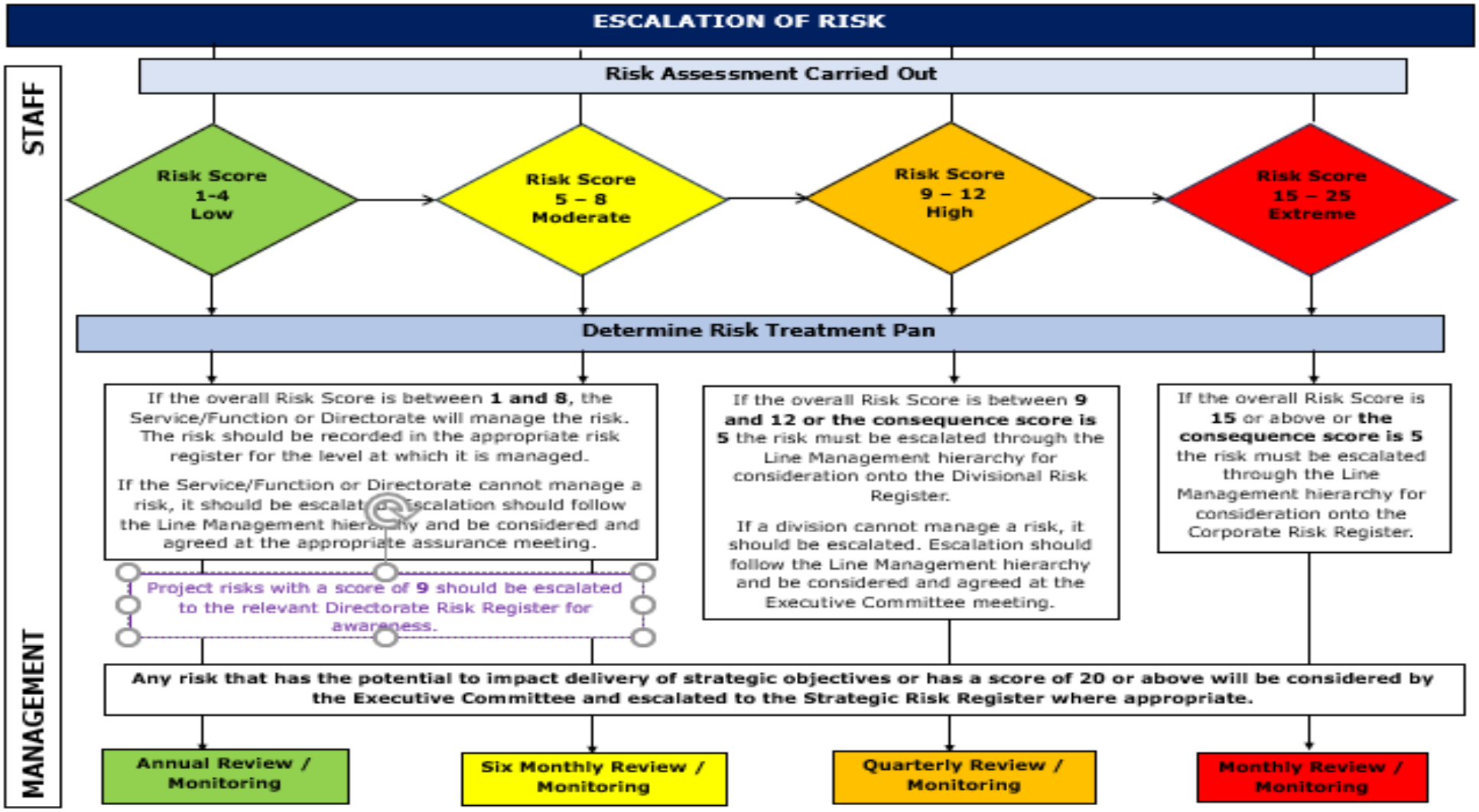
APPENDIX 4: Risk Assessment Template Strategic/Corporate Risk

RISK THEME	USE RISK APPETITE DOCUMENT TO DETERMINE					
LINK TO IMTP / ANNUAL PLAN	USE IMTP 2025 - 28					
Strategic/ Corporate Risk SRR XXX / CRR XXX	There is a risk				**Publication Status**	**Public**
Threat *(As a result of)*					**Risk Appetite Level – Use Risk Appetite Document**	
Impact *(Consequences of the threat)*	**Patient**	**Staff**	**Organisation**		**Risk Appetite Threshold –**	
					SUMMARY	
Lead Director		**Risk Exposure**	**Current Level**	**Target Level**		
Monitoring Committee / Group		**Likelihood**				
Initial Date of Assessment		**Impact**				
Last Reviewed		**Risk rating**				
Next Review (xx based on risk score)						

Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
EXAMPLES • Policies /procedures/protocols etc • Systems • Meetings	

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*		**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*			
EXAMPLES • Adherence to clinical guidelines, protocols, and standard operating procedures (SOPs). • Dashboards measuring compliance • Performance dashboards KPI's	• Performance – workforce – finance reporting • Incident reporting • Thematic reviews	What information would give you assurance. e.g., dashboards, report data,	What do you need to implement in to provide you with the assurance e.g., develop a dashboard, pull report data from ESR, local audit of process
Level 2 Organisational *(Executed by risk management and compliance functions)*			
EXAMPLES • Reports to assurance and oversight committees (performance data against KPIs, objectives) • Findings and reports form inspections, annual reporting	• Training and competence data • HB level Accreditation	• Governance processes • risk management input (register, risk assessment)	What do you need to implement in to provide you with the assurance e.g., develop a dashboard, pull report data from ESR, local audit of process
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*			
EXAMPLES • Internal Audit Plan • External Audits • HIW Inspections	• External Visits and accreditations • Independent Reviews • Patient/staff/public surveys and feedback	• Independent assurance that the controls are mitigating the risk	What do you need to implement in to provide you with the assurance e.g., commission an independent review, develop feedback surveys
Assurance Rating *(Overall Assessment of controls and assurances)* *Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable** - adequate evidence that the controls in place are working effectively.	**Positive** - robust evidence that the controls in place are working effectively.	**OVERALL ASSURANCE RATING**

APPENDIX 5: Escalation Process



Internal Audit Progress Report

Audit, Risk and Assurance Committee

April 2025

Aneurin Bevan University Health Board

NWSSP Audit and Assurance Services

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1. Introduction

The purpose of this report is to:

- confirm the status of the audit work for the 2024/25 Internal Audit Plan for Aneurin Bevan University Health Board (the 'Health Board') to the April 2025 Audit, Risk and Assurance Committee (the 'Committee');
- approve the deferral of two audits - Welsh Intensive Care Information System audit and the Capital Systems audit and note the delivery profile changes for the Nevill Hall Regional Satellite Centre and Electronic Document and Records Management Solution audits;
- approve the draft 2025/26 Internal Audit Plan; and
- provide an overview of other activity undertaken since the previous meeting.

2. Progress against 2024/25 Internal Audit Plan

There were 33 individual reviews in the 2024/25 Internal Audit Plan, including assurance work completed by our Specialist Services Unit (SSU) over major capital projects.

The table below details progress against the 2024/25 Internal Audit Plan.

Number of audits in plan:	33
Less audit merger	(1)
Less deferral	(1)
Less potential additional deferrals	(2)
Revised total	29
Number of audits at final report stage	16
Number of audits at draft report stage	3
Number of audits work in progress	9
Number of audits at planning stage – NHH SRC	1

The following final reports have been issued since the meeting of the Audit, Risk and Assurance Committee on 18th February 2025:

AUDIT ASSIGNMENT	**ASSURANCE RATING**
Speaking up Safely Framework	Limited
Divisional Governance Arrangements	Reasonable
Mental Health and Learning Disabilities	Reasonable
Maternity Services Improvement Plan	Reasonable
Staff Culture	Reasonable
The Grange Accident and Emergency Expansion	Reasonable

The delivery status of the audits is illustrated within Appendix A and further information over the assurance rating detailed above is included within Appendix B.

3. Summary of Findings

Limited assurance reports are considered by the Audit, Risk and Assurance Committee in detail. The following summary provides the Committee with the main messages from the reports issued since the last meeting on 18th February 2025.

Speaking up Safely Framework (limited assurance)

We sought to assess whether the Speaking up Safely: A Framework for the NHS in Wales has been fully implemented.

The review focused mostly on the Health Board's previous process to track speaking up safely concerns with a new process only coming into practice December 2024. Another speaking up safely audit will focus on the new process and is scheduled within the upcoming 2025/26 internal audit plan. The significant matters requiring management attention from this audit include:

- **Lack of resources:** The Speaking Up Safely framework has no dedicated staff or budget, relying solely on existing staff managing it alongside existing responsibilities.
- **Unclear case management:** Before December 2024, concerns were tracked across multiple spreadsheets without clear categorisation, leading to inconsistent handling and evidence of compliance to the speaking up safely framework was not maintained.
- **Manual system risks:** Management of speaking up safely concerns and general workforce concerns rely on Excel spreadsheets which increases the risk of errors, data loss, and inefficiencies, including but not limited to lack of automation and security issues.

Divisional Governance Arrangements (reasonable assurance)

The review assessed whether the governance arrangements in place within the Primary Care and Community (PCC) Division ensure key risks and matters arising were escalated and managed effectively.

The matters requiring management attention include:

- Policies and/ or procedures were required to provide guidance on the process for escalating issues and key risks.
- Staff would benefit from guidance on how to assess whether a risk is key and requires escalation.
- A system should be put in place to record, monitor and track escalated risks – to ensure that feedback from Divisional Managers is recorded and, where appropriate, that actions are tracked to provide assurance to Senior Leadership Team (SLT) that issues have been addressed.

Mental Health and Learning Disabilities (reasonable assurance)

We reviewed the arrangements from the 90-day Plan for the Mental Health and Learning Disabilities division, to ensure that these have been embedded.

The 90-day Plan was implemented alongside 30-day and 60-day actions as part of an Improvement Plan to address concerns raised in July 2023, following HIW inspections and other concerns relating to assurance of safety and quality of services within the Division.

The Improvement Plan targeted the initial areas of concern, but helped launch wider initiatives which focused on workforce, leadership, performance and governance, to help drive continuous improvement across the Division. The Division has encountered different challenges since the Improvement Plan was put in place, one being the change in the whole triumvirate team.

Whilst recently, progress has been made in implementing the actions (three of the four actions) from the Plan not all of actions have been fully implemented and subsequently, not embedded.

The significant matters requiring management attention include:

- A governance structure is in place within the Division but is still being developed. Whilst progress has been made there is a benefit in defining the governance structure more clearly.
- Progress discussion is taking place at multiple forums across operational, divisional and executive levels, however there was a lack of detailed focus and challenge when actions are not implemented on time.
- The Plan lacks specific timelines to ensure accountability and transparency.
- The Plan is not fully complete, so it is not yet possible to observe the embedding of the outcomes.

Maternity Services Improvement Plan (reasonable assurance)

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

The Welsh Government's reporting tool from May 2022 had been largely completed, with outstanding actions now included in the Improving Together for Wales Maternity Neonatal Discovery Phase Report 2023.

The Maternity Neonatal Phase report outlined 124 areas of improvement across maternity, neonatal and perinatal services in Wales, prioritising actions that require minimal resource and are easily implemented as part of a systematic approach to ensure patient safety. Good progress was being made to address the actions.

The outstanding actions from the reporting tool have been assessed within this review, along with a sample of other actions from the Maternity Neonatal Phase Report to ensure there is a comprehensive approach to tracking and monitoring of implementation. The key matter requiring management attention was:

- Given the timescale since the July 2023 publication of the Improving Together for Wales Maternity Neonatal Discovery Phase Report, it is prudent to review the current monitoring arrangements, especially for short-term actions, to enable more detailed progress tracking.

Staff Culture (reasonable assurance)

The audit reviewed the actions underway to influence change following on from the Employee Experience Survey (internal staff survey) results.

We found a lack of a centralised action plan and inconsistent implementation across directorates. Promising initiatives need broader adoption and robust monitoring to drive lasting improvements. The survey findings provide valuable insights into key areas requiring improvement, for example staff workload pressures, ensuring fairness, and staff retention. Whilst directorate leads value the survey results feedback provided to them; the absence of a coordinated action plan presents a risk to achieving sustained improvement. The Health Board may consider developing a formalised framework to ensure consistent monitoring and accountability for addressing identified concerns.

The Grange Accident and Emergency Expansion (reasonable assurance)

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

At the time of audit fieldwork the project was forecast to be delivered marginally outside of the original cost parameters i.e. 0.13% but was not considered material at this stage.

Whilst a delay to the original delivery date was being reported, contractual implications remained under assessment. While the forecast delay inevitably impacts on the delivery of the project's originally intended targets/benefits, the longer-term benefits of the improved facility will not be adversely impacted.

There were several matters requiring management attention including the need to:

- enhance the role / remit of the Project Board and associated reporting;
- apply improved contract mechanisms i.e. Parent Company Guarantees and Collateral Warranties;
- obtain a project programme matching site activity from the contractor (i.e. no programme was provided in the first five months on site);
- obtain Welsh Government approval for 2025/26 project funding recognising the slippage in the delivery programme; and
- profile key matters to the Project Board within performance reporting e.g. the delayed programme provision.

4. Audits for Deferral

At the last Committee, we highlighted that the funding arrangements are still to be confirmed by the Welsh Government for the Welsh Intensive Care Information System. This has still not been confirmed and as such, we are unable to proceed with the audit at this stage. In addition, we have the following updates to highlight, including:

1. The Capital Systems audit (which are audit days assigned to lower value capital projects) will commence in line with the decontamination unit project, but this will be during Q1 of 2025/26.
2. The joint audit with Velindre, as part of the Integrated Audit and Assurance Plan (separately funded capital audit work) on the Nevill Hall Regional Satellite Centre will commence in Q1 of 2025/26, due to the timing of project progress.
3. The Electronic Document and Records Management Solution (EDRMS) audit has temporarily been paused due to the availability of IT Audit and Assurance staff and will be resumed over the coming weeks. Whilst significantly progressed already, the pause will likely delay the reporting timeline, but will still be taken into account within the Head of Internal Audit Opinion.

Overall, we are seeking **approval** for the deferral of the Welsh Intensive Care Information System audit; the deferral of the Capital Systems audit into Q1 of 2025/26; and to **note** that the Nevill Hall Regional Satellite Centre will commence shortly, but conclude during 2025/26, with the Electronic Document and Records Management Solution audit temporarily paused due to resource availability, but will still be considered as part of the 2024/25 Head of Internal Audit Opinion.

5. 2025/26 Draft Internal Audit Plan

The 2025/26 Draft Internal Audit Plan (the 'Plan') has been produced and is reported to the April Committee meeting for review, discussion and approval. The process for the development of the Plan is the same as for previous years.

The draft Plan reflects the general risk profile of the organisation, as shown in the risk register and rotational coverage of key areas. The Plan may require revision, both in terms of coverage and timing when it is appropriate to do so. If required, this will be done through the established governance and approval processes.

6. Other Activity

The following meetings have been held/attended during the reporting period:

- monthly meetings with the Director of Corporate Governance;
- monthly meetings with the Director of Finance, Procurement and Value;
- Audit, Risk and Assurance Committee pre-meeting with the Audit, Risk and Assurance Committee Chair;
- review and advice over financial control procedures and workforce procedures; and
- liaison with senior management.

7. Recommendation

The Audit, Risk and Assurance Committee is invited to **note** the above points within the report and **approve** the deferral of Welsh Intensive Care Information System and Capital Systems audits and to **approve** the draft 2025/26 Internal Audit Plan.

Appendix A: Progress against 2024/25 Internal Audit Plan

Audits	Status
Financial Sustainability	Work in Progress
IMTP – Service Delivery Plans (merged with Intelligence Led Organisation)	Final Report
Contract Management	Draft Report
Facilities Stock	Final Report
Performance Framework	Work in Progress
Embedding of Policies	Final Report
Declarations of Interest	Final Report
Divisional Governance Arrangements	Final Report
Directorate Review - Mental Health and Learning Disabilities	Final Report
Maternity Services Improvement Plan	Final Report
End of Life Care	Final Report
Health and Safety (comprising of two parts)	Part One: Complete Part Two: Work in Progress
Waiting List Management	Work in Progress
Partnership Arrangements	Deferred
Health Board Managed Practices	Draft Report
Medical Equipment and Devices	Work in Progress
Records Management	Final Report
Job Planning	Draft Report
Staff Culture	Final Report
Medical E-Rostering	Work in Progress
Providing Care to Asylum Seekers and Refugees	Final Report
Follow-up of High Priority Recommendations	Work in Progress
Welsh Intensive Care Information System	Not started (deferral)
Analytics and Information Use (Intelligence Led Organisation)	Final Report (merged)
Technical Continuity	Work in Progress
Electronic document and records management solution	Work in Progress
Capital Systems/Major Project Provisions (not separately provided)	Not started (deferred)
Nevill Hall RAAC	Final Report
Estates Assurance – Energy Management	Final Report
Newport East HWBC	Final Report
NHH Regional Satellite Centre	Planning (2025/26)
The Grange A&E Expansion	Final Report

Appendix B: Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

 **Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
 **Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
 **Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
 **No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
 **Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Internal Audit Plan 2025/26

Aneurin Bevan University Health Board

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GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

1. Introduction

This document sets out the Internal Audit Plan for 2025/26 (the 'Plan') detailing the audits to be undertaken and information of the corresponding resources. It also contains the Internal Audit Mandate and Charter which defines the over-arching purpose, authority and responsibility of Internal Audit and the Key Performance Indicators for the service.

The Accountable Officer (the Chief Executive) is required to certify, in the Annual Governance Statement, that they have reviewed the effectiveness of the organisation's governance arrangements, including the internal control systems, and provide confirmation that these arrangements have been effective, with any qualifications as necessary including required developments and improvement to address any issues identified.

The purpose of Internal Audit is to provide the Accountable Officer and the Board, through the Audit, Risk and Assurance Committee, with an independent and objective annual opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control. The opinion should be used to inform the Annual Governance Statement.

Additionally, the key findings and agreed actions from internal audit reviews may be used by Aneurin Bevan University Health Board's (ABUHB) management to improve governance, risk management, and control within their operational areas.

In January 2025 new Global Internal Audit Standards (the 'Standards') became effective and apply to UK public sector audits from 1 April 2025 to align with the financial year. These new standards replace the previous guidance: the Public Sector Internal Audit Standards. The new Standards are accompanied by a UK public sector application note (the 'Application Note'), which provides public sector interpretations and additional requirements for the Standards The new Standards require that a risk based internal audit plan is created that supports the achievement of the organisation's objectives.

Accordingly, this document sets out the risk-based approach and the Plan for 2025/26. The Plan will be delivered in accordance with the Internal Audit Mandate and Charter and the agreed KPIs, which are monitored and reported to you. All internal audit activity will be provided by Audit & Assurance Services, a part of NHS Wales Shared Services Partnership (NWSSP).

1.1 National Assurance Audits

The proposed Plan includes assurance audits on some services that are provided by other organisations on behalf of NHS Wales. These are: Digital Health and Care Wales (DHCW); NHS Wales Shared Services Partnership (NWSSP); and the NHS Wales Joint Commissioning Committee (JCC), which replaced EASC and WHSSC from April 2024. These audits will be included in Appendix A when agreed formally. These audits are part of the risk-based programme of work for DHCW, NWSSP and Cwm Taf Morgannwg UHB (for the JCC), but the results, as in previous years, are reported to the relevant health organisations and are used to inform the overall annual Internal Audit opinion for those organisations.

2. Developing the Internal Audit Plan

2.1 Link to the Global Internal Audit Standards

The Plan has been developed in accordance with Principle 9: Plan Strategically, which includes Standard 9.4 – Internal Audit Plan, of the Standards, and the accompanying Application Note, which provides public sector interpretations and additional requirements for the Standards, to enable the Head of Internal Audit to meet the following key objectives:

- the need to establish risk-based plans to determine the priorities of the internal audit activity, consistent with the organisation's goals.
- provision to the Accountable Officer of an overall independent and objective annual opinion on the organisation's governance, risk management, and control, which will in turn support the preparation of the Annual Governance Statement;
- audits of the organisation's governance, risk management, and control arrangements which afford suitable priority to the organisation's objectives and risks.
- improvement of the organisation's governance, risk management, and control arrangements by providing line management with recommendations arising from audit work.
- confirmation of the audit resources required to deliver the Internal Audit Plan.
- effective co-operation with Audit Wales as external auditor and other review bodies functioning in the organisation; and
- provision of both assurance (opinion based) and consulting engagements by Internal Audit.

2.2 Risk based internal audit planning approach

Our risk-based planning approach recognises the need for the prioritisation of audit coverage to provide assurance on the management of key areas of risk, and our approach addresses this by considering:

- the organisation's risk assessment and maturity;
- the organisation's response to key areas of governance, risk management and control;
- the previous years' internal audit activities; and
- the audit resources required to provide a balanced and comprehensive view.

Our planning considers the NHS Wales Planning Framework and other NHS Wales priorities and is mindful of significant national changes that are taking place. In addition, the Plan aims to reflect the significant local changes occurring as identified through the Integrated Medium-Term Plan (IMTP) and other changes within the organisation, assurance needs, identified concerns from our discussions with management, and emerging risks.

We will ensure that the plan remains fit for purpose by recommending changes where appropriate and reacting to any emerging

issues throughout the year. Any necessary updates will be reported to the Audit, Risk and Assurance Committee in line with the Internal Audit Mandate and Charter.

While some areas of governance, risk management and control will require annual consideration, our risk-based planning approach recognises that it is not possible to audit every area of an organisation's activities every year. Therefore, our approach identifies auditable areas (the 'audit universe'). The risk associated with each auditable area is assessed and this determines the appropriate frequency for review.

In addition, we will, if requested, also agree a programme of work through both the Director of Corporate Governance (Board Secretary) and Directors of Finance networks. These audits and reviews may be undertaken across all NHS bodies or a particular sub-set, for example at Health Boards only.

Therefore, our Plan is made up of several key components:

1) Consideration of key governance and risk areas: We have identified several areas where an annual consideration supports the most efficient and effective delivery of an annual opinion. These cover the Governance, the Board Assurance Framework, Risk Management, Clinical Governance and Quality, Financial Sustainability, Performance Monitoring & Management, and an overall assessment of Digital and Information Technology. In each case we anticipate a short overview to establish the arrangements in place including any changes from the previous year with detailed testing or further work where required.
2) Organisation based audit work – this covers key risks and priorities from the Board Assurance Framework and the Strategic Risk Register, together with other auditable areas identified and prioritised through our planning approach. This work combines elements of governance and risk management with the controls and processes put in place by management to effectively manage the areas under review.
3) Follow up - this is follow-up work on previous 'limited' and 'unsatisfactory' assurance reports as well as other medium and high priority recommendations. Our work here also links to the organisation's recommendation tracker and considers the impact of their implementation on the systems of governance and control.
4) Work agreed with the Directors of Corporate Governance, Directors of Finance, other executive peer groups, or Audit Committee Chairs in response to common risks faced by several organisations. This may be advisory work to identify areas of best practice or shared learning.
5) The impact of audits undertaken at other NHS Wales bodies that may impact on HEIW, namely NHS Wales Shared Services Partnership (NWSSP), Digital Health and Care Wales (DHCW), and the Joint Commissioning Committee (JCC).
6) Where appropriate, Integrated Audit & Assurance Plans will be agreed for major capital and transformation schemes and charged for separately. Health bodies are able to add a provision for audit and assurance costs into the final business case for major capital bids.

These components are designed to ensure that our internal audit programmes comply with all of the requirements of the

Standards, supports the maximisation of the benefits of being an all-NHS Wales wide internal audit service, and allows us to respond in an agile way to requests for audit input at both an all-Wales and organisational level.

2.3 Link to Aneurin Bevan University Health Board systems of assurance

The risk based internal audit planning approach integrates with the Health Board's systems of assurance; therefore, we have considered the following:

- A review of ABUHB's vision, values and forward priorities as outlined in the Integrated Medium Term Plan (IMTP).
- An assessment of ABUHB's governance and assurance arrangements and the contents of the strategic risk register.
- Risks identified in papers to the Board and its Committees (in particular the Audit, Risk and Assurance Committee).
- Key strategic risks identified within the strategic risk register and assurance processes.
- Discussions with Executive Directors regarding risks and assurance needs in areas of corporate responsibility, including compliance and ethics programmes.
- Cumulative internal audit knowledge of governance, risk management, and control arrangements (including a consideration of past internal audit opinions).
- New developments and service changes.
- Legislative requirements to which the organisation is required to comply.
- Planned audit coverage of systems and processes provided through NWSSP, DHCW, and the JCC.
- Work undertaken by other supporting functions of the Audit and Assurance Committee including Local Counter-Fraud Services (LCFS) and the Post-Payment Verification Team (PPV), where appropriate.
- Work undertaken by other review bodies, including Audit Wales.
- Coverage necessary to provide assurance to the Accountable Officer in support of the Annual Governance Statement.

2.4 Audit planning meetings

In developing the Plan, in addition to consideration of the above, the Head of Internal Audit has met and spoken with the executive team and independent members to discuss current areas of risk and related assurance needs.

3. Audit risk assessment

The prioritisation of audit coverage across the audit universe is based on both our and the organisation's assessment of risk and assurance requirements as defined in the Board Assurance Framework and strategic risk register.

The maturity of these risk and assurance systems allows us to consider both inherent risk (impact and likelihood) and mitigation (adequacy and effectiveness of internal controls). Our assessment also considers strategic risk, materiality or significance, system complexity, previous audit findings, and potential for fraud.

4. Planned internal audit coverage

4.1 Internal Audit Plan 2025/26

The Plan is set out in Appendix A and identifies the audit assignments, lead executive officers, outline scopes, and proposed timings. It is structured under the six components referred to in section 2.2.

Where appropriate the Plan refers to key strategic risks identified within the strategic risk register and related systems of assurance, together with the proposed audit response within the outline scope.

When developing the audit scope, in discussion with the responsible executive director(s) and operational management, the scope, objectives and audit resource requirements, and timing will be refined in each area.

The scheduling takes account of the optimum timing for the performance of specific assignments in discussion with management, and Audit Wales requirements if appropriate.

The Audit, Risk and Assurance Committee will be kept appraised of performance in delivery of the Plan, and any required changes, through routine progress reports to each Audit, Risk and Assurance Committee meeting.

Most of the audit work will be undertaken by our regionally based teams with support from our national capital and estates team, in terms of capital audit and estates assurance work, and from our IM&T team, in terms of information governance, IT security and digital work.

4.2 Keeping the plan under review

Our risk assessment and resulting Plan is limited to matters emerging from the planning processes indicated above.

Audit & Assurance Services is committed to ensuring its service focuses on priority risk areas, business critical systems, and the provision of assurance to management across the medium term and in the operational year ahead. As in any given year, our Plan will be kept under review and may be subject to change to ensure it remains fit for purpose. To this end, the need for flexibility and a revisit of the focus and timing of the proposed work will be necessary at some point during the year.

Consistent with previous years, and in accordance with best professional practice, an unallocated contingency provision has been retained in the Plan to enable Internal Audit to respond to emerging risks and priorities identified by the executive team

and endorsed by the Audit, Risk and Assurance Committee. Any changes to the Plan will be based upon consideration of risk and need and will be presented to the Audit, Risk and Assurance Committee for approval.

Regular liaison with Audit Wales, as your External Auditor, will take place to coordinate planned coverage and ensure optimum benefit is derived from the total audit resource.

5. Resource needs assessment

The Plan has been put together based on the planning process described in this document. The Plan includes sufficient audit work to be able to give an annual Head of Internal Audit opinion in line with the requirements of Standard 11.3 – Communicating Results, and Application Note 10B – Overall conclusions and annual reporting.

Audit & Assurance Services confirms that it has the necessary human, financial and technological resources to deliver the agreed plan.

Provision has also been made for other essential audit work including planning, management, reporting and follow-up.

If additional work, support or further input necessary to deliver the plan is required during the year over and above the total indicative resource requirement a fee may be charged. Any change to the plan will be based upon consideration of risk and need and presented to the Audit, Risk and Assurance Committee for approval.

The Standards enable Internal Audit to provide consulting services to management. The commissioning of these additional services by ABUHB, unless already included in the plan, is discretionary. Accordingly, a separate fee may need to be agreed for any additional work.

In addition, any capital audit work in relation to specific projects will be charged for separately on the basis of a separately agreed Integrated Audit & Assurance Plan. Where this is the case, a provision for this work would have been included by ABUHB in its business case submission.

6. Action required

The Audit and Assurance Committee is invited to consider the Internal Audit Plan for 2025/26 and:

- approve the Internal Audit Plan for 2025/26;
- approve the Internal Audit Mandate and Charter; and
- note the associated Internal Audit resource requirements and Key Performance Indicators.

Stephen Chaney
Head of Internal Audit
NHS Wales Shared Services Partnership

Appendix A: Internal Audit Plan 2025/26

Planned output, Outline scope, Review reference	Strategic Priority (SP)/BAF Risk / [Strategic Risk Register (SRR)] / Rationale	Executive Lead/Responsible Director	Planned start
1. Divisional Budgetary Control (Assurance) To ensure the Budgetary Control FCP is adhered to at a sample of divisions, with the overall objective of determining if financial sustainability is being maintained.	SRR 001 (financial sustainability)	Director of Finance / Chief Operating Officer	Q3
2. Standing Orders Compliance (Assurance) To assess adherence to the model Standing Orders (Reservation and Delegation of Powers) and Standing Financial Instructions, as determined by the Welsh Government.	SRR 001 (financial sustainability)	Director of Corporate Governance / Director of Finance	Q1
3. Strategic Risk and Assurance (Assurance) To determine and evaluate whether the Health Board's governance and strategic oversight of risk and assurance are effective, aligned with organisational goals, and support long-term objectives.	Rotational audit	Director of Corporate Governance	Q4
4. Subject Access Requests (Assurance) To ensure the Health Board is complying with legal and regulatory obligations with effective processes and whether the system for managing subject access requests (SARs) is robust, secure, and efficient.	SRR 006 (service delivery)	Director of Digital	Q1
5. Benefits Realisation (excluding digital) (Assurance) To ensure appropriate processes are embedded for the management and achievement of anticipated benefits arising from change management within the Health Board.	SRR 001 (service delivery)	Director of Strategy, Planning and Partnerships / Chief Operating Officer / Director of Finance	Q3

Planned output, Outline scope, Review reference	Strategic Priority (SP)/BAF Risk / [Strategic Risk Register (SRR)] / Rationale	Executive Lead/Responsible Director	Planned start
6. Business Continuity Plan (Assurance) Evaluate the effectiveness and comprehensiveness of the organisation's business continuity planning, focusing on risk assessment, preparedness, response strategies, and recovery procedures to ensure minimal service disruption during unforeseen events (e.g. loss of suppliers).	SRR 004 (compliance and safety)	Director of Strategy, Planning and Partnerships	Q2
7. Capital Projects: Service Readiness (Assurance) Evaluate the preparedness of services for operational deployment in capital projects, focusing on compliance with project timelines, resource allocation and risk management processes, to ensure a timely commencement of the new / revised operations.	SRR 005 (service delivery)	Director of Strategy, Planning and Partnerships / Chief Operating Officer	Q2
8. Falls Management (Assurance) To provide assurance that the Falls Policy for hospital adult inpatients was being adhered to by staff and monitored appropriately.	SRR 001 (compliance and safety) SRR 005 (service delivery)	Director of Allied Health Professionals and Health Science	Q2
9. Directorate Review – CAMHS (Assurance) To ensure that appropriate arrangements are in place for the management of risk and performance within the CAMHS directorate.	SRR 005 (service delivery) SRR 008 (transformation and partnership working)	Chief Operating Officer	Q3
10. Professional Staff Registration (Assurance) To ensure appropriate arrangements are in place to demonstrate that all staff (medical, clinical, nursing and other groups) requiring professional registration are appropriately registered throughout their employment.	SRR 001	Medical Director / Director of Nursing / Director of Allied Health Professionals and Health Science / Director of Workforce and OD	Q2

Planned output, Outline scope, Review reference	Strategic Priority (SP)/BAF Risk / [Strategic Risk Register (SRR)] / Rationale	Executive Lead/Responsible Director	Planned start
11. Clinical Audit (Assurance) To provide an opinion over whether there are effective processes in place to manage local and national clinical audit plans.	SRR 001	Medical Director	Q4
12. Directorate Review – Opthamology / ENT (Assurance) To determine if the Opthamology and ENT service areas have effective processes embedded for the management of resources, service delivery and budgetary responsibilities.	SRR 005 (service delivery)	Chief Operating Officer	Q2
13. Public Health (Advisory) To determine if the Health Board has effective controls in place to ensure that public health objectives are being met at a local level, in support of the IMTP and the requirements of the Well-being of Future Generations (Wales) Act 2015, whilst recognising the responsibilities of Public Health Wales.	SRR 007 (transformation and partnership working)	Director of Public Health	Q1
14. Six Goals Programme (Assurance) To ensure that the Six Goals Programme links appropriately to other plans and processes for a congruent delivery of strategy and actions, with a focus on primary and community care goals.	SRR 001 (service delivery; and transformation and partnership working)	Director of Nursing	Q3
15. Discharge Planning (Assurance) To provide an opinion over the discharge planning process of the Health Board, with a focus on the management and delivery of planned discharges. This audit will consider the recommendations raised within the 2022/23 internal audit of Discharge Planning.	SRR 001 (financial sustainability) SRR 005 (service delivery)	Director of Nursing	Q2
16. Safeguarding (Assurance) To ensure key policies and procedures are embedded and adhere to safeguarding regulations.	SRR 001 (compliance and safety) SRR 005 (service delivery)	Director of Nursing	Q1

Planned output, Outline scope, Review reference	Strategic Priority (SP)/BAF Risk / [Strategic Risk Register (SRR)] / Rationale	Executive Lead/Responsible Director	Planned start
17. Cancer Referral Rates (Assurance) To determine if the referral and application processes within the Health Board are consistent with the rest of NHS Wales.	SRR 005 (service delivery)	Chief Operating Officer	Q4
18. Occupational Health (Assurance) To provide assurance over the arrangements and controls in place for the management of the occupational health service.	SRR 001 (service delivery)	Director of Workforce and OD	Q4
19. Overseas Recruitment (Assurance) To ensure the Health Board is adhering to and updating visa requirements within sufficient timeframes for overseas staff.	SRR 001 (service delivery; and financial sustainability)	Director of Workforce and OD	Q4
20. Speaking up Safely (Assurance) To ensure the newly implemented Speaking Up Safely fully incorporates the principles of the All-Wales Speaking Up Safely Framework issued by the Welsh Government.	Based on a limited assurance internal audit report issued during 2024/25	Director of Workforce and OD	Q1/2
21. Follow-up of High Priority Recommendations To assess whether high priority internal audit recommendations have been implemented.	Annual review of audit recommendation implementation as set out within the Global Internal Audit Standards	Director of Corporate Governance	Q4
22. Cyber Security (including cyber incident response) (Assurance) To assess the governance process for cyber security, associated risk statements and the management and delivery of improvement plans.	SRR 006 (service delivery)	Director of Digital	Q1

Planned output, Outline scope, Review reference	Strategic Priority (SP)/BAF Risk / [Strategic Risk Register (SRR)] / Rationale	Executive Lead/Responsible Director	Planned start
23. Shadow IT (Assurance) To ensure that appropriate processes are in place to assess the presence and impact of unauthorised IT systems and applications within the Health Board, including identifying security vulnerabilities, compliance issues and potential risks to data integrity.	SRR 006 (service delivery)	Director of Digital	Q2
24. RGH Central Decontamination Unit (Assurance) The UHB has been successful in obtaining capital funding of £4.714m for the development of a Centralised Decontamination Unit at Royal Gwent Hospital (RGH) to address the current inadequate and non-compliant facilities. The audit will examine the delivery of the project against the key project parameters inc. time, cost and quality. This will be the only audit of the project.	SSR001, SSR002 SSR010 JAG, WHTM compliant	Director of Strategy, Planning and Partnerships	Q2/3
25. Estates Assurance - Space Utilisation (Assurance) To assess the systems and controls in place within the UHB to measure the efficiency and effectiveness of space utilisation across the UHB's facilities ensuring the optimal use of available space and identifying opportunities for improvement.	SSR001, SSR002 SSR010 Compliance with H&S requirements	Chief Operating Officer	Q2
Audit management, reporting, Audit Committee attendance, development of Integrated Audit Plans, attendance at associated project/programme boards meetings and associated UHB Committees etc.			

The above will be supplemented by (currently) one additional project audit during 2025/26 agreed through the respective FBC/OBC funding provisions i.e. The Grange Emergency Department.

Appendix B: Key performance indicators (KPI)

KPI	SLA required	Target 2025/26
Audit plan 2025/26 agreed/in draft by 30 April	⚑	To deliver plan
Audit opinion 2024/25 delivered by 31 May	⚑	To deliver opinion
Audits reported versus total planned audits, and in line with Audit Committee expectations	⚑	varies
% of audit outputs in progress	No	varies
Report turnaround fieldwork to draft reporting [10 working days]	⚑	95%
Report turnaround management response to draft report [15 working days maximum]	⚑	80%
Report turnaround draft response to final reporting [10 working days]	⚑	95%

Appendix C: Internal Audit Mandate and Charter

1 Introduction

1.1 This Mandate and Charter is produced and updated annually to comply with the Global Internal Audit Standards (introduced from 1 April 2025 for the UK Public Sector). The Standards (with specific reference to Standard 6.1 Internal Audit Mandate and 6.2 Internal Audit Charter) require the production and maintaining of an Internal Audit Mandate and Charter that, at a minimum, sets out:

- The purpose of Internal Auditing;
- a commitment to adhere to the Global Internal Audit Standards;
- the Mandate, including the scope and types of services to be provided, and the Board's responsibilities and expectations regarding management's support of the internal audit function; and
- the organisational position and reporting relationships, including Independence.

The Mandate and Charter are complementary to the relevant provisions included in the organisation's own Standing Orders and Standing Financial Instructions.

1.2 The terms 'board' and 'senior management' are required to be defined under the Standards and therefore have the following meaning in this Mandate and Charter:

- Board means the Board of Aneurin Bevan University Health Board with responsibility to direct and oversee the activities and management of the organisation. The Board has delegated authority to the Audit Committee in terms of providing a reporting interface with internal audit activity; and
- Senior Management means the Chief Executive as being the designated Accountable Officer for Aneurin Bevan University Health Board. The Chief Executive has made arrangements within this Mandate and Charter for an operational interface with internal audit activity through the Director of Corporate Governance (Board Secretary).

1.3 Internal Audit seeks to comply with all the appropriate requirements of the Welsh Language (Wales) Measure 2011. We are happy to correspond in both Welsh and English.

2 Purpose and responsibility

2.1 Internal audit is an independent, objective assurance and advisory function designed to add value and improve the operations of the Health Board. Internal audit helps the organisation accomplish its objectives by bringing a systematic and disciplined approach to evaluate and improve the effectiveness of governance, risk management and control processes. Its mission is to enhance and protect organisational value by providing risk-based and objective assurance, advice and insight.

2.2 Internal Audit is responsible for providing an independent and objective assurance opinion to the Accountable Officer, the Board and the Audit Committee on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. In addition, internal audit's findings and recommendations are beneficial to management in securing improvement in the audited areas.

2.3 The organisation's risk management, internal control and governance arrangements comprise:

- the policies, procedures and operations established by the organisation to ensure the achievement of objectives.
- the appropriate assessment and management of risk, and the related system of assurance.
- the arrangements to monitor performance and secure value for money in the use of resources.
- the reliability of internal and external reporting and accountability processes and the safeguarding of assets.
- compliance with applicable laws and regulations; and
- compliance with the behavioural and ethical standards set out for the organisation.

2.4 Internal audit also provides an independent and objective consulting service specifically to help management improve the organisations risk management, control and governance arrangements. The service applies the professional skills of internal audit through a systematic and disciplined evaluation of the policies, procedures and operations that management have put in place to ensure the achievement of the organisations objectives, and through recommendations for improvement. Such consulting work contributes to the opinion which internal audit provides on risk management control and governance.

3 Independence and Objectivity

3.1 Independence is described in the Global Internal Audit Standards as the freedom from conditions that threaten the ability of the internal audit activity to carry out internal audit responsibilities in an unbiased manner. To achieve the degree of independence necessary to effectively carry out the responsibilities of the internal audit activity, the Head of Internal Audit will have direct and unrestricted access to the Board and Senior Management, in particular the Chair of the Audit Committee and Accountable Officer.

3.2 Organisational independence is effectively achieved when the auditor reports functionally to the Audit Committee on behalf of the Board. Such functional reporting includes the Audit Committee:

- approving the internal audit mandate and charter.
- approving the risk based internal audit plan.
- approving the internal audit resource plan.
- receiving outcomes of all internal audit work together with the assurance rating. and

- reporting on internal audit activity's performance relative to its plan.

3.3 While maintaining effective liaison and communication with the organisation, as provided in this Mandate and Charter, all internal audit activities shall remain free of untoward influence by any element in the organisation, including matters of audit selection, scope, procedures, frequency, timing, or report content to permit maintenance of an independent and objective attitude necessary in rendering reports.

3.4 Internal Auditors shall have no executive or direct operational responsibility or authority over any of the activities they review. Accordingly, they shall not develop nor install systems or procedures, prepare records, or engage in any other activity which would normally be audited.

3.5 This Mandate and Charter makes appropriate arrangements to secure the objectivity and independence of internal audit as required under the standards. In addition, the shared service model of provision in NHS Wales through NWSSP provides further organisational independence.

3.6 In terms of avoiding conflicts of interest in relation to non-audit activities, Audit & Assurance has produced a Consulting Protocol that includes all of the steps to be undertaken to ensure compliance with the relevant Standards that apply to non-audit activities.

4 Authority and Accountability

4.1 Internal Audit derives its authority from the Board, the Accountable Officer and Audit Committee. These authorities are established in Standing Orders and Standing Financial Instructions adopted by the Board.

4.2 The Minister for Health and Social Services has determined that internal audit will be provided to all health organisations by the NHS Wales Shared Services Partnership (NWSSP). The service provision will be in accordance with the Service Level Agreement agreed by the Shared Services Partnership Committee and in which the organisation has permanent membership.

4.3 The Director of Audit & Assurance leads the NWSSP Audit and Assurance Services and after due consultation will assign a named Head of Internal Audit to the organisation. For line management (e.g. individual performance) and professional quality purposes (e.g. compliance with the Global Internal Audit Standards), the Head of Internal Audit reports to the Director of Audit & Assurance.

4.4 The Head of Internal Audit reports on a functional basis to the Accountable Officer and to the Audit Committee on behalf of the Board. Accordingly, the Head of Internal Audit has a direct right of access to the Accountable Officer, the Chair of the Audit Committee and the Chair of the organisation if deemed necessary.

4.5 The Audit Committee approves all Internal Audit plans and may review any aspect of its work. The Audit Committee also has regular private meetings with the Head of Internal Audit.

4.6 In order to facilitate its assessment of governance within the organisation, Internal Audit is granted access to attend any

committee or sub-committee of the Board charged with aspects of governance.

5 Relationships

5.1 In terms of normal business the Accountable Officer has determined that the Director of Corporate Governance will be the nominated executive lead for internal audit. Accordingly, the Head of Internal Audit will maintain functional liaison with this officer.

5.2 In order to maximise its contribution to the Board's overall system of assurance, Internal Audit will work closely with the organisation's Director of Corporate Governance in planning its work programme.

5.3 Co-operative relationships with management enhance the ability of internal audit to achieve its objectives effectively. Audit work will be planned in conjunction with management, particularly in respect of the timing of audit work.

5.4 Internal Audit will meet regularly with the external auditor, Audit Wales, to consult on audit plans, discuss matters of mutual interest, discuss common understanding of audit techniques, method and terminology, and to seek opportunities for co-operation in the conduct of audit work. Internal Audit will make available their working files to the external auditor for them to place reliance upon the work of Internal Audit where appropriate.

5.5 The Head of Internal Audit will establish a means to gain an overview of other assurance providers' approaches and output as part of the establishment of an integrated assurance framework.

5.6 The Head of Internal Audit will take account of key systems being operated by organisation's outside of the remit of the Accountable Officer, or through a shared or joint arrangement, such as the Digital Health and Care Wales, NHS Wales Shared Services Partnership, the Joint Commissioning Committee.

5.7 Internal Audit strives to add value to the organisation's processes and help improve its systems and services. To support this Internal Audit will obtain an understanding of the organisation and its activities, encourage two-way communications between internal audit and operational staff, discuss the audit approach and seek feedback on work undertaken.

5.8 The Audit Committee may determine that another Committee of the organisation is a more appropriate forum to receive and action individual audit reports. However, the Audit Committee will remain the final reporting line for all our audit and consulting reports.

6 Standards, Ethics, and Performance

6.1 Internal Audit must comply with the Global Internal Audit Standards and the UK Public Sector Application Note in discharging its responsibilities.

6.2 Internal Audit will operate in accordance with the Service Level Agreement (updated 2024) and associated performance standards agreed with the Audit Committee and the Shared Services Partnership Committee. The Service Level Agreement includes several Key Performance Indicators, and we will agree with each Audit Committee which of these they want

reported to them and how often.

7 Scope

7.1 The scope of Internal Audit encompasses the examination and evaluation of the adequacy and effectiveness of the organisation's governance, risk management arrangements, system of internal control, and the quality of performance in carrying out assigned responsibilities to achieve the organisation's stated goals and objectives. It includes but is not limited to:

- reviewing the reliability and integrity of financial and operating information and the means used to identify measure, classify, and report such information.
- reviewing the systems established to ensure compliance with those policies, plans, procedures, laws, and regulations which could have a significant impact on operations, and reports on whether the organisation is in compliance.
- reviewing the means of safeguarding assets and, as appropriate, verifying the existence of such assets.
- reviewing and appraising the economy and efficiency with which resources are employed, this may include benchmarking and sharing of best practice.
- reviewing operations or programmes to ascertain whether results are consistent with the organisation’s objectives and goals and whether the operations or programmes are being carried out as planned.
- reviewing specific operations at the request of the Audit Committee or management, this may include areas of concern identified in the strategic risk register.
- monitoring and evaluating the effectiveness of the organisation's risk management arrangements and the overall system of assurance.
- ensuring effective co-ordination, as appropriate, with external auditors and other regulators. and
- reviewing the Annual Governance Statement prepared by senior management.

7.2 Internal Audit will devote particular attention to any aspects of the risk management, internal control and governance arrangements affected by material changes to the organisation’s risk environment.

7.3 If the Head of Internal Audit or the Audit Committee consider that the level of audit resources or the Mandate and Charter in any way limit the scope of internal audit or prejudice the ability of internal audit to deliver a service consistent with the definition of internal auditing, they will advise the Accountable Officer and Board accordingly.

8 Approach

8.1 To ensure delivery of its scope and objectives in accordance with the Mandate and Charter and Standards, Internal Audit has produced an Audit Manual (called the Quality Manual). The Quality Manual includes arrangements for planning the audit work. These audit planning arrangements are organised into a hierarchy as illustrated in Figure 1.

Figure 1: Audit planning hierarchy

NHS Wales Level	NWSSP overall audit strategy	Arrangements for provision of internal audit services across NHS Wales equirements of the Mandate & Charter
Organisation Level	Entity strategic 3-year audit plan	Entity level medium term audit plan linked to organisational objectives priorities and risk assessment
	Entity annual internal audit plan	Annual internal audit plan detailing audit engagements to be completed in year ahead leading to the overall HIA opinion
Business Unit Level	Assignment plans	Assignment plans detail the scope and objectives for each audit engagement within the annual operational plan

8.2 NWSSP Audit & Assurance Services has developed an overall audit strategy which sets out the strategic approach to the delivery of audit services to all health organisations in NHS Wales. The strategy also includes arrangements for securing assurance on the national transaction processing systems including those operated by DHCW and NWSSP on behalf of NHS Wales.

8.3 The main purpose of the Strategic 3-year Audit Plan is to enable the Head of Internal Audit to plan over the medium term on how the assurance needs of the organisation will be met as required by the Standards and facilitate:

- the provision to the Accountable Officer and the Audit Committee of an overall opinion each year on the organisation's risk management, control and governance, to support the preparation of the Annual Governance Statement.
- audit of the organisation's risk management, control and governance through periodic audit plans in a way that affords suitable priority to the organisation's objectives and risks.
- improvement of the organisation's risk management, control and governance by providing management with constructive recommendations arising from audit work.

- an assessment of audit needs in terms of those audit resources which 'are appropriate, sufficient and effectively deployed to achieve the approved plan'.
- effective co-operation with external auditors and other review bodies functioning in the organisation. and
- the allocation of resources between assurance and consulting work.

8.4 The Strategic 3-year Audit Plan will be largely based on the Board Assurance Framework where it is sufficiently mature, together with the organisation-wide risk assessment.

8.5 An Annual Internal Audit Plan will be prepared each year drawn from the Strategic 3-year Audit Plan and other information and outlining the scope and timing of audit assignments to be completed during the year ahead.

8.6 The strategic 3-year and annual internal audit plans shall be prepared to support the audit opinion to the Accountable Officer on the risk management, internal control and governance arrangements within the organisation.

8.7 The annual internal audit plan will be developed in discussion with executive management and approved by the Audit Committee on behalf of the Board.

8.8 The NWSSP Audit Strategy is expanded in the form of a Quality Manual and a Consulting Protocol which together define the audit approach applied to the provision of internal audit and consulting services.

8.9 During the planning of audit assignments, an assignment brief will be prepared for discussion with the nominated operational manager. The brief will contain the proposed scope of the review along with the relevant objectives and risks to be covered. In order to ensure the scope of the review is appropriate it will require agreement by the relevant Executive Director or their nominated lead and will also be copied to the Director of Corporate Governance.

9 Reporting

9.1 Internal Audit will report formally to the Audit Committee through the following:

- An annual report will be presented to confirm completion of the audit plan and will include the Head of Internal Audit opinion provided for the Accountable Officer that will support the Annual Governance Statement.
- The Head of Internal Audit opinion will:
  a) State the overall adequacy and effectiveness of the organisation's risk management, control and governance processes.
  b) Disclose any qualification to that opinion, together with the reasons for the qualification.
  c) Present a summary of the audit work undertaken to formulate the opinion, including reliance placed on work by other assurance bodies.
  d) Draw attention to any issues Internal Audit judge as being particularly relevant to the preparation of the Annual

Governance Statement.

e) Compare work undertaken with the work which was planned and summarise performance of the internal audit function against its performance measurement criteria. and

f) Provide a statement of conformity in terms of compliance with the Public Sector Internal Audit Standards and associated internal quality assurance arrangements.

- For each Audit Committee meeting a progress report will be presented to summarise progress against the plan. The progress report will highlight any slippage and changes in the programme. The findings arising from individual audit reviews will be reported in accordance with Audit Committee requirements; and
- The Audit Committee will be provided with copies of individual audit reports for each assignment undertaken unless the Head of Internal Audit is advised otherwise. The reports will include an action plan on any recommendations for improvement agreed with management including target dates for completion.

9.2 The process for audit reporting is summarised below:

- Following the closure of fieldwork and the resolution of any queries, Internal Audit will discuss findings with operational managers to confirm understanding and shape the reporting stage.
- Operational management will receive discussion draft reports which will include any proposed recommendations for improvement within 10 working days following the discussion of findings. A copy of the draft report will also be provided to the relevant Executive Director.
- The draft report will give an assurance opinion on the area reviewed in line with the criteria at Appendix B (unless it is a consulting review). The draft report will also indicate priority ratings for individual report findings and recommendations.
- Operational management will be required to respond to the draft report in consultation with the relevant Executive Director within 15 working days of issue, identifying actions, identifying staff with responsibility for implementation and the dates by which action will be taken.
- The Head of Internal Audit will seek to resolve any disagreement with management in the clearance of the draft report. However, where the management response is deemed inadequate, or disagreement remains then the matter will be escalated to the Director of Corporate Governance. The Head of Internal Audit may present the draft report to the Audit Committee where the management response is inadequate or where disagreement remains unresolved. The Head of Internal Audit may also escalate this directly to the Audit Committee Chair to ensure that the issues raised in the report are addressed appropriately.
- Reminder correspondence will be issued after the set response date where no management response has been received. Where no reply is received within 5 working days of the reminder, the matter will be escalated to the Director of Corporate Governance. The Head of Internal Audit may present the draft report to the Audit Committee where no

management response is forthcoming.

- Internal Audit issues a Final report to Executive Director within 10 working days of receipt of complete management response. Within this timescale Internal Audit will quality assess the responses, and if necessary, return the responses, requiring them to be strengthened.
- Responses to audit recommendations need to be SMART:
  - Specific
  - Measurable
  - Achievable
  - Relevant / Realistic
  - Timely.
- The relevant Executive Director, Director of Corporate Governance and the Chair of the Audit Committee will be copied into any correspondence.
- The final report will be copied to the Accountable Officer and Director of Corporate Governance and placed on the agenda for the next available Audit Committee.

9.3 Internal Audit will make provision to review the implementation of agreed action within the agreed timescales. However, where there are issues of particular concern provision maybe made for a follow-up review within the same financial year. Issue and clearance of follow up reports shall be as for other assignments referred to above.

9.4 Timescales are to be included in all initial scopes sent prior to commencing an audit.

10 Access and Confidentiality

10.1 Internal Audit shall have the authority to access all the organisation's information, documents, records, assets, personnel and premises that it considers necessary to fulfil its role. This shall extend to the resources of the third parties that provide services on behalf of the organisation.

10.2 All information obtained during a review will be regarded as strictly confidential to the organisation and shall not be divulged to any third party without the prior permission of the Accountable Officer. However, open access is granted to the organisation's external auditors.

10.3 Where there is a request to share information amongst the NHS bodies in Wales, for example to promote good practice and learning, then permission will be sought from the Accountable Officer before any information is shared.

11 Irregularities, Fraud & Corruption

11.1 It is the responsibility of management to maintain systems that ensure the organisation's resources are utilised in the manner and on activities intended. This includes the responsibility for the prevention and detection of fraud and other illegal acts.

11.2 Internal Audit shall not be relied upon to detect fraud or other irregularities. However, Internal Audit will give due regard to the possibility of fraud and other irregularities in work undertaken. Additionally, Internal Audit shall seek to identify weaknesses in control that could permit fraud or irregularity.

11.3 If Internal Audit discovers suspicion or evidence of fraud or irregularity, this will immediately be reported to the organisation's Local Counter Fraud Service (LCFS) in accordance with the organisation's Counter Fraud Policy & Fraud Response Plan and the agreed Internal Audit and Counter Fraud Protocol.

12 Quality Assurance

12.1 The work of internal audit is controlled at each level of operation to ensure that a continuously effective level of performance, compliant with the Global Internal Audit Standards, is being achieved.

12.2 The Director of Audit & Assurance will establish a quality assurance and improvement programme designed to give assurance through internal and external review that the work of Internal Audit is compliant with the Global Internal Audit Standards and to achieve its objectives. A commentary on compliance against the Standards will be provided in the Annual Audit Report to the Audit Committee.

12.3 The Director of Audit & Assurance will monitor the performance of the internal audit provision in terms of meeting the service performance standards set out in the NWSSP Service Level Agreement. The Head of Internal Audit will periodically report service performance to the Audit Committee through the reporting mechanisms outlined in Section 9.

13 Resolving Concerns

13.1 NWSSP Audit & Assurance was established for the collective benefit of NHS Wales and as such needs to meet the expectations of client partners. Any questions or concerns about the audit service should be raised initially with the Head of Internal Audit assigned to the organisation. In addition, any matter may be escalated to the Director of Audit & Assurance. NWSSP Audit & Assurance will seek to resolve any issues and find a way forward.

13.2 Any formal complaints will be handled in accordance with the NWSSP complaint handling procedure. Where any concerns relate to the conduct of the Director of Audit & Assurance, the NHS organisation will have access to the Managing Director of Shared Services.

14 Review of the Internal Audit Mandate and Charter

14.1 This Internal Audit Mandate and Charter shall be reviewed annually and approved by the Board, taking account of advice from the Audit Committee.

Simon Cookson
Director of Audit & Assurance
NHS Wales Shared Services Partnership
March 2025

Disclaimer

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Mandate and Charter as approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Aneurin Bevan University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given regarding the advice and information contained.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management of the Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Global Internal Audit Standards



Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023. Please note that new Global Internal Audit Standards apply from April 2025, and all future audit work will comply to these new Standards.

Embedding of Policies

Final Internal Audit Report

2024/25

Aneurin Bevan University Health Board



Limited Assurance

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Review Reference	ABU-2425-06
Fieldwork	November 2024 - February 2025
Executive Sign Off	14th April 2025
Audit Committee	April 2025
Executive Lead	Sarah Simmonds, Director of Workforce & OD
Audit Team	Stephen Chaney, Head of Internal Audit
	Eifion Jones, Deputy Head of Internal Audit
	Laura Howells, Internal Audit Manager

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

The review assessed whether the Speaking up Safely: A Framework for the NHS in Wales (the 'Framework') has been fully implemented. This audit was completed in line with the Aneurin Bevan University Health Board (the 'Health Board') 2024/25 Internal Audit Plan.

A revised process for monitoring and managing referrals / cases was rolled out from the beginning of December 2024. We have tested to ensure that the Framework requirements have been adhered to following its implementation, including as part of the previous and revised process arrangements.

Overview

We have concluded limited assurance on this area. The review focuses mostly on the Health Board's previous process to track speaking up safely concerns with a new process only coming into practice December 2024. Another speaking up safely audit will focus on the new process and is scheduled within the upcoming 2025/26 internal audit plan. The significant matters requiring management attention from this audit include:

- **Lack of resources:** The Speaking Up Safely framework has no dedicated staff or budget, relying solely on existing staff managing it alongside existing responsibilities.
- **Unclear case management:** Before December 2024, concerns were tracked across multiple HR spreadsheets without clear categorisation, leading to inconsistent handling and evidence of compliance to the speaking up safely framework was not maintained. The new system addresses these.
- **Manual system risks:** Management of speaking up safely concerns and general HR concerns rely on Excel spreadsheets which increases the risk of errors, data loss, and inefficiencies, including but not limited to lack of automation and security issues.

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

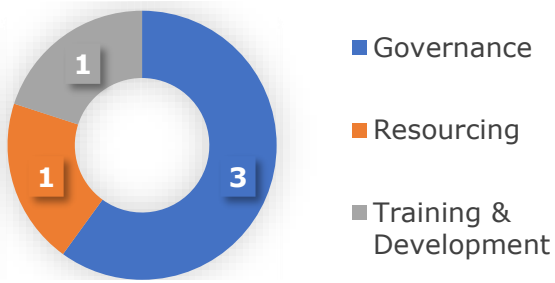
Scope & Assurance Summary

Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	Clear processes, embedding the Framework requirements, were in place and communicated to staff, including appropriate escalation routes for all types of concerns (e.g. informal) and the recent process revisions.	-	**Reasonable**
2	Appropriate resource levels were in place for current and anticipated future demand.	1	**Limited**
3	Any remaining Framework implementation progress was monitored and delivered / escalated accordingly.	2	**Reasonable**
4	All disclosures were consistently reviewed and, where appropriate, investigated in accordance with the Principles of the Framework, in a timely manner.	3	**Limited**
5	Appropriate and effective records were retained of all disclosures received by the Health Board together with any subsequent actions taken.	4, 5	**Limited**

Management Actions

3	2
High Priority	Medium Priority

Themes



Risk Types

Legal & Regulatory Non-Compliance

Speaking Up Safely: A Framework for the NHS in Wales - At a Glance

Old Process (Pre-December 2024)
Prior to December 2024, the Health Board did not have a structured approach for managing Speaking Up Safely concerns. Instead, concerns were processed under existing HR mechanisms, such as the All Wales Raising Concerns Policy or Respect and Resolution Policy, without a clear distinction between them. Concerns were recorded manually using multiple Excel spreadsheets, leading to inconsistencies, inefficiencies, and a lack of evidence to demonstrate compliance with the Speaking Up Safely framework. There were no dedicated resources, meaning staff responsible for handling concerns managed this alongside their existing roles, increasing the risk of delays and non-compliance. Additionally, there was no structured process for tracking lessons learned from raised concerns.

New Process (Post-December 2024)
A revised process was introduced in December 2024, providing a more structured, detailed and consistent approach. The new process aims to provide a more transparent, accessible, and structured way for staff to raise concerns while ensuring compliance with the NHS Wales Speaking Up Safely framework.

Key Features of the New Process:

- Dedicated Reporting Channels: Staff can now raise concerns through a specific Speaking Up Safely online form available on the Health Board's intranet, or via a dedicated email address.
- Enhanced Accessibility: Bilingual (English and Welsh) promotional materials, including posters and SharePoint pages, guide staff on how to report concerns.
- Tracking System: A designated spreadsheet has been introduced to track Speaking Up Safely cases separately from general HR cases. This ensures cases are logged, monitored, and responded to within expected timeframes.
- Escalation and Support: The process includes signposting staff to appropriate support services and clear pathways for resolution, ensuring concerns are acknowledged within seven days and feedback is provided throughout.

Future Improvements and Considerations:
While the new process is a significant improvement, concerns are still logged manually, which presents risks related to errors and inefficiencies. The Health Board would benefit from exploring a case management system to further enhance tracking and security. Since the new system had just been launched during the audit, there were no cases available for testing, but another audit is scheduled in the 2025/26 financial year to assess new process's effectiveness.

Findings & Agreed Action Plan

Objective 1: Speaking up safely process	**Reasonable**

Overview / Summary of Observations

The Speaking Up Safely framework is outlined earlier in this report.

The Health Board benefits from access to a range of established policies, including the All-Wales policies on Raising a Concern, Respect and Resolution, and the Speaking Up Safely framework. Staff have access to these policies via the Health Board's Intranet site. No additional procedures have been introduced beyond those already in place.

During the 12-month period of review, the Health Board had operated two different systems:

- Prior to December 2024 - Additional processes were not introduced to ensure strict adherence to the framework, alternatively, all concerns raised were processed as Speaking Up Safely issues and taken through the appropriate HR process such as Respect and Resolutions.
- Post December 2024 - The Health Board implemented a new process for handling speaking up safely concerns. While a structured approach had been established to ensure proper handling of concerns, no concerns had been reported during our fieldwork testing period (which we started in November 2024). The new system was able to demonstrate alignment with the framework and included signposting to appropriate support and resolution pathways.

Since the launch of the new process in December 2024, promotional materials for the new speaking up safely pathway outlined the various options available for submitting concerns, ensuring accessibility and ease of use. Staff members were able to raise concerns through a dedicated speaking up safely form on the intranet or by emailing the designated speaking up safely contact address. Additionally, the Health Board had developed several SharePoint pages to provide guidance on how to raise concerns. Bilingual posters had been created and further information on speaking up safely was available on both the English and Welsh sections of the public Health Board website.

Overall, the audit identified that the pre-December 2024 processes for speaking up safely had not been formalised, however, the recent improvements and planned initiatives demonstrate a commitment to continuous enhancement and should address the gaps of the historical processes. Therefore, we have given this area reasonable assurance.

Objective 2: Resourcing	**Limited**

Overview / Summary of Observations

There was a concern about the Health Board's ability to continue to effectively embed and uphold the framework as prescribed by Welsh Government, noting:

- The financial resourcing for the Speaking Up Safely framework is limited to Charitable Funds for a period of 12 months at a cost of £8,000 (excluding VAT) for the external reporting platform, Vivup.
- There is no dedicated resource for delivering and overseeing the framework, risking delays and inadequate responses to staff concerns. The Assistant Director of Workforce & OD and the Consultant Clinical Psychologist currently handle these responsibilities alongside their existing roles. This lack of specific leadership may hinder the framework's effectiveness due to competing priorities. Without dedicated personnel or funding, timely and structured responses to concerns are at risk.

The absence of dedicated funding and personnel within the Health Board places an increased burden on existing staff, who are expected to manage the framework alongside their core duties. Additionally, funding for promotional materials, such as posters, is reliant on the current workforce budget, rather than being specifically allocated for this purpose.

Key Findings		Risk & Impact	Agreed Management Action
1	**Resourcing** The current resourcing for the speaking up safely framework is insufficient, with no dedicated staff or budget allocation, except for the external reporting platform Vivup, which is funded for 12 months through charitable and income generation sources. Depending upon the volume of cases that are raised this may change in the future. Currently, the Assistant Director of Workforce & OD and the Consultant Clinical Psychologist serve as speaking up safely guardians but manage this role in addition to their existing responsibilities.	There is a risk that: • Failure to comply with framework. • Unsustainable reliance on current staff. • Limited long-term funding. • Reputational and compliance risks. • Inequity compared to other NHS organisations.	A review of demand for Speaking up Safely will be undertaken and the outcome of this review will inform an organisational discussion on resourcing implications. **Expected Evidence of Implementation:** Evidence of a demand and capacity review of the first 6 months with recommendations on the most suitable route forward. Outcome of review will be available September 2025
		High Priority	**Officer:** Assistant Director of Workforce & OD **Date:** 30th June 2025
	Theme: Resourcing	Control Design	

Objective 3: Framework implementation - new process	**Reasonable**

Overview / Summary of Observations

The new speaking up safely process was launched without issue, improving the previous process in place before 2 December 2024, which failed to meet all the requirements of the framework. Although the revised process appears to address these gaps, we were unable to test its effectiveness during our fieldwork testing (which we started in November 2024), as no concerns had been raised through the new system at the time of review. A fresh audit to review the new process is planned within the Health Board's 2025/26 internal audit plan.

A review of the new SharePoint pages, which were accessible to all staff, confirmed that clear guidance was provided on how to raise a concern. The new online form allowed staff to raise a concern or email the dedicated speaking up safely inbox, from where they were manually added to an Excel spreadsheet specifically created for speaking up safely concerns.

However, reliance on a manual spreadsheet introduces a high risk of errors and potential data loss, particularly as it lacks the security and functionality of a dedicated database. While the spreadsheet was password protected and was stored within a controlled area on SharePoint, with access restricted to the speaking up safely guardians, these measures did not mitigate the fundamental risks associated with manual data handling. When reviewing the previous process, it was noted that HR cases were also being tracked using Excel spreadsheets raising the same risks as noted above (see objective 4 for more information).

The spreadsheet incorporated key requirements from the speaking up safely framework, such as acknowledging concerns within seven days and providing feedback. However, without a more robust system, the Health Board remains at risk of inefficiencies, data management issues, and potential non-compliance with the framework in the future.

	Key Findings	Risk & Impact	Agreed Management Action
2	**Concern Management System** The reliance on manual Excel spreadsheets for recording speaking up safely and HR concerns presented significant risks. Unlike a dedicated database, it required manual data entry, increasing the likelihood of errors, data loss, and inefficiencies. The system lacks automation, security, and robust tracking capabilities, making long-term sustainability and compliance challenging.	There is a risk of: • Manual entry increases the risk of human error and data loss. • Limited security and risk of unauthorised access or breaches. • Inefficiency and non-compliance risks.	**Agreed Action:** It is noted that the sample contains other employee relations issues which would not be considered via Speaking up Safely Framework. This has been addressed by the new system referred to in this report with consideration of this finding. Management will review options to implement a case management system for both general HR cases and speaking up safely concerns. For Speaking up Safely concerns this may be combined with a new external reporting system which may have this built in capability such as Work in Confidence which is being widely used across Health Boards. However, it is important to note that Welsh Government are currently exploring a national solution to this for which we await the outcome.

			Expected Evidence of Implementation: Evidence of review of feasibility of implementing a case management system. This will fit in with timeline for demand and capacity review noted above.
		Medium Priority	**Officer:** Assistant Director of Workforce & OD **Date:** 30th September 2025
	Theme: Governance	Control Design	

Objective 4: Speaking up safely compliance	**Limited**

Overview / Summary of Observations

The audit reviewed the management of speaking up safely concerns over the past 12 months. The majority of the period was managed under the previous process (i.e. pre-December 2024) – recognising that the speaking up safely framework was launched in September 2023.

It was observed that rather than a structured and consistent approach, HR used multiple Excel spreadsheets to log concerns, with no clear distinction between those specifically related to speaking up safely and those processed under other mechanisms, such as Respect and Resolutions.

A sample of seven concerns was selected for testing from the 12-month period. While the client was confident that the framework had been followed, the evidence provided did not substantiate this view. Although there was documentation showing engagement with the individuals involved in each case, there was no clear evidence demonstrated that this engagement took place within the required timeframe. Furthermore, there was an absence of documentation indicating that lessons had been learned or that outcomes had been appropriately recorded and analysed.

This lack of structured oversight raises concerns about how the framework was managed in the period prior to December 2024. The reliance on multiple spreadsheets, rather than a centralised and controlled database, further compounds the risk of inefficiencies, incomplete records, and potential non-compliance with the framework's requirements.

	Key Findings	Risk & Impact	Agreed Management Action
3	**Speaking up safely framework compliance** Pre-December 2024 all concerns raised were managed through multiple HR spreadsheets under various mechanisms such as Respect and Resolution, Raising Concerns, Capability, and Disciplinary. The lack of clear categorisation meant that all concerns were treated as speaking up safely concerns, without a structured approach to differentiate and manage them per the framework. Key gaps included, but not limited to: • No documented proof of compliance with required timeframes (acknowledgment within 7 days, follow-up within 14 days, and resolution communication within 28 days). • No evidence of lessons learned being identified from concerns raised.	Lack of structured tracking risks accurate monitoring and compliance are compromised. Lack of lessons learned may allow ongoing systemic issues to continue. Failure to demonstrate compliance may leave staff feeling unheard and impact organisational trust.	**Agreed Action:** Management will ensure the new process for speaking up safely concerns fills all gaps from the old process. This may include but not limited to: **Centralised reporting** – Create a dedicated speaking up safely repository separate from HR cases, replacing spreadsheets with a case management system. **Consider collaboration with HR** – ensure regular meetings with HR to identify data triangulation and a possibility of a joint case management system. **Ensure timely responses** – monitor the timeframe for responses to concerns raised using the new system. **Expected Evidence of Implementation:** Evidence of compliance to the speaking up safely framework demonstrated through new

			speaking up safely internal audit due in 2025/26.
		High Priority	**Officer:** Assistant Director of Workforce & OD **Date:** 31st May 2025
	Theme: Governance	Control Design	

Objective 5: Speaking up safely framework records management	**Limited**

Overview / Summary of Observations

Through testing, it was confirmed that the Health Board was unable to provide assurance that its previous approach to speaking up safely (pre-December 2024) aligned with the Speaking Up Safely framework. While the new process may address gaps, its effectiveness remained untested.

The framework states, 'Managers will have training on how to deal with concerns that have been raised', however, there is a lack of sufficient training with existing modules based on NHS England resources and with minimal uptake, and no targeted training for NHS Wales. It is recognised that this is an issue for all NHS Wales organisations and is not specific to the Health Board. Following the conclusion of testing we were informed these are now on ESR.

Promotion of the speaking up safely process had also been inconsistent in the period. While information was available online, posters created had yet to be widely distributed due to lack of time and resource.

The PADR process did provide an opportunity for staff to discuss workplace challenges, including concerns related to speaking up. While it did not explicitly reference speaking up safely, supporting materials within the PADR form include resources on the speaking up safely process, ensuring staff have access to relevant guidance. This was in line with the framework.

The absence of structured reporting mechanisms raised governance concerns. No evidence existed of lessons learned being documented, and formal Executive Board reporting is not planned until December 2025, although we did confirm speaking up safely was currently presented to the People and Culture Committee. The assurance rating for this objective reflects the previous process having operated for the significant part of the audit testing period (i.e. the previous 12 months).

	Key Findings	Risk & Impact	Agreed Management Action
4	**Evidence documentation** We tested seven concerns raised over the past 12 months and the Health Board was unable to provide adequate evidence of their compliance to the speaking up safely framework. Although a new process is in place this remains untested, and action should be taken to ensure any gaps in process are rectified.	There is a risk of: • Poor documentation may lead to delayed responses and failure to meet framework timeframes. • Speaking up safely issues that remain open under the old process may not be effectively managed without being transferred to the new process.	**Agreed Action:** Management will: **Improve documentation** – Record-keeping and conduct regular audits for compliance. Transfer old concerns – management will review any open speaking up safely cases being managed under the old process and transfer them to the new process where appropriate. **Communication to Board** – Continue to present Concerns raised at the People and Culture Committee, also present at the Trade Union Partnership Forum, LNC and within the annual Workforce Director Annual Board report. **Expected Evidence of Implementation:** Evidence of review of feasibility of implementing a case management system.

			Regular agenda item at key committees.
		High Priority	**Officer:** Assistant Director of Workforce & OD **Date:** 30th June 2025
	Theme: Governance	Control Design	
5	**Training** The framework states, 'Managers will have training on how to deal with concerns that have been raised', however, there is a lack of sufficient training with existing modules based on NHS England resources and with minimal uptake, and no targeted training for NHS Wales.	There is a risk that: • Mishandled concerns: Lack of training may lead to inappropriate responses, discouraging staff from speaking up. • Non-compliance risks: Failure to follow the framework could result in breaches of required procedures and timeframes. • Loss of trust: Staff may lose confidence in the process, leading to unresolved issues and a negative workplace culture.	**Agreed Action:** Management will train staff – Provide required speaking up safely training for effective case management.
			Expected Evidence of Implementation: Evidence of completed and tracked training for speaking up safely.
		Medium Priority	**Officer:** Assistant Director of Workforce & OD **Date:** 31st August 2025
	Theme: Training & Development	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.

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 Governance Arrangements

Final Internal Audit Report

2024/25

Aneurin Bevan University Health Board



Reasonable Assurance

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Review Reference	ABUHB-2425-08
Fieldwork	November 2024 - January 2025
Executive Sign Off	April 2025
Audit Committee	April 2025
Executive Lead	Leanne Watkins, Chief Operating Officer
Audit Team	Stephen Chaney, Acting Head of Internal Audit
	Henry Wellesley, Audit Manager
	Philip Lewis-Davis, Principal Auditor

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

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

Overview

We have concluded **reasonable** assurance on this area. The matters requiring management attention include:

- Policies and/ or procedures were required to provide guidance on the process for escalating issues and key risks.
- Staff would benefit from guidance on how to assess whether a risk is key and requires escalation.
- A system should be put in place to record, monitor and track escalated risks – to ensure that feedback from Divisional Managers is recorded and, where appropriate, that actions are tracked to provide assurance to Senior Leadership Team (SLT) that issues have been addressed.

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

Scope & Assurance Summary

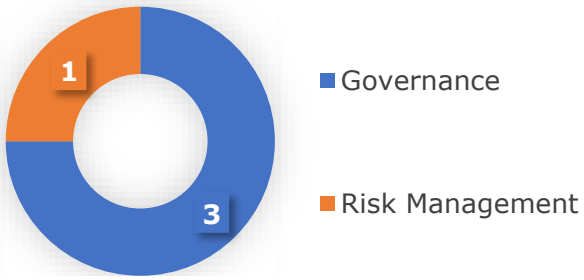
Objectives The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion		Related Findings	Assurance
1	Policies and procedures commenting on the escalation of key risks and matters by Divisional Management were current and effectively communicated.	-	**Substantial**
2	Guidance was provided on examples of key risks and matters that should be considered for escalation, and judgement required.	1,2	**Reasonable**
3	Key risks and matters considered requiring escalation by Divisional Management were recorded effectively and tracked to ensure they were reported to relevant body for consideration.	3	**Reasonable**
4	Feedback received by Divisional Management was recorded effectively, tracked and promptly acted upon, where required.	4	**Reasonable**

Management Actions

0 High Priority

4 Medium Priority

Themes



Risk Types

Quality or Safety Issues

Findings & Agreed Action Plan

Objective 1: Policies and procedures on the escalation of key risks	**Substantial**

Overview / Summary of Observations

The governance structures within Primary Care & Community (PCC) Services were designed to escalate issues from directorates to divisional structures and, if necessary, to external parties. The Strategic Leadership Team (SLT) reviewed risks and reports to the Executive via the monthly PCC Division Assurance Group meeting. PCC specific governance meetings established included:

- Finance Meetings (6-8 weekly).
- Monthly Head of Services / Head of Nursing Meetings – Action Log maintained.
- Bi-monthly Meetings of Quality and Patient Safety matters (fed by exception reports from service and location directorates).

Risk capture, assessment and reporting was based on the Health Board's Risk Management Policy and Procedures. We were advised that the lead SLT members (Divisional Director, General Manager and Deputy Head of Nursing) have an open-door approach and the feed from directorates to division governance structures was strong, thereby ensuring that key matters and risks were escalated within the PCC division promptly. We also reviewed the Health Board's Risk Management and Assurance Framework to confirm that a route is in place for the escalation of applicable risks / matters from the Division (i.e. to a corporate level).

Objective 2: Guidance on key risks and matters that should be considered for escalation.	**Reasonable**

Overview / Summary of Observations

We were unable to identify any formal guidance regarding the specific Divisional structures in place for the escalation of key risks. There also did not appear to be any specific guidance provided on what judgement to apply when assessing whether a matter should be considered a key risk and then escalated for consideration and monitoring.

We were advised that any key matters or risks were considered by both directorate teams and the senior PCC Division management, escalated if deemed necessary, however we were unable to identify any risks/matters which had been escalated. Consequently, we were also unable to easily identify items that should have been escalated but had not been.

We reviewed minutes from the September 2024 Divisional Assurance Meeting, the review of documents showed there was no indication of the relative importance of risks and whether escalation was required. There was no evidence in the report that any escalation was sought, suggesting a lack of clarity on when matters require escalation.

	Key Findings	Risk & Impact	Agreed Management Action
1	**Guidance on Key Risks** There was no specific guidance provided on the nature of key risks and matters that should be considered for escalation, and the judgement required, including how this links into the risk management escalation process, set out within the Risk Management and Assurance Framework. Staff would benefit from specific guidance/ clarity on the threshold for issues to be escalated.	Keys risks may not get escalation.	**Agreed Action:** We accept this recommendation and recognise that the absence of clear guidance on what constitutes a "key risk" and when escalation is appropriate may result in inconsistent or delayed escalation of important issues. To strengthen our risk management culture and improve consistency, the following actions will be taken: • Add a Risk management page introduced on Divisional Intranet. • Adhere to the Risk Management and Assurance Framework reference escalation routes, risk grading, and ownership responsibilities. • Communication and Awareness of the Risk Management Framework. • Risk management training. **Expected Evidence of Implementation:** **Monitoring Uptake and Impact** Use of the guidance and consistency of escalations will be reviewed through quarterly governance audits and feedback loops at SLT and divisional Programme meetings, as delegated by SLT.

		Medium Priority	**Officer: Assistant Head of Business & Performance** **Date: 27th June 2025**
	Theme: Governance	Control Operation	
2	**Key Risks May not be Escalated** Meeting notes from the SLT held on the 8th of October 2024, detailed specific operational issues with corresponding actions in progress. Notably, in the case of 'Posts for Future Care Planning,' it was indicated that PCC could not address the risks internally, but there was no reference to any escalation. We were able to further clarify that the issue was addressed outside of the meeting and addressed outside of the PCC. It is important that all risks identified for escalation are documented and given an appropriate route for escalation.	Risks are not addressed.	**Agreed Action:** We acknowledge the recommendation and agree that all risks requiring escalation must be clearly documented and followed through appropriate escalation pathways. The following actions will be implemented: **Documenting of risk escalation:** An Action/ Decision log will be introduced for SLT meeting to capture risks identified for escalation, including details of: ○ Nature of the risk. ○ Why internal resolution is not feasible. ○ Agreed escalation route. ○ Responsible person for escalation. ○ Timeline for escalation and follow-up. Strengthen the Divisional Risk escalation process through the QPS forum. **Strengthen Governance Links:** We will ensure a clear governance pathway exists between Divisional Programmes, Operational Directorates, SLT and Corporate. Once a quarter, SLT will review the Divisional and Programme Risk Registers, and ensure appropriate escalation processes are in place. **Expected Evidence of Implementation:** **Audit & Review:** A quarterly review will be conducted on SLT and PCC action logs/ meeting notes to ensure that escalations are being appropriately documented, and that risk is a standard item on Assurance/ Programme meetings to ensure locally managed/ escalated risks are being effectively managed/mitigated. A quarterly review of Divisional Risk Registers and escalation processes.

		Medium Priority	**Officer: Assistant Head of Business & Performance**
	Theme: Governance	Control Operation	**Date: 27th June 2025**

Objective 3: Key risks and matters requiring escalation are recorded and tracked	**Reasonable**

Overview / Summary of Observations

As discussed above, risks were identified at the Divisional Assurance Group meetings, and it was also established that issues were identified and brought to the attention of SLT. A sample of Divisional Assurance, SLT and Divisional Delivery Group meetings were reviewed, and this demonstrated the discussion of key risks. No examples were found of matters raised which had been escalated to SLT.

Key Findings		Risk & Impact	Agreed Management Action

3	**Recording & Tracking of Risks**
	
	Although risks were identified at the Divisional Assurance meetings and addressed at SLT meetings, we were unable to establish if key risks were identified in a manner which means they were considered for escalation beyond SLT or formally tracked to ensure they were reported to a relevant forum / body.
	
	Arrangements would be strengthened from improved monitoring/ tracking of key risks.
		Risks are not escalated or resolved.	**Agreed Action:**
			
			We accept this recommendation and recognise the importance of ensuring that key risks are not only addressed at SLT level but are also monitored, tracked, and escalated to the appropriate forums where necessary. The following action will be implemented:
			
			Introduction of an action log for the Divisional Senior Leadership team meetings, to ensure actions, items for escalation or discussion outside of the meeting are captured, including defined lead/timeframes and to provide a feedback mechanism for each action.
			
			Expected Evidence of Implementation:
			
			Meeting Notes and Agendas
			
			• SLT and Divisional Assurance meeting action/decision log:
			  ○ Clearly recording key risks discussed.
			  ○ Documenting decisions to escalate (or not) with rationale.
			• Agendas showing follow-up of previously escalated risks.
			• Access to the Corporate Risk Register showing risks escalated from SLT/divisions.
			
			Updated Risk Registers

			Divisional risk registers updated to reflect escalated risks
		Medium Priority	**Officer: Business Manager** **Date: 30th May 2025**
	Theme: Risk Management	Control Operation	

Objective 4: Feedback received by Divisional Management is recorded effectively, tracked and promptly acted upon.	**Reasonable**

Overview / Summary of Observations

As discussed above, a sample of Divisional Assurance, SLT and Divisional Delivery Group meetings were reviewed. Matters or risks had been escalated to Divisional Management and had been recorded in SLT minutes. However, tracking of issues could be further enhanced to provide assurance that issues had been addressed in a timely manner.

	Key Findings	Risk & Impact	Agreed Management Action
4	**Feedback** A formal process was not in place for the escalation, recording and tracking of key risks, to ensure that Divisional Management can be confident that key risks were escalated to them for consideration and their feedback had been fully implemented/ addressed. This should be considered alongside the development of a divisional process and the recording / tracking of risks referenced above.	Risks may not be addressed.	**Agreed Action:** We acknowledge the absence of a formal process for the escalation, recording, and tracking of key risks at divisional level, and we agree this has the potential to impact assurance and oversight by divisional management. To address this, the following actions will be taken: Creation of a SLT meeting Action/Decision Log to record: ○ All risks escalated from services or teams. ○ Divisional-level decisions and actions. ○ Whether the risk was escalated further (e.g., to SLT or corporate level). ○ Date of review, feedback loop, and closure. Strengthen the Divisional Risk escalation process through the QPS forum. **Improved Feedback Mechanism** A feedback loop will be embedded so that services that escalate risks receive formal confirmation of actions taken or rationale for non-escalation. **Governance Oversight** Risk Management processes will be reviewed quarterly and monitored by a divisional risk lead. **Expected Evidence of Implementation:** • Action/Decision logs with escalation history. • Meeting minutes/notes showing divisional review and feedback.

			• Periodic reviews or audits confirming compliance with the process.
		Medium Priority	**Officer: Business Manager/ Assistant Head of Business & Performance**
	Theme: Governance	Control Design	**Date: 27th June 2025**

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

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Mental Health & Learning Disabilities

Final Internal Audit Report

2024/25

Aneurin Bevan University Health Board



Reasonable Assurance

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Review Reference	ABUHB-2425-09
Fieldwork	October – November 2024
Executive Sign Off	March 2025
Audit Committee	April 2025
Executive Lead	Leanne Watkins, Chief Operating Officer
Head of Internal Audit	Stephen Chaney, Head of Internal Audit
	Rhian Gard, Audit Manager

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Executive Summary

Purpose

We reviewed the arrangements from the 90-day Plan (the 'Plan') for the Mental Health and Learning Disabilities division (the 'Division'), to ensure that these have been embedded.

Overview

We have concluded reasonable assurance on this area. The 90-day Plan (the 'Plan') was implemented alongside 30-day and 60-day actions as part of an Improvement Plan to address concerns raised in July 2023, following HIW inspections and other concerns relating to assurance of safety and quality of services within the Division. The Improvement Plan targeted the initial areas of concern, but helped launch wider initiatives which focused on workforce, leadership, performance and governance, to help drive continuous improvement across the Division. The Division has encountered different challenges since the Improvement Plan was put in place, one being the change in the whole triumvirate team. Whilst recently, progress has been made in implementing the actions (three of the four actions) from the Plan not all of actions have been fully implemented and subsequently, not embedded.

The significant matters requiring management attention include:

- A governance structure is in place within the Division but is still being developed. Whilst progress has been made there is a benefit in defining the governance structure more clearly.
- Progress discussion is taking place at multiple forums across operational, divisional and executive levels, however there was a lack of detailed focus and challenge when actions are not implemented on time.
- The Plan lacks specific timelines to ensure accountability and transparency.
- The Plan is not fully complete, so it is not yet possible to observe the embedding of the outcomes.

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

Scope & Assurance Summary

	Objectives	Related Findings	Assurance
1	To ensure appropriate governance and monitoring / communicating arrangements are in place to support the implementation if the 90-day plan.	1, 2	**Reasonable**
2	To determine if there is a clear accountability for actions, with defined timescales for implementation and there is clear management of them.	3	**Reasonable**
3	To ensure the outcomes of the 90-day plan are delivering the intended outcomes	4	**Reasonable**

Management Actions

0
High Priority

4
Medium Priority

Themes



Risk Types

Financial Loss

Legal & Regulatory Non-Compliance

Public Perception & Reputational Risk

Quality or Safety Issues

Findings & Agreed Action Plan

Objective 1: Governance, monitoring and communicating arrangements	**Reasonable**

Prior to the development of the Improvement / 90-day Plan (the 'Plan'), there were few governance arrangements in place. However, the interim leadership team are implementing a longer-term governance structure, with ongoing adaptations still being completed to suit the needs of the Division. The new governance arrangements were introduced in February 2024 and focus on four pillars: Assurance; Quality Patient Safety (QPS); Strategic change (the Annual Plan); and Sustainability (workforce). We found numerous meetings taking place at operational, divisional and executive levels regarding the Plan's actions. Some of the initial meetings focussed on the Plan but have now been stepped down and these have become part of business-as-usual discussions, within the operational and divisional forums.

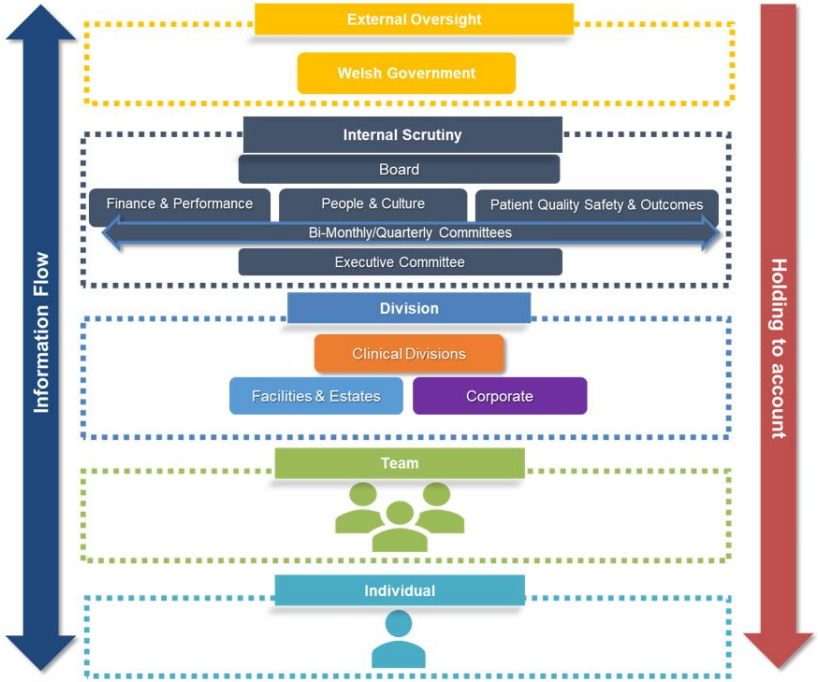
Although there is evidence of discussions and updates provided, the meetings observed and the minutes from other forums sampled, did not focus on the management of actions within these sessions. Furthermore, some of the discussions focus on steps being taken rather than defined actions being monitored until completion.

Regular executive involvement is evident, but it has not been possible to observe challenge over the progress and delivery of the Plan. We reviewed Committee and Board papers over the last 12 months and confirmed regular discussion is underway and reported to the Patient, Quality and Safety Outcomes Committee (PQSOC) and Board. However, we did not identify extensive formal discussion within the Mental Health Act Monitoring Committee. Overall, actions completed, progress underway and implementation of the Plan is discussed within formal settings, but there is no accountability against pre-determined delivery milestones. Consequently, there is a risk that actions are not implemented in a timely manner.

	Key Findings	Risk & Impact	Agreed Management Action
1	**Governance arrangements** The Division is in the process of undertaking a review of its governance structure to ensure it is fit for purpose, recognising that the existing structure is slightly complicated with many different meetings taking place. During our review, we identified discussion taking place, across multiple forums, however, there was no clearly defined pathway for the monitoring and reporting on the actions outlined in the 90-day plan.	Potential risk of: The Plan not being implemented fully.	**Agreed Action:** • Continuous reporting through daily, fortnightly, and monthly meetings, and the reinstated MH&LD Committee. • Regular reporting to the Patient, Safety, Quality, and Outcome Committee with NHS Executive Colleagues' advisory role. • Improvement plan aligns with Health Board's Quality Strategy and new accountability framework. **Expected Evidence of Implementation:** • Monitor against the Performance Management and Accountability Framework (PMF) at Divisional Assurance (DA) meetings, quarterly and mid-year reviews with the wider execs.

- Agreed workplan for the MH&LD Committee and plan for the year – starts April 2025.
- Triangulate inspection and audit data, linking it with the wider QPS team identifying any trends or areas of concerns.
- Continue monthly IQPD reporting.
- Continue reporting to JET twice yearly.
- Bespoke Board Development sessions as required.

Evidence of working to the framework below:



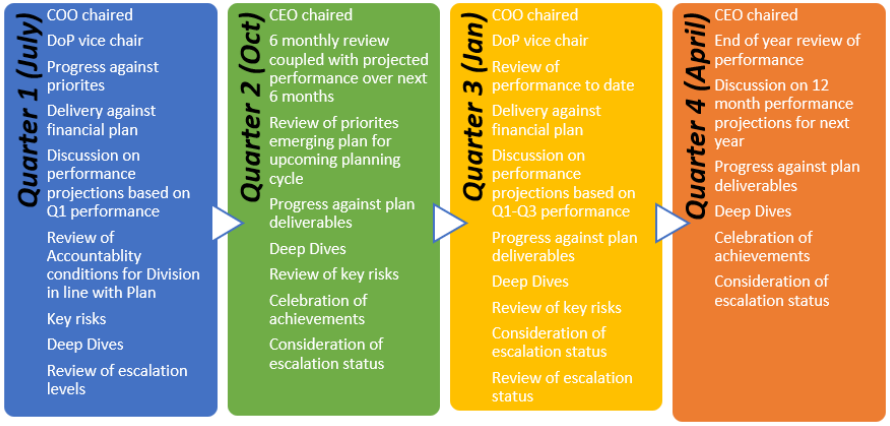
By the end of Q1, we plan to showcase our reporting through the outlined structure, including minutes, action plans, and presentations.

		Medium Priority	**Officer: Divisional Director, General Manager, Divisional Nurse (Triumvirate), Directorates** **Date: 30th June 2025**
	Theme: Governance	Control Design	

2	**Monitoring and communicating arrangements**
	Whilst discussion and updates are provided at numerous committees, in addition to the Board. However, there is no detailed specific monitoring / challenge over the delivery (or non-delivery) of actions within the Plan against agreed timeframes and the intended outcomes. In addition, where actions are not delivered on time there is no formal escalation or subsequent tracking over any remediation.
		Potential risk of:
		The Plan not being implemented fully.
			Agreed Action:
			• We will continue discussions and updates at various committees and the Board, emphasising the need for detailed monitoring and challenge over long-term actions and outcomes – using the performance and accountability framework.
			• The 90-day improvement plan has evolved into a broader, long-term improvement program, focusing on culture change and workforce development, requiring sustained effort and commitment. These measures will enhance accountability and ensure timely delivery of initiatives.
			Expected Evidence of Implementation:
			• Monthly Divisional Assurance Review Meetings.
			• Quarterly Divisional Performance Review Meetings.
			• Corporate teams – 6 monthly assurance review meetings.
			• Internal Divisional and corporate team arrangements
			  • Performance meeting including key metrics and delivery against agreed trajectories and forecast.
			  • Quality and safety which risk, clinical governance, patient experience, health & safety etc. is discussed.

- Monthly financial position review (key drivers of the financial position to be discussed in detail; this will vary by Division and Directorate).
- Monthly savings review to assure in-year plans and build a pipeline of future savings opportunities.

- Agreed workplan for the MH&LD Committee and plan for the year **– starts April 2025.**
- Triangulate inspection and audit data, linking it with the wider QPS team.
- Continue monthly IQPD reporting.
- Continue reporting to JET twice yearly.
- Bespoke Board Development sessions as required.



Specifics

- Alignment of ward standards with HB procedures is currently underway.
- Regular briefings and improved BAU escalation methods have been implemented.
- Continuous Patient Safety Incident reviews are conducted with the Executive Director of Nursing and COO, focusing on safeguarding, incident reporting, and disciplinary actions.

			• Integration of the Right Care Right Person initiative with the new police and health alliance for mental health crisis management. • All registered staff undergo training in clinical risk assessment (WARRN), delivered internally by dedicated trainers and supported by clinical staff. • WARRN risk formulations are completed where risks are identified, reviewed annually or when circumstances change, including transitions between outpatient or inpatient care and crisis services. • Specialist risk assessments are available, coordinated via the forensic service, highlighting risks in suicide, violence, and fire setting. • An improved discharge plan for acute inpatient care is in place. • The Disengagement and DNA policy has been recently updated and is currently out for review, outlining actions for teams and directorates. • Ongoing work on patient search, observation policy and practice, safeguarding reporting, and escalation. We will show evidence and progress through the established monitoring framework. We recommend a 6-month period to ensure processes are fully embedded and sustained.
		Medium Priority	**Officer: Divisional Director, General Manager, Divisional Nurse (Triumvirate), Directorates** **Date: 30th September 2025**
	Theme: Communication & Engagement	Control Operation	

Objective 2: Implementation	**Reasonable**

The 30, 60 and 90-day action Improvement Plan was put in place during July 2023 and agreed by the previous triumvirate team, alongside Executive input.

Within the 90-day Plan (the 'Plan'), as of November 2024 we found that not all the actions had been fully implemented. Initially, actions were detailed in two Excel spreadsheets, one for an Executive update and one for internal use, with responsible owners, timescales, and RAG ratings. This was later changed to a PowerPoint version without RAG ratings, timescales and responsible officers. The current format outlines actions required, expected outcomes, current position and next steps. Discussion with key members of the Division demonstrates a focus on improvement and ensuring the actions in the plan are implemented. However, as described within objective one, we have not regular evidence of clear accountability when actions are incomplete. We found that two out of the four actions sampled in detail were complete (Missing Persons Policy in Commissioning Services and Patient experience engagement), whereas the two remaining (NCCU in commissioning services and WCCIS functionality) are still work in progress with no deadline in place. We recognise that some actions may involve other stakeholders, but delivery is not clearly defined.

In January 2025 we received updated evidence and a revised Improvement Plan, following a review within the Division. The updated Improvement Plan is the amalgamation of the live documents mentioned above. We have reviewed this evidence and found further progress has been made but the WCCIS functionality is partially complete. As the tendering process for the new system is not yet complete, it will not be in place until September 2025.

Key Findings		Risk & Impact	Agreed Management Action
3	**Implementation** The 90-day action plan was originally scheduled for completion by December 2023. However, as of January 2025, we confirmed three out of the four actions have been fully completed with one action partially complete. Whilst we confirmed that progress has been made against each of the actions, with considerable work completed / underway, the Plan has still not been fully delivered. Overall, we found that the Plan lacked specific delivery milestones and we found multiple live records in use to record status updates. Upon implementation of the Plan, there is value in reviewing the process adopted for the delivery and monitoring of actions to inform future plans. In particular, how accountability for the delivery of actions is maintained.	Potential risk of: • A lack of management resulting in delayed deliverables and benefits	**Agreed Action:** • From September 2024, MH&LD transitioned into Phase 2 of the Improvement Plan, focusing on sustaining actions and developing long-term initiatives. • The Triumvirate and senior leadership team are now permanent, with ongoing efforts in culture change and workforce development. • A robust monitoring framework is being implemented, including detailed tracking, regular progress reviews, and formal escalation procedures. This will have oversight by the COO and the QPS Team. • Staff training and development are prioritised to enhance accountability and ensure timely delivery of actions.

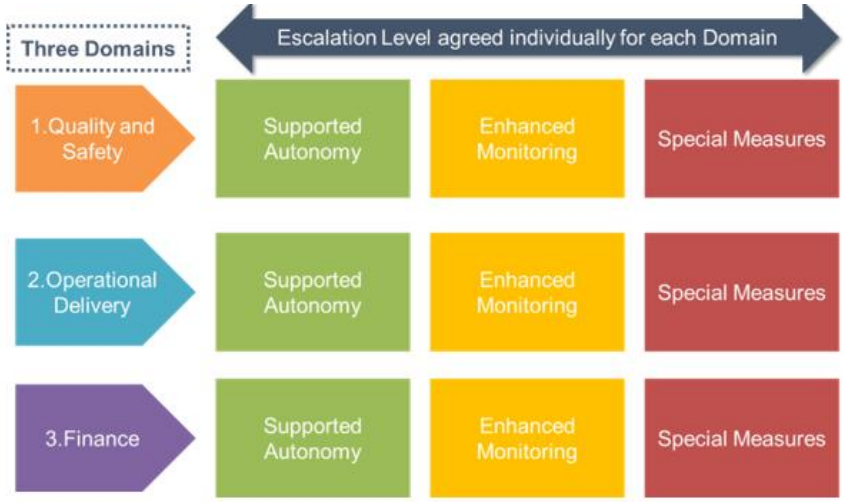
			Expected Evidence of Implementation: • Staff engagement events scheduled. • Participate in National events. • Improved inspections and management of serious incidents and improve safeguarding, quality, safety, and governance practices. • Robust audit and risk process. • Continue regular reporting to committees. • Agreed workplan for the MH&LD Committee and plan for the year. • Triangulate inspection and audit data, linking it with the wider QPS team. • Continue IQPD reports. • Continue JET twice yearly reporting. • Bespoke Board Development sessions as required. We will provide evidence through DA minutes and documentation, thoroughly reviewing action logs to demonstrate decision-making processes and accountability at all levels.
		Medium Priority	**Officer: Divisional Director, General Manager, Divisional Nurse (Triumvirate), Directorates** **Date: 30th September 2025**
	Theme: Planning, Delivery & Deadline Management	Control Operation	

Objective 3: Intended Outcomes	**Reasonable**

As previously described, we have observed progress towards implementing the 90-day actions, as three of the four actions have been fully completed, and one is partially complete. Whilst we recognise that a period of time has lapsed, since the Improvement Plan was first launched and the initial focus on the actions have now been integrated into a divisional focus of improvement, we have been unable to observe clear outcomes or deliverables linked to the completed actions.

There is evidence of regular updates at the PQSOC and Board and some scrutiny in Divisional assurance meetings. However, there is a lack of analysis to demonstrate outcomes of the fully completed actions and whether they have delivered their intended outcome. Furthermore, at this stage there has been no post implementation review completed, to highlight any gaps in the actions and to ensure actions are embedded once fully implemented. Consequently, we have been unable to fully test against this objective.

Key Findings		Risk & Impact	Agreed Management Action
4	**Intended outcomes** We found progress is being made in implementing the 90-day actions; however, not all actions have been fully implemented, preventing us from determining if the Division is achieving the intended outcomes. Completing a post-plan analysis would be beneficial in outlining the necessary steps to embed these actions once they are all fully implemented.	Potential risk of: Intended outcomes from the 90-day action plan not being delivered resulting in-patient harm and reputational risk.	**Agreed Action:** • Tight oversight on Disability Division for serious incidents and governance. • Improvement plan sustained. • Initiatives in workforce, leadership, performance, risk, and service changes progress. • Reporting to key committees and meetings. • NHS Executive Colleagues' advisory role continues. **Expected Evidence of Implementation:** • Staff engagement events / staff survey results. • Staff retention. • Improved inspections and management of serious incidents and improve safeguarding, quality, safety, and governance practices. • Robust audit and risk processes/plans in place. • Continue regular reporting to committees. • Agreed workplan for the MH&LD Committee and plan for the year. • Triangulate inspection and audit data, linking it with the wider QPS team and escalate when needed. • Continue monthly IQPD reporting. • Continue reporting to JET twice yearly. • Bespoke Board Development sessions, as required.

			• Evidence of adhering to the principles of escalation as outlined in the PMF.  Evidence this progress with documentation and reporting to the DA meeting each month. Demonstrate how issues or concerns are escalated and responded to.
		Medium Priority	**Officer: Divisional Director, General Manager, Divisional Nurse (Triumvirate), Directorates** **Date: 30th September 2025**
	Theme: Planning, Delivery & Deadline Management	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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Maternity Services Improvement Plan

Final Internal Audit Report

2024/25

Aneurin Bevan University Health Board



Reasonable Assurance

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Review Reference	ABU-2425-10
Fieldwork	January - February 2025
Executive Sign Off	March 2025
Audit Committee	April 2025
Executive Lead	Jennifer Winslade, Director of Nursing
Audit Team	Stephen Chaney, Head of Internal Audit
	Eifion Jones, Deputy Head of Internal Audit

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Executive Summary

Purpose

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

Overview

We have provided reasonable assurance in this area. Considering recent high-profile commissioned reviews of maternity services across Wales, this review examined the mechanisms in place to ensure that actions from these reviews were effectively tracked, monitored, and implemented as part of a robust process.

The Welsh Government's reporting tool from May 2022 had been largely completed, with outstanding actions now included in the *Improving Together for Wales Maternity Neonatal Discovery Phase Report 2023*. The Maternity Neonatal Phase report outlined 124 areas of improvement across maternity, neonatal and perinatal services in Wales, prioritising actions that require minimal resource and are easily implemented as part of a systematic approach to ensure patient safety. Good progress was being made to address the actions. The outstanding actions from the WG reporting tool have been assessed within this review, along with a sample of other actions from the Maternity Neonatal Phase Report to ensure there is a comprehensive approach to tracking and monitoring of implementation.

The key matter requiring management attention was:

- Given the timescale since the July 2023 publication of the *Improving Together for Wales Maternity Neonatal Discovery Phase Report*, it is prudent to review the current monitoring arrangements, especially for short-term actions, to enable more detailed progress tracking.

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

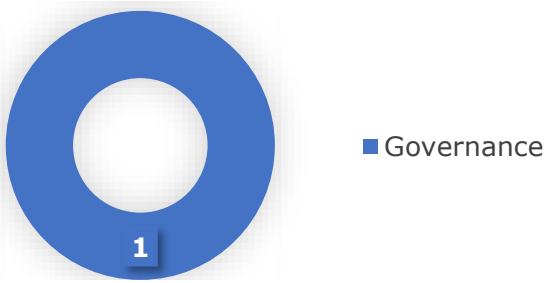
Scope & Assurance Summary

Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	Appropriate tracking and progress of maternity related actions being implemented	1	**Reasonable**

Management Actions

-	1
High Priority	Medium Priority

Themes



Risk Types

Quality or Safety Issues

At a Glance

The *Improving Together for Wales Maternity Neonatal Discovery Phase Report (July 2023)* outlined 124 areas of improvement which were assigned as follows:

Responsibility	Actions
Health Board	46
Health Board with national support / input	37
National with Health Board support / input	11
National only	30
Total	124

When excluding the 30 actions that do not require Health Board input, the position is as follows:

	Status				Total
	Red	Amber	Green	Undefined	
Short Term	2	10	26	4	42
Medium Term	1	11	24	10	46
Long Term	-	1	3	2	6

The definition for timescales as prescribed by the *Improving Together for Wales Maternity Neonatal Discovery Phase Report (July 2023)* were as follows:

- Short term: 6-12 months;
- Medium term: 1-2 years; and
- Long term: up to 3 years.

Findings & Agreed Action Plan

Objective 1: Tracking and monitoring	**Reasonable**

Overview / Summary of Observations

Testing confirmed that regular monitoring and scrutiny occurred across various forums. Progress updates were provided at Executive team meetings, Patient Quality Safety Outcomes Committee (PQSOC), and Board meetings when required, for assurance purposes. Operational groups were actively working to ensure the implementation of actions. Additionally, there were multiple forums at an All-Wales level involving Welsh Government and NHS Executive for further scrutiny.

A sample of actions were tested to assess progress, the assessment was of associated evidence that demonstrated progress and implementation. The sample of ten included the three outstanding amber actions from the previous WG reporting tool to ensure continuity, we were able to identify their inclusion in the Maternity Neonatal phase report actions and seven other actions were also picked to complete the testing. The ten actions tested were either implemented (rated green) or on-going (rated amber) on the Health Board's Maternity Neonatal Phase working spreadsheet. It was confirmed that the three actions rated red on the spreadsheet were there to maintain visibility of the ongoing work, as it may not be possible to fully implement them, as they require wider Health Board decisions. The testing found five actions were implemented and five in progress.

Overall, strong progress was observed as per the 'At a Glance' summary. However, given the timescale since the publication of the *Improving Together for Wales Maternity Neonatal Discovery Phase Report (July 2023)*, it would appear prudent to review the existing monitoring arrangements, particularly relating to the short-term actions, to allow more granular monitoring of progress.

	Key Findings	Risk & Impact	Agreed Management Action
1	**Reporting** It would aid the reader if the Maternity Neonatal Phase working spreadsheet could include the following: • Individually assigned responsibility for actions, such as the Head of Midwifery, to enhance accountability and provide a clear point of contact for updates. • Defining specific timelines for key milestones would offer the Board tangible assurance of progress (rather than the current method of targeting short, medium and long term). • Clearly identify those aspects that cannot be achieved e.g. those requiring external support or relating to broader All-Wales issues.	Actions not being implemented, reported or monitored correctly.	**Agreed Action:** Head of Midwifery and Service Improvement Manager have completed the following actions to include :- • Review of the Maternity and Neonatal assurance tracker regarding priority areas for action same updated to include additional information regarding specific accountability. Ie Lead Nurse for neonates/ HoM • Maternity and Neonatal assurance tracker updated by to reflect timelines against Health Board priorities • Maternity and Neonatal assurance tracker updated, rag rated red, amber and green, to all all areas, and those not applicable made evident.

	• The status of all actions will be reviewed for accuracy, particularly those included at the spreadsheet without a formal status (i.e. red, green, amber). • Minor discrepancies at the spreadsheet were identified and shared with management for addressing. Establishing well-defined accountability routes will improve reporting, ensuring stakeholders understand their roles and responsibilities. This structured approach will strengthen oversight, enhance transparency, and support better outcomes for maternity service.		• Minor discrepancies rectified ie Overview tab and amended where responsibility outside of the Health Board. Oversight will be via Multi professional Monthly Divisional QPS, quarterly Directorate and Maternity and Neonatal Assurance Group. With any areas for escalation highlighted.
			Expected Evidence of Implementation: The Maternity Action Plan Tracker serves as evidence of progress against established actions. It is readily accessible and can be utilised to provide assurance of both implementation and ongoing progress.
		Medium Priority	**Officer: Jayne Beasley**
	Theme: Governance	Control Design	**Date: 27th March 2025**

Appendix A

Assurance Opinion

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Priority	Explanation
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Staff Survey

Final Internal Audit Report

2024/25

Aneurin Bevan University Health Board



Reasonable Assurance

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Fieldwork	November 2024 - January 2025
Executive Sign Off	1st April 2025
Audit Committee	February 2025
Executive Lead	Sarah Simmonds, Director of Workforce & OD
Audit Team	Stephen Chaney, Head of Internal Audit
	Laura Howells, Principal Internal Auditor

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Executive Summary

Purpose

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

Overview

We have concluded reasonable assurance on this area. The matters requiring management attention include:

- The lack of a centralised action plan and inconsistent implementation across directorates risks effective responses to staff survey findings. Promising initiatives need broader adoption and robust monitoring to drive lasting improvements.

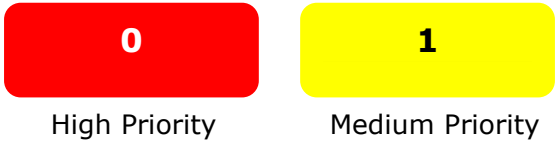
Full details of matters arising are detailed within the Findings & Agreed Action Plan.

The survey findings provide valuable insights into key areas requiring improvement, for example staff workload pressures, ensuring fairness, and staff retention. Whilst directorate leads value the survey results feedback provided to them; the absence of a coordinated action plan presents a risk to achieving sustained improvement. The Health Board may consider developing a formalised framework to ensure consistent monitoring and accountability for addressing identified concerns.

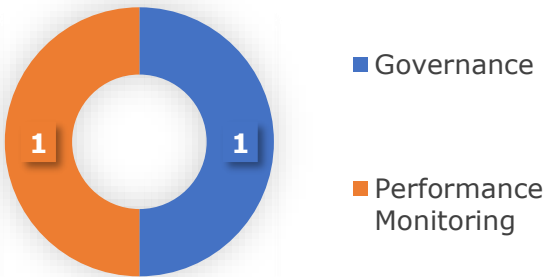
Scope & Assurance Summary

	Objectives	Related Findings	Assurance
1	Analysis of the staff survey has been completed and key areas for improvement have been identified	-	**Reasonable**
2	An action plan is in place and being acted upon to address the areas for improvement from the staff survey	1	**Reasonable**
3	Progress against the plan is monitored with issues being escalated and staff are kept informed of the actions being implemented	1	**Limited**

Management Actions



Themes



Risk Types

Quality or Safety Issues

Public Perception & Reputational Risk

Staff Survey Results- At a Glance

Survey Participation:

- 2919 responses received; a 24% increase compared to 2023.

Speaking Up:

- Staff feeling safe to voice concerns improved from 57% (2023) to 62% (2024).
- Confidence that the organisation would address concerns rose to 38%, up from 25% (2023).

Discrimination, Bullying, and Harassment:

- Reports of discrimination decreased to 13% (2024) from 19% (2023).
- 15% of staff experienced bullying/harassment from patients or the public, while 21% reported it from managers or colleagues.

Employee Satisfaction and Retention:

- 63% of staff are satisfied with their roles.
- 56% have considered leaving in the last 12 months, with 32% actively taking steps to do so.
- Factors driving intention to leave: workload, burnout, lack of recognition, and limited career progression.

Burnout:

- 42% experience symptoms of burnout, with 6% reporting severe burnout.
- Burnout levels are higher in Clinical Support Services, Urgent Care, and Medicine.

Psychological Safety:

- Overall mean score of 76.5%, reflecting a solid sense of psychological safety but with room for improvement.

Employee Experience Framework:

- Six pillars of work satisfaction include belonging, control, and fairness.
- Sense of purpose saw a slight increase (53% in 2024 vs. 49% in 2023), while fairness (49%) remains an area for improvement.

Findings & Agreed Action Plan

Objective 1: Survey Analysis	**Reasonable**

The analysis of the employee experience survey has been completed, identifying areas for improvement across various aspects of staff culture and well-being. The survey analysis is broken down into multiple categories including but not limited to:

- Demographic;
- Intention to Leave;
- Satisfaction with the Health Board;
- Burnout;
- The Employee Experience Framework;
- Psychological Safety;
- Speaking Up;
- Discrimination; and
- Other.

Whilst significant insights have been gained, the responsibility for implementing change rests with individual departments within the Health Board. The Workforce and OD team serve as facilitators of the survey process, but the monitoring or mandating of specific actions is the respective division's responsibility. Individual directorates are responsible for identifying areas for improvement once the survey findings have been relayed to them (see objective two for more detail). This decentralised approach may limit consistency and accountability in addressing identified weaknesses, however, we have not raised a recommendation here as this is covered within objectives two and three.

Objective 2: Survey action plans	**Reasonable**

There is no overarching action plan to comprehensively address the survey findings. Responsibility for creating and implementing actions is delegated to individual directorates.

Methods of feedback varied across directorates and was in the form of presentations, direct communication with team leads and email dissemination of results. We selected nine directorates for testing, but only received information regarding five (the scope of our audit was limited to those that responded), indicating inconsistency in the implementation and monitoring of actions. Several directorates acknowledged the importance of survey findings but exhibited variability in their approach. Some implemented changes such as the Facilities division who created a Workforce and Wellbeing Steering Group to promote survey findings and inform strategies. However, others deferred action, awaiting further clarity from the Senior Clinical Psychologist.

No formal requirement exists for directorates to create or report on action plans. Without a centralised plan, assurance that issues are being addressed remains weak. Variability in directorate responses highlights the absence of standardised processes for addressing survey findings. Lack of formal tracking mechanisms increases reliance on informal accounts of progress. We have raised matter arising one, which is also linked to and reported under audit objective two. However, through our testing, there is evidence that directorates/divisions are utilising the findings in different ways, such as to make improvements like the Facilities Wellbeing Steering Group, to help identify trends to support the need for rectifying actions or asking for more information before making changes. Therefore, we have provided reasonable assurance for this objective.

Objective 3: Monitoring	**Limited**

There is no centralised mechanism or formal oversight body ensuring systematic monitoring of actions arising from staff survey findings. Divisional teams are responsible for leading their respective actions, with influence and support provided by the Senior Clinical Psychologist. The Senior Clinical Psychologist reports significant time limitations, dedicating less than half a day per week to staff survey-related work amidst competing responsibilities, including clinical duties.

No formalised process exists for escalating delays or revising timelines for actions. Consequently, accountability and consistent progress monitoring are limited. Survey findings have been presented to key stakeholders, including Executives and the People and Culture Committee, where results were discussed. We reviewed the presentations for these stakeholders and confirmed they detailed the key survey findings.

Staff are encouraged to engage with the survey through intranet and SharePoint resources. Survey results are accessible to teams upon request and have been highlighted in leadership development programs. Individual divisions have reached out to obtain a more detailed around key areas such as around bullying trends. There is evidence that, in particular, the Senior Clinical Psychologist engages with directorates/divisions to provide further detail and support any actions or monitoring taking place. However, without a consistent formalised approach it is challenging to provide assurance the necessary steps are being taken and therefore, we have given this area limited assurance.

Key Findings		Risk & Impact	Agreed Management Action
1	**Action Plan and monitoring** As above. The absence of a formalised, centralised action plan and inconsistent directorate-level implementation pose significant risks to effectively addressing issues identified in the staff survey. While some initiatives, such as the Workforce and Wellbeing Steering Group, show promise, broader adoption and monitoring mechanisms are required to ensure sustained improvement.	Lack of accountability and assurance that issues identified in the staff survey are being addressed could result in: **Worsened staff morale**: Employees may feel their feedback is ignored or undervalued. **Missed opportunities for improvement**: Inconsistent implementation of actions across directorates reduces the overall impact of the survey findings. **Reputational damage**: Failure to act on survey insights undermines trust in leadership and the organisation's commitment to staff well-being. **Operational inefficiencies**: Persistent challenges like burnout, bullying, or low	**Agreed Action:** Following the recent audit and recognising that the resources needed to meaningfully respond to the findings are not available (i.e. to ensure high engagement, responsiveness and accountability from Divisions), we have decided to step the survey down from an organisational wide level and will focus only on the annual All Wales staff survey launched every October. Access to the employee experience survey will be on a bespoke self-service model so ensuring high engagement where teams feel this is relevant or appropriate. **Expected Evidence of Implementation:** Clear SMART action plans linking directly to findings from the staff survey. • All actions deferred to the annual staff survey

		satisfaction could affect performance, retention, and service delivery.	
		Medium Priority	
	Theme: Governance	Control Design	**Officer:** Assistant Director of Workforce & OD **Date:** 1 April 2025
	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.

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]

Grange University Hospital Emergency Department Extension

Final Internal Audit Report

2024/25

Aneurin Bevan University Health Board



Reasonable Assurance

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

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Review Reference	ABU-SSU-2425-30
Fieldwork	July / August 2024
Executive Sign Off	March 2025
Audit Committee	April 2025
Executive Lead	Hannah Evans, Director of Strategy Planning and Partnerships
Head of Internal Audit	Huw Richards

Executive Summary

Purpose

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

Overview

We have concluded reasonable assurance at this project review following the assessment of the key delivery objectives and the governance, risk management, and internal control arrangements applied to date.

At the time of audit fieldwork the project was forecast to be delivered marginally outside of the original cost parameters i.e. 0.13% but was not considered material at this stage. Whilst a delay to the original delivery date was being reported, contractual implications remained under assessment.

While the forecast delay inevitably impacts on the delivery of the project's originally intended targets/benefits, the longer-term benefits of the improved facility will not be adversely impacted.

There were several matters requiring management attention including the need to:

- enhance the role / remit of the Project Board and associated reporting;
- apply improved contract mechanisms i.e. Parent Company Guarantees and Collateral Warranties;
- obtain a project programme matching site activity from the contractor (i.e. no programme was provided in the first five months on site);
- obtain Welsh Government approval for 2025/26 project funding recognising the slippage in the delivery programme; and
- profile key matters to the Project Board within performance reporting e.g. the delayed programme provision.

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

Scope & Assurance Summary

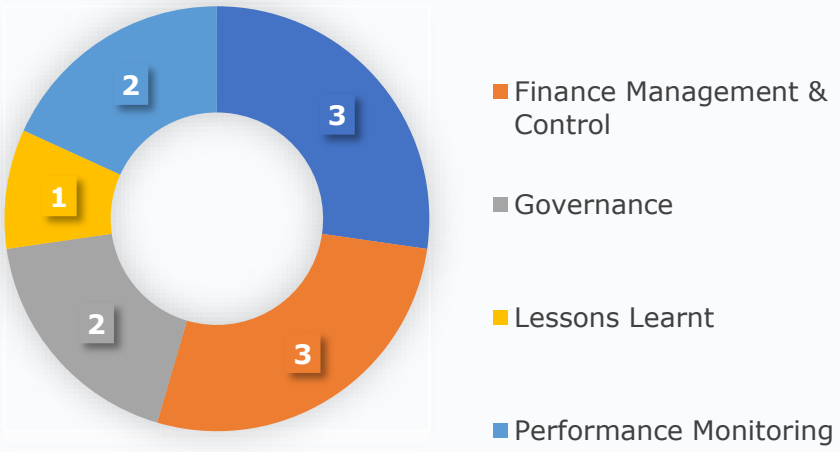
	Objectives	Related Findings	Assurance
1	Project Performance: achievement of the project's key delivery objectives (time, cost, and quality).	-	**Reasonable**
2	Project Governance: to obtain assurance that appropriate governance arrangements were in place for project progression including, effective operation of defined roles and responsibilities, project groups and workstreams, stakeholder engagement, appropriate approvals and monitoring and reporting requirements.	1, 2	**Reasonable**
3	Procurement and Contractual Controls: to obtain assurance on the operation of appropriate procurement and contractual arrangements including adviser appointments and assurance of value for money (including Target Cost).	3, 4, 5, 6	**Limited**
4	Design Development: to obtain assurance on the appropriate development of agreed design and equipping requirements, including user sign-off; planning control, derogations and change control.	7, 8	**Reasonable**
5	Project Management: to obtain assurance that appropriate project management controls were applied including risk management, contractor/adviser performance monitoring.	9	**Reasonable**
6	Financial Controls: Including use of a Project Bank Account, budget setting, validation of costs to date, and reimbursement of the contractor and advisers in accordance with the contract.	10, 11	**Reasonable**

Management Actions

0 High Priority

11 Medium Priority

Themes



Risk Types

Financial Loss

Legal & Regulatory Non-Compliance

Public Perception & Reputational Risk

Legal & Regulatory Non-Compliance

Grange University Hospital Emergency Department Extension – At a Glance

The extension will enable the service to address over-crowding and provide improved service delivery, including an additional 75 seats, and additional triage areas.

Welsh Government approved funding of £14,356,867 in December 2023.

The project has two defined contractual delivery phases:

- Phase 1 – a new build emergency department (target completion December 2024); and
- Phase 2 – reconfiguration of the existing waiting area (target completion March 2025).

The following was evidenced at the Project Manager's August 2024 report.

Time

Contract progress was reported as follows:

Table 1

Milestone	***Contract start Date***	***Actual start Date***	***Contract Completion Date***	***Current Forecast*** (*August 2024*)	***Contracted Duration*** *(months)*	***Current Forecast duration*** *(months)*	***Forecast Delay*** *(duration -months)*
Phase 1 – new waiting area & extension	22/12/2023	29/01/2024	13/12/2024	17/01/2025	11.75	12.75	1
Phase 2 – reconfiguration of existing waiting area to a rapid assessment area	18/12/2024	TBC	07/03/2025	04/04/2025	2.75	2.75	0
Overall project	22/12/2023	29/01/2024	07/03/2025	04/04/2025	14.5	15.5	1

There had been some slippage in the delivery programme for the Phase 1 (new build) works, adversely impacting the overall forecast completion of both phases by approximately 1 month, extending completion into the winter period.

The forecast delay included provision for an amendment to the contract commencement date of approximately 4 weeks (while awaiting planning approval).

At the time of audit, contractual extensions of time for the contractor were subject to ongoing scrutiny and agreement.

Cost

The total approved project funding of £14,356,867 (inclusive of works costs, fees, contingency, and other costs) was provided by Welsh Government based on a "not to exceed" figure.

Following a value engineering (VE) exercise, the anticipated contract sum of £9,445,643 was reduced to £9,041,181, effectively providing additional contingency of £404,462. Planning requirements have subsequently required the re-instatement of certain of these omitted items i.e. louvres and brick cladding, reducing this additional contingency (reported separately – as below).

As a result, planning re-instatements of £58,011 together with further design development of £489,216, have increased the contracted build cost by £547,227 to date.

At the time of concluding the audit fieldwork a total projected project over-spend of circa £18,165 was being reported against the approved Welsh Government's approved allocation (Cost Report to end August 2024) (see **Table 2** below).

Table 2

Item	*£ WG Approval*	*£ Revised Budget*	*£ Current Forecast*	*£ Variance*	
Contract Sum	9,445,643	9,041,181	9,041,181	0	
Compensation Events			489,216	489,216	
Health Board fees	1,541,043	1,541,043	1,551,574	10,531	
Non works costs	571,063	571,063	522,207	-48,856	
Equipment	101,500	101,500	101,500	0	
Health Board contingency	582,962	582,962	278,402	-304,560	
Additional contingency (from Value Engineering (VE) exercise		404,462	346,451	-58,011	
VAT	2,114,656	2,114,656	2,045,089	-69,567	
PROJECT COST	**14,356,867**	**14,356,867**	**14,375,620**	18,753	
TOTAL PROJECT ANTICIPATED OVER / (UNDERSPEND)				**18,753**	**+ 0.13%**

Findings & Agreed Action Plan

Objective 1: Project performance	**Reasonable**

Overview / Summary of Observations

At a project audit, levels of assurance are determined on whether the project achieves its original key delivery objectives and that governance, risk management and internal control are effectively designed and applied.

At this audit, when assessing progress against the original delivery objectives (see also the "Grange University Hospital Emergency Department Extension - At A Glance" (previous)), it was noted that there has been some slippage in the delivery programme for the Phase 1 (new build) works. This has adversely impacted the forecast completion by approximately 1 month.

At the time of concluding the audit fieldwork, the project was forecast to be delivered marginally outside of the original cost parameters i.e. a forecast £18,165 overspend against the total approved (not to exceed) allocation of £14,356,867. The current forecast out-turn cost represents only 0.2% of the works cost and 0.13% of the total approved sum and is therefore not considered material at this stage.

At the time of audit fieldwork, no outstanding quality issues associated with the construction were detailed within the Supervisor's reports. The forecast delay inevitably impacts on the delivery of the project's originally intended targets/benefits for the opening of the new build prior to peak winter pressures (Christmas 2024) (including delays to improved capacity; reduced triage wait times; and enhancement to the patient experience and outcomes). However, it may be considered that the original targets were unachievable recognising the planning delays from the outset and limited time contingency within the delivery programme. The longer-term benefits of the improved facility will not be adversely impacted by the delays.

Noting the above, reasonable assurance has therefore been determined in respect of project performance (at the time of completion of the audit fieldwork) and the achievement of the project's key delivery objectives (time, cost, and quality).

Objective 2: Governance	**Reasonable**

Overview / Summary of Observations

An accountable Project Board had been appropriately established to "monitor" and "manage" project delivery, with allocated responsibilities for the key roles of Project Owner, Project Director, and Project Manager (as supported by external consultants). This was in accordance with best practice and the defined arrangements included within the Project Execution Plan.

Governance arrangements were therefore generally designed and implemented appropriately. However, the role of the Project Board in oversight and responsibility (as operated) was unclear e.g. whether their input was limited to agreeing user requirements, or wider scrutiny of costs and performance.

There was also a need for the Project Board to be better informed / supported to fulfil its monitoring and scrutiny role, and to record decisions made as part of its wider scrutiny and approval function.

In accordance with Health Board policies, there was also a need for Declarations of Interest specific to the ongoing involvement of staff at the project (in the same way as declarations are typically made specific to meetings).

Key Findings		Risk & Impact	Agreed Management Actions
1	**Lack of effective / timely reporting to the Project Board potentially impacting oversight and scrutiny** The key role of a Project Board is to provide appropriate oversight, scrutiny, and approval of key decisions. It was evident that the timing of the Project Board's establishment (post FBC approval), impacted initial scrutiny. Thereafter, evidence to support the receipt, scrutiny and approval of key project issues was limited (ref other key findings below). It is acknowledged that key technical issues may be considered outside of the Project Board (by the UHB's Advisers etc), but associated advice and decisions should be communicated to the Project Board as appropriate. There would therefore be benefit in reviewing the functioning of the Project Board and associated project support / advice.	Potential risk that the project is not appropriately controlled, impacting delivery to time, cost, and quality.	The role of Project Board will be considered in future projects which are taken forward through the SCAPE Framework. Expected Evidence of Implementation: Review of Project Board role for future projects including how the role is articulated within the Project Execution Plan.
		Medium Priority	Officer: Assistant Director of Strategic Capital Date: Actioned April 2025. To be reviewed at future Projects taken through the SCAPE Framework
	Theme: Governance	Control Operation	

2	**Declarations of Interest** The Health Board requires officers to provide Declarations of Interest including any connection to a private body. This would be relevant for Health Board officers with such involvements with the project. As contracted parties and those involved in the project change over time, it is important therefore that these are current e.g. as per declarations which are refreshed at Health Board meetings. However, project specific Declarations of Interest were not made and maintained for Health Board officers on an on-going basis.	Reputational risk, with the potential for adverse publicity; and Fraud with the potential for financial loss.	Declarations of interest will be added as an agenda item at project meetings. Expected Evidence of Implementation: Project agendas including declarations of interest.
		Medium Priority	Officer: Project Director Date: March 2025
	Theme: Governance	Control Operation	

Objective 3: Procurement and contract controls	**Limited**

Overview / Summary of Observations

While signed contracts were in place for all parties, some mandatory contract inclusions such as Collateral Warranties remained to be evidenced. While the option for a Parent Company Guarantee was not selected (which may incur additional costs), there was no associated reporting or approval. In the event of contactor insolvency, a Parent Company Guarantee, can be an important financial safeguard. Similarly, Collateral Warranties also provide a financial safeguard (of direct legal recourse to sub-contractors).

Contracted costs were scrutinised by the Cost Adviser. However, a Target Cost report was only provided to the Health Board post contract, and a commentary on the near doubling in price from the pre-tender estimate was not provided.

A current project programme is also a key contract control. However, five months into construction a programme reflecting on-site activities remained to be supplied by the contractor.

The contract strategy was included within the approved business case, outlining the key benefits of early delivery at a fixed charge. However, delivery has been delayed by over a month, with build cost increasing by £547,227. At the time of concluding audit fieldwork additional delays relating to design issues had been notified, the contractual agreement of which was on-going. Accordingly, it has been recommended that lessons learnt review includes consideration of the matters raised at this audit.

Key Findings		Risk & Impact	Agreed Management Action
3	**Collateral Warranties** The contract requires the completion of Collateral Warranties. These provide direct legal recourse to sub-contractors in the event of main contractor insolvency. Collateral warranties should therefore be in place for key subcontractors prior to the delivery of any associated works. To enforce timely provision, the contract states that "*if the contractor has not .. submitted .. Collateral Warranties required...one quarter of the Price for Work Done to Date which relates to the work....is retained by the Client in assessments of the amount due to the contractor*". At the time of audit, the foundations had been completed, and works on the main structure had commenced.	Potential of un-insured risk resulting in financial loss.	Actioned since audit fieldwork: Relevant Collateral Warranties are being obtained as relevant to those commenced within the programme. Warranties can only be issued to sub-contractors once the sub-contracts were signed by the sub-contractors. Queries have been raised by a number of sub-contractors over minor wording changes, which the CA has responded to.
			Expected Evidence of Implementation: Collateral warranties (as defined and agreed within the contract) will be obtained for works within the programme to date.
		Medium Priority	Officer: Project Director Date: April 2025
	Theme: Contractual	Control Operation	

4	**Parent Company Guarantee** In the event of contactor insolvency, a Parent Company Guarantee, can be an important financial safeguard. This enables recourse to the Parent Company for any outstanding liabilities, including completion of the works. The build contract provides the option of an "*ultimate holding company guarantee*." While the chosen contractor benefitted from a parent company, this option was not selected. The associated risks and benefits were not considered within the procurement strategy or otherwise reported and approved.	Potential risk of financial loss.	Parent Company Guarantee requirements (and alternatives) will be considered, with decisions approved (by the Project Board) and documented at all future projects. Expected Evidence of Implementation: The consideration of Parent Company Guarantee requirements (and alternatives) will be documented Project Board minutes (at all future projects).
		Medium Priority	Officer: Project Director Date: Actioned April 2025. To be evidenced at future projects
	Theme: Contractual	Control Operation	
5	**The need for a current project programme** A project programme reflective of site activities is a key project control. It informs both forecasting and understanding of project progress, performance, and cash flow requirements. The absence of a current programme also impedes the assessment of Compensation Events (which relate to time and cost impacts of project changes). Six months into construction, the project had yet to be provided with a current project programme. While this issue was narrated within Project Management reports, it was not profiled as a key issue. A Project Manager Instruction was issued in June 2024, subsequently securing its delivery. However, on-going programme slippage makes timely update an imperative.	• Site activities are not appropriately managed leading to late delivery; • Compensation Events may not be appropriately assessed leading to financial loss; • Cash flow may not be appropriately understood impacting project finance.	Actioned since audit fieldwork – a current programme has now been obtained. Expected Evidence of Implementation: Provision of a programme current to the works by the contractor (as being progressed on site).
		Medium Priority	Officer: Project Director Date: N/A
	Theme: Contractual	Control Operation	

6	**Lessons learnt** The stated intention of the procurement strategy was to ensure delivery ahead of winter 2024/25, with a fixed lump sum price. At the time of audit, the contract price had increased by £547,227 with delivery over a month in delay (largely attributable to a one month delay in planning approval). At the time of concluding audit fieldwork additional delays relating to design issues had been notified, the contractual agreement of which was on-going. Risks and controls can be impacted by a variety of factors such as the nature of contractual arrangements e.g. separately contracted design and build, where a builder may challenge some technical buildability. Noting the variance between objectives and out-turn, a formal lessons learnt review would benefit future projects.	Potential risk of financial loss. **Medium Priority**	A formal lessons learnt review will be undertaken, this will include for example, time and cost delivery, performance of the parties, and application of chosen framework. Expected Evidence of Implementation: Publication of lessons learnt review to relevant forums. Officer: Project Director Date: December 2025
	Theme: Lessons Learnt	Control Operation	

Objective 4: Design development			**Reasonable**
Overview / Summary of Observations Design has generally been appropriately progressed (including equipping requirements). However, the Project Manager's report detailed a key reason for notification of further potential project delays to be the delayed provision / agreement of technical design issues. There was therefore a need to review the efficacy of design development controls. Additionally, there was a need to align defined change control processes with intended practice, notably in respect of delegated authorities for expert advisers, and the role of the Project Board (also see **Finding 1** re: role of Project Board). The defined arrangements could also usefully include reference pre-approved budgets, and "not to exceed" approvals for urgent works (based on estimates).			
Key Findings		**Risk & Impact**	**Agreed Management Action**
7	**Change control** There was a need to align the operation of change control with procedures detailed within the Project Execution Plan (see above). The Project Board Terms of Reference included a remit to "m*onitor and manage the agreed change control process."* While changes were reported to the Project Board, their role in approval was not described within the Project Execution Plan and their approval was not minuted. Noting this, there is also the opportunity to clarify processes.	Potential risks of: • incurring undue costs; and that • sums are paid ultra vires; • potentially resulting in financial loss and reputational impact. **Medium Priority**	We will ensure the function of Project Board is clarified in relation to Change Control within the Project Execution Plan. Expected Evidence of Implementation: Review of Project Execution Plan for projects taken forward through this Capital route. Officer: Project Director Date: Actioned April 2025. To be evidenced at future projects delivered through the SCAPE route
	Theme: Financial Management & Control	Control Operation	

8	**Design development / change** Design change / development is managed through the Early Warning / CE processes defined within the NEC contract. At the time of the audit, the project was reported to be delayed by over a month (with the contractor referencing the potential of further delays to the provision / clarification of design information / drawings). There was a need to review the design development processes being applied at the contract by all parties to determine the reasons for delay and ensure early resolution and the avoidance of additional costs / further delays. The Project Execution Plan should also define these processes, including client sign-off. (The associated need for effective performance monitoring and controls is considered at the **Project Management** section).	Potential risks of: • incurring undue costs; and that • sums are paid ultra vires; • potentially resulting in financial loss and reputational impact.	Actioned – a review was conducted into the causality of delay. This determined that it arose from contractor performance issues rather than procedural issues. Expected Evidence of Implementation: Project lessons learnt to include Contractor delay review.
		Medium Priority	Officer: Project Director Date: N/A
	Theme: Performance Monitoring	Control Operation	

Objective 5: Project Management	**Reasonable**

Overview / Summary of Observations

A range of project management tools to manage the construction were operated including project reporting, and a risk register for both Health Board and contractor risks.

However, as considered under **contractual controls** (above), as of June 2024 (five months into construction), a programme reflecting on-site activities remained to be supplied by the contractor. Design delays were also stated to be impacting project performance. However, these matters had not been profiled at performance monitoring.

There were also significant issues relating to project cash flow (see **financial controls**) (with the lack of a current programme making assessment of Compensation Events against programme difficult).

While no construction issues have been raised by the Project Supervisor, there was a need to ensure effective performance monitoring of the parties.

	Key Findings	Risk & Impact	Agreed Management Action
9	**Project Performance reporting** The project required performance monitoring returns to the SCAPE contractor framework. The Project Board should also be informed of project performance via such reporting. Issues arising at the project included: • five months into delivery the project had yet to benefit from a programme reflecting on-site progress; • project delays associated with late planning approvals; • cash flow arrears, potentially impacting project funding (see **financial controls**); and • the need to supply Collateral Warranties. However, the Health Board rated contractor performance as 9/10 – narrated as "*content".* Performance monitoring had not therefore highlighted key control matters to the Project Board for scrutiny/action.	Potential risk that performance is not effectively managed impacting delivery.	a) Key Performance Indicator (KPI) are being completed for the project within internal review and discussions. As the project is not run through the Designed for Life Framework there is no requirement to return to NWSSP: Specialist Estates Services. b) Based on this best practice KPI collation, we are ensuring robust performance monitoring feedback to the contractor. c) We are additionally ensuring that performance issues are summarised and reported to the Project Board. Expected Evidence of Implementation: • Performance monitoring feedback to the contractor and professional team; and • Performance summaries to the Project Board (as contained within reporting / minutes).
		Medium Priority	Officer: Project Director Date: April 2025
	Theme: Performance Monitoring	Control Operation	

Objective 6: Financial controls	**Reasonable**

Overview / Summary of Observations

Approved funding was in place, supported by robustly assessed budgets and associated reporting. Valuations were appropriately assessed against site progress.

However, the funding approval by Welsh Government indicated the need for all expenditure to be concluded during 2024/25 to avoid repayment of funding.

From the outset, delay had impacted cash flows (and in-year funding requirements). In the early months of the project, it was anticipated that project acceleration would correct expenditure to the budgeted profile. At this point, the issue was potentially therefore a technical one of balancing cash flows and funding. While Welsh Government were fully appraised (by Health Board finance officers), and the Project Board were in receipt of the Cost Adviser's report, the cash flow arrears were not specifically highlighted to the Project Board some five months into construction (to June 2024). By August 2024 cash flow was £2.178m in arrears (on construction costs of circa £10m). This would therefore require close monitoring and management to ensure no further slippage / recovery of the cash flow position. The Project Board's ability to scrutinise and query these matters was therefore impacted by the reporting that had received (notably as profiled within the Project Manager's report). (Note – *the matter of Project Board reporting has been assessed under* ***Objective 2*** *and* **Finding 1**).

While Welsh Government were informed of the intention not to utilise a Project Bank account, there was a need to confirm their approval, and to evidence compensating (framework) payment controls.

(Also ref. the need to withhold payments for un-provided Collateral Warranties **Finding 3**).

	Key Findings	Risk & Impact	Agreed Management Action
10	**Funding** The Welsh Government funding approval letter stipulated: *"Funding ..must be claimed in full by 31 March 2025"* This placed any potential delay beyond March 2025 at funding risk. It was confirmed at the time of the audit fieldwork that, the Head of Capital Finance intended to write to Welsh Government to clarify the requirement. Confirmation of appropriate future funding provisions was required.	There is a risk that funding is not in place impacting project completion.	Actioned - Confirmation has been obtained from Welsh Government that having accepted funding in full, expenditure can be continued into 2025/26. Expected Evidence of Implementation: Letter of funding and expenditure clarification from Welsh Government.
	Theme: Financial Management & Control	**Medium Priority** Control Operation	Officer: Project Director Date: N/A
11	**Project Bank Account** Welsh Government require that their funded: *"construction and infrastructure contracts of £2m .. are required to apply a Project Bank Account unless there are compelling reasons not to do so."*	There is a risk of acting in breach of Welsh Government requirements and best payment practices with potential adverse financial impacts to sub-contractors	Operation of a Project Bank account had already been discussed with Welsh Government, and the appropriate form has also now been submitted to Welsh Government for approval. Expected Evidence of Implementation:

	This enables timely payments to the contractor and safeguards funds in the event of main contractor insolvency). An approved Decision Report submitted to Welsh Government is required for any exceptions. A Project Bank Account was de-selected as a contract option. However, while Welsh Government were informed, a Decision Report was not completed, and the intended operation of alternative controls was not documented at the Project Execution Plan. A formal approval was not therefore obtained.	(e.g. late payments, bankruptcy, or possible loss of monies in the event of insolvency of the contractor).	Approval of a Project Bank Account Decision Report by Welsh Government.
		Medium Priority	Officer: Project Director Date: N/A
	Theme: Financial 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.

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 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 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 Aneurin Bevan University Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership]

Archwilio Cymru
Audit Wales

Audit, Risk and Assurance Committee Update – Aneurin Bevan University Health Board

Date issued: April 2025

Document reference: 3997A2024

This document has been prepared for the internal use of Aneurin Bevan University Health Board as part of work performed / to be performed in accordance with statutory functions.

The Auditor General has a wide range of audit and related functions, including auditing the accounts of Welsh NHS bodies, and reporting on the economy, efficiency, and effectiveness with which those organisations have used their resources. The Auditor General undertakes his work using staff and other resources provided by the Wales Audit Office, which is a statutory board established for that purpose and to monitor and advise the Auditor General.

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About this document

1 This document provides the Audit, Risk and Assurance Committee with an update on our current and planned accounts and performance audit work at Aneurin Bevan University Health Board.

2 We also provide additional information on:

- Other relevant examinations and studies published by the Audit General.
- Relevant corporate documents published by Audit Wales (e.g. fee schemes, annual plans, annual reports), as well as details of any consultations underway.

3 Details of future and past Good Practice Exchange (GPX) events are available on our website.

Accounts audit update

4 Exhibit 1 summarises the status of our current and planned accounts audit work.

Exhibit 1 – Accounts audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Audit of Accounts 2024-25	Rob Holcombe – Director of Finance and Procurement	We will follow the audit approach designed as part of our planning work and undertake appropriate audit testing to enable to Auditor General to provide his opinions on the financial statements of the Health Board.	Planning & interim testing	June 2025 ARAC & Board.
Audit of Charitable Fund Accounts 2024-25	Rob Holcombe – Director of Finance and Procurement	We will follow the audit approach designed as part of our planning work and undertake appropriate audit testing to enable to Auditor General to provide his opinion on the financial statements of the Charitable Fund.	Not yet started	To be confirmed

Performance audit update

5 Exhibit 2 summarises the status of our current and planned performance audit work.

Exhibit 2 – Performance audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Urgent and Emergency Care	Chief Operating Officer	This work will examine different aspects of the unscheduled care system and will include analysis of national data sets to present a high-level picture of how the unscheduled care system is currently working. The work will include an examination of the actions being taken by NHS bodies, local government, and Regional Partnership Boards to secure timely and safe discharge of patients from hospital to help improve patient flow (Part 1). We also plan to review progress being made in managing unscheduled care demand by helping patients access services which are most appropriate for their unscheduled care needs (Part 2).	Phase 1 Flow out of Hospital Part a – Final Part b - Final Phase 2 Managing Urgent and Emergency care – internal clearance	April 2025 June 2025

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Local Project Work - Quality Governance Review Follow up	Executive Director of Nursing Medical Director Executive Director of Therapies and Health Sciences	The work will assess the extent to which previous audit recommendations arising from our thematic review of Quality Governance arrangements have been implemented and are delivering the intended outcomes / benefits. It will also focus on the Health Board's preparedness for the Duty of Quality and Candour and the effectiveness of its governance arrangements in providing assurance over its compliance.	Report in clearance with Health Board	June 2025
All-Wales thematic review of planned care	Chief Operating Officer	This work will follow on from the national report on tackling the planned care backlog. Whilst the exact focus of this work is still to be determined, it is likely to consider: • The extent that health boards have achieved Welsh Government targets for recovering planned care services; • The efficacy of local plans and activity to recover waiting lists; and • Use of the additional Welsh Government financial allocations to improve waiting lists.	Report in clearance with Health Board	June 2025

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Local Project Work 2024 - Eye Care Review	Chief Operating Officer	The precise focus of this work is still to be determined but will look to assess the Health Board's eye care services to ensure they are delivered efficiently, effectively, and economically, and there are clear plans to meet current and future population needs.	Drafting report	June 2025
Structured Assessment 2024 Deep Dive - Review of investment in digital systems	Chief Executive Officer	This review will examine digital arrangements, with a particular focus on how NHS bodies are investing in digital technologies, solutions, and capabilities to support the workforce, transform patient care, meet demand, and improve productivity and efficiency.	Scoping	September 2025
Local project work 2025 – Follow up Outpatients	Chief Operating Officer	The review will focus the Health Board's arrangements to manage follow up outpatient appointments and will also assess the extent to which the Health Board has addressed audit recommendations from our follow-up outpatient reviews in 2015 and 2017.	Scoping	December 2025

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Structured Assessment 2025 - Core	Chief Executive Officer	Our structured assessment work is designed to examine the existence of proper arrangements for the efficient, effective, and economical use of resources. Our 2025 Structured Assessment will review: • Board and committee cohesion and effectiveness; • Corporate systems of assurance; • Corporate planning arrangements; and Corporate financial planning and management arrangements.	Scoping	December 2025
Structured Assessment 2025 – Deep Drive Estates	Chief Executive Officer	This review will examine the effectiveness of corporate arrangements to manage the Health Board's estate with a particular focus on how NHS bodies are prioritising resources to meet strategic priorities whilst also ensuring the current estate remains fit for purpose.	Scoping	December 2025

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
All-Wales thematic review of cancer services	Chief Operating Officer	This work will follow on from the review of national leadership arrangements for cancer services. Whilst the exact focus of this work is to be determined, it is likely to consider: • The progress NHS bodies are making towards achieving Welsh Government targets and quality standards for cancer services; • The efficacy of local plans and associated actions to recover cancer waiting lists; and • Use of the additional Welsh Government financial allocations to improve cancer services.	Scoping	March 2026

Other relevant publications

6 Exhibit 3 provides information on other relevant examinations and studies published by the Auditor General in the last six months. The links to the reports on our website are provided. The reports highlighted in **bold** have been published since the last committee update. We will be bringing the Cancer Services in Wales report to the Committee for presentation once a response to the recommendations has been received from Welsh Government.

Exhibit 3 – Relevant examinations and studies published by the Auditor General

Title	Publication Date
The Biodiversity and Resilience of Ecosystems Duty	**March 2025**
Addressing Workforce Challenges in NHS Wales	**February 2025**
Cancer Services in Wales	January 2025
National Fraud Initiative Self-Assessment Template	December 2024

Additional information

7 Exhibit 4 provides information on corporate documents published by Audit Wales. The reports highlighted in bold have been published since the last committee update. Links to the documents on our website are provided. There are no relevant Audit Wales consultations currently underway.

Exhibit 4 – Audit Wales corporate documents

Title	Publication Date
Annual Plan 2025-26	**April 2025**
Fee Scheme 2025-26	January 2025
Audit Quality Report 2024: Strengthening Trust in Audit	January 2025
Equality Report 2023-24	November 2024
Estimate of Income and Expenses for Audit Wales for the year ended 31 March 2026	November 2024

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Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Archwilio Cymru
Audit Wales

Aneurin Bevan University Health Board – Audit Plan 2025

Audit year: 2024-25

Date issued: March 2025

Document reference: 4709A2025



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Introduction



Adrian Crompton

Auditor General for Wales

I am pleased to share my 2025 Audit Plan. The Plan sets out how I will undertake your audit.

My audit team has developed the Plan following a structured and risk-based planning process, which will remain ongoing throughout the audit. My Code of Audit Practice provides further detail on how my audit and certain other functions are to be carried out by my auditors.

At the core of all our work is our commitment to maintaining the highest standards of professional integrity, objectivity, independence and audit quality. Our three lines of assurance model (page 23) sets out how we will ensure those standards of quality are met. Our latest annual quality report, Audit Quality Report 2024, provides more information about our audit quality arrangements.

My audit team will work constructively with your staff to understand the issues you are facing, ensure the audit process operates as smoothly as possible, and provide valuable insights about any areas for improvement.

My local performance audit work programme, as outlined in this Plan, sits alongside other national audit work that may include coverage of your organisation. Local performance audit work may also inform wider national reporting.

Should you have any questions about your audit my audit team will be happy to discuss them with you. They will also keep you regularly updated as work progresses.

Our aims and ambitions

Our purpose

- Assure people that public money is being managed well
- Explain how that money is being spent
- Inspire the public sector to improve

Our vision

- Fully exploiting our unique perspective, expertise and depth of insight
- Strengthening our position as an authoritative, trusted and independent voice
- Increasing our visibility, influence, and relevance
- Being a model organisation for the public sector in Wales and beyond

Our areas of focus

- A strategic, dynamic, and high-quality audit programme
- A targeted and impactful approach to communications and influencing
- A culture and operating model that enables us to thrive

You can find out more about Audit Wales in our Annual Plan 2024-25 and Our Strategy 2022-27.

Financial audit work

Audit of financial statements

I am required to issue a report on your financial statements which includes an opinion on their 'truth and fairness', their proper preparation in accordance with accounting and legal requirements, and the regularity of income and expenditure and the proper preparation of key elements of your Accountability and Performance Report. I lay them before the Senedd together with any report that I make on them.

I will also report by exception on a number of matters which are set out in more detail in our Statement of Responsibilities.

I am also required to certify a return to the Welsh Government which provides information about the Health Board to support preparation of the Whole of Government Accounts.

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

Financial statements materiality

I do not seek to obtain absolute assurance on the truth and fairness of the financial statements and related notes but adopt a concept of materiality. My aim is to identify material and correct misstatements, that is, those that might result in a reader of the accounts being misled. Materiality applies not only to financial misstatements, but also to disclosure requirements and adherence to the applicable accounting framework and law.

I set planning and performance materiality to:

- Determine the level of misstatement that could cause the user of the accounts to be misled;
- Assist in the scoping of our audit approach and resultant audit tests;
- Determine sample sizes;
- Assess the effect of known and likely misstatements in the financial statements; and

- Report to those charged with governance any unadjusted misstatements above a trivial level, our reporting threshold.

The levels at which I judge such misstatements to be material is set out below.

Planning materiality

represents 1% of gross expenditure based upon 2023/24 audited financial statements/draft financial statements.

£19.4m

Performance materiality

represents 75% of materiality.

£14.6m

Reporting threshold (trivial)

represents 5% of materiality.

£0.97m

There are some areas of the accounts that may be of more importance to the user of the accounts, and we have set a lower materiality level for these:

Remuneration report	Related party disclosures
£5,000 or nearest banding	£10,000 (relating to individuals)

My audit team will assess materiality levels throughout the audit.

Significant financial statements risks

Significant risks are identified risks of material misstatement for which the assessment of inherent risk is close to the upper end of the spectrum of inherent risk or those which are to be treated as a significant risk in accordance with the requirements of other International Standard on Auditing (ISAs). The ISAs require us to focus more attention on these significant risks.

Risk of management override

The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.32-33].

Our planned response

My audit team will:

- test the appropriateness of journal entries and other adjustments made in preparing the financial statements;
- review accounting estimates for bias; and
- evaluate the rationale for any significant transactions outside the normal course of business.

Risk of fraud in revenue and expenditure recognition

There is a risk of material misstatement due to fraud in revenue and expenditure recognition and as such is treated as a significant risk [ISA 240.27 & PN 10].

Our planned response

In addition to the planned response already set out to the risk of management override, we will also:

- substantively test income and expenditure and review it for completeness to ensure that it is appropriately recorded; and
- test cut off to provide assurance that items are recorded in the correct year.

Failure of financial duties

There is a significant risk that you will fail to meet your first financial duty to break even over a three year period. The position at month 11 shows a year-to-date deficit of £7.240million and a forecast year-end deficit of £7.356million. This, combined with the outturns for 2022-23 and 2023-24, predicts a three-year deficit of £94million.

Where you fail this financial duty, we will place a substantive report on the financial statements highlighting the failure and qualify your regularity opinion.

Your current financial pressures increase the risk that management judgements and estimates could be biased in an effort to achieve the financial duty.

The second financial duty requires LHBs to prepare and have approved by Welsh Ministers a rolling three-year integrated medium-term plan. Should you fail this financial duty, we will place a substantive report on the financial statements highlighting this.

Our planned response

- continue to monitor the Health Board's financial position for 2024-25 and the cumulative three-year period to 31 March 2025;
- perform enhanced substantive testing on areas in the financial statements where transactions are at higher risk of being reported

in the incorrect period or misclassified between capital and revenue; and
- consider the impact of any relevant uncorrected misstatements over the three-year period to 31 March 2025.

Other areas of focus

I set out below other identified risks of material misstatement which, although not determined to be significant risks as above, I would like to bring to your attention.

Remuneration report disclosures

Remuneration paid to senior officers and board members continues to be an area of high interest and is material by nature. We have also previously identified material issues with these disclosures.

Therefore, there is a risk that even low value errors in the disclosure could result a material misstatement.

Our planned response

My audit team will:

- understand the movements in the senior management team and Board during 2024-25;
- ensure that remuneration disclosed is consistent with supporting evidence;
- ensure that amounts paid are consistent with those approved by the Board and are in accordance with Welsh Government pay rates; and
- ensure that disclosures are complete based on the team's knowledge and are prepared in accordance with requirements.

Valuation of property assets

The value of property assets reflected in the balance sheet and notes to the accounts are material estimates.

Property assets are required to be held on a valuation basis which is dependent on the nature and use of the assets. This estimate is subject to a high degree of subjectivity, depending on the specialist and management assumptions, and changes in these can result in material changes to valuations.

Assets are required to be formally revalued every five years as a minimum, with indexation applied in interim years, but values may also change year on year, particularly where there are ongoing refurbishment projects resulting in subsequent expenditure being capitalised.

There is a risk that the carrying value of assets recognised in the accounts could be materially different to the current value of assets as at 31 March 2025.

Our planned response

My audit team will:

- review the indices used by management for reasonableness;
- evaluate the competence, capabilities and objectivity of the professional valuer;
- test a sample of assets revalued in the year to ensure the valuation basis, key data and assumptions used in the valuation process are reasonable, and the revaluations have been correctly reflected in the financial statements;
- confirm that indexation has been appropriately applied and has been correctly reflected in the financial statements; and
- test the reconciliation between the financial ledger and the asset register.

Related party disclosures

The financial statements must disclose any related party relationships along with the transactions and balances between the LHB and the other body/party.

The LHB has many relationships that could be considered a related party. Many are well known for example, Welsh Government as funder.

However, where related party relationships arise via individual officer or member relationships, there is likely to be less transparency regarding these relationships. These transactions are of high interest and are considered to be material by their nature.

There is therefore a risk of material misstatement due to incomplete or inaccurate disclosures, even where these are of relatively low value.

Our planned response

My audit team will:

- review management's process for identifying related party relationships and associated transactions and balances;
- undertake procedures to confirm the completeness of related party relationships; and
- ensure disclosures are complete, accurate, consistent with evidence and are in accordance with requirements.

Provisions and contingent liabilities

The financial statements include provisions for legal obligations, particularly in relation to clinical negligence.

There is a significant degree of subjectivity and uncertainty in the measurement and valuation of these provisions.

This subjectivity and uncertainty increases the risk of material misstatement.

Our planned response

My audit team will:

- Review management's estimation process for the valuation of provisions;

- Consider the competence, capability and objectivity of the management experts who are prepare the estimates; and
- Ensure that disclosures are in accordance with the FReM and Welsh Government's Manual for Accounts.

Financial statements audit timetable

Below is a timetable showing the key stages of the audit and our key audit deliverables that we will provide to you.

Exhibit 1: Financial statements audit timetable

Planning **February - March 2025**	Planning meeting High level risk assessment procedures Fraud risk assessment Accounting estimates planning IT environment risk assessment Indicative audit fee Draft Audit Plan
Interim **March - April 2025**	Information flows Detailed risk assessment procedures IT controls review Develop testing strategy Early sample testing
Fieldwork **May to June 2025**	Update risk assessment Audit of financial statements to include narrative report and annual governance statement Complete audit testing Evaluate audit findings Audit closure meeting
Reporting **June to July 2025**	Audit of Accounts Report Recommendations for improvement Present findings to those charged with governance

	Auditor General certification Submission of accounts to Welsh Government Laying of accounts with Senedd Cymru Annual audit summary Post project learning

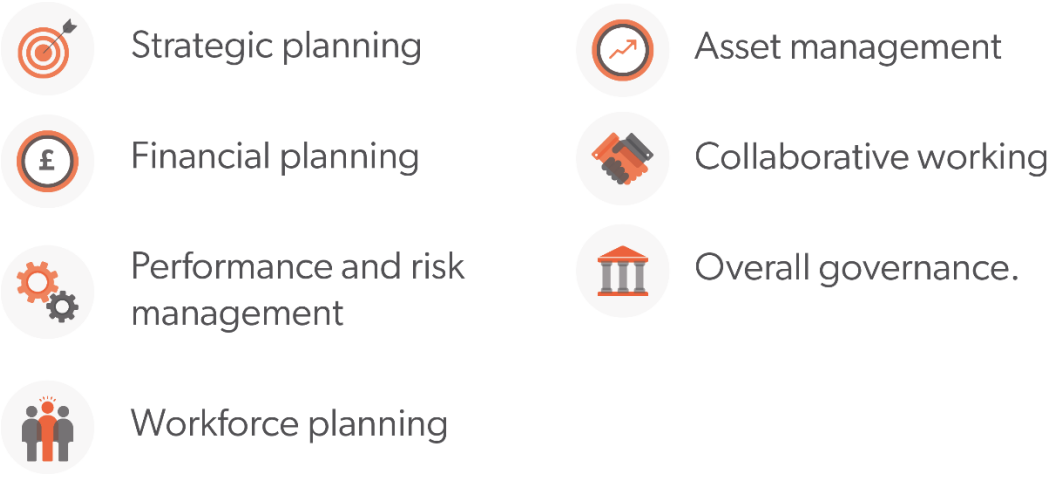
Performance audit work

Proper arrangements

As set out in the Code of Audit Practice, I must satisfy myself that the Health Board has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources ('value for money'), and conclude accordingly.

I do this by undertaking an appropriate programme of performance audit work each year. I base my work programme on an assessment of risks of the Health Board and the wider NHS in Wales not having the proper arrangements in place, with the work typically focusing on the areas of greatest risk.

In designing the programme, my auditors must have considered corporate and service level arrangements, including:



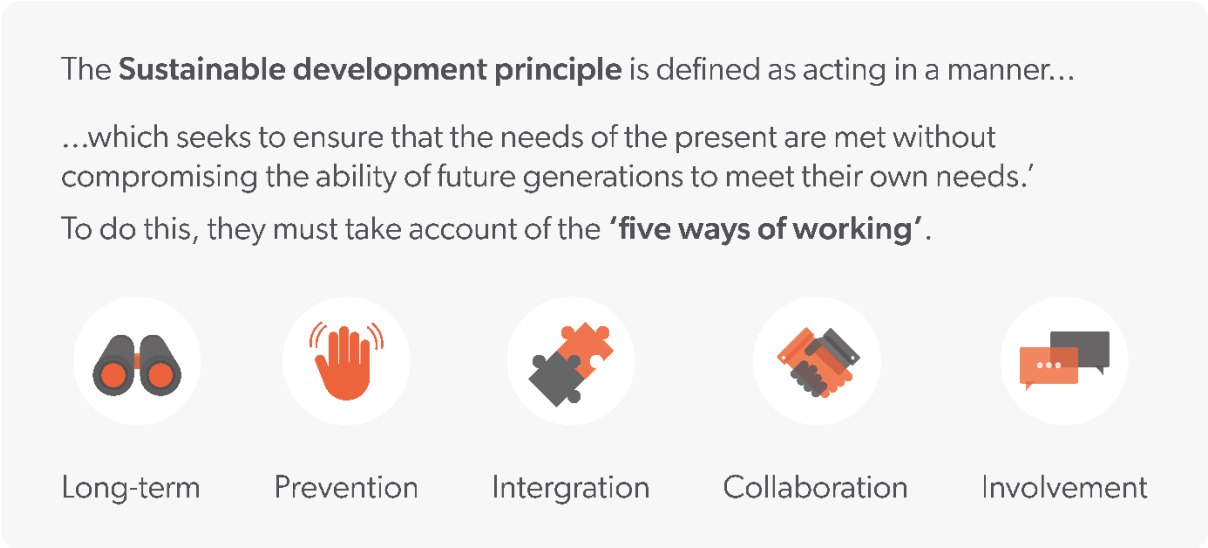
My auditors will also have taken account of relevant work that is being undertaken or planned by other audit, regulatory and inspection bodies at the Health Board.

I conduct my performance audit work using the ISSAI 3000 standard developed by the International Organisation of Supreme Audit Institutions (INTOSAI). INTOSAI is a global umbrella organisation for the performance audit community. It is a non-governmental organisation with special

consultative status with the Economic and Social Council (ECOSOC) of the United Nations.

Well-being of future generations

Section 15 of the Well-being of Future Generations (Wales) Act 2015 (the Act) requires me to carry out examinations of public bodies for the purposes of assessing the extent to which a body has acted in accordance with the sustainable development principle when setting well-being objectives and taking steps to meet those objectives.



I must carry out these examinations at each public body covered by the Act at least once during a specified period.

These could be stand-alone examinations as part of my performance audit programme. However, where relevant and appropriate to do so, my auditors will integrate the work required into other planned performance audit work for the Health Board. My auditors will continue to engage closely with the Office of the Future Generations Commissioner for Wales to help coordinate our respective activities.

Planned performance audit work

I set out below details of my performance audit work.

Structured Assessment – core

Scope of the work

Structured assessment will continue to form a key part of the work my audit teams do at each NHS body to examine the existence of proper arrangements for the efficient, effective, and economical use of resources.

My core 2025 structured assessment work will review the following areas:

- Board and committee cohesion and effectiveness.
- Corporate systems of assurance.
- Corporate planning arrangements; and
- Corporate financial planning and management arrangements.

My structured assessment work will also include a review of the arrangements that are in place to track progress against previous audit recommendations. This allows the audit team to obtain assurance that the necessary progress is being made in addressing areas for improvement identified in previous audit work. It also enables us to more explicitly measure the impact our work is having.

Indicative timescales

Fieldwork to commence between June and August 2025 and reporting by the end of December 2025.

Structured Assessment – review of the arrangements to manage estates

Scope of the work

In addition to the core structured assessment work described above, my audit teams will also review certain arrangements at NHS bodies in more depth. This year, my audit teams will examine the effectiveness of corporate arrangements to manage the Health Board's estate with a particular focus on how NHS bodies are prioritising resources to meet

strategic priorities whilst also ensuring the current estate remains fit for purpose.

Indicative timescales

Fieldwork to commence between May and June 2025 and reporting by the end of October 2025.

All-Wales thematic review of cancer services

Scope of the work

I plan to undertake work following on from my recent review of the national leadership arrangements for cancer services. Whilst the exact focus of this work is still to be determined, it is likely to consider:

- The progress NHS bodies are making towards achieving Welsh Government targets and quality standards for cancer services;
- The efficacy of local plans and associated actions to recover cancer waiting lists; and
- Use of the additional Welsh Government financial allocations to improve cancer services.

Indicative timescales

Fieldwork to commence between September and October 2025 and reporting by the end of March 2026.

Local project work – Follow up Outpatients

Scope of the work

Where appropriate, my audit team will also undertake performance audit work that reflects issues specific to the Health Board. In February 2025, my team initially identified that it would include a local review of operational risk management arrangements in my outline plan. Since then, my team has undertaken additional planning work. As a result, we are now proposing to review follow up outpatient arrangements. This is an area of increasing challenge for the Health Board. Follow up outpatients also complements our wider ongoing audit work on eye care services and planned care.

My work will focus the Health Board's arrangements to manage follow up outpatient appointments and will also assess the extent to which the Health Board has addressed audit recommendations from our follow-up outpatient reviews in 2015 and 2017.

Indicative timescales

Fieldwork to expected to commence September 2025 and reporting by February 2026.

Timing of Performance Audit Work

My team will work with officers in the Health Board to arrange exact timescales for the individual projects and will be communicated regularly through our Audit & Risk Committee update. My auditors aim to substantially complete the performance audit work set out in this plan by the end of March 2026.

Audit fee

In January 2025 we published our 2025-26 Fee Scheme following approval by the Senedd Finance Committee which details the average increase to fee rates of 1.7%.

The actual fee that any individual audited body will pay depends not just on our fee rates but on the quantum of work and the skill mix required.

In 2022-23 you will recall that we implemented a fundamentally different audit approach for our financial audit work, required by new international auditing standards. This required a richer, more costly skill mix that was reflected in higher fees. We have now reviewed the implementation of this new audit approach and identified efficiencies which allows us to reduce our fee for the audit of the financial statements by £15,736 (5.8%), when comparing our 2025 and 2024 fee estimates, as well as refund the Health Board £17,200 in respect of the audit of the 23-24 accounts.

The average fee increase has been applied as an estimate to the other areas of my audit work.

Your estimated total audit fee: £446,088

Planning will be ongoing, and changes to my programme of audit work, and therefore my fee, may be required if any key new risks emerge. I shall make no changes without my auditors first discussing them with the Director of Finance. **Exhibit 2** sets out a further breakdown of your estimated audit fee.

I base my audit fee on the following assumptions:

- The agreed audit deliverables set out the expected working paper requirements to support the financial statements and include timescales and responsibilities.
- The audit requirements of my individual performance audit projects are met by the audited body, or suitable alternative arrangements are put in place that satisfy the needs of my audit team.
- No matters of significance, other than as summarised in this plan, are identified during the audit.

Exhibit 2: Breakdown of my estimated audit fee for 2025 (and 2024 for comparison)

Estimated fee for 2025 (£)[1]

Audit of financial statements	Performance audit work	Grant certification work
£255,069	£187,019	£4,000

Total fee: £446,088

[1] The fees shown in this document are exclusive of VAT.
[2] Payable November 202X to October 202X

[4] Payable April 202X to March 202X.
[5] Payable as work is undertaken.

Actual/estimated fee for 2024 (£)

Audit of financial statements	Performance audit work	Grant certification work (est)
£253,605	£183,806	£4,000

Total fee: £441,411

Audit team

My audit team will continue to work and engage remotely using technology, but some on-site audit work will continue where it is appropriate to do so.

Audited bodies have a responsibility to ensure the safety and wellbeing of Audit Wales staff when they are on your premises.

The main members of my team, together with their contact details, are summarised in **Exhibit 3**.

Exhibit 3: My local audit team

Engagement Director	Richard Harries richard.harries@audit.wales	
	Financial Audit	**Performance Audit**
Engagement Lead	Richard Harries richard.harries@audit.wales	Dave Thomas dave.thomas@audit.wales
Audit Manager	Julie Rees julie.rees@audit.wales	Andrew Doughton andrew.doughton@audit.wales
Audit lead	Angharad Clemens anghard.clemens@audit.wales	Sara Utley sara.utley@audit.wales

I can confirm that my team members are all independent of Health Board and your officers.

Audit quality

Our commitment to audit quality in Audit Wales is absolute. We believe that audit quality is about getting things right first time.

We use a three lines of assurance model to demonstrate how we achieve this. We have established an Audit Quality Committee to co-ordinate and oversee those arrangements. We subject our work to independent scrutiny by the Institute of Chartered Accountants in England and Wales and our Chair of the Board, acts as a link to our Board on audit quality. For more information see our Audit Quality Report 2024.



Our People

- Selection of right team
- Use of specialists
- Supervisions and review



Arrangements for achieving audit quality

Selection of right team

- Audit platform
- Ethics
- Guidance
- Culture
- Learning and development
- Leadership
- Technical support



Independent assurance

- EQRs
- Themed reviews
- Cold reviews
- Root cause analysis
- Peer review
- Audit Quality Committee
- External monitoring

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Our newsletter which provides you with regular updates on our public service audit work, good practice, and events.

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We welcome correspondence and telephone calls in Welsh and English.

Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Archwilio Cymru
Audit Wales

Discharge Planning Progress Update – Aneurin Bevan University Health Board

Date issued: September 2024

Document reference: 4753A2025

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

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

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

Mae'r ddogfen hon hefyd ar gael yn Gymraeg. This document is also available in Welsh.

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Summary report

About this report

1 In 2017, the Auditor General reviewed discharge planning across all Health Boards in Wales. That work focussed on strategic planning, arrangements for monitoring and reporting on discharge planning, and action being taken to manage discharge planning and secure improvements. Our 2017 report on discharge planning for Aneurin Bevan University Health Board (the Health Board) found that '**the Health Board has well-developed plans for improving discharge planning, however performance fluctuates and there is scope to improve the discharge policy, pathways and training'**. We made several recommendations for the Health Board to address as part of that report.

2 The Auditor General had originally included work in his 2021 local audit plans to examine whole system issues affecting urgent and emergency care services, including the discharge of patients from hospital. The COVID-19 pandemic resulted in this work being postponed and brought back on stream in 2023-24. Our work has sought to examine whether health boards and local authorities have effective arrangements in place to ensure the timely discharge of patients out of hospital. The findings from that work are set out in a separate report to the Health Board and its local authority partners in the Gwent region. The regional report will be made available on our website once considered by the appropriate Health Board and local authority committees.

3 As part of our regional review, we have sought to assess the progress made by the Health Board in addressing the recommendations set out in our 2017 discharge planning report. This report sets out the findings with respect to progress against those recommendations. The approach we adopted to deliver our work is set out in **Appendix 1**.

4 We have undertaken the follow-up work and our wider regional review to help discharge the Auditor General's statutory requirement to be satisfied that NHS bodies and local authorities have proper arrangements to secure economy, efficiency, and effectiveness in their use of resources, as required by the Public Audit Wales Act 2004. In addition, to support our previous work on discharge planning, we produced 'What's the hold up? Discharging patients in Wales' which sets out important issues that board members should be sighted of when seeking assurance that patients are discharged from hospital in safe and timely ways. Many of the issues identified are still relevant and should be considered alongside the findings of this report.

Key findings

5 Data from February 2024 showed that across the Health Board's main sites, there were 240 patients whose discharge had been delayed beyond 48 hours. Approximately, 17% of these delays related to discharge planning issues within the Health Board, including the completion of clinical assessments.

6 Our 2017 report made four recommendations that set out seven specific actions for the Health Board. Noting that the Health Board had accepted these recommendations, our follow up work found that:

- no progress has been made against one of the actions;
- work is still ongoing against four of the actions; and
- two of the actions have been implemented.

7 Specifically, we found that:

- the Health Board has made progress developing supporting tools for discharge, but these have not been developed with partners and the communication and monitoring of the tools need improving;
- there is clear guidance setting out when patient transport should be used but there is a lack of awareness of the transport booking policy and communicating predicted waiting times continues to be reliant on local arrangements;
- the Health Board has taken steps to improve its induction training in relation to discharge but needs to go further to improve refresher training and embed joint training with other partners; and
- there is no access for health staff to up-to-date information about waiting times for needs assessments or services to commence, although there are examples of positive integrated working which provide information on a case-by-case basis.

8 The following sections of this report set out our follow-up findings in more detail and **Appendix 2** summarises our assessment of progress against each of the actions identified in our 2017 report.

Recommendations

9 Our follow-up work and wider regional report on patient flow have identified some fresh recommendations on discharge planning for the Health Board, and where relevant, its local authority partners. These have replaced the outstanding recommendations from our 2017 work that are shown in **Appendix 2**.

10 Recommendations arising specifically from this follow-up work are set out in **Exhibit 1**. The Health Board's response to these updated recommendations is captured in **Appendix 3**. Recommendations arising through our wider regional report on patient flow which are relevant to, and have replaced, the recommendations from our 2017 work are set out in **Exhibit 2**. The Health Board should respond to these recommendations as part the finalisation of the regional report.

Exhibit 1: new recommendations arising from this follow-up work

Recommendations
Discharge pathways R1 The Health Board should ensure future and updated tools to support discharge pathways are developed with partners (where relevant), communicated to staff and displayed prominently on wards.
Patient transport R2 The Health Board should strengthen arrangements for managing patient transport by: 2.1. ensuring staff have easy access to relevant transport policies and information and their use is monitored to ensure they are operating as intended; and 2.2. putting in place a formal mechanism to monitor waiting times for patient transport to enable any themes to be highlighted and challenges to be addressed.
Waiting times for services to commence R3 The Health Board should work with its local authority partners to identify ways of providing staff with up-to-date information on waiting times for needs assessments for community-based services and the lead-in time for those services to commence.

Source: Audit Wales

Exhibit 2: recommendations included in the regional report on patient flow replacing previous 2017 recommendations

Recommendations
Improving training and guidance R1 The Health Board and local authorities should embed processes to communicate discharge planning guidance to all relevant health and social services staff, including those working on a temporary basis, supported by an ongoing programme of refresher training and induction training for new staff. Where possible, this should be done on a joint basis.

Recommendations

Improving the quality and sharing of information

R8 The Health Board and local authorities should implement ways in which patient information can be shared more effectively, including opportunities to provide wider access to organisational systems and ultimately joint IT solutions.

Source: Audit Wales

Detailed report

Implementation of previous audit recommendations

11 We considered the Health Board's progress in implementing our 2017 audit recommendations. These focus on:

- discharge pathways (2017 Recommendations 1);
- discharge lounge (2017 Recommendations 2a and b);
- discharge planning training (2017 Recommendations 3a, b and c); and
- information on community services (2017 Recommendation 4).

12 Overall, we found that **the Health Board has made progress developing supporting tools for discharge and a clear process for arranging patient transport. But discharge training should be more impactful and regular, and integrated data sharing needs to be developed to ensure staff have the relevant information they need for efficient discharge.**

Discharge pathways

13 We considered whether the Health Board has:

- developed supporting tools for the main discharge pathways in an appropriate format, for example flow-charts or tables. These documents should have been developed with partner organisations, appended to the revised discharge policy, and displayed prominently (2017 Recommendation 1).

14 We found that **the Health Board has made progress developing supporting tools for discharge, but these have not been developed with partners and the communication and monitoring of the tools need improving.**

15 A range of tools to support effective discharge are in place but these have not been developed with partners. The updated Health Board's discharge policy in October 2023 is aimed at all health care professionals, voluntary and third sector staff involved in discharge in a clinical setting so would benefit from being collaboratively created. This is a missed opportunity to develop integrated approaches to discharge across partners which could make the process more efficient and improve awareness and communication of the policy. This is especially relevant for sites which have social care staff embedded with health teams such as the Caerphilly Council social care team and on the Integrated Frailty Ward.

16 The discharge policy provides links to several useful tools, such as the choice of accommodation policy or the policy for managing patients reluctant to discharge from hospital. The discharge policy also usefully appends the D2RA[1] pathways which provide the journey patents should move through for each stage. However, it is not clear how the discharge policy is communicated to operational staff to enable its intended impact.

17 A Standard Operating Procedure (SOP) was developed for the 'Homeward Bound' ward[2] in November 2022 which outlines the purpose of the ward in promoting independence for medically optimised patients. Discharge letters are appended to the SOP along with a flow chart for 'assessment escalation of a deteriorating patient'. Whilst this is a useful tool and approach to promote discharge of medically optimised patients, it is not clear who is responsible for communicating this or how it is embedded into staff training and induction. The development of the 'Ready to Go Unit'[3] may want to consider these challenges.

18 We saw no evidence of the Health Board assessing compliance with its discharge policy. Although the policy states that an annual programme of learning would be reported annually to the Patient Quality, Safety, and Outcomes Committee, at the time of our review we did not see any evidence that this had occurred.

19 All the Health Board's documents with respect to discharge must be accessed online to prevent old versions being used. While this is understandable, it is not always helpful to busy ward staff, and makes it difficult for these documents to be displayed prominently. A number of these support tools are, however, included in the staff handbooks for each of the hospital sites.

20 We therefore consider that **ongoing action is needed to address recommendation 1 (replaced with 2024 Recommendation 1).**

Discharge lounge

21 We considered whether the Health Board has:

- developed clear transport booking guidance for nurses (2017 Recommendation 2a); and

[1] Discharge to Recover then Assess (D2RA) is designed to support people to recover at home before being assessed for any ongoing need, thereby reducing length of stay in hospital.

[2] The purpose of the Nurse Led Ward is to provide an environment for patients who are medically optimised for discharge but still require support and nursing interventions. The ward promotes a philosophy of independence, whilst improving patient experience through streamlined support within an Enhanced Local General Hospital.

[3] This unit at Royal Gwent Hospital is co-located alongside the Discharge Lounge to help prepare patients for discharge supporting physical, psychological and social wellbeing needs.

- fostered better communication with the non-emergency ambulance service so nurses can communicate predicted waiting times to patients (2017 Recommendation 2b).

22 We found that **there is clear guidance setting out when patient transport should be used but there is a lack of awareness of the transport booking policy and communicating predicted waiting times continues to be reliant on local arrangements.**

23 Guidance within the discharge policy explicitly states to staff that patients should be encouraged to arrange their own transport, and that family, friends and voluntary organisations should be used before relying on the Patient Transport Service run by the Welsh Ambulance Services NHS Trust. A discharge planning 'Guide for Patients, Families and Carers' has also been appended to the main discharge policy. This reiterates in accessible language that patients should arrange their own travel arrangements with hospital transport only available to those with a medical need.

24 The policy also accommodates for unexpected 'on the day' discharges and refers readers to a separate linked document on Transport Booking for Patient Discharge and Transfer Policy. However, staff awareness of this policy is low, and it is not easily accessible meaning its impact is limited, although the use of discharge lounges and whether patients are eligible for patient transport is included in the staff handbook for each hospital site. We therefore consider that **recommendation 2a has been implemented** but further work is required to raise staff awareness **(2024 recommendation 2.1).**

25 During our review of discharge planning in 2017, staff expressed concerns about long waits for patients in the discharge lounges due to patient transport delays and not being able to tell patients how long their wait will be. Since our previous work, the Health Board has developed a Flow Centre which co-ordinates most inter-site patient transport. However patient discharge transport is booked directly from wards through a dedicated phone number and staff maintain communication with the Patient Transport Service for updates, as expected times of collection are not given when booking. These ongoing checks can be time intensive, and patients do not know how long they will have to wait in discharge lounges before being collected. Although discharge lounges are in use, patients can frequently be waiting in different parts of the hospital, resulting in lots of different points of contact. Whilst there were no known issues of escalation at the time of our work, the Health Board cannot be assured this mechanism is effective if there is no formal way of measuring and monitoring the waiting times. The Health Board should put in place a mechanism to understand and monitor patient waiting times at the point of discharge. This will help identify and address any themes and challenges which arise. We therefore consider **ongoing action is needed to address recommendation 2b (replaced with 2024 recommendation 2.2)**.

Discharge planning training

26 We considered whether the Health Board has:

- included discharge planning on induction programmes for staff that will be involved in discharge planning (2017 Recommendation 3a);
- offered regular refresher training (2017 Recommendation 3b); and
- for consistency, considered offering training to staff from partner organisations, who are involved in discharge planning (2017 Recommendation 3c).

27 We found that **the Health Board has taken steps to improve its induction training in relation to discharge planning but needs to go further to improve refresher training and embed joint training with other partners.**

28 To ensure smooth discharge across all sectors, discharge training at induction needs to be impactful and consistent. The Health Board's corporate induction programme includes the discharge policy, and discharge planning training is provided to all newly registered nurses along with competency checks. In addition, all Band 4 nurses undertake competency checks in relation to discharge planning. Local ad-hoc training is also provided to new starters via a buddy mechanism, and when there are large groups of new starters such as the onboarding of overseas nurses, group training sessions take place. We therefore consider that **recommendation 3a has been implemented.**

29 The Health Board's programme of refresher training on discharge planning was impacted by the pandemic and further work is required to ensure that this training is consistently implemented across each hospital site. The need for such training is evidenced by inconsistencies in current approaches to discharge across hospital sites and by the fact that we heard differing views from operational staff as to whether refresher training is offered. We therefore consider that **ongoing action is needed to address recommendation 3b (replaced by 2024 Regional Recommendation 1).**

30 Whilst operational staff reported good working relationships across health and social care, no action has been taken against the previous recommendation around offering joint training to staff across health and social care. Notwithstanding that capacity issues and the number of statutory bodies involved can make this challenging to organise, there are still benefits to be secured in terms of ensuring guidance is understood and consistently adopted, and that expectations between partners are both understood and managed. **Recommendation 3c has therefore been replaced by 2024 Regional Recommendation 1.**

Information on community services

31 We considered whether the Health Board has:

- considered including information about waiting times for needs assessments and for services to commence within the wider information it collates on community service provision (2017 Recommendation 4).

32 We found that **typically health staff do not have access to up to-date information about waiting times for needs assessments or for community-based services to commence, although there are examples of positive integrated working which provide information on a case-by-case basis**.

33 Many staff are unaware of the complete range of community-based services that exist and the associated waiting times for those services to commence. This was noted as part of our work as a significant training need. To address this, the Health Board should work with its local authority partners to identify ways of providing staff with up-to-date information on waiting times for needs assessments for community-based services and the lead in time for those services to commence.

34 At an operational level the Health Board has regular multi-disciplinary operational meetings to discuss patient discharge. This includes ward rounds and length of stay meetings with input from social workers to help understand the waits for services to commence. In addition, ward-based discharge co-ordinators can access both health and local authority systems, as can the Integrated Frailty Team. These are further examples of good integrated information sharing, albeit that the capacity of discharge co-ordinators is limited.

35 However, waiting times for community-based services such as housing adaptations are not well known. This is made more complicated by cross-authority service provision and the lack of shared IT solutions across health and local government to provide information on waiting times for needs assessment and for services to commence. In the absence of such systems, there is a reliance on staff making time consuming manual enquiries for each patient on a case-by-case basis. We therefore consider that **ongoing action is needed to address recommendation 4 (replaced with 2024 Recommendation 3).**

Appendix 1

Audit methods

Exhibit 3 sets out the methods we used to deliver this work. The methods formed part of the audit methods used to deliver our wider regional review.

Exhibit 3: audit methods

Element of audit methods	Description
Documents	We reviewed a range of documents, including: • Board and committee papers • Updates on the Six Goals Programme and urgent and emergency care to committees • Operational and strategic plans relating to urgent and emergency care • Standard Operating Procedure for discharge planning • Corporate risk registers and performance reports • Operational documents, such as proformas and checklists, escalation processes, staff handbooks and leaflets and guidance
Interviews	We interviewed the following: • Head of Patient Discharge • Executive Director of Operations • General Manager Family & Therapies • General Manager Urgent Care • Assistant Head of Patient Discharge • General Manager for Medicine • Deputy Head of Operations • Divisional Operations Manager • Director of Primary and Community Care and Mental Health • Chief Officer of Aneurin Bevan Community Health Council (now Llais)

Element of audit methods	Description
Observations	We observed the following meeting(s): • Cross site flow meeting via Teams • Flow Meeting (Gwanwyn MDT) • Flow Meeting (Education Centre Ysbyty Ystrad Fawr) • Six Goals Urgent Care Meeting • System Leadership and Response Meeting We also observed the following individual(s): • Discharge Co-ordinator at Neville Hall Hospital
Data analysis	We analysed the following national data: • Monthly social services dataset submitted to the Welsh Government • Monthly delayed discharges dataset submitted to the NHS Executive • StatsWales data • Ambulance service indicators We also analysed data provided by the Health Board relating to all emergency medicine patients discharged in October 2022 with a length of stay greater than 21 days (excluding those who died).
Case note review	We reviewed a sample of 29 case notes relating to emergency medicine patients discharged in October 2022 with a length of stay greater than 21 days (excluding those who died).
Focus Groups	We undertook focus groups with the following: • Discharge co-ordinators
Self-assessment	We asked the Health Board to complete and submit a self-assessment, setting out its view of progress against our 2017 recommendations.

Source: Audit Wales

Appendix 2

Summary of progress against our 2017 recommendations

Exhibit 4 sets out the recommendations we made in 2017 and our summary of progress.

Recommendations	Progress
Discharge pathways R1 Whilst discharge pathways are in place, we found no evidence of documents to support staff to implement them. The Health Board should develop supporting tools for the main discharge pathways in an appropriate format, for example, flow-charts or tables. The documents should be developed with partner organisations, appended to the revised discharge policy, and displayed prominently.	**Ongoing** – see paragraphs 15-20 (replaced with 2024 Recommendation 1).
Discharge lounge R2 Ward staff expressed concerns about patients waiting for long periods of time in discharge lounges, mainly due to issues with nonemergency patient transport and staff not booking the right form of transport. The Health Board should: a) Develop clear transport booking guidance for nurses. b) Foster better communication with non-emergency ambulance services so nurses can communicate predicted waiting times to patients.	**Implemented** – see paragraph 24 **Ongoing** – see paragraph 25 (replaced with 2024 Recommendation 2.2)

Recommendations	Progress
Discharge planning training R3 We found induction programmes for nursing, medical and therapy staff did not include training on discharge planning. The Health Board should: a) Include discharge planning on induction programmes for staff that will be involved in discharge planning. b) Offer regular refresher training. c) For consistency, consider offering training to staff from partner organisations, who are involved in discharge planning.	**Implemented –** see paragraph 28 **Ongoing –** see paragraph 29 (replaced with 2024 Regional Recommendation 1) **No action –** see paragraph 30 (replaced with 2024 Regional Recommendation 1)
Information on community services R4 We found the Health Board regularly collates information about community services; however, waiting times are not included. The Health Board should consider including information about waiting times for needs assessments and for services to commence.	**Ongoing –** see paragraphs 33 to 35 (replaced with 2024 Recommendation 3)

Source: Audit Wales

Appendix 3

Management response to audit recommendations

Exhibit 5 sets out the Health Board's response to our audit recommendations.

Exhibit 5: management response

Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
Discharge pathways R1 The Health Board should ensure future and updated tools to support discharge pathways are developed with partners (where relevant), communicated to staff and displayed prominently on wards.	Policy: • The Health Board will review its Discharge Policy in light of the new National Policy published in September 2024. • The Policy will include standard operating procedures (SOP) for Discharge to ensure that there is clarity for staff. • A communication plan for staff, partners and managers will be completed and posters for ward areas will be developed which set out simply the SOPs. Pathways: • Clinical Workstation 2 (CWS2), which is currently being rolled out across the health	January 2025 November 2024	Executive Director of Nursing Executive Director of Nursing

Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	board has the functionality to assign the correct pathway to each patient: this will integrate with Qlik to ensure daily live capture of patient pathways.		
	• 'Complex List' to be developed into CWS2 with daily data feedbacks, local authority and health staff to have access to the digital system.	March 2024	Executive Director of Nursing/Director of Digital
	• Agreement has been reached to develop an app called 'Ask Annie: this app will provide access to information on Integrated Discharge Pathways and Services. This app is in the early stages of development.	April 2025	Executive Director of Nursing/Director of Digital
	• A series of workshops are planned to develop a single integrated pathway for Discharge – this will aim to reduce complexity and duplication by creating single access points for discharge services and advice and guidance. This follows a successful piece of work on integrating front door pathways.	January 2025	Executive Director of Nursing
	• An optimal ward project 'Perfect Ward' is planned which will right size the processes, capacity and capability within ward environments to optimise patient flow and discharge.	March 2025	Executive Director of Nursing/Chief Operating Officer
	• Audit and evaluation of the Discharge improvements, plans and pathways will be undertaken post implementation.	June 2025	Executive Director of Nursing

Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	• A patient discharge leaflet will be developed to reinforce the 'what matters' conversation and discharge planning at point of admission. Training: • The Health Board and its partners have secured additional funding to pilot the Balancing Rights and Responsibilities Training – the first cohort took place in November 2024 and following evaluation will be embedded within the discharge programme. • Further review of the training for new registrants and additional update training will be scoped in the context of the above training and the development of the app. • Embedding of the Optimal Hospital Flow Framework across all sites – Red to Green, SAFER, D2RA, Deconditioning	April 2025 June 2025 April 2025 April 2025	Executive Director of Nursing Executive Director of Nursing/Director of Workforce & OD Executive Director of Nursing Executive Director of Nursing
Patient transport R2 The Health Board should strengthen arrangements for managing patient transport by:	The Health Board will: • Review current guidance on transport booking that is on the Intranet and update as required. • Develop communication plan with the Health Board's Communications Team to	December 2024 December 2024	Chief Operating Officer Chief Operating Officer

Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
2.1 ensuring staff have easy access to relevant transport policies and information and their use is monitored to ensure they are operating as intended; and 2.2 putting in place a formal mechanism to monitor waiting times for patient transport to enable any themes to be highlighted and challenges to be addressed.	disseminate information across the Health Board. • Roll out renewed guidance to service users. • Discuss potential for live reporting system with the National NEPTS Delivery Action Group and Joint Commissioning Committee. • Utilise current WAST reports available to provide monthly updates on waiting times and themes. Arrange for standing agenda item at Tier 3 Transport Group meeting. • Discharge Lounges to be operational across all sites, to ensure timely patient transport.	January 2025 March 2025 January 2025 February 2025	Chief Operating Officer Chief Operating Officer Chief Operating Officer
Waiting times for services to commence R3 The Health Board should work with its local authority partners to identify ways of providing staff with up-to-date information on waiting times for needs assessments for community-based services and the lead in time for those services to commence.	Further work to improve the flow of information will be addressed through the 'Perfect Ward' project which will create the optimal environment for clinical teams working with social care colleagues to optimise discharge. Agreement has been reached to develop an app called 'Ask Annie': this app will provide access to information on Integrated Discharge Pathways and Services. This app is in the early stages of development.	March 2025 April 2025	Executive Director of Nursing Executive Director of Nursing/Director of Digital

Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	The Integrated Discharge Board will be formalised as a Tactical sub-group of the RPB. It is intended and has been agreed that greater transparency in reporting will be developed. A dashboard providing access to waiting times for community assessment and service availability will be included.	September 2025	Executive Director of Nursing/Chief Operating Officer
	Weekly review of Pathway of Care Delays, patients over 100 days, working local authority partners.	December 2025	Executive Director of Nursing



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Aneurin Bevan University Health Board

Health Board Committee Assurance Note

Executive Lead	Jennifer Winslade, Director of Nursing
Reporting to:	Audit, Risk & Assurance (ARA) Committee

Summary

At a previous Committee meeting, it was requested that an additional progress report would be produced on any outstanding recommendations relating to the Discharge Planning 2022 Audit.

At the end of Quarter 4 (Reporting Period 1st October 2024 – 31st December 2024) there were 5 outstanding recommendations from the 2022 Discharge Planning Audit. Following review 2 of the 5 have been completed and the remaining 3 are in progress with an aim to complete by the end of March 2025, further details are provided below;

R 3.1	R.3.3	R 4.3	R 5	R 7

1. Audit Report Title: **Discharge Planning 2022**

Recommendation 3.1:	All patient discharges from the care of the Health Board are effectively controlled and evidenced by issuing a timely, completed discharge notification.
Management Response:	The Medical Director is aware that the timeliness of some discharge notifications needs to be improved. A letter was sent to all medical staff outlining their responsibilities in respect of timely discharge notifications in 2021. This is now being followed up by the Assistant Medical Director for Planning who will be leading a task & finish group to develop standardisation of approach. This work will aim to ensure that patients are able to leave hospital with their discharge summary / notification and ensure it will be sent electronically to the GP on the same day
Status:	Ongoing

CWS technical change to be completed in 2025/2026 aligned to Health Board digital priorities timescale to be confirmed. Perfect week to be delivered **Q1 2025/2026** linking with Divisions and operational teams. Communication and engagement undertaken with Divisional Directors through Medical Leadership forum to reinforce the approach and outline plan for the perfect week.

Recommendation 3.3:	A consistent discharge approach is adopted for all day care appointments and for inpatient transfers between Health Board sites
Management Response:	In respect of day care episodes of care, there are many diagnostic / treatment areas and specialities who have different methods of notifying both the GP and patient of the care episode. We acknowledge that this is not a standard approach with some departments combining the clinical details as the discharge summary. As part of the Task and Finish group, the Assistant Medical Director for planning will ensure that discharge notifications form part of the standardised approach. For inter-site transfers an SBAR is completed for every patient that outlines the patient's condition, diagnosis and any actions needed to be taken by the receiving site.
Status:	Ongoing
New step-down process rolled out w/c 6th January, monitoring and review of process via Integrated Discharge Board post 6 months of implementation. Assistant Medical Director to focus on ensuring that discharge notifications form part of standardised approach through pilot of perfect week in **Q1 2025/2026** linking with Divisions and operation teams.	
Recommendation 4.3:	A method for identifying delays during the discharges of 'simple' cases should be introduced, monitored and reported
Management Response:	Discharge delays can affect both simple and complex discharges and therefore emphasis should be improving the process for all patients. Length of stay data is available to explore the feasibility and the benefits of such an approach. The Health Board continually seeks to identify the factors that delayed discharge and this work forms part of the workstream for goal 5 of the Welsh Government '6 Goals for Urgent and Emergency Care' programme. As part of this programme, the Delivery Unit has recently released the 'optimal patient flow framework', and the Health Board will be embedding these principles as 'business as usual'. The framework will also feature in the new All Wales Discharge Policy, to include the introduction of the SAFER principles, D2RA and 'red & green days. These concepts have the potential to reduce LOS and improve discharge planning, so will be embedded within our policy.
Status:	Completed

Roll out of CWS2 across all wards and sites to support the recording of data which includes D2RA pathway, Red to Green days, reason for delay and clinically optimised status aligned to the 'Optimal Hospital Flow Framework'. Development of ward dashboards to assist operational staff with identifying reasons for delayed discharge and support with timely discharge planning. Ongoing monitoring re compliance, training and education to improve patient flow and deliver timely pathways of care	
Recommendation 5:	Determining whether to make the use of the discharge checklist mandatory (including which aspects to include) or not and if so, the document should be consistently completed. Performance should be monitored until fully embedded.
Management Response:	Discharge checklists are used by most wards; however, we acknowledge there is an inconsistent approach in their use. The Welsh Nursing Care Record is currently being rolled out across the Health Board and may provide the opportunity to make the checklist part of the digital record as part of a standardised approach. In the interim, the use of checklists will be reviewed as part of the Discharge Improvement Board workstreams. The use of checklists will be further defined in the new discharge policy.
Status:	Completed
Discharge Champions appointed - rolling programme of teaching sessions in place. WNCR rolled out across the HB - discharge checklist features within this. Further work being led nationally to refine with a lead in time of circa 1 year.	
Recommendation 7:	We recommend that the Health Board continue to analyse the reasons behind re-admissions within a suitable period of time. Where themes and trends are identified that these are investigated further
Management Response:	The analysis of readmission rates is acknowledged as being problematic, as without clinical input at the time of readmission, our current systems are unable to differentiate between a readmission for a reason connected to a prior episode of care, or one that relates to a completely different clinical scenario. CHKS, which is the national benchmarking solution choice for Wales looks at the number of patients who have been readmitted regardless of specialty, consultant, diagnosis etc. This makes any analysis difficult to interpret or perhaps meaningless. The planning department is currently working with clinical teams to develop a number of meaningful measures to determine and understand readmission trends, and to identify where improvement is required. A number of data viewers have been

	developed and can provide 'bespoke' data by request. Moving forward, these measures will be included within the outcome measures and QPS insights. The Health Board has dedicated services to address frequent or 'high impact' service users that are working across Divisional Boundaries to provide alternative pathways. There is also a workstream focusing on patients at high risk of readmission supported by Lightfoot data and linked to goals 1 and 2 of the 6 Goals for Urgent & Emergency Care programme.
Status:	Ongoing
Re-admission rates to be monitored as part of the optimal ward model, across three wards at RGH, Medicine, Community and Surgical, identifying reason for re-admission aligned to the 50-Day Integrated Care Winter Challenge. Senior Nurse for Discharge at RGH in post to provide leadership. Enhanced resource in Corporate Performance team to support analysis of discharge data and information reported via the Integrated Discharge Board. Optimal ward model evaluation to be undertake post March 2025 reported via the Integrated Discharge Board to include learning and recommendations.	

Archwilio Cymru
Audit Wales

Urgent and Emergency Care: Flow out of Hospital – Gwent Region

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Mae’r ddogfen hon hefyd ar gael yn Gymraeg. This document is also available in Welsh.

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Summary report

About this report

1 Once a patient is considered medically or clinically well enough to leave hospital (also referred to as medically fit or clinically optimised) the timely discharge of that patient to the right setting for their ongoing needs is vital. Timely, effective, and efficient moving of patients out of an acute hospital setting holds important benefits for patient care and experience as well as for the use of NHS resources.

2 When the discharge process takes longer than it should there can be significant implications for the patient in terms of their recovery, rehabilitation, and independence. Delayed discharges will also have implications for other patients coming into the urgent and emergency care system[1] who need a hospital bed. Poor patient "flow" create bottlenecks in the system that contribute to well documented problems such as over-crowded emergency departments and an inability to secure timely handover of patients from ambulance crews.

3 The Auditor General had originally included work in his 2021 local audit plans to examine whole system issues affecting urgent and emergency care services, including the discharge of patients from hospital. The COVID-19 pandemic resulted in this work being postponed and brought back on stream in 2023. Our work has sought to examine whether health boards and local authorities have effective arrangements in place to ensure the timely discharge of patients out of hospital. The approach we adopted to deliver our work is detailed in **Appendix 1.**

4 This work is part of a broader programme of work the Auditor General is currently undertaking in respect of urgent and emergency care services in Wales. We are also examining the arrangements in place to help manage urgent and emergency care demand, and to direct patients to the care setting that is most appropriate to their needs. The findings from that work will be reported separately in 2024.

5 The Auditor General's work on urgent and emergency care is designed to help discharge his statutory duties. Specifically, this work is designed to satisfy the Auditor General that NHS bodies and local authorities have proper arrangements in place to secure the efficient, effective, and economical use of resources, as required by Sections 17 and 61 of the Public Audit Wales Act 2004.

6 This report sets out the findings from the Auditor General's review of the arrangements to support effective flow out of hospital in the Gwent Region (the region). The region encompasses:

- Aneurin Bevan University Health Board (the Health Board);
- Blaenau Gwent County Borough Council;

[1] Urgent and emergency care describes any unplanned, urgent, and emergency care provided by health and social care services. The urgent and emergency care system is complex with numerous organisations involved in providing services and it deals with acutely unwell, vulnerable, and distressed people in need of urgent assistance.

- Caerphilly County Borough Council;
- Monmouthshire County Council;
- Newport City Council; and
- Torfaen County Borough Council

7 In undertaking this work, we have also considered progress made by the Health Board against previous recommendations made in our 2017 report on discharge planning. Our findings from this work are set out in a separate report to the Health Board.

Key messages

8 Overall, we found that **despite a clear focus on improving patient flow within the region, a significant number of medically fit patients are occupying hospital beds. This continues to have serious knock-on effects on other NHS pathways of care and creates risks for patients' physical and mental well-being. More timely assessments of patients, a less risk averse approach to discharge planning and more consistent application of discharge policy is needed. Workforce and IT system challenges continue to be key barriers that partners will need to focus on to secure value from the investments they have made and to achieve the improvements they recognise are needed.**

9 For the twelve months up to and including February 2024, each month there were an average of 250 medically fit patients in the Health Board's hospitals whose discharge was delayed. The completion of joint and clinical assessments were the main causes for delayed discharge and the total number of bed days that had been lost to delayed discharges over that period was 55,685 which equates to £27.8 million of NHS resource based on an average bed cost of £500. A full list of the reasons for discharge delays is included in **Appendix 2**.

10 The consequent impact on patient flow within hospitals and the urgent and emergency care system is significant, with waiting times in emergency departments and ambulance handovers falling well short of national targets. In February 2024, there were over 3,000 lost ambulance hours because of handover delays, and the average wait within the Health Board's emergency department was 8.5 hours. More detailed analysis of the region's performance across a range of urgent and emergency performance indicators is included in **Appendix 3**.

11 Several factors are contributing to delayed discharges. Complexity and volume of demand are increasing in line with an ageing population, but the Health Board may be exacerbating that complexity by being risk averse to discharge which is contributing to problems elsewhere in the patient pathway. Workforce capacity in both health and social care is a challenge for the region, impacting on joint and clinical assessments, although waits for social care assessments are less problematic than many other parts of Wales, and the care sector capacity across the region is generally meeting demand. There are regular multi-disciplinary meetings in relation to patient discharge, but use of the existing discharge policy is

not embedded, the approach to staff training is inconsistent, and the discharge planning process is not well documented within patient case notes. Staff involved in the discharge process have created operational workarounds for data sharing such as patient flow meetings, but formal data sharing and data quality are variable and digital interfaces between organisations are not compatible.

12 We found that addressing patient flow is central to relevant strategic and operational plans across the Gwent region and in line with Welsh Government requirements. Strategic partnership working is evident building on existing collaborative relationships, but operational partnership working is less well developed. Financial resources are being targeted to support patient flow with positive outcomes, although the ability of the partners to match fund is increasingly challenging and the impact of the funded initiatives could be more transparent. There is clear oversight and scrutiny of actions being taken to improve patient flow, although more could be done to gather patient and service user feedback and oversee compliance with current discharge policies.

13 Whilst there is a clear recognition by regional partners of the problems associated with discharge, a desire to address them with the right focus within strategies and plans, impactful projects and good strategic relationships, the number of delayed discharges across the region have not significantly reduced. Continued action is needed across a range of areas to secure the improvements which are necessary for patients, their families, and the wider urgent and emergency care system.

Recommendations

14 Recommendations arising from this audit are detailed in **Exhibit 1**. The combined management response by the statutory bodies included in this review to these recommendations will be summarised in **Appendix 5** once considered by the relevant committees.

Exhibit 1: recommendations

Recommendations
Improving training and guidance on discharge planning
R1 The Health Board and local authorities should embed processes to communicate discharge planning guidance to all relevant health and social services staff, including those working on a temporary basis, supported by an ongoing programme of refresher training and induction training for new staff. Where possible, this should be done on a joint basis.
R2 The Health Board should update its discharge policy to ensure that it reflects the national guidance issued by the Welsh Government in December 2023.

Recommendations

Embedding a seven-day approach to discharge

R3 The Health Board and local authorities should review capacity to embed and deliver seven-day discharge. Despite discharges needing to happen daily, current ways of working do not support this, and a lack of weekend discharge means patients have a prolonged stay in hospital which increases risk of deconditioning and acquiring infection.

Clarify roles and responsibilities in relation to informal over prescribing of care packages

R4 The Health Board should clarify roles and responsibilities regarding care package prescribing to ensure patients are not given unrealistic and unnecessary expectations in relation to care provision. This is particularly the case with older patients who may be seen as frail. This can disempower patients from being independent and may lead to future readmissions.

Review risk appetite in relation to patient discharge

R5 The Health Board should review its cultural appetite and approach to risk in relation to patient discharge. This should ensure risk is assessed across the whole patient pathway, so beds are not unnecessarily occupied.

Embedding the Trusted Assessor model

R6 The Health Board should embed its approach to the Trusted Assessor model and communicate this approach to all partners. Whilst there is recognition this may not help secure care packages or placements more quickly; it will ensure there is capacity to assess patients when required.

Improving oversight of policies and guidance

R7 The Health Board should monitor compliance with its discharge policy to assess the effectiveness and consistency of the application, and whether the intended outcomes are being achieved. This includes adhering to its own policy that an annual programme of learning will be reported to the Patient Quality, Safety and Outcomes Committee.

Improving the quality and sharing of information

R8 The Health Board and local authorities should implement ways in which patient information can be shared more effectively, including opportunities to

Recommendations

provide wider access to organisational systems and ultimately joint IT solutions.

R9 The Health Board should improve record keeping by:

9.1. ensuring all staff involved in discharge planning fully understand the importance of documenting comprehensive information in patient case-notes to support effective discharge planning.

9.2. establishing a programme of case-note audits focused on the quality of record keeping.

Patient, service user and staff feedback

R10 The Health Board should ensure it has mechanisms in place to understand the experiences of patients and carers in the discharge process in line with their existing policy and apply learning.

R11 The local authorities should ensure relevant social services teams routinely capture service users and carers' experiences and apply learning.

Detailed report

What is the scale of the challenge?

15 This section sets out the scale of the challenge that the region is facing in respect of delayed discharges and the subsequent impact on patient flow and the patient experience.

16 We found that **while the region has comparatively lower rates of delayed discharges, these are impacting on patient flow particularly in the emergency department and consistent patient access to stroke wards. Waiting for a joint assessment is the main cause of delay but there are challenges throughout the health and social care system.**

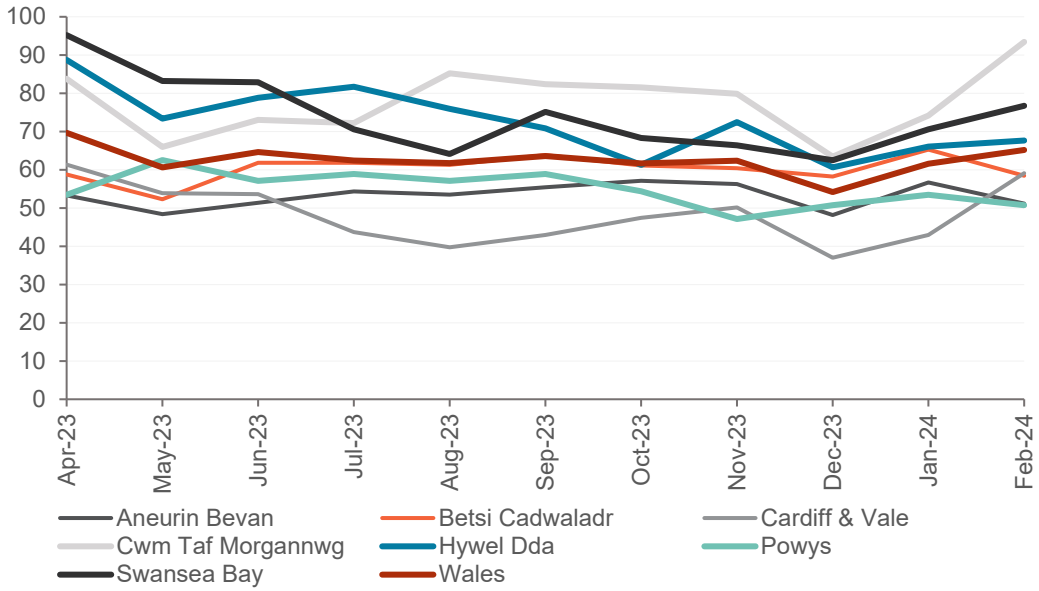
Delayed discharges

17 We found that **the region has comparatively low and stable rates of delayed discharges, though delays in completion of joint assessments continue to present a challenge.**

18 Delays discharging patients from hospital has been a longstanding issue for bodies in Wales and other parts of the UK. The available data shows that this issue has become significantly worse in recent years.

19 **Exhibit 2** sets out the number of delayed discharges experienced by the Health Board between April 2023 and February 2024, compared with other health boards across Wales. These relate to patients who are considered medically fit but remain in a hospital bed 48 hours after the decision was made that they were well enough to leave hospital. Whilst performance is slightly better than the average for Wales, there is still a large number of delayed discharges impacting bed capacity and patient flow.

Exhibit 2: number of delayed discharges per 100,000 head of population (April 2023 – February 2024)



Source: Welsh Government

20 Since the pandemic, the way in which delayed discharges are measured has changed. No data on delayed discharges was formally reported between the period March 2020 and March 2023. Prior to the pandemic, delayed discharges were reported as 'delayed transfers of care' which were defined as those who continue to occupy a bed after the date in which the patient is declared to be ready to move on to the next stage of their care. This compares with the current method for counting delays which focuses on those who remain in a hospital bed 48 hours after being identified as medically fit.

21 Although not a direct comparison, in February 2020 the Health Board reported 72 delayed transfers of care. The position at the end of February 2024 of 240 delayed discharges equates to 16.4% of the Health Board's total bed capacity[2]. However, this is below the all-Wales average of 17.9% (ranging between 13.7% and 31.3%).

22 The top five reasons for delayed discharges compared to the all-Wales position are set out in **Exhibit 3**, with the most common reason being awaiting joint assessment (between health and social care). A full list of reasons for delay in the Health Board, and by local authority are set out in **Appendix 2**.

[2] Based on general and acute bed availability data in July 2023, StatsWales website (https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Hospital-Activity/NHS-Beds/nhsbeds-by-organisation-site)

Exhibit 3: top 5 reasons for delayed discharges for the Health Board compared to the all-Wales position (February 2024)

Reason for delay	Percentage delayed	All-Wales average
Awaiting joint assessment	14.2	9.0
Awaiting completion of clinical assessment (nursing/ allied health professional/ medical/ pharmacy)	9.6	10.3
Awaiting reablement care package	6.3	3.0
Awaiting residential care home manager to visit and assess (Standard 3 residential)	6.3	2.5
Awaiting start of new home care package	5.8	8.0

Source: Welsh Government

23 When broken down by local authority, the rate of delayed discharges per 100,000 head of population is generally lower when compared to the all-Wales position. This is except for Monmouthshire where the rate has occasionally been higher than the all-Wales position. Awaiting joint assessment is the highest cause of delay in Monmouthshire and Newport. Awaiting clinical assessments is the highest cause of delay in Blaenau Gwent and Torfaen. Awaiting residential care home manager visit and assessment is the highest cause of delay in Caerphilly.

24 **Exhibit 3** indicates that delayed discharges are a result of challenges throughout the health and social care system and cannot be wholly attributed to one sector. Although waiting for a joint assessment is the highest cause of delay in the region, awaiting completion of a clinical assessment is the second highest with reablement waits and care home delays next. Any action to address delayed discharges in one area will need to consider the impact on other areas causing waits for patients.

25 Based on data reported in February 2024, the total number of delayed patients accounted for 5,211 bed days. Based on a typical cost per bed day[3], this equates to costs in the region of £2.6 million for the month, and a full year effect of just under £30.43 million. Given the financial pressures facing the public sector, this represents a significant amount of NHS resource that is being used sub-optimally and which should be employed in other ways to meet other demand in the system.

[3] Based on £500 per bed-day as set out in the NHS Confederation briefing for the statement by the Minister for Finance and Local Government on the 2023-24 financial position

Impact on patient flow

26 We found that **delayed discharges are having an impact on patient flow, particularly in relation to the Health Board's emergency department performance.**

27 Delays in discharging patients from hospital have consequences for patient flow and in particular the ability for patients to access services when they need them. Beds being used by patients who no longer need them means that they are not available for those who do, resulting for example, in longer waits in emergency departments. This in turn impacts on the ability for ambulance crews to hand over patients and respond to 999 calls in the community.

28 **Appendix 3** sets out the region's performance across a range of urgent and emergency care performance indicators in comparison to the position across Wales since April 2022. In summary:

- whilst the percentage of ambulance red calls responded within 8 minutes has been consistently better than the all-Wales position it has not reached the national target of 65% since July 2020 (**Exhibit 18**);
- the median amber response time is longer than the national target of 20 minutes but generally in line with the all-Wales average, with performance at 81 minutes in February 2024 (**Exhibit 19**);
- the percentage of ambulance handovers within 15 minutes at the Health Board's major emergency department is broadly in line with the all-Wales average, at around 21% which is significantly below the national target of 100% (**Exhibit 20**);
- the percentage of ambulance handovers taking over one hour is relatively static at around 40%, and below the all-Wales average, compared to a national target of zero[4] **(Exhibit 21)**;
- the total number of hours lost following notification to handover over 15 minutes is below the all-Wales average, fluctuating between 2,700 and 4,500 hours per month (**Exhibit 22**);
- once the patient is in the emergency department, the median time from arrival to triage is generally in line with the all-Wales position at 21 minutes (**Exhibit 23**);
- the median time from arrival to being assessed by a senior clinical decision maker is above the Wales average and since May 2023, is the highest in Wales fluctuating between two and just over three hours **(Exhibit 24)**;
- the percentage of patients seen within four hours in a major emergency department is below the all-Wales average and the second lowest in Wales, compared with the national target of 95% **(Exhibit 25)**;

[4] The target for no patient handover to take longer than one hour was introduced as an additional metric by the Welsh Government within the NHS planning framework in 2023/2024 as part of work to try and reduce the increasing trend of lost hours

- the percentage of patients spending less than 12 hours in a major emergency department is also below the all-Wales position and the second lowest in Wales **(Exhibit 26); and**
- the proportion of bed days accrued by people with a length of stay over 21 days has been better than the all-Wales average **(Exhibit 27)**.

29 Based on our analysis of Health Board data relating to all emergency medicine patients discharged in October 2022, we found the average total length of stay for patients staying over 21 days in the acute sites was 44 days (compared to 56 days across Wales). This varied across the three acute sites, with the average total length of stay of 31 days at Grange University Hospital, compared to 47 days at Royal Gwent Hospital. The average total length of stay at Nevill Hall Hospital was 46 days. This demonstrates that the region's approach to discharge is having favourable impacts on a patient's length of stay compared with the all-Wales average for this period.

30 The Health Board's total bed capacity has fluctuated over recent years, with 1,793 total beds available in 2022-23, with just under 40% of these allocated to acute medicine (668). Bed occupancy in the acute medicine beds has been at 89.2%, compared with an optimal level of 85%. The Health Board is one of four health boards to have community hospital beds managed by GPs. These beds provide step-down facilities for patients who no longer need acute care. The number of these beds has remained stable at around 30 since 2010-11, however occupancy levels have been running high at 99%.

31 Pressure on available beds because of delayed discharges means that health boards are not always able to ensure that patients are placed on the best wards for their clinical needs. For example, health boards will usually hold vacant beds on stroke units to ensure that stroke patients have fast and direct access, enabling them to access stroke specialists and equipment.

32 Health boards have increasingly experienced difficulties in admitting stroke patients to a stroke ward as problems with patient flow and bed availability mean that these beds have been needed for non-stroke patients. Between April 2022 and April 2023, performance was volatile with the percentage of stroke patients with direct access to a stroke ward within four hours having fluctuated between a low of 5.9% and a high of 31%.

33 The impact of poor patient flow is also often felt within scheduled (or planned) care, as patients with their booked procedures are increasingly having their treatments cancelled due to the lack of available beds. During 2022-2023, 161 planned care admissions were cancelled due to the lack of an available ward bed in the Health Board, with half of those during June and July 2022, and February 2023. For the period, 2023-24 up to and including February 2024, only 42 planned care admissions were cancelled. Whilst this is below the levels of some other health boards, these cancellations represent poor patient experience and risk the conditions of planned care patients further deteriorating while they wait for their treatment to be rescheduled.

Meeting patients' needs

34 We found that **the region is largely managing to avoid the use of inappropriate short term unplanned care home placements. However, a stronger multidisciplinary approach to discharge planning is needed to reconcile different views on patients' needs and to avoid unnecessary discharge delays.**

35 The pressure to discharge patients and the lack of available care options can lead to patients being discharged to settings that are not always the most appropriate ones for their needs including:

- being discharged home before a proper care package is in place;
- being discharged to a residential care home when they could have gone home with a support package;
- being discharged to a temporary residential care home to await availability of longer-term placement;
- being discharged to a community hospital bed to await availability of a package of care; and
- being discharged to a setting which is far away from family and friends.

36 Patients who are delayed within hospital can become deconditioned, are at higher risk of experiencing an injury from a fall or contracting a hospital acquired infection. which can exacerbate their care needs, lengthening their hospital stay and making them more vulnerable to re-admission after they have been discharged.

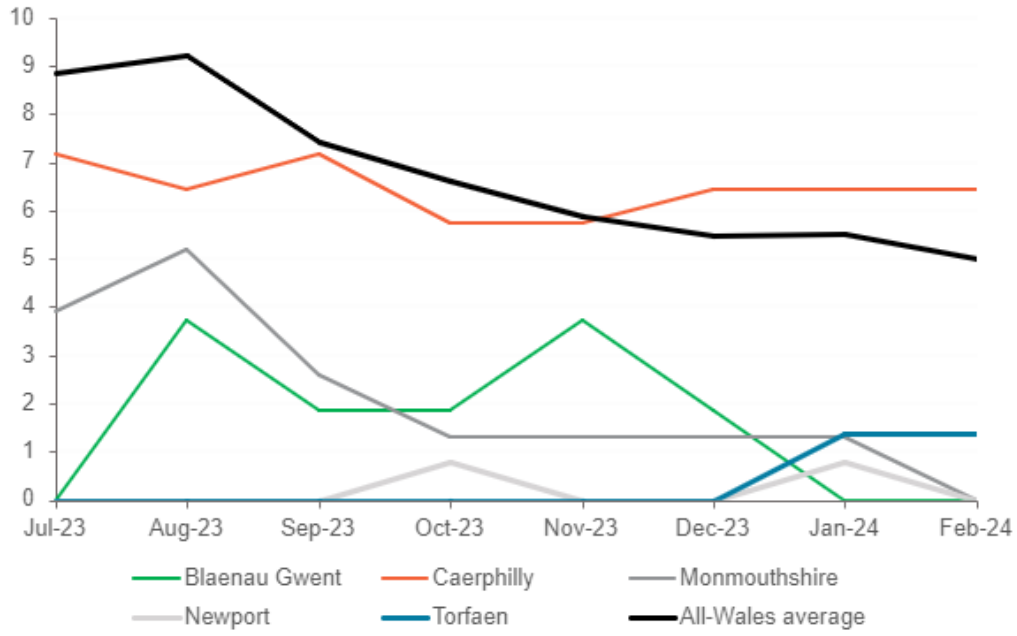
37 Within the region, we found that both health and social care staff are focused on discharging people quickly, but general capacity and practical ways of working do not always support this. We heard how despite the discharge system being expected and needed to work seven days a week, patient discharge rarely happens on a weekend, and this prolongs the patient stay in hospital.

38 Staff from across the region recognise the challenge in acquiring suitable support for patients such as domiciliary care or a care home placement, but this is sometimes frustrated by senior clinicians "over prescribing" a patient's future care needs. We heard how some patients and families are reluctant to return home without the level of care in place senior clinicians have said they need, despite the patient not being assessed as needing that level of care by social workers. We also heard how some patients were not discharged home despite living independently before admission and not feeling the need for any form of care package. This is particularly the case with older patients who may be seen as frail. This can disempower patients from being independent and may lead to future readmissions. As a result, good multidisciplinary discussions on post discharge needs that seek to maintain independence whilst also minimising risks of re-admission are key, particularly for tackling risk aversion in discharge.

39 The use of unplanned short term care home accommodation should be limited so patients can use it as a transition to a more sustainable arrangement rather than a long-term placement. **Exhibit 4** sets out the extent to which unplanned short term care home accommodation is used across the region. Except for Caerphilly, since

July 2023 the region has had some of the lowest numbers of adults per 100,000 population in unplanned short term care home accommodation and well below the all-Wales average. The data indicates that the region is generally not moving patients into short-term accommodation inappropriately, although the situation in Caerphilly does merit some attention.

Exhibit 4: number of adults waiting 3+ months in a care home with no planned end date, per 100,000 head of population (July 2023 – February 2024)



Source: Welsh Government

What is impacting effective and timely flow of patients out of hospital?

40 This section sets out the issues impacting on effective discharge planning and the timely flow of patients out of hospital across the region.

41 We found that **increasing complexity of patient demand combined with general workforce capacity has limited the region's ability to embed its discharge policy amongst partners and share information through compatible databases.**

Volume and complexity of demand

42 We found that **complexity and volume of demand are increasing in line with an ageing population, but the Health Board may be exacerbating that complexity**

by being risk averse to discharge which is contributing to problems elsewhere in the patient pathway.

43 Across the Gwent region, population increases are predicted for people aged 65 and over in the next 10 years. Around 1 in 4 people will be aged 65 and over, compared to 1 in 5 currently and an increase of 147% of those aged 85 and over is expected by 2036[5]. As people live for longer, there is a correlating increase in the number of people who live with multiple long-term conditions and complex health needs and who will therefore need to rely on health and care services for support.

44 Those we spoke to during this review told us of increases they see in demand, particularly in terms of more complex, higher acuity demand. We were often told that patients come in with one problem, but routine tests can quickly uncover several other conditions that need to be treated and managed, which will typically require more complex discharge planning.

45 COVID-19 exacerbated this increase in complex demand. During the pandemic, demand for emergency departments declined rapidly. In addition, families provided additional care and support to avoid their loved ones being admitted to hospital or long-term care out of fear of contracting COVID-19. We were told that as the pandemic eased, demand began presenting through the emergency departments which was much more complex than before as people's condition had deteriorated at home. In recognition of the challenges relating to the increased complexity in demand, emergency departments have remained at high levels of escalation since the pandemic.

46 We also heard how some private care homes are reluctant to accept some patients back after a hospital stay if their needs have become more complex and therefore difficult for the care home to safely manage.

47 We were told that the risk aversion within the discharge process referred to in the previous section of this report is contributing to volume and complexity of demand. Keeping (especially older) patients in hospital until they have an arranged package of care can lead to further deconditioning and increase the complexity of need when packages of care become available utilising a bed which may be needed for a more profoundly unwell patient elsewhere in the system.

48 The risk of discharging a patient needs to be considered alongside the wider risk of contributing to complexity and volume of demand more generally.

[5] Demography - what does "Gwent" look like?

Workforce capacity

49 We found that **workforce capacity in both health and social care is a challenge for the region, impacting on joint and clinical assessments, although waits for social care assessments are less problematic that many other parts of Wales.**

50 Increasingly staff involved in discharge planning are finding their capacity stretched due to factors such as high vacancy rates and unplanned absence rates. Reduced numbers of staff leads either to a reliance on agency staff or to fewer permanent staff attempting to manage increasingly complex patients and organise the ongoing care they need for discharge. High usage of agency staff has inevitable impacts on continuity within the workforce and risks having temporary staff who are not familiar with protocols and processes.

51 As of March 2024, the Health Board was reporting 4.8% vacancies as a percentage of its total establishment, with nursing and midwifery vacancies at 6.9% and medical vacancies at 15.6%. Nursing and midwifery vacancies are broadly in line with the all-Wales average, although medical vacancies are much higher (all-Wales average of 10.3%). The unplanned absence rate was at 7.3% for nursing and midwifery staff, and 8.7% for healthcare assistants and support workers. Again, broadly in line with the all-Wales average. The rate was much lower at 1.2% for medical staff.

52 In June 2023, the Gwent councils were reporting between 4%-15% vacancies in adult social services, with the highest rate of vacancies in Newport and the lowest in Caerphilly[6]. In February 2024, the unplanned absence rate in adult social services ranged between 6%-10%, as shown in **Exhibit 5**.

Exhibit 5: percentage of unplanned absence in adult social services (February 2024)

Local authority	Unplanned absence
Blaenau Gwent	9
Caerphilly	10
Monmouthshire	6
Newport	8
Torfaen	7
All-Wales average	**7.9**

Source: Welsh Government

[6] Caerphilly 4%, Monmouthshire 6%, Blaenau Gwent 8%, Torfaen 13% and Newport 15%. No data has been made available since June 2023.

53 Newport has experienced higher rates of unplanned absence and vacancies compared with the all-Wales position, with the local authority carrying some significantly higher vacancy rates earlier in 2023. The other local authorities have had higher rates of vacancies but lower rates of unplanned absences, or vice versa. The use of agency staff across the five local authorities is generally low (below 2%) with Newport and Torfaen not utilising agency staff.

54 Workforce issues are recognised as a challenge by the Gwent Regional Partnership Board (RPB) and are a core theme action plan priority within the Regional Area Plan. There are initiatives supported by the RPB to help address capacity across the care sector including self-employed micro care initiatives and recruitment campaigns. A regional Workforce Board develops, monitors and coordinates the workforce plan. Actions, owners, milestones and progress measures all appear within the priority with a clear focus on what difference each action will make. The Q4 End of Year Reporting for 2023-24 on the Gwent Workforce Board recognises success such as integrated training for all care partners across the five local authorities and the development of a Restorative Culture Group. This group encourages sharing of best practices across health and social care in Gwent and improving working environments and wellbeing for employees. The Workforce Board also recognises some challenges such as pace of delivery across some of its objectives due to competing pressures and the need to improve communication channels across partners.

55 Workforce capacity constraints can adversely affect the discharge planning process. For example, pressure on ward nursing numbers means that time for proper discharge planning is constrained which may be exacerbated by using agency staff who are less familiar with discharge processes. Similarly, pressure on social worker capacity may affect their ability to complete assessments for a patient in a timely way. As highlighted in **Exhibit 3**, delays in joint assessments between health and social care staff and clinical assessments by hospital staff are some of the main reasons for delayed discharges across the region, accounting for 23.8% of all delays. Delays awaiting social care worker allocations and social care assessments account for a further 7.5% of all delays as of February 2024, although this compares significantly lower than the all-Wales average of 24.2%.

56 **Exhibit 6** sets out the extent to which adult social services across the five local authorities can meet demand for assessment. The number of patients waiting for a social care assessment in hospital account for a small proportion of the total number of people waiting for assessment.

Exhibit 6: number of social care assessments completed and awaiting to be completed per 100,000 head of population (February 2024)

Local authority	Social care assessments completed	Adults waiting for a social care assessment	% of those waiting for a social care assessment that are in hospital
Blaenau Gwent	158	44	0.0%
Caerphilly	453	148	2.3%
Monmouthshire	277	181	2.1%
Newport	155	84	4.0%
Torfaen	310	84	3.2%
All-Wales average	**250**	**125**	**8.7%**

Source: Welsh Government

57 Waiting lists for social care assessments are higher than the all-Wales average in Caerphilly and Monmouthshire, although the number of social care assessments completed in Caerphilly is the second highest in Wales. This may be due to their social work staff being part of an Integrated Frailty Team within the Health Board and actively seeking out and case managing people to speed up assessment and discharge from the emergency departments.

58 The number of social care assessments completed is below the all-Wales average in Blaenau Gwent and Newport. All five local authorities however appear to prioritise social care assessments for patients in hospital, with a low proportion of those waiting for assessment in hospital.

59 To support the completion of assessments, the partners introduced the Trusted Assessor Model[7] during the pandemic. Health Board staff spoke very positively about the model but there was some confusion over whether the model was still operating. Directors of Social Services also recognised the benefits, although some noted that the model does not help secure care packages or placements any quicker. There was also recognition that standardising forms across all local authorities would help improve the process.

[7] The Trusted Assessor is a specific role, with the associated skills and competence, to undertake a proportionate assessment on behalf of another organisation to support a discharge from hospital to the person's next stage in their care journey.

Care sector capacity

60 We found that **the care sector capacity across the region is generally meeting demand, with more people being supported at home than many other areas in Wales.**

61 Availability of home (domiciliary) care packages and long-term residential care home accommodation can be key causes of discharge delay across Wales. Across the region, very few delays were reported due to awaiting residential care availability, although waiting for home care packages accounted for 5.8% of all delays in February 2024. Waiting for reablement accounted for a further 6.3%. **Exhibit 7** sets out the number of adults receiving care sector support and the extent to which there are waits for provision. **Appendix 4** sets out waiting list performance for social care assessments and care packages since November 2022.

Exhibit 7: number of adults receiving (and waiting for) care packages and placements per 100,000 head of population (February 2024)

Local authority	Domiciliary care[8] in receipt (waits)	Reablement[9] in receipt (waits)	Long-term care home accommodation[10] in receipt (waits)
Blaenau Gwent	663 (5)	41 (9)	408 (2)
Caerphilly	480 (11)	10 (3)	515 (12)
Monmouthshire	789 (37)	41 (20)	412 (-)
Newport	677 (2)	40 (31)	494 (13)
Torfaen	762 (3)	57 (11)	409 (0)
All-Wales average	**665 (34)**	**46 (9)**	**536 (11)**

Source: Welsh Government

62 Three of the local authorities (Monmouthshire, Newport and Torfaen) were providing more people with domiciliary care packages than the all-Wales average, with Blaenau Gwent in-line with the all-Wales average. Except for Monmouthshire, all other local authorities have significantly less people waiting for a domiciliary care package than the all-Wales average. This suggests that overall, the region appears to be coping better than others at providing domiciliary care packages despite the pressure it faces. This is also reflected in **Exhibit 8** which indicates the extent to which there are domiciliary hours unfilled. Except for Monmouthshire, the

[8] Includes domiciliary care both provided and commissioned by local authorities.

[9] Includes reablement provided by local authorities.

[10] Includes long-term care home accommodation commissioned by local authorities.

number of hours waiting to be filled are well below the all-Wales average and some of the lowest in Wales.

Exhibit 8: unfilled domiciliary hours and average hours of domiciliary care provided per adult, per 100,000 head of population (February 2024)

Local authority	Domiciliary care hours waiting to be filled	Average hours per adult in receipt of domiciliary care
Blaenau Gwent	75	14.6
Caerphilly	86	13.0
Monmouthshire	372	14.7
Newport	13	15.0
Torfaen	14	14.6
All-Wales average	**353**	**13.2**

Source: Welsh Government

63 Except for Caerphilly, the local authorities in the region provide some of the highest average hours of domiciliary care per adult per 100,000 head of population across Wales (**Exhibit 8**). Monmouthshire's high number of people receiving domiciliary care and the high number of hours waiting to be filled may be linked to its increased older population and more complex needs. It may also suggest that proportionally more people in Monmouthshire are being discharged home with a domiciliary care package as a first option or potentially that domiciliary care is being requested at higher levels than patients need.

64 Also except for Caerphilly, the local authorities in the region are broadly in line with the all-Wales average for the provision of reablement services with Torfaen exceeding the average. The Aneurin Bevan Winter Plan 2021-2022 implemented a reablement scheme which recruited five reablement support workers per local authority to help with admission avoidance and quicker discharge. However, waits for reablement services are high in Monmouthshire and Newport. These have fluctuated quite considerably since November 2022, although the number of people waiting for reablement in Monmouthshire has remained consistently above the all-Wales average. Monmouthshire's Integrated Medium-Term Plan 2023-2026 recognises 'Reablement' as one of its themes within the 'Hospital Admission and Discharge' workstream with the aim to decrease unmet need and lower the future need of those following reablement support. The Gwent Regional Partnership Board Annual Report 2022-2023 recognises that more needs to be done to enhance its reablement support and the Aneurin Bevan Winter Resilience Plan 2023-24 still identifies reablement as a significant capacity challenge resulting in delayed discharge.

65 As of February 2024, the Gwent local authorities provided some of the lowest numbers of long-term care accommodation per 100,000 head of population. Blaenau Gwent, Torfaen and Monmouthshire have the second, third and fourth lowest rate in Wales. While both Caerphilly and Newport have just below average rates of long-term care accommodation provision, waits are just above the all-Wales average. There are very few people, if any, waiting in Blaenau Gwent and Torfaen, which suggests that the level of long-term care accommodation in those counties is meeting demand.

Discharge process

66 We found that **there are regular multi-disciplinary meetings in relation to operational discharge, but the existing discharge policy is not embedded, there is inconsistent training, and the discharge planning process is not well documented within case notes.**

67 Good discharge planning is reliant on good communication and co-ordination across different professional groups, with consideration of discharge as soon as a patient is presented to services. Good discharge planning is also facilitated by having clearly documented processes which are shared with all staff involved to promote understanding and awareness of the different roles in the discharge process.

68 Regular operational meetings to discuss patient discharge such as multi-disciplinary ward rounds and length of stay meetings take place. Those we observed were well attended and provided a useful opportunity to discuss patients and assign actions related to discharge. However, the frequency of these meetings appeared to leave little time to take forward actions.

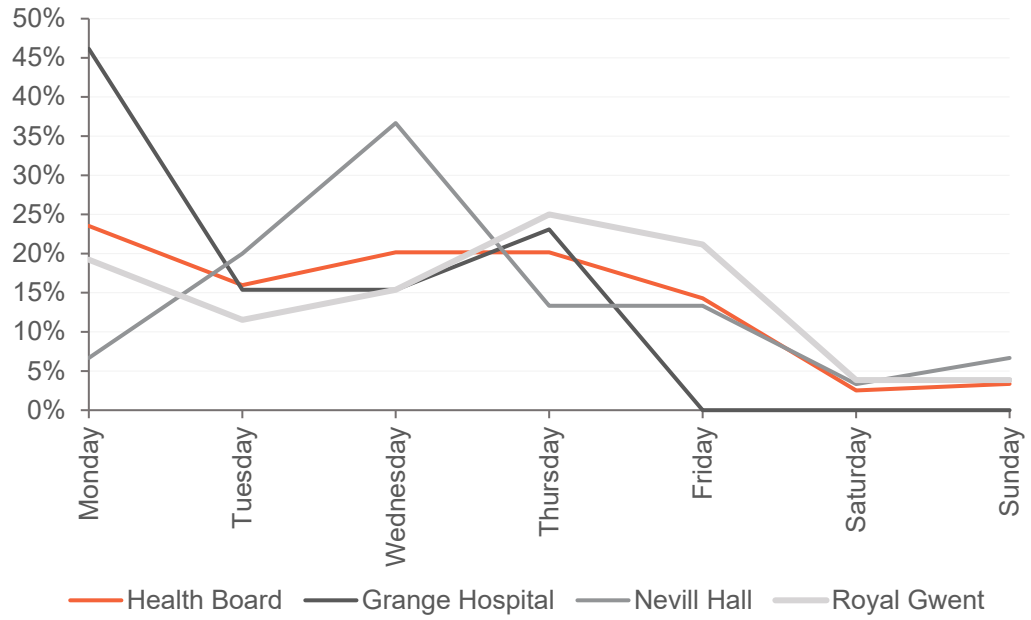
69 The Health Board has an updated discharge policy (October 2023) which is aimed at all clinical staff and those involved in the discharge process. The discharge policy provides links to several useful tools, such as the choice of accommodation policy or the policy for managing patients reluctant to discharge from hospital and includes several useful flowcharts. The discharge policy also usefully appends the D2RA[11] pathways which provide the journey patients should move through for each stage. However, it is not clear how the discharge policy is communicated to operational staff to enable its intended impact and there is limited evidence the implementation of the policy is being monitored and reviewed.

70 The policy encourages seven-day discharge and morning release to free up beds early for the rest of the working day. However, a review of data relating to all patients discharged from the Health Board's acute sites in October 2022, indicated that only 5.9% of patients were discharged at the weekend (**Exhibit 9**). During the week, discharges peak on a Monday, with the greatest proportion of Monday discharges taking place at Grange Hospital. No discharges took place at the

[11] Discharge to Recover then Assess (D2RA) is designed to support people to recover at home before being assessed for any ongoing need, thereby reducing length of stay in hospital.

Grange Hospital on a Friday, or at the weekend. The peak in Monday discharges would suggest that some of these patients could have been discharged earlier. Discharges peak on a Wednesday in Nevill Hall Hospital, and Thursday in Grange Hospital and Royal Gwent Hospital. We were told by staff that this pattern of midweek discharge persists and having the sufficient staff including consultants and senior clinicians available to support weekend discharge remains a challenge.

Exhibit 9: day of discharge of all patients discharged from acute hospital sites in October 2022, as a percentage of total discharges[12]



Source: Audit Wales

71 Our hospital patient case note review found that discharge planning is not considered early enough in the patient journey and is not always well documented with the quality of note taking variable. There was no evidence in our sample that expected dates of discharge were set within 48 hours of admission in line with the policy, and evidence of discharge planning within the notes was limited. Without clear discharge information in patient notes patients may stay in hospital longer than required.

72 Case notes did identify challenges such as a lack of suitable accommodation for patients, and fluctuations in patients' status of 'medically fit', which impacted the ability to discharge. There was evidence of patients' overall wellbeing, including discharge preferences being considered but in general, information recorded within

[12] Excludes patients who died.

the case notes was insufficient to gain assurance that discharge processes are routinely followed as intended.

73 In November 2020, the Health Board developed a guide for patients, families and carers which explains what happens during the discharge planning process and the next steps. This aligns with the Health Board's discharge policy and has been updated and appended to the updated policy for staff to access, but it is unclear how or when patients are made aware of the guide or how it is distributed.

74 To ensure a consistent culture and approach to discharge planning across all sectors, discharge training needs to be consistent. Although we were told discharge planning training takes place as part of staff induction in the Health Board, there were inconsistent views from operational staff about whether relevant refresher training is offered. Training also needs to include social care staff to ensure that there is clarity on roles, responsibilities and expectations. While staff indicated that this would be useful, joint training had not been in place largely due to the number of statutory partners to coordinate. Joint refresher training would help ensure all relevant staff understand current policies and processes and embed the Health Board's approach across disciplines.

75 In 2018, the Welsh Government introduced the Discharge to Recover then Assess (D2RA) model, which is designed to support people to recover at home before being assessed for any ongoing need, thereby reducing length of stay in hospital. Implementation of the model was accelerated during the pandemic, and the Welsh Government has subsequently supported regions with additional monies to embed D2RA further.

76 National data submitted to the Welsh Government in early 2023 indicated the Health Board had difficulty in discharging patients to an appropriate setting for their assessment, as is advocated by D2RA. Data for the Health Board showed it had high proportions of patients waiting to transfer to D2RA pathways. Many of these patients were waiting to be discharged to their own homes, or step-down beds but were unable to leave hospital due to the lack of availability of such beds in the community. The Welsh Government issued updated national guidance on D2RA in December 2023. The partners will need to ensure that policies and procedures reflect this updated guidance.

Information sharing

77 We found that **staff involved in the discharge process have created operational workarounds for data sharing such as patient flow meetings, but formal data sharing and data quality are variable and digital interfaces between organisations are not compatible**.

78 Professionals within and across organisations will typically be required to share information about the patient to facilitate appropriate discharge arrangements and ongoing care, especially where the patient has more complex needs.

79 Agency and locum staffing can present a barrier to effective information sharing across organisations. Embedding ward and team procedures and local knowledge

can be hindered by transitional staff who may not know who to contact to progress a discharge or what local support options are available. This is the case for both health board and local authority staff. This can slow communication between them and with partner organisations such as care suppliers and the third sector. As a result, patients' length of stay in hospital is not reduced as quickly as it might have been.

80 There has been some success of data sharing at a local level. Health Board staff share information at various meetings regarding patient flow at operational meetings and on the ward. These meetings vary in form but have similar function and involve teams identifying patients and their stage of care. We observed some meetings and staff seem to be able to access this relevant information in a timely manner and provide verbal updates on patients whose recent changes have not yet been through the system.

81 Systems holding patient information have not been connected or viewable to all staff involved in the care and discharge planning of individual patients. Various IT systems that hold this information are not universally accessible across the different organisations involved. While four of the local authorities have implemented the Welsh Community Care Information System[13], Monmouthshire council has not and although the Health Board has committed to using the system in mental health, it has not implemented the system across the Health Board.

82 Within the Health Board, there are differences in information access across hospital sites. Staff at Ysbyty Ystrad Fawr have access to the local authority data which allows them to see which care packages are being assessed and coordinated and keep up to date with progress. It is not clear why this is not standard across all hospital sites as it is seen as a positive tool by staff for driving effective discharge and communicating with patients and families.

83 Although we did identify some good examples of sharing information across organisational boundaries, we were made aware that the data may not always be accurate. For example, care home bed spaces may not reflect beds out of commission due to refurbishment or beds which cannot be staffed. This can cause frustration for staff regarding data integrity and can hinder discharge planning in the short and medium term preventing effective data analysis.

84 Introduced in 2021, the Six Goals Programme[14] was discussed at a recent board meeting and the Health Board recognised that there are quality issues with the data relating to patient discharge. Data reliability issues were identified in respect of the number of medically fit patients and in coding the reasons for discharge

[13] The Welsh Community Care Information System (WCCIS) is a single system and a shared electronic record for use across a wide range of adult and children's services. The idea being that all 22 local authorities and seven health boards should implement it, with the initial intended implementation date of the end of 2018. A new national programme 'Connecting Care' was established in May 2024 to replace WCCIS from January 2026.

[14] Further information on the Welsh Government six goals for urgent and emergency care can be found via https://www.gov.wales/written-statement-six-goals-urgent-and-emergency-care-programme-update

delays. The Health Board recognise there is work to be done in this area but in the interim, there must be recognition internally that data is flawed.

85 Ultimately, whilst there is a significant amount of data held by both the Health Board and local authorities within the Gwent region, data sharing and access to the relevant IT systems are variable. Regular meetings are used to validate existing assumptions, but data cannot always be relied upon or interrogated sufficiently to contribute to discharge planning in a consistent way.

86 In line with other health boards, staff are not always fully aware of the range of services within the community, and this is made more difficult by cross-borough service provision. However, we had feedback that where social care staff are an integral part of the discharge planning within hospital settings, access to this information was improved.

87 The lack of integrated digital systems with reliable data for patient information also means staff spend time calling settings such as care homes to verify if the beds listed as available really are. In June 2023 the Health Board invested £37,000 in a new digital 'Discharge to Recover then Assess (D2RA)' system. The system called CWS2 will hold data including a patient's clinically optimised status and their reason for delay. This is intended to help with discharge planning and reporting including the provision of real time ward level information. Unfortunately, technical challenges mean the implementation of this system and subsequent reporting have now been delayed.

What action is being taken?

88 This section considers the actions being taken by the statutory organisations, including through the Regional Partnership Board to improve the flow of patients out of hospital.

Strategic and operational plans

89 We found that **addressing patient flow is central to relevant strategic and operational plans across the Gwent region and in line with Welsh Government requirements.**

90 We reviewed relevant Health Board and local authority plans in relation to discharge planning, and urgent and emergency care and social care more generally. We found that plans in the region reflect a good understanding of the challenges affecting the flow of patients out of hospital. For example, the Integrated Winter Resilience Plans for 2022-23 and 2023-24 were collaboratively developed through the Regional Partnership Board. Keeping people well at home and early facilitated discharge were key aspects of the plans recognising the limitation of both bed capacity and workforce in the hospitals. The plans set out the challenges the Health Board faced and some of the activity which was planned to address these challenges.

91 The Winter Resilience Plan 2022-23 reflected key Welsh Government planning requirements, such as those in the Six Goals for Urgent and Emergency Care Programme, as well as the Welsh Government 1,000 bed challenge[15]. The plan was strategic but had some operational aspects. This included a high-level action plan outlining specific schemes, the impact required and the lead organisation. Schemes included reintroduction of the trusted assessor model and increased pharmacy support to the Grange Emergency Department.

92 The Winter Resilience Plan 2023-24 developed three core principles of Focus, Processing Power and Capacity to target the areas of specific challenge which remain largely the same as the previous year such as pressures within social care, urgent care and planned care recovery. Many of the actions within the core principles aim to have impact on patient flow such as an Elderly Frailty Unit in Royal Gwent Hospital to reduce unnecessary admissions. Another action was therapy focussed assessments at the Emergency Department in Grange University Hospital in the hope to assess patients and discharge home the same day, which has shown some early signs of success.

93 The Health Board's Integrated Medium-Term Plan (IMTP) 2022-2025 has a specific priority for older adults. This has been a developing area for the Health Board with transformation taking place each year. The Health Board intends to create a single pathway for older people in collaboration with social care and the third sector. This should streamline how patients and providers access services and places prevention at the core. Specific frailty units at acute hospitals for short stay assessment and diagnostics will be introduced where patients who would not benefit from traditional models of medical care can be admitted. If successful, this should reduce length of stay, reduce risk and align with the Six Goals Programme ambition for right care, right place, first time. However, the recent performance reporting to the Health Board's Board meeting shows that the length of stay measure has remained unchanged and that there has been little or no improvement in discharge and flow indicators such as increases in discharges before midday.

94 The Six Goals for Urgent and Emergency Care Programme contains two goals that are linked to improving discharge: 'goal five – optimal hospital care and discharge from the point of admission', and 'goal six: home first approach and reduce risk of readmission'. The Health Board has a specific six goals plan which is separate to its IMTP and is a one-year delivery plan. A section of 'key achievements' against each goal provides a useful narrative of activities underway although this could be more detailed. Goal 5 – optimal hospital care and discharge from the point of admission and Goal 6 – home first approach and reduce risk of readmission have

[15] In July 2022 the Health and Social Care Minister set a challenge for Health Boards and Local Authorities to establish an additional 1,000 bed spaces or their equivalents to support timely discharge https://www.gov.wales/written-statement-six-goals-urgent-and-emergency-care-programme-update. The continuation of the additional bed spaces was included in the Welsh Government 'Building capacity through community care further, faster' statement of intent launched in June 2023.

been combined into ‘Return and Stay Well at Home’. This includes five separate workstreams including ‘Trusted Assessor Model’ and an ‘Integrated Discharge Hub’. The Delivery Plan includes anticipated impact and measures and quarterly deliverables. However, the plan would benefit from more defined targets to monitor progress.

95 The joint integrated service partnership board (ISPB) plans for 2023-26 set out high-level priorities for each of the local authority areas. Although they do not all discuss issues in relation to flow out of hospital directly, they do reflect the need to keep older people well and a whole system approach to supporting people after hospitalisation. The ISPBs also recognise the need to work together to support people at home and address the impact of workforce challenges. The Blaenau Gwent ISPB goes further and specifically refers to the need to deliver the ambitions of the six goals, and positively also, the need to provide system leadership across partners to ensure that population needs are met. All the ISPBs support the delivery of the Regional Area Plan.

Partnership working

96 We found that **strategic partnership working is evident across the region building on existing collaborative relationships, but operational partnership working is less well developed.**

97 Strategically partnership working is well developed and continues to build on existing positive partnerships throughout the Gwent region. Joint ownership for finding solutions to challenges is embedded within the RPB and its associated sub-groups and forums, and collective responsibility and collaboration appear to be central to project development and the way in which the RPB governance has been developed.

98 There is diverse representation from a range of statutory and voluntary organisations at the RPB. This partnership work is echoed throughout various projects supported by the RPB, including the development of the Winter Plan. Urgent and emergency care pressures and discharge planning feature as regular discussions at the RPB and the Regional Leadership Group which reports to the RPB. Previous updates have included progress with the 1,000-bed challenge during late 2022. The Welsh Government requirement was for Gwent to supply 122 of the 1,000 beds by October 2022. In November 2022, the region reported that it had identified 132 beds. These beds remained in place for 2023-24.

Use of funding

99 We found that **financial resources are being targeted to support patient flow with positive outcomes, although the ability of the partners to match fund is increasingly challenging and the impact of the funded initiatives could be more transparent.**

100 The region makes use of the Health and Social Care Regional Integration Fund (RIF) to support schemes aimed to improve discharge planning. The RIF is a

Welsh Government 5-year fund to deliver a programme of change from April 2022 to March 2027. The aim of the fund is to establish and mainstream at least six new national models of integrated care to provide a seamless and effective service for the people of Wales. Two contain a clear link to improving flow out of hospital for patients, namely: Home from Hospital Services; and Accommodation Based Solutions.

101 There is a clear expectation within the RIF guidance that partners 'match fund' projects up to 50% by the end of year 5, with Welsh Government funding for each project tapering each year to allow for successful projects to become business as usual. However, due to the financial pressures that the NHS is currently facing, this expectation has been relaxed.

102 More broadly, RIF monies have been used to support the wider health and social care community. Monies have been used to increase fuel allowances for social care staff to aid recruitment and retention and develop micro-carers in response to the national shortage of care workers. According to the RIF Strategic Outline Plan, partners were expected to contribute a total of £7.3 million in total to all RIF funded schemes by way of match funding. Those we spoke to highlighted that the requirement to match fund projects can create a reluctance to commit to new projects that require match funding in future years.

103 The RPB collects and reports data to the Welsh Government on the various RIF projects which take place on a regional basis. This is also shared with partners quarterly. Members are confident that projects are robustly monitored. However, it is not always clear to them what the data is being used for from an operational perspective and the impact this monitoring is having. However, the RIF Annual Report 2022-23 presents performance data for schemes, including the positive impact from the Improving System Flow programme on 8,824 individuals. The RPB Annual Report 2023-24 details there are now 18 projects under the Improving System Flow programme. This programme is collaboratively delivered with the Health Board, local authorities and the third sector with over 60,000 people having been supported to return home, recover, rehabilitate and regain independence in 2023-24.

104 The Gwent RPB developed a quarter 4 update 'Story for Change' as an annual reflection of the projects delivered under the RIF for the 2023-24 financial year. The full year allocation of the Improving System Flow programme was £5.395 million with all the money spent in year. A Project called 'Newport including OT' has had success in Royal Gwent Hospital by developing collaborative working between occupational therapists and the discharge team. This is to ensure pre-discharge assessments and planning ensure support is in place for the patient to return home, limiting readmission and encouraging recovery.

105 Similarly, the Monmouthshire County Council Hospital Discharge Co-ordination project has yielded success reducing hospital stays for patients and enhancing patient flow through coordinating more effectively between healthcare settings and community care providers. Case studies are provided as part of the 'Story for

Change' report, but these could be made more widely available on the RPB website.

106 Changes to the discharge lounge model have also been undertaken using RIF capital expenditure at the Royal Gwent Hospital using learning from a site in Somerset which operates a 'pull' model to pull patients who are ready to be discharged from the acute ward setting. The implementation and expansion of the updated discharge lounge is being monitored throughout 2024-25 under the Six Goals Programme to assess impact. This includes closer involvement of WAST services and pharmacy services to improve discharge. Going forward, space at the Grange University Hospital is also being scoped for potential discharge lounge expansion.

107 A 'Ready to Go' unit has also been established at the Royal Gwent Hospital which mirrors the support patients would receive in their home environment. This is for therapy optimised patients and has limited nurse involvement without regular medical intervention. Whilst this is not a project which the Health Board sees as sustainable in the long term, it is one which is seen as necessary given current bed capacity pressures. Again, the model is designed to pull people from acute sites whilst they wait for packages of care and encourage independence. However, a September 2024 update to Board regarding Discharge Improvement noted highest delay numbers in Royal Gwent Hospital with a review of discharge hubs, discharge lounges and the Ready to Go unit due to understand the delays in more detail.

108 According to the six goals programme update to the Health Board's Board meeting in May 2024, since October 2023, the average number of discharges per month from the Royal Gwent Hospital has been higher (535) than the average number of discharges between May 2021 and September 2023 (479). Whilst it may not be possible to attribute this improvement solely to the changes in the updated discharge lounge and the 'Ready to Go' ward, it is likely this initiative has contributed to improved patient flow and certainly patient independence.

Scrutiny and assurance

109 We found that **there is clear oversight and scrutiny of actions being taken to improve patient flow, although more could be done to gather patient and service user feedback, oversee compliance with current discharge policies and increase oversight of RPB activity by local authorities.**

110 The Health Board receives regular performance and activity reports which focus on delivery against key national targets included in the performance dashboard, via the Board and more specifically the Finance and Performance Committee. It also receives a quarterly Outcomes and Performance Report which includes some updates on progress against the six goals including milestones and actions for the next quarter.

111 The Health Board has operational structures in place to deliver and monitor the six goals programme through a Six Goals Programme Board. This is underpinned by three overarching workstreams which each have an allocated Senior Responsible Officer, Programme Manager and Executive Lead. This encourages ownership at

senior levels. The Six Goals Programme Board reports into the Health Board Executive Committee and the RPB.

112 A standalone Six Goals Programme update was presented at the May 2024 meeting of the Board. This included key updates, priorities and data. There was some evidence of scrutiny and challenge at the meeting, but this could be strengthened to be more discharge specific considering the current challenges the Health Board faces on the impact of patient flow. Reports on the six goals are routinely presented to the Quality and Patient Safety Committee.

113 The RPB oversees and monitors delivery of RIF funded projects against the regional plan through its performance management office and partnership structure such as the Gwent Adult Strategic Partnership. The RPB also enables identification and sharing of learning and good practice across partners and both Health Board and local authority staff we spoke to were broadly positive of its role. The RPB's Annual Report includes a mix of accessible narrative and data on projects including how it has engaged with citizens to include their views.

114 The Gwent Regional Partnership Board Annual Report 2023-24 provides useful narratives and case studies of the work undertaken in the previous year with some impactful service user feedback statistics included. Hospital discharge is recognised as a core theme for 2024-25 with work focusing particularly on the impact and support for carers.

115 There is oversight at public Health Board meetings of the challenges with patient flow. A May 2024 update to Board outlined in its Finance Performance Report noted that the estimated cost for the year for blocked beds for all reasons was approximately £15.5 million. Finance and Performance Committee received an update report in September 2024

116 As mentioned earlier in this report, we have seen no evidence to suggest an audit is undertaken against the discharge policy and learning from it reported annually to the Quality and Patient Safety Committee, as set out in the policy. There is also limited evidence of organisations monitoring and scrutinising patient, service user and staff feedback. Although the discharge policy refers to an annual survey of users and carers to understand their discharge experiences, we saw no evidence of this happening. Social services directors referred to seeking feedback from clients and their families through conversations rather than surveys but acknowledged more could be done to routinely capture service user experience and feedback.

117 The oversight of the Regional Partnership Board activity at local authority level is variable. There is evidence that progress and performance are reported to scrutiny committees, but this is infrequent and usually annual which provides only sporadic, monitoring of activity.

What more can be done?

118 Whilst there is a clear recognition by regional partners of the problems associated with discharge, a desire to address them with the right focus within strategies and

plans, impactful projects and good strategic relationships, the number of delayed discharges across the region have not significantly reduced.

119 Our work has found that there are several further actions that could be taken which would help improve timely and effective flow out of hospital across the region and reduce some of the challenges currently being experienced by the health and social care system. These actions are explored in the following exhibit and align with the recommendations that are set out earlier in the report.

Exhibit 10: further actions for partners to help tackle the challenges for patient flow out of hospital

Improving training and guidance on discharge planning	Having access to **jointly agreed guidance** which clearly sets out roles and responsibilities, and expectations around when and how staff should share information, including referrals, is vital to ensuring consistency between wards, hospitals, professions, and organisations. Offering a **comprehensive training programme** for relevant staff involved in patient flow, including bank and agency staff as well as new starters, also ensures guidance is embedded.
Embed a 7- day approach to discharge	The ability to move away from a Monday to Friday approach and **embed a 7-day approach to discharge** across all disciplines including consultants and senior clinicians will have a positive impact on patient flow. Even focusing weekend discharges on those which are not complex will help avoid prolonged stays and reduce discharge pressure at the beginning of the working week.
Roles and responsibilities in relation to informal over prescribing of care packages	Ensuring all staff understand their roles and responsibilities regarding **informal prescribing of care packages** can prevent over prescribing and unnecessary expectations in relation to future care provision. **Empowering patients** to have only the level of care the relevant professional prescribes encourages future independence and may lead to reduced readmissions.
Risk appetite in relation to patient discharge	Having a **consistent and management led risk appetite to patient discharge** will encourage timelier discharge of patients.

	Balancing the risk of discharge against the risk of deconditioning and loss of independence and/or care packages for patients needs to be a key consideration.
Embed approach to the Trusted Assessor Model	**Embedding the Trusted Assessor model** and communicating this approach to all partners will increase capacity in the assessment phase. Whilst there is recognition this may not help secure care packages or placements more quickly; it will ensure there is capacity to accurately assess patients when required.
Improving oversight of policies and guidance	Ensuring monitoring and **compliance of the Health Board's discharge policy** will help assess the effectiveness and consistency of its application and if any changes to the policy need to be made. This will also ensure the Health Board is **complying with its own commitment of undertaking** an annual review of the policy and reporting that to its Patient Quality, Safety, and Outcomes Committee.
Improving the quality and sharing of information	Documenting and **sharing patient information more effectively** can enable smoother patient discharge and encourage better relationships. Having **clear and comprehensive information** within patient case-notes which sets out the actions being taken to support discharge, enables a clearer understanding of what is happening with a patient and supports effective discharge planning by all professionals involved in the care of patients whilst in hospital. Having **joined-up systems** that are accessible by all staff (regardless of organisation) involved in the care of individual patients enables effective and efficient methods of communication between organisations and supports effective flow out of hospital.
Establish mechanisms to gather feedback and apply learning	Establishing **mechanisms where patient, staff and service user feedback can be monitored and analysed** will help develop the patient journey.

By understanding the experience of people who have been part of a discharge process, the Health Board and the local authorities can develop more patient focused approaches.

Appendix 1

Audit methods

Exhibit 11 sets out the methods we used to deliver this work. Our evidence is limited to the information drawn from these methods.

Exhibit 11: audit methods

Element of audit methods	Description
Documents	We reviewed a range of documents, including: • Board, Cabinet, and committee papers • Updates on the Six Goals Programme and urgent and emergency care to committees • Operational and strategic plans relating to urgent and emergency care • RPB papers, including case studies • Standard Operating Procedure for discharge planning • Corporate risk registers and performance reports • Operational documents, such as proformas and checklists, escalation processes, staff handbooks and leaflets and guidance
Interviews	We interviewed the following: • Lead for Regional Partnership Board • Head of Patient Discharge • Executive Director of Operations • General Manager Family amd Therapies • General Manager Urgent Care • Assistant Head of Patient Discharge • General Manager for Medicine • Deputy Head of Operations • Divisional Operations Manager • Director of Primary and Community Care and Mental Health • Chief Officer of Aneurin Bevan Community Health Council (now Llais) • Directors of Social Services for Blaenau Gwent, Caerphilly, Monmouthshire, Newport and Torfaen • Heads of Adult Social Services for Blaenau Gwent, Caerphilly, Monmouthshire, Newport and Torfaen

Element of audit methods	Description
Observations	We observed the following meeting(s): • Cross site flow meeting via Teams • Flow Meeting (Gwanwyn MDT) • Flow Meeting (Education Centre Ysbyty Ystrad Fawr) • Six Goals Urgent Care Meeting • System Leadership and Response Meeting We also observed the following individual(s): • Discharge Coordinator at Neville Hall Hospital
Data analysis	We analysed the following national data: • Monthly social services dataset submitted to the Welsh Government • Monthly delayed discharges dataset submitted to the NHS Executive • StatsWales data • Ambulance service indicators We also analysed data provided by the Health Board relating to all emergency medicine patients discharged in October 2022 with a length of stay greater than 21 days (excluding those who died)
Focus groups	We undertook focus groups with the following: • Social workers (Blaenau Gwent and Caerphilly) • Social workers (Monmouthshire, Newport and Torfaen) • Discharge coordinators
Case Note Review	We reviewed a sample of 29 case notes relating to emergency medicine patients discharged in October 2022 with a length of stay greater than 21 days (excluding those who died).

Appendix 2

Reasons for delayed discharges

The following exhibit sets out the reasons for delayed discharges compared to the all-Wales position.

Exhibit 12: reasons for delayed discharges as a percentage of all delays (February 2024)

Reason for delay	Percentage delayed	All-Wales average
Awaiting joint assessment	14.2	9.0
Awaiting completion of clinical assessment (nursing/ allied health professional/ medical/ pharmacy)	9.6	10.3
Awaiting reablement care package	6.3	3.0
Awaiting residential care home manager to visit and assess (standard 3 residential)	6.3	2.5
Awaiting start of new home care package	5.8	8.0
Awaiting completion of assessment by social care	5.4	15.7
Awaiting completion of arrangements prior to placement	4.6	3.5
Awaiting nursing/residential home self-funding	4.6	1.3
Awaiting community resource capacity	3.8	1.2
Awaiting transfer to intermediate care bedded facility	3.8	4.0
Awaiting health completion of assessment/provision for equipment	3.3	1.4
Awaiting nursing care home manager to visit and assess (standard 3 residential)	2.9	2.1
Awaiting extra care/supported living availability	2.5	0.9
Awaiting continuing healthcare (CHC) assessment	2.1	1.7
Awaiting social worker allocation	2.1	8.5
Mental capacity	2.1	2.1
Awaiting nursing home availability	1.7	2.6
Awaiting social care completion of assessment/provision for equipment	1.7	0.5
No suitable abode	1.7	2.3
Awaiting elderly mentally ill (EMI) residential availability	1.3	2.3
Awaiting funding decision (funded nursing care (FNC)/ continuing healthcare (CHC))	1.3	1.5

Reason for delay	Percentage delayed	All-Wales average
Awaiting specialist bed availability	1.3	1.1
Court of protection delays	1.3	0.6
Homeless	1.3	0.9
Intervention by patient's legal representation	1.3	0.2
Patient/family refusing to move to next stage of care/discharge	1.3	1.6
Safeguarding issues impacting discharge arrangements	1.3	0.5

Source: Welsh Government

Note: where the reasons for delay relate to two or less patients, these have been excluded to minimise any risk of identifying individual patients.

Top five reasons for delayed discharges by local authority

The following exhibits set out the top five reasons for delayed discharges for each of the local authorities compared to the Health Board wide and all-Wales position.

Exhibit 13: top five reasons for delayed discharges as a percentage of all delays (February 2024) – Blaenau Gwent

Reason for delay	Percentage delayed	Health Board average	All-Wales average
Awaiting completion of clinical assessment (nursing / allied health professional / medical / pharmacy)	24.1	9.6	10.3
Awaiting joint assessment	13.8	14.2	9.0
Awaiting reablement care package	6.9	6.3	3.0
Awaiting community resource capacity	6.9	3.8	1.2
Mental capacity	6.9	2.1	2.1

Source: Welsh Government

Exhibit 14: top five reasons for delayed discharges as a percentage of all delays (February 2024) – Caerphilly

Reason for delay	Percentage delayed	Health Board average	All-Wales average
Awaiting residential care home manager to visit and assess (standard 3 residential)	11.8	6.3	2.5
Awaiting completion of clinical assessment (nursing / allied health professional / medical / pharmacy)	10.3	9.6	10.3
Awaiting joint assessment	10.3	14.2	9.0
Awaiting community resource capacity	8.8	3.8	1.2
Awaiting completion of assessment by social care	5.9	5.4	15.7

Source: Welsh Government

Exhibit 15: top five reasons for delayed discharges as a percentage of all delays (February 2024) – Monmouthshire

Reason for delay	Percentage delayed	Health Board average	All-Wales average
Awaiting joint assessment	17.0	14.2	9.0
Awaiting nursing/residential home self-funding	17.0	4.6	1.3
Awaiting completion of assessment by social care	6.4	5.4	15.7
Awaiting start of new home care package	6.4	5.8	8.0
Awaiting nursing care home manager to visit and assess (standard 3 residential)	6.4	2.9	2.1

Source: Welsh Government

Exhibit 16: top five reasons for delayed discharges as a percentage of all delays (February 2024) – Newport

Reason for delay	Percentage delayed	Health Board average	All-Wales average
Awaiting joint assessment	19.1	14.2	9.0
Awaiting transfer to intermediate care bedded facility	17.0	3.8	4.0
Awaiting reablement care package	10.6	6.3	3.0
Awaiting completion of arrangements prior to placement	8.5	4.6	3.5
Awaiting completion of assessment by social care	8.5	5.4	15.7

Source: Welsh Government

Exhibit 17: top five reasons for delayed discharges as a percentage of all delays (February 2024) – Torfaen

Reason for delay	Percentage delayed	Health Board average	All-Wales average
Awaiting completion of clinical assessment (nursing / allied health professional / medical / pharmacy)	15.3	9.6	10.3
Awaiting joint assessment	13.0	14.2	9.0
Awaiting completion of arrangements prior to placement	10.9	4.6	3.5
Awaiting residential care home manager to visit and assess (standard 3 residential)	8.7	6.3	2.5
Awaiting start of new home care package	6.5	5.8	8.0

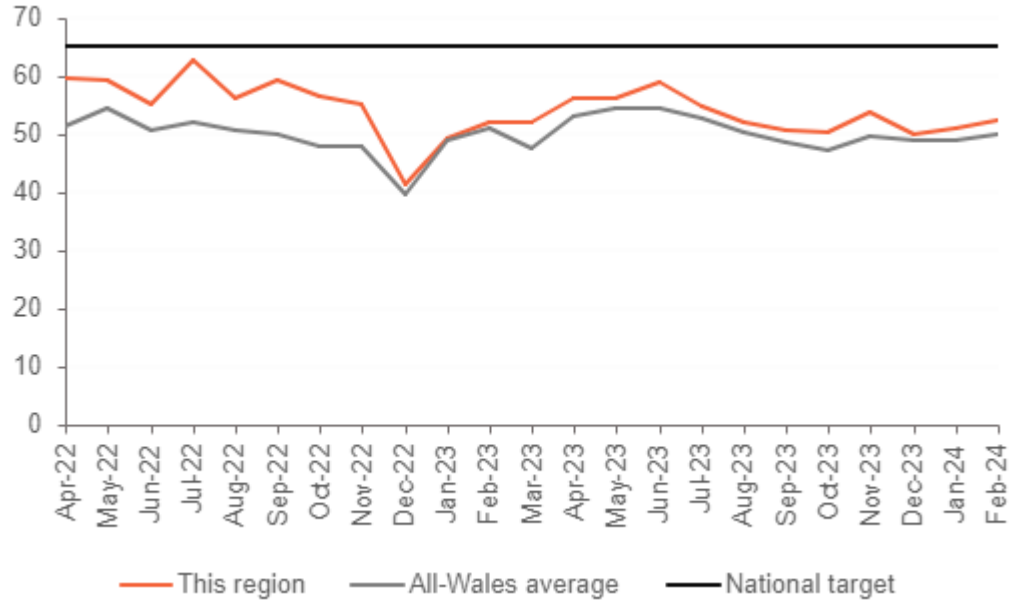
Source: Welsh Government

Appendix 3

Urgent and emergency care performance

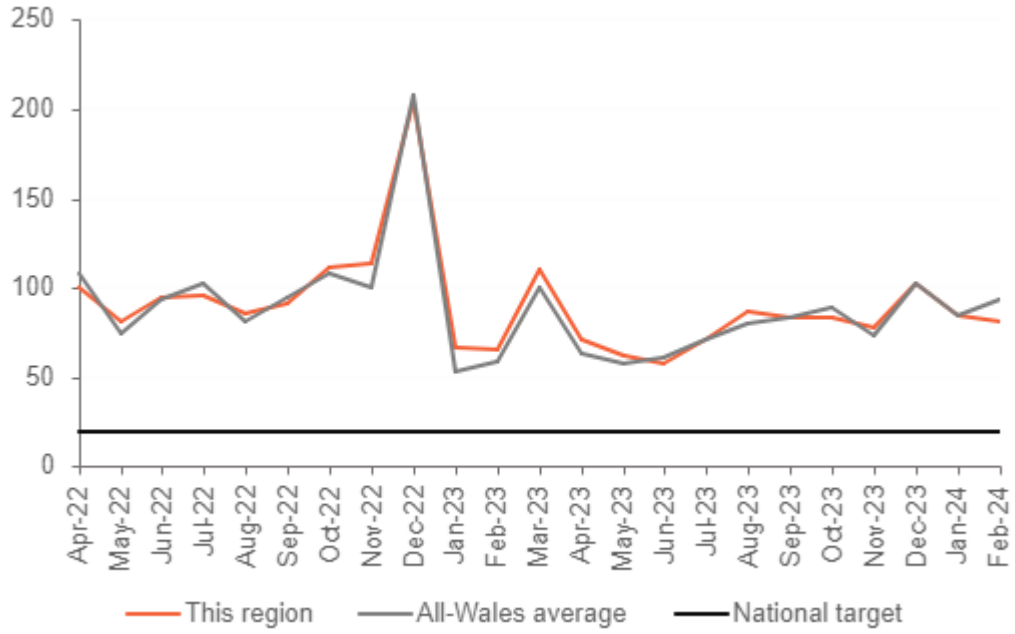
The following exhibits set out the region's performance across a range of urgent and emergency care performance indicators in comparison to the position across Wales since April 2022.

Exhibit 18: percentage of emergency responses to red calls arriving within (up to and including) 8 minutes – national target of 65%



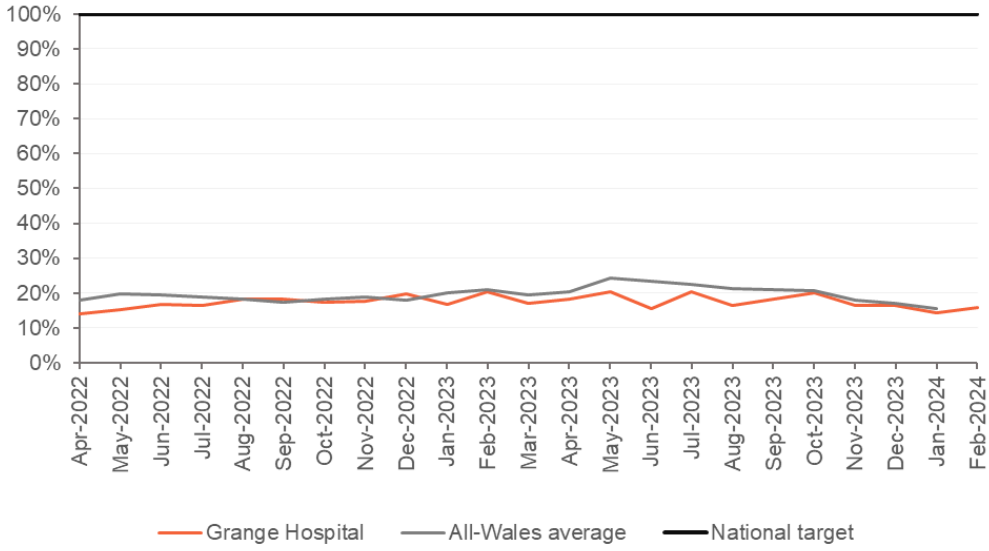
Source: StatsWales

Exhibit 19: median response time for amber calls (minutes) – 50th percentile – national target of 20 minutes



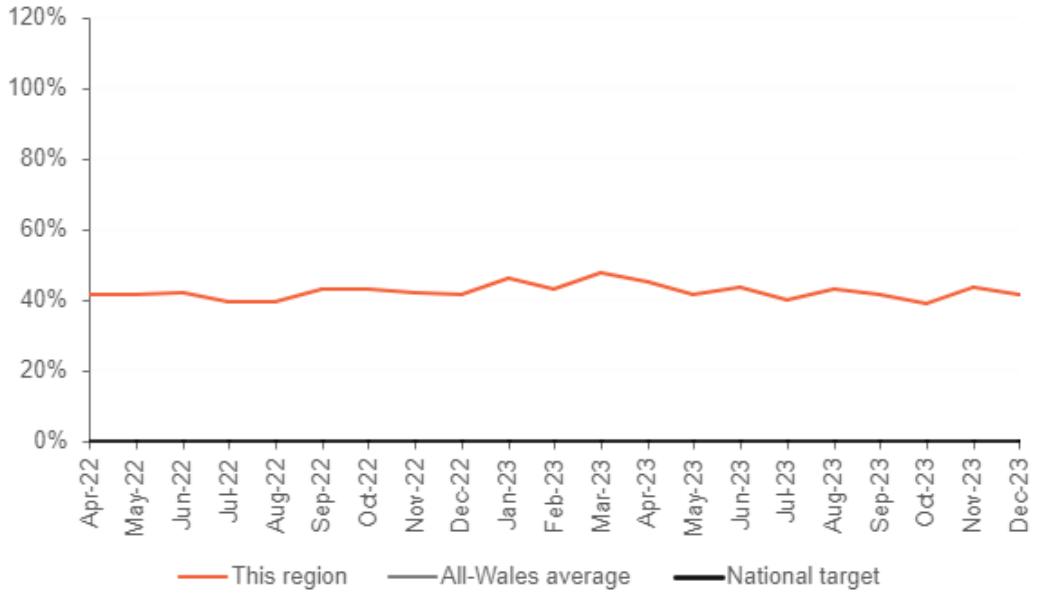
Source: Ambulance Services Indicators

Exhibit 20: percentage of ambulance handovers within 15 minutes at a major emergency department – national target of 100%



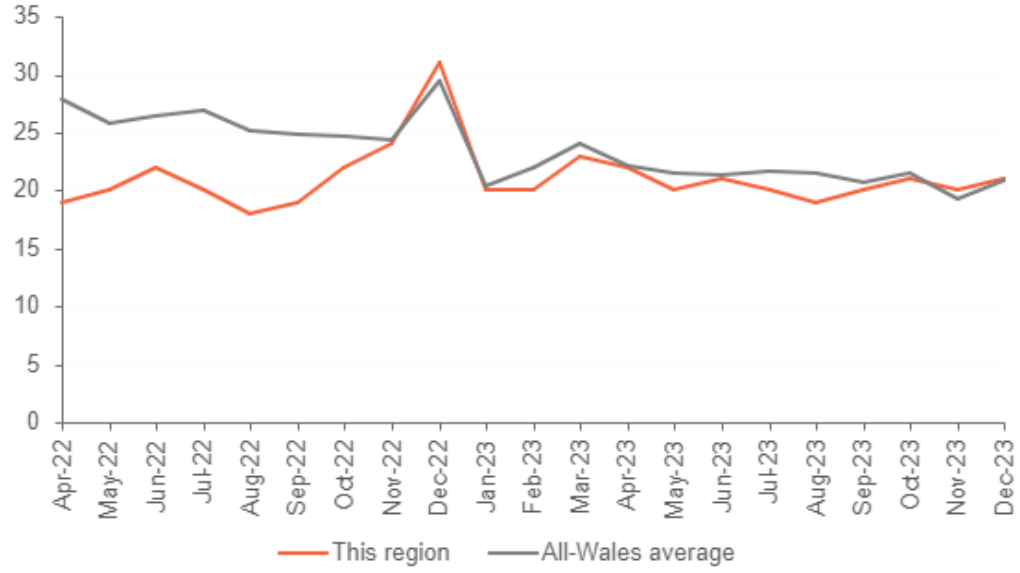
Source: Welsh Ambulance Services NHS Trust

Exhibit 21: percentage of ambulance handovers over 1 hour – national target of zero



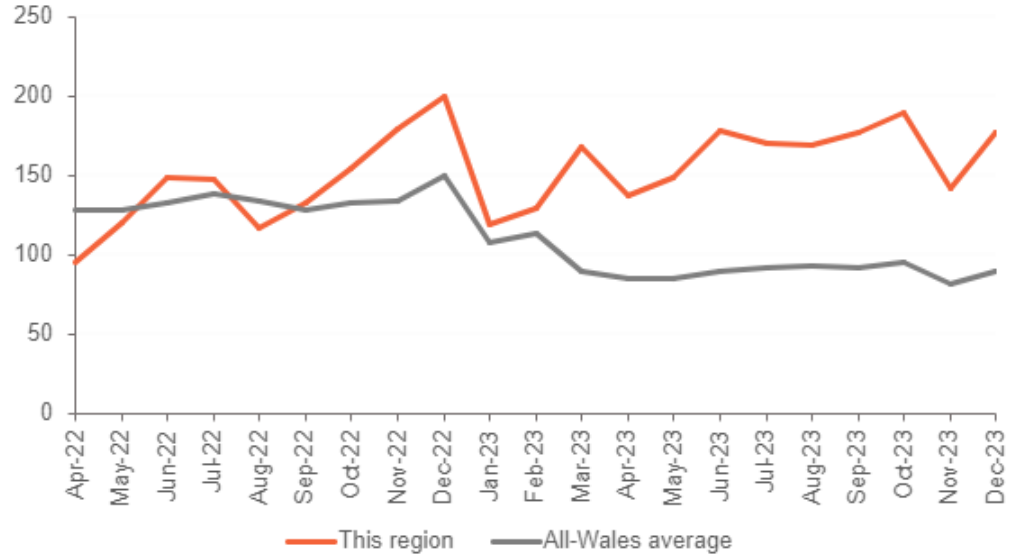
Source: Ambulance Services Indicators

Exhibit 22: median time (minutes) from arrival at an emergency department to triage by a clinician) – national target of 12-month reduction



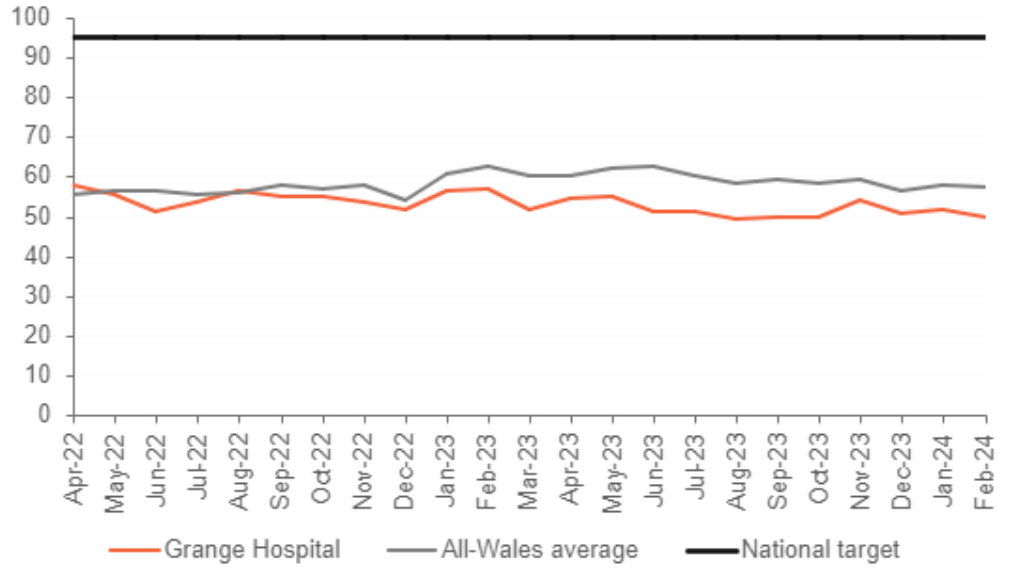
Source: Health Board performance reports

Exhibit 23: median time (minutes) from arrival at an emergency department to assessment by senior clinical decision maker – national target of 12-month reduction



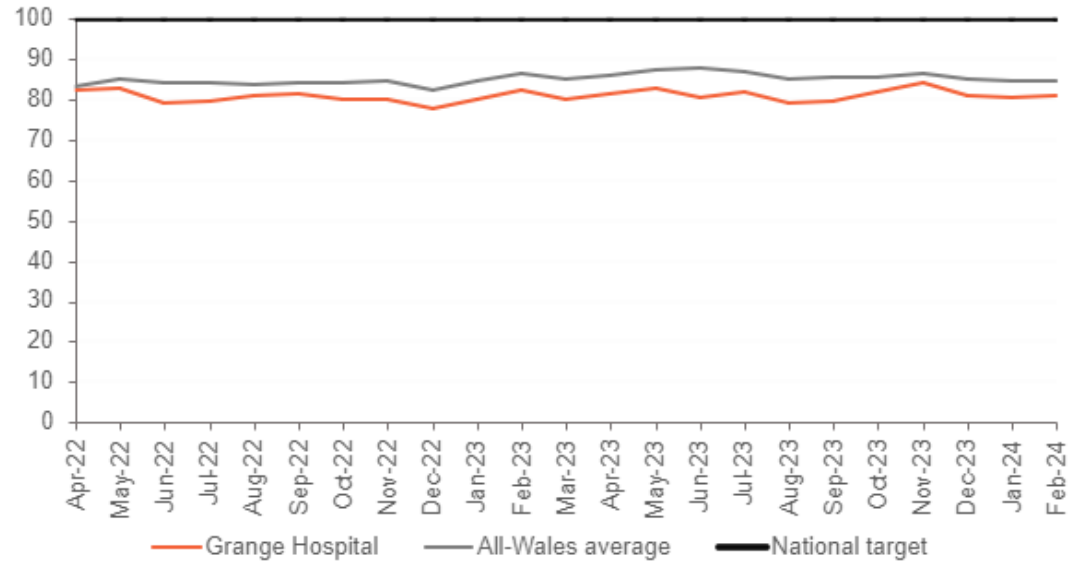
Source: Health Board performance reports

Exhibit 24: percentage of patients spending less than four hours in a major emergency department – national target of 95%



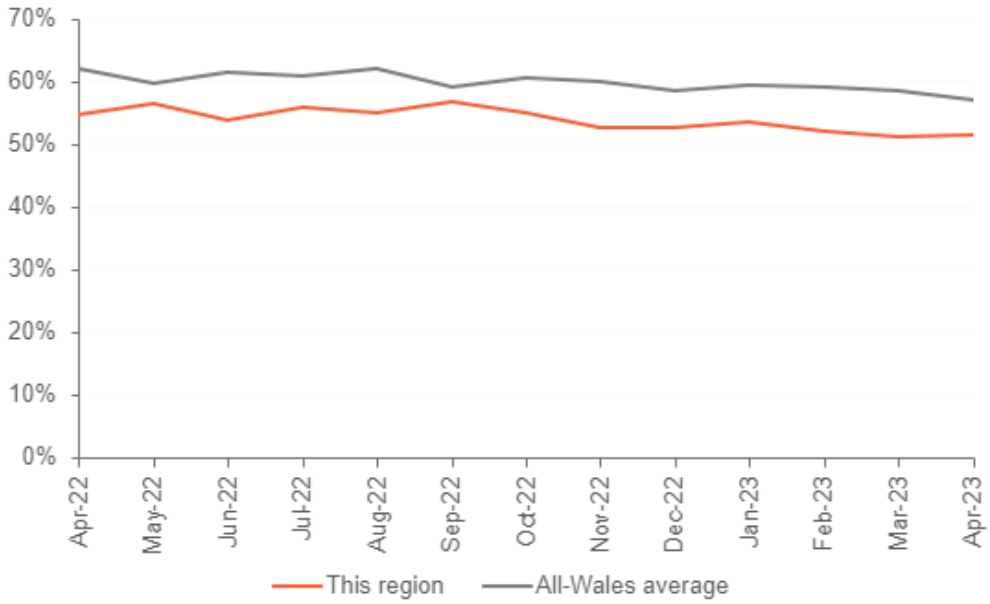
Source: StatsWales

Exhibit 25: percentage of patients spending less than 12 hours in a major emergency department – national target of 100%



Source: StatsWales

Exhibit 26: percentage of total emergency bed days accrued by people with a length of stay over 21 days – national target of 12-month reduction



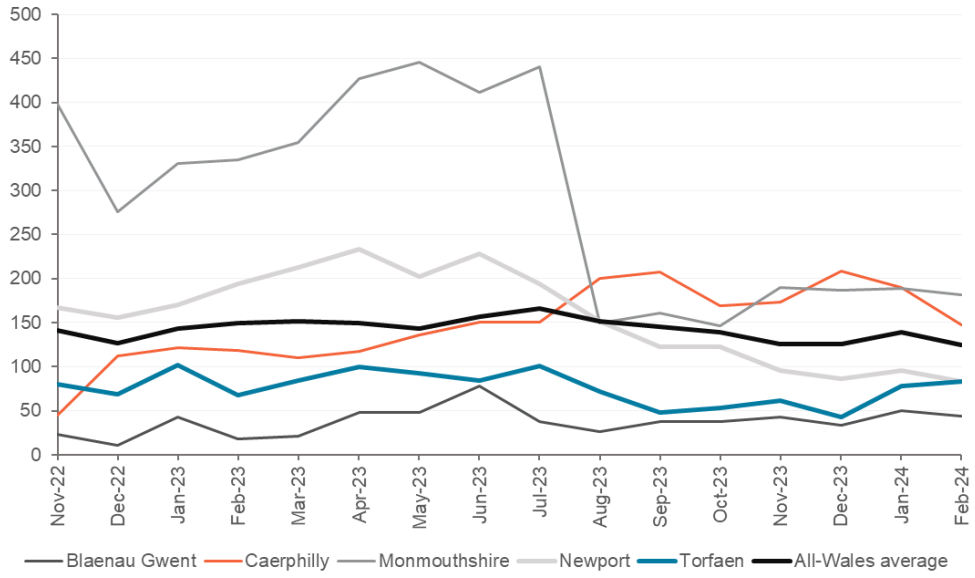
Source: Health Board performance reports

Appendix 4

Waits for social care assessments and care packages

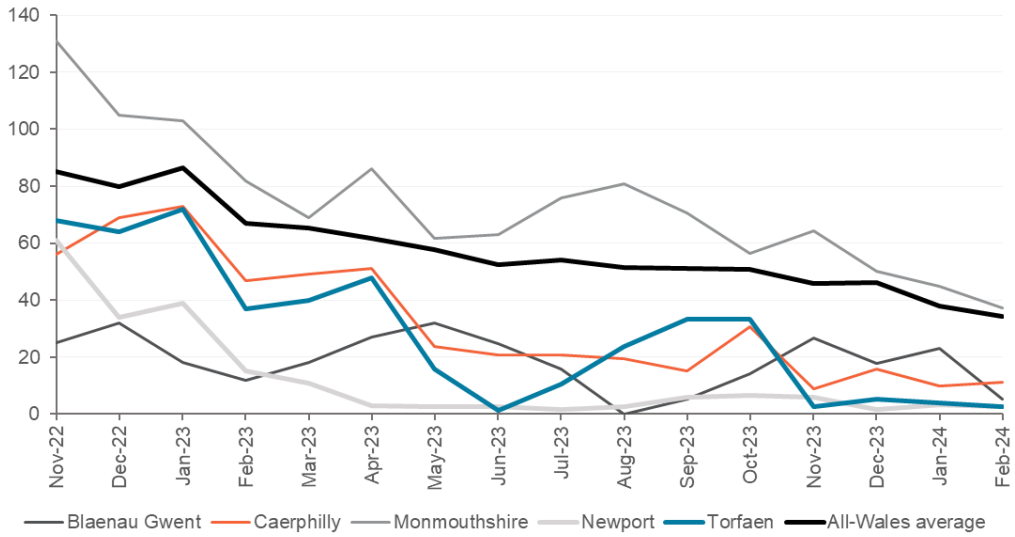
The following exhibits set out the region's waits performance for social care assessment and receipt of a range of care packages in comparison to the position across Wales since November 2022.

Exhibit 27: number of adults waiting for a social care assessment (per 100,000 head of population)



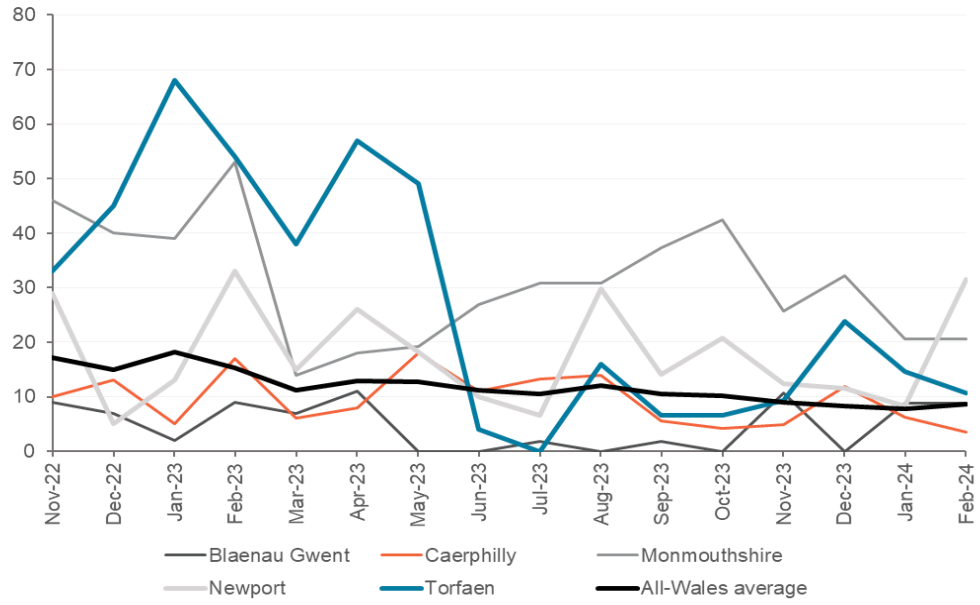
Source: Welsh Government

Exhibit 28: number of adults waiting for domiciliary care (per 100,000 head of population)



Source: Welsh Government

Exhibit 29: number of adults waiting for reablement (per 100,000 head of population)



Source: Welsh Government

Appendix 5

Combined management response to audit recommendations

Exhibit 30: combined management response

Recommendation	Management response		Completion date	Responsible officer
Improving training and guidance on discharge planning				
R1 The Health Board and local authorities should embed processes to communicate discharge planning guidance to all relevant health and social services staff, including those working on a temporary basis, supported by an ongoing programme of refresher training and induction training for new staff. Where possible, this should be done on a joint basis.	Current hospital discharge models are being reviewed and once finalised will be communicated clearly to all hospital and community staff. The current system is over complex and must be simplified for the benefit of people Significant investment across the region on Balancing Rights and Responsibilities (BRR) training, focussing on front door pathways to support staff to take proportionate rights and risk-based decisions that put the person at the heart of		March 2025	**Executive Director of Nursing/ Local Authority Heads of Service/ Head of Patient Discharge**

Recommendation	Management response		Completion date	Responsible officer
	decision making and whether an admission is necessary and appropriate. This is multi-professional and multi-agency training across the five Local Authorities and Health Board. All staff operating in the hospital discharge space will have access to the range of policies and procedures as part of their induction and ongoing CPD			
R2 The Health Board should update its discharge policy to ensure that it reflects the national guidance issued by the Welsh Government in December 2023.	Update discharge policies including – complex and reluctant discharges and choice policy to reflect the national guidance		February 2025	**Executive Director of Nursing/ Local Authority Heads of Service/ Head of Patient Discharge**
Embedding a 7-day approach to discharge				
R3 The Health Board and local authorities should review capacity to embed and deliver 7-day discharge. Despite discharges needing to happen daily, current ways of working do not support this, and a lack	The Local Authorities and Health Board have discharge support in place to via Home First and Hospital to Home 7 days per week. Care packages can be reinstated and restarted on weekends, continue to embed a 7-day approach to discharge across the		March 2025	**Executive Director of Nursing/ Local Authority Heads of Service**

Recommendation	Management response		Completion date	Responsible officer
of weekend discharge means patients have a prolonged stay in hospital which increases risk of deconditioning and acquiring infection.	system. Temporary care can also be commissioned. Continue to embed 7-day discharge planning via the Home First and Hospital to Home, there is often reluctance to support discharges at weekends (risk averse) even where the Local Authorities'/Health Boards' assessments indicate the person can be safely discharged home. Trusted Assessor model via Home First, workforce is a challenge Progression of nurse led discharge as part of the optimal hospital ward model at RGH across three wards Community Resource Team – medical staff to work 7-day end of January Senior Nurse for Discharge appointed at RGH, in post from 6 January, Senior Nurse for Discharge Community Hospitals out to advert, focus on embedding the delivery of 7-day discharge		March 2025 March 2025 January 2025 January 2025	**Executive Director of Nursing/ Local Authority Heads of Service**

Recommendation	Management response		Completion date	Responsible officer
Clarify roles and responsibilities in relation to informal over prescribing of care packages				
R4 The Health Board should clarify roles and responsibilities regarding care package prescribing to ensure patients are not given unrealistic and unnecessary expectations in relation to care provision. This is particularly the case with older patients who may be seen as frail. This can disempower patients from being independent and may lead to future readmissions.	Review of roles and responsibilities regarding care package prescribing through the optimal ward model at RGH across three wards to include education/training and review of board rounds. Develop roll out plan for the optimal ward framework across all Hospital sites.		March 2025	**Executive Director for Nursing**
Review risk appetite in relation to patient discharge				
R5 The Health Board should review its cultural appetite and approach to risk in relation to patient discharge. This should ensure risk is assessed across the whole patient pathway, so beds are not unnecessarily occupied.	Updated discharge policies will be shared and form part of the education and communication framework to help prioritise the discharge agenda across the MDT, supported by the Strategic lead for discharge and the senior nurse. The risk in relation to non-compliance with the discharge		March 2025	**Executive Director for Nursing**

Recommendation	Management response		Completion date	Responsible officer
	framework is evaluated and discussed at divisional and corporate level via local meetings and integrated boards and will feed into the discharge work streams			
Embedding the Trusted Assessor model R6 The Health Board should embed its approach to the Trusted Assessor model and communicate this approach to all partners. Whilst there is recognition this may not help secure care packages or placements more quickly; it will ensure there is capacity to assess patients when required.	The Local Authorities and Health Board have undertaken a review of opportunities to embed a Trusted Assessor model against national best practice and local datasets for Pathway of Care Delays linked to assessment codes. Three areas of recommendation have been presented to Integrated Discharge Board to progress. **Integrated front door** • Embedding of quality conversations that promote positive risk management through the Balancing Rights and Responsibilities training plan prepared with first cohort targeting the Integrated Front Door team, 2 cohorts arranged for February 2025 for up to 60 spaces. **Wider system opportunities**		Ongoing	**Executive Director for Nursing**

Recommendation	Management response		Completion date	Responsible officer
	Review undertaken of assessment code delays from POCD datasets, top areas identified. • Embedding of DST model in the community not hospital to reduce 'joint assessment' delays, December figures reduced dramatically following focus on this. • Work with care homes to implement model of 'trusted assessor' for patient discharge when there is a vacancy, rather than waiting for a visit. Project streams to be established to implement the work identified: • Integrated front door, bringing trusted assessor model. • Facilitating early discharge, moving DST to community not as inpatient. • Care Homes accepting nursing assessment and not requiring to visit to review a patient.			
Improving oversight of policies and guidance				

Recommendation	Management response		Completion date	Responsible officer
R7 The Health Board should monitor compliance with its discharge policy to assess the effectiveness and consistency of the application, and whether the intended outcomes are being achieved. This includes adhering to its own policy that an annual programme of learning will be reported to the Patient Quality, Safety and Outcomes Committee.	Data collected via POCD, CWS2 length of stay and discharge work streams will form the cornerstone of improving guidance, shaping the educational programme and focusing resources to improve and evaluate outcomes. Further development of CWS2 to replace the Complex List. Formal dashboard in development and reported to the Integrated Discharge Board. Learning and feedback to be presented at local forums and integrated boards and the patient Quality outcomes committee.		Next 12 months	**Director of Digital** **Executive Director of Nursing**
Improving the quality and sharing of information R8 The Health Board and local authorities should implement ways in which patient information can be shared more effectively, including opportunities to provide wider access to organisational	Local Authorities in the process of replacing the existing IT client record (WCCIS) over the next 18 months. There is potential with a new system for it to link with the Health Board system over time. There are processes in place to share information to support		Next 18 Months	**Director of Digital/Executive Director Nursing/Local Authority Heads of Service**

Recommendation	Management response		Completion date	Responsible officer
systems and ultimately joint IT solutions.	discharge planning, but this does not amount to a joint IT solution. Health Board progressing with scoping an IT solution to merge the Complex List with CWS2, with sharing of data across Local Authorities to support meaningful, real-time data analysis.		Priority for 2025/2026	
R9 The Health Board should improve record keeping by: 9.1. ensuring all staff involved in discharge planning fully understand the importance of documenting comprehensive information in patient case-notes to support effective discharge planning. 9.2. establishing a programme of case-note audits focused on the quality of record keeping.	Monthly Audits: Ward staff conduct monthly audits of nursing documentation to assess the standard and detail of information recorded in patient records. This includes Admission documents, Risk Assessments, Care Records, and Discharge documents. Ward Accreditation Programme: The completion and detail of information recorded on these documents are included in the Ward Accreditation programme, which ensures that staff are aware of the importance of comprehensive documentation. Electronic WNCR Programme: Discharge Planning documentation is available on the electronic WNCR programme, which		Monthly Audits	**Deputy Director of Nursing** **Assistant Director for Quality and Patient Safety** **Head of Health Records/Referral and Booking**

Recommendation	Management response		Completion date	Responsible officer
	facilitates better access and understanding of the importance of documenting comprehensive information. Audit Results: Recent audits have shown room for improvement in documenting estimated discharge dates (EDD) and discharge planning. For example, the documentation of discharge planning in medical and nursing notes/PSAG was 76.6% in October, 82.7% in November, and 77.3% in December. Medical Records Review: A review conducted in March 2024 found that only 19% of Discharge Planning documents were completed, indicating a need for more rigorous audits and follow-up actions. Case note audits are part of the internal audit plan for the Health Board. Medical records audit the notes, as do the Corporate QPS audit team to look at standards of record keeping .		January 2024 Ongoing	**Deputy Head of Health Records – DHR** **Medical Director / Clinical Audit Team – Corporate**

Recommendation	Management response		Completion date	Responsible officer
	Case-Note Audit Programme: The Health Board has a structured programme aimed at assessing and improving the quality of record keeping. This programme focuses on compliance with established standards, enhancing patient safety, and ensuring adherence to relevant policies and guidelines. This audit has been undertaken and will be presented at Clinical Standards and Effectiveness Group. **Medical records Audit Programme:** The Health Board carries out regular case-note audits. Compliance checks include audit criteria of: black ink, dates, legible, signed and times. The current compliance for outpatients for this audit is 68% and in-patients' documents is 95%. By focusing on these areas, the Health Board can ensure that staff understand the importance of comprehensive documentation and establish a robust audit programme to maintain high-quality record keeping.		Ongoing monthly audits	**Medical Director / Clinical Audit Team – Corporate**

Recommendation	Management response		Completion date	Responsible officer
	The results from the audit findings are scheduled to be fed back at the Clinical Standards and Effective Group. Audit results will be used to develop targeted action plans and address specific deficiencies. Recommendations from the Group will be presented at the Learning and Improvement Forum. Learning from the current practices and audit results will enhance the Health Board's record-keeping processes. Regular audits are scheduled for 2025/26 and will help identify gaps in record keeping and provide opportunities for continuous improvement. Immediate feedback and actions for improvement will be fed back to service leads. This supports learning from the current practices and, the Health Board can improve the quality of record keeping, ensuring better patient care and compliance with standards.		April 2025	

Recommendation	Management response		Completion date	Responsible officer
Patient, service user and staff feedback				
R10 The Health Board should ensure it has mechanisms in place to understand the experiences of patients and carers in the discharge process in line with their existing policy and apply learning.	Patient experience feedback is captured within the Health Board on the CIVICA Experience Platform. This system is across all inpatient wards and a number of other areas e.g., ED, MIU, SDEC, AMU, etc. All feedback captured is viewed by the ward and wider Directorate and Division, so any comments around discharge could be viewed (from open questions in surveys), however, there is no specific question regarding 'Discharge'. In addition, all comments collected are analysed by the system and put into themes to understand trends. One theme is dedicated to 'Patient Pathway' with a sub theme around 'Discharge', this allows for specific analysis of experience on this subject and understanding of where the feedback has been recorded if any patient or relative has referenced anything specifically about discharge.		Ongoing	**Executive Director for Nursing**
R11 The local authorities should ensure relevant social services teams routinely capture service	Local Authorities regularly seek feedback from service users both		Ongoing	**LA Heads of Service**

Recommendation	Management response		Completion date	Responsible officer
users' and carers' experiences and apply learning.	formally and informally. This can be more challenging in relation to hospital discharge but is an area for improvement. There is the annual census questionnaire and a range of internal feedback mechanisms/ questionnaires including complaints and compliments. Annual report re complaints and compliments.			



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Cancer Services in Wales:

A review of the strategic approach to improving the timeliness of diagnosis and treatment

January 2025



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Key facts

Exhibit 1: key facts

Cancer is the **leading cause of death** in Wales

Wales has the **second highest** cancer mortality in the UK. The UK has one of the highest cancer mortality rates of all OECD countries

Five-year cancer survival has improved. **62%** of people diagnosed with cancer between 2016-2022 survived at five years compared to **54%** of people diagnosed between 2002-2006

4 in 10
annual cancer cases in Wales could be prevented

At £719 million in 2022-23, spending on cancer services was the **third highest area of NHS spending** after mental health and trauma and orthopaedics

Real terms spending on cancer services has **increased by 54%** from 2009-10 to 2022-23

Since August 2020, no health board has met the overall target that **75%** of patients should start their first definitive treatment within **62 days** of first suspicion of cancer

From August 2023 to August 2024, between **53%** and **61%** of patients started treatment within **62 days**

In 2021, **24%** of cancer patients were diagnosed at stage 4 and **18%** at stage 3

Survival decreases as stage advances for all cancer types

Bowel screening eligibility has expanded in stages since October 2021. It now includes people aged **50 to 74** and uses a more sensitive test.

From July 2023 to July 2024, just **21%** of bowel screening participants referred to their health board for a colonoscopy were offered the procedure within 4 weeks against a standard of **90%**

Breast and cervical screening uptake were **below standard**

Non-melanoma skin cancer, bowel, female breast, lung and prostate cancers are the most **common cancers** in Wales

Source: Audit Wales

Notes: *Welsh Government data: NHS Expenditure by programme budget category and year, 'cancer and tumours', on StatsWales

Key messages

Context

1 One in two people in the UK born after 1960 will be diagnosed with some form of cancer during their lifetime[1]. Many people go on to survive cancer and lead healthy lives. Early diagnosis and timely treatment are key to survival for most cancers.

2 Services to detect, diagnose and treat cancers and to support cancer patients are provided by many public and third sector organisations. Some services, notably Systemic Anti-Cancer Therapy[2] and radiotherapy, mostly serve cancer patients. However, much of the outpatient, diagnostic and surgical capacity needed for cancer patients is part of the wider planned care system.

3 The Welsh Government is responsible for setting the vision and targets for health care and for the allocation of funding. It sets out a range of expectations for the NHS Executive, including supporting improvement in cancer services, through an annual remit letter. The National Strategic Clinical Network for Cancer[3] is part of the NHS Executive and brings together clinicians and health professionals to support improvement. Health boards are responsible for providing high quality care to patients and meeting performance targets. **Appendix 1** explains roles and responsibilities for cancer services and key elements of the strategic approach.

4 Our work has examined the coherence of the national arrangements to drive improvements in cancer services in Wales. The report includes an overview of NHS Wales' performance in providing cancer diagnosis and treatment and offers views on the prospects for improvement, including through prevention. The report does not comment on the performance of individual NHS bodies as this will be examined as part of the Auditor General's 2025 programme of local audit work at those bodies. **Appendix 3** provides more detail about our work.

1 Cancer Research UK.

2 Systemic Anti-Cancer Therapy includes chemotherapy, immunotherapy and hormonal therapy.

3 Called the Wales Cancer Network at the time. We refer to the Network as the 'Cancer Network' throughout the report for ease of reference.

Overall conclusions

5 Overall, we found that despite increased investment, there is a continuing failure to meet the national performance targets for cancer with a minority of patients facing unacceptably long waits for diagnosis and/ or treatment. Cancer outcomes in Wales have improved over recent years but are still poor compared to other countries. Stronger and clearer national leadership is urgently needed to help drive the necessary improvements in the timeliness and sustainability of cancer diagnosis and treatment.

Key findings

Performance and resources

6 Demand from suspected cancer patients is increasing ahead of the NHS' ability to meet it. As a result, the waiting list for diagnosis and treatment is growing. Our indicative modelling shows that without a significant increase in activity to diagnose and treat patients, the waiting list will not return to pre-pandemic levels.

7 The national target that 75% of cancer patients should start their first definitive treatment within 62 days of first suspicion has not been met by any of Wales' health boards since August 2020. Performance deteriorated following the pandemic and has been stable since early 2022 with between 52% and 61% of patients starting their treatment within the target time. Waiting times for some cancer types are particularly long with some patients waiting over 100 days for treatment[4]. There are also growing waits between diagnosis and the start of treatment.

8 A significant minority of people are being picked up with late-stage cancer which impacts their likelihood of survival. In 2021, patients diagnosed with cancers of the gall bladder, pancreas and lung were more likely than patients with other types of cancers to be diagnosed at stage four (74%, 52% and 48% of patients).

9 Screening plays a vital role in early detection. While the standard for uptake of bowel screening is being achieved, this is not the case for breast and cervical screening programmes.

4 See **Exhibit 8.**

10 Patient outcomes have improved over time. But Wales has the second highest cancer mortality rate in the UK after Scotland. The UK itself has a worse rate than many OECD countries. Mortality rates in Wales are significantly worse for people living in deprived areas and the gap between the most and least deprived is growing.

11 Real terms spending on cancer care over the last 13 years has grown considerably more than the overall increase in real terms NHS spending. However, this increase does not necessarily translate into extra activity as there are a range of inflationary cost pressures, including costs of drugs and new treatments. There are also challenges around capacity – including gaps in the workforce and concerns about a shortage of modern scanning equipment.

Strategic direction

12 The Welsh Government has set out its high-level strategic vision for cancer services in its 2021 Quality Statement for Cancer. In February 2023, at the request of the then Minister for Health and Social Care, the Cancer Network published a three-year Cancer Improvement Plan as a collated NHS response to the Quality Statement. The NHS Executive is developing a National Cancer Recovery Programme as part of the wider national approach to transforming planned care. The Welsh Government has also launched a 'Cancer: Improving Outcomes' initiative through its Life Sciences Hub aimed fostering innovation and collaboration between the NHS and industry.

13 Whilst these various developments demonstrate a clear national commitment to improve cancer services, their collective efficacy is undermined by a lack of clarity over the status of the three-year Cancer Improvement Plan. Welsh Government officials were clear that the Plan was not their document but rather the collated response of the NHS to the Quality Statement.

14 However, NHS and third sector bodies are confused about the Cancer Improvement Plan's status and what, if anything, they should be doing to implement it. Many were also confused about the links between the Improvement Plan, the National Cancer Recovery Programme and the Cancer: Improving Outcomes initiative.

15 There is similar confusion about the split of leadership and accountability between the Welsh Government and the NHS Executive and about roles within the NHS Executive. Overall, we identified a consensus, including within the Welsh Government and the NHS Executive, that the arrangements were not yet providing the strong leadership needed to drive system-wide improvement in cancer services.

16 We identified examples of important Welsh Government investment to improve cancer services and broader planned care including rapid diagnostic centres and a new cancer centre for Velindre NHS Trust. However, the pace at which some new developments are taken forward can be slow, in areas such as digital cellular pathology and lung cancer screening.

17 There is also a risk that the Welsh Government may not get a good return on its £3.4 million investment in a National Imaging Academy. The Academy is training more radiologists to address workforce shortages, but some NHS bodies have not been able to create jobs for newly qualified people.

18 The Welsh Government relies heavily on its performance management arrangements to oversee and drive improvement. However, these arrangements are focussed predominantly on the 62-day timeliness target, which only covers part of the patient pathway. The Welsh Government told us it also focuses on delivery of National Optimised Pathways, although at the time of drafting the NHS Executive was still developing plans for monitoring compliance with those pathways.

19 The Welsh Government's Quality Statement does not set out any specific expectations in respect of cancer prevention despite around 38% of cancers being preventable. Whilst there are other Welsh Government strategies and frameworks aimed at encouraging healthier lifestyles these do not constitute a coherent policy framework for population health and disease prevention.

20 Data and digital are two other key areas for improvement. We identified inaccuracies in national data and a need for more consistent national data that helps track delivery across the patient pathway. Work is underway to replace the previous outdated cancer information system. However, progress has been slow, and services continue to rely on fragmented digital systems that consume time and carry risks to patient safety.

The Welsh Government's Quality Statement, the identification of nationally optimised pathways and the publication of a Cancer Improvement Plan are all examples of a clear commitment to secure high quality cancer care for the people of Wales.

However, despite this and increased investment over recent years, too many people are experiencing unacceptably long waits for cancer diagnosis and treatment. Variations in performance and outcomes persist within and between health bodies in Wales, and insufficient attention is being placed on prevention of the lifestyle factors that can cause cancer and other major health conditions.

The arrangements for the national leadership and oversight of cancer services in Wales need to be clarified and strengthened as a matter of urgency. This must include a clear statement on the status of the NHS Wales Cancer Improvement Plan and how the Welsh Government and NHS Executive expect it to be used, alongside other programmes and initiatives, to shape the improvements which are needed in cancer services in Wales.

Adrian Crompton
Auditor General for Wales



4 Recommendations

Exhibit 2: recommendations

Setting out a coherent, long-term strategic approach for cancer in Wales, supported by clear system leadership and informed oversight

R1 The Welsh Government should publicly clarify the status of the Cancer Improvement Plan and its links to the National Cancer Recovery Programme and the Cancer: Improving Outcomes initiative. As part of this the Welsh Government should clarify how it intends to hold NHS bodies to account for delivery of the Cancer Improvement Plan.

R2 The Welsh Government should set out a coherent model for system leadership in respect of cancer services that clarifies its own role and that of the NHS Executive and sets out how it will bring on board clinicians and other key stakeholders to build a common view of cancer service performance, quality and opportunities for improvement.

R3 The Welsh Government should review its oversight and performance framework in respect of cancer services to focus on a broader range of issues, including a more explicit alignment to the ambitions and quality attributes set out in the Quality Statement for Cancer.

Developing the strategic approach to population health improvement and disease prevention

R4 The Welsh Government should develop a more coherent approach to population health improvement by setting out how it intends to use its Science Evidence Advice: NHS in 10+ Years to harness the opportunities associated with prevention to reduce the incidence of cancer and other major conditions.

Exploiting specific opportunities for improvement

R5 The Welsh Government should work with Public Health Wales to accelerate decision making for a national lung screening programme. It should clarify as soon as possible whether it will fund national lung screening for Wales and the timescale for implementing such a programme.

R6 As part of a wider approach to encourage greater regional working between health boards, the Welsh Government and the NHS Executive should work with the service to understand and help address any key barriers to delivering regional services. This should include working with DHCW to identify digital solutions to support shared waiting lists for cancer diagnosis and treatment, where it is appropriate to do so.

R7 The Welsh Government should work with the NHS Executive, HEIW and other NHS bodies to ensure there are employment opportunities for radiologists who have been trained in the National Imaging Academy.

Improving Data and Digital

R8 The Welsh Government should clarify national roles and responsibilities for monitoring and ensuring compliance with its data standards including how it will hold NHS bodies to account for poor compliance.

R9 The Welsh Government should work with the NHS Executive (particularly the Cancer Network), DHCW and Public Health Wales NHS Trust to develop a more comprehensive set of publicly available data on cancer services, which as a minimum should include:

- the number of people currently waiting for cancer diagnosis or treatment (open pathway data).
- performance against the 62-day target for the health board providing diagnosis and treatment and health board of residence, including people living Powys Teaching Health Board area.
- performance across the patient pathways including timeliness of diagnostic reporting across different tumour sites; timeliness from the decision to treat a patient to the start of that treatment (including surgery, radiotherapy and Systemic Anti-Cancer Therapy); and diagnosis and treatment of recurrent disease. Performance information should be provided at cancer sub-tumour level where possible.
- timeliness of diagnosis and treatment for patients referred from the breast and cervical screening programmes.
- accurate information on equity of access, including ethnicity of cancer patients as well as the experiences of different patient groups (this should include children and young people).

R10 The Welsh Government should work with DHCW and NHS England to share regular and consistent data on the timeliness of diagnosis and treatment for Welsh cancer patients treated by NHS England.

Source: Audit Wales



Performance and resources

01

1.1 This part of the report looks at how well services to diagnose and treat cancer are performing, including against national targets. It considers performance in the wider context of demand, financial and capacity pressures.

What we looked for

We looked for evidence that the NHS is sustainably meeting demand to diagnose and treat cancer; whether it is meeting the national performance targets for timeliness of cancer diagnosis and treatment; and for evidence that outcomes for cancer patients are improving and compare well internationally.

Demand is increasing ahead of the NHS's ability to meet it and the waiting list for diagnosis and/ or treatment is growing

The number of people referred for suspected cancer has continued to rise following a sharp drop during the pandemic

1.2 Suspected cancer referrals create demand for NHS services even though the vast majority of those referrals (over 84%[5]) go on to find out that they do not have cancer. Around 80% of patients with suspected cancer are referred by GPs. However, because they are far less likely than those coming from other routes[6] to actually have cancer, those referred by GPs only make up around 54% of patients who go on to start treatment.

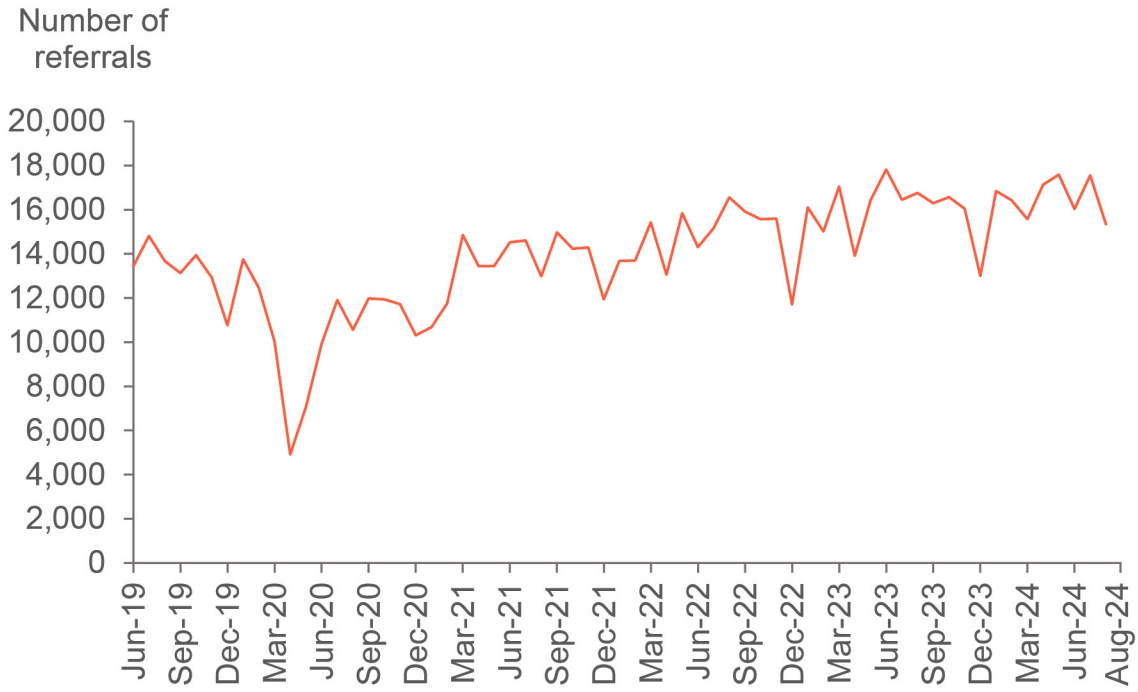
1.3 The number of suspected cancer referrals increased by 14% from June 2019 to August 2024 (**Exhibit 3**); equivalent to around 3% growth each year. Referrals have increased after a drop at the start of the pandemic. The highest numbers of referrals in August 2024 were for skin (excluding basal cell carcinoma[7]) and lower gastrointestinal cancers (17% and 15% of referrals respectively).

5 Since November 2020.

6 Other routes include screening services, emergency departments, and other secondary care professionals.

7 Basal cell carcinoma is the most common type of skin cancer and less likely than other skin cancers to spread to other parts of the body. NHS Wales does not refer suspected basal cell carcinomas via the suspected cancer pathway unless there is a concern that delayed investigation may cause significant impact to the patient in line with NICE Guidance NG12, last updated October 2023.

Exhibit 3: urgent suspected cancer referrals, June 2019 – August 2024



Source: DHCW, Suspected Cancer Pathway – Open Pathways Dataset, on StatsWales.

Note: data from June 2019 to November 2021 is based on experimental analysis on StatsWales and may not be directly comparable to the validated data from December 2021 onwards.

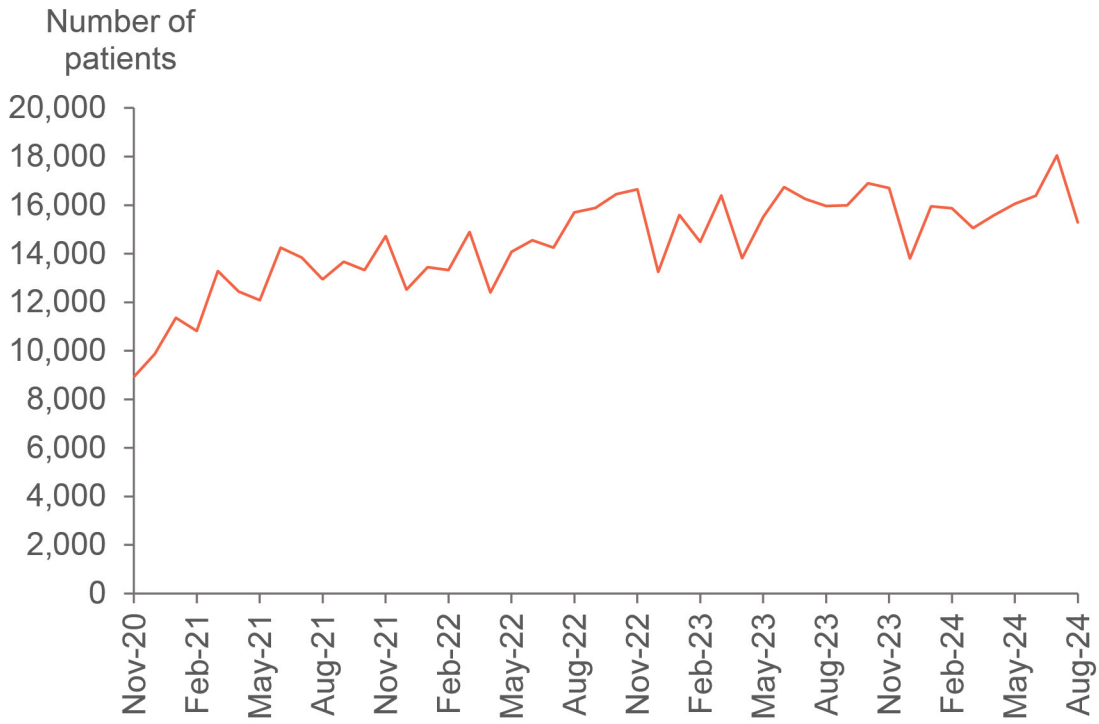
1.4 The number of newly diagnosed cancer patients has also increased over time (by 22% from 2002 to 2021) (see **Appendix 2, Exhibit 26**). Numbers fell in 2020, probably because fewer people accessed healthcare during the pandemic. Numbers of newly diagnosed cancers increased in 2021 but have not yet returned to pre-pandemic levels. The Welsh Cancer Intelligence and Surveillance Unit (WCISU)[8] has not yet published clinical cancer registry data beyond 2021.

8 WCISU is part of the Public Health Wales NHS Trust.

The sharp increase in activity after the pandemic seems to have levelled off

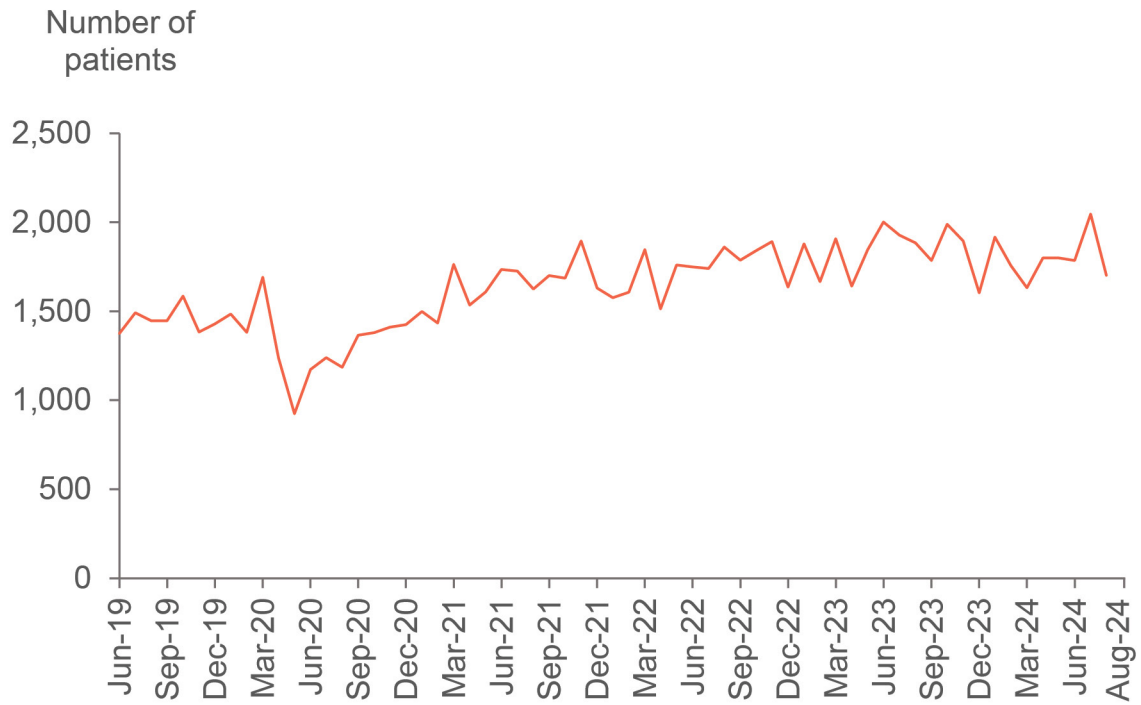
1.5 Activity to diagnose and treat suspected cancer patients[9] has increased since the pandemic but seems to be levelling off. The overall number of pathways closed – including those who were told they do not have cancer and those who started treatment – has increased since November 2020 (**Exhibit 4a**). There is no comparable historic data to show how overall activity levels compare with pre-pandemic levels. However, the number of patients starting treatment for cancer increased quickly after a drop at the start of the pandemic and exceeded pre-pandemic figures by March 2021 (**Exhibit 4b**). The number of patients starting treatment appears to have to broadly levelled out from November 2022.

Exhibit 4a: all closed pathways November 2020 – August 2024



9 As measured by pathways closed.

Exhibit 4b: pathways closed due to patient starting first treatment, June 2019 – August 2024



Source: DHCW, Suspected Cancer Pathway – Closed Pathways Dataset, on StatsWales.

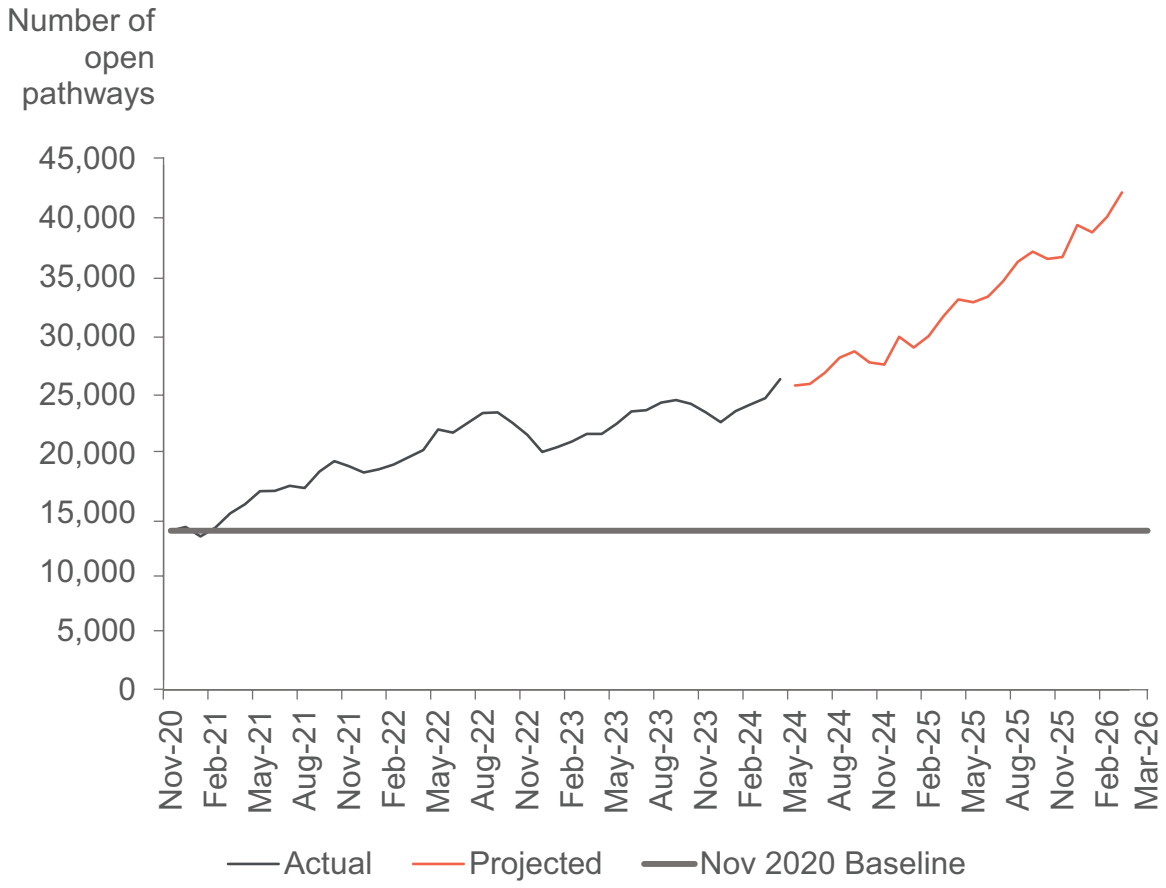
1.6 The available data understates the amount of activity because it only includes activity to the point of first treatment. Many people will need multiple episodes of care after they start their first treatment. It is likely that the amount of activity after first starting treatment is growing with the increasing complexity of new treatments, particularly in immunotherapy. The three cancer centres in Wales[10] hold information on the timeliness of access to radiotherapy and Systemic Anti-Cancer Therapy. However, inconsistencies in the way some of the data is collected means it cannot currently provide any insight on national trends or comparative timeliness of ongoing treatment across Wales.

10 In north Wales, southwest Wales, and south Wales. The centres are managed individually by Betsi Cadwaladr University Health Board, Swansea Bay University Health Board and Velindre NHS Trust.

The numbers of patients awaiting diagnosis or treatment is growing and our analysis suggests the NHS needs to further increase activity if it is to reduce the backlog and sustainably meet demand

1.7 As part of its vision for quality cancer care, the Welsh Government wants to see the waiting list volume return to pre-pandemic levels. It has also set a target that 80% of cancer patients start treatment within 62-days by March 2026. However, the waiting list for diagnosis and/ or treatment has continued to increase, and it is difficult to see how that target will be achieved (**Exhibit 5**). Our indicative modelling shows that the list will continue to grow based on recent trends of demand and activity. It is clear that without a significant increase in activity to diagnose and treat more patients the waiting list is unlikely to return to previous levels.

Exhibit 5: actual and modelled numbers of open suspected cancer pathways to March 2026



Source: Audit Wales analysis of DHCW data, open suspected cancer pathways at month end

Note: Patients may have more than one pathway if they are waiting for diagnosis or treatment for more than one cancer.

Our projection assumed demand, as measured by referrals, increases by 3% a year in line with recent trends and that activity increases by 1% a year.

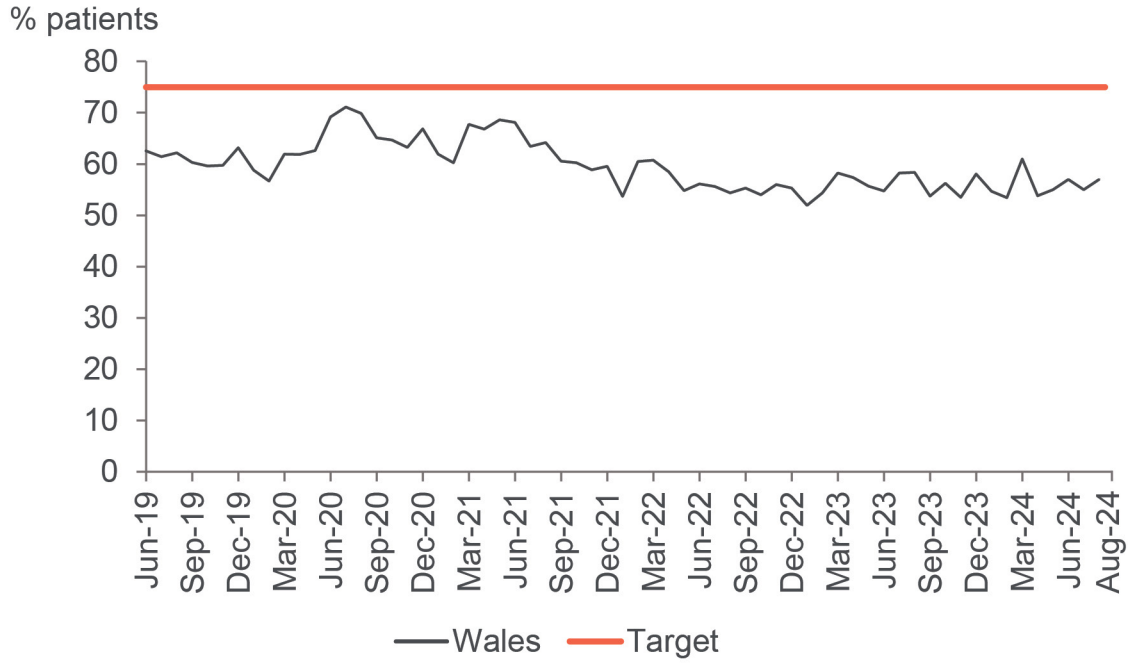
1.8 Much of the capacity the NHS uses to diagnose and treat cancer patients is also used for other non-cancer patient pathways. Achieving the political and policy ambitions to improve access to both cancer and wider planned care within the system's existing capacity will therefore be challenging. Priorities on cancer care will need to be balanced with other planned care priorities. A consideration of how existing capacity can be better used or expanded will also be needed.

The NHS in Wales is continuing to miss the national performance target for cancer treatment

While the majority of patients start their treatment within 62 days, performance is well short of the national target of 75%

1.9 The Welsh Government started implementing its Suspected Cancer Pathway in June 2019, with a target that 75% of cancer patients should start their first definitive treatment within 62 days of the first suspicion of cancer[11]. No health board has met the overall 75% target since August 2020 although performance has been better for some individual tumour sites (**paragraphs 1.10 and 1.11**). During the summer of 2020, referrals were lower and health boards were prioritising urgent and cancer care over other patients due to the pandemic. Since then, despite some month on month variations, performance has stayed between 52 and 61% (**Exhibit 6**).

Exhibit 6: performance against the 62-day Suspected Cancer Pathway Target, June 2019 – August 2024

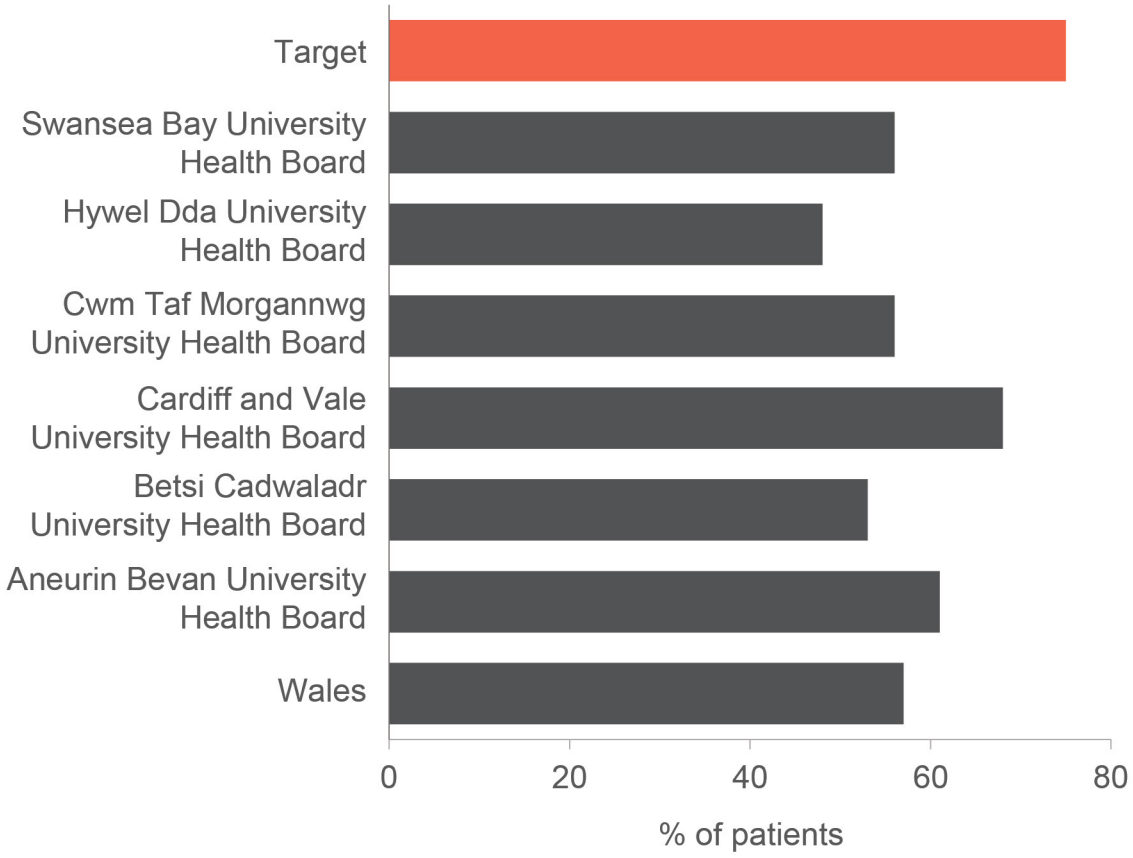


Source: DHCW, Suspected Cancer Pathway – Closed Pathways Dataset, on StatsWales.

11 Some data on performance against the target is available from June 2019 and the Welsh Government officially required health boards to report against the target from February 2021.

1.10 There is considerable variation and fluctuation in performance against the target by health board area. In August 2024, Cardiff and Vale University Health Board was closest to meeting the target at 68%, and Hywel Dda University Health Board was the worst performer at 48% (**Exhibit 7**). Health board performance has fluctuated considerably since 2019 (see **Appendix 2, Exhibits 27a to f**).

Exhibit 7: health board performance against the 62-day Suspected Cancer Pathway Target, August 2024



Source: DHCW, Suspected Cancer Pathway – Closed Pathways dataset, on StatsWales.

Note: StatsWales publishes data for residents of each health board unless they are treated by NHS England. Residents of Powys Teaching Health Board treated by other Welsh health boards are included in that health boards' figures. StatsWales does not distinguish between residents of Powys and residents of the health board they are treated by.

Time to start treatment varies by type of cancer and some patients can face unacceptably long waits

1.11 Waiting times vary depending on the site of the cancer. Waiting times for skin cancer, excluding basal cell carcinoma (BCC) have been consistently above the 75% target, aside from a brief dip in November 2023. However, waiting times for other tumour sites have rarely been at or above the target at an all-Wales level[12]. Waiting times for gynaecological, lower gastrointestinal and urological cancers, and sarcoma are particularly poor with less than half of patients starting their first treatment within 62 days of first suspicion in August 2024 (**Exhibit 8**). Performance may vary within the sub-tumour sites[13] for these cancers but there is no nationally available information to understand performance by sub-tumour site (**recommendation 9**).

12 Performance for breast and lung cancers briefly met the target in June 2021 but has deteriorated since. Brain and central nervous system and haematological cancers, acute leukaemia and sarcoma have all met the target at various points from November 2020 to June 2024 but represent low numbers of patients.

13 For instance, cervical and ovarian cancers are both gynaecological sub tumour sites.

Exhibit 8: performance against the Suspected Cancer Pathway target, median and 75th percentile waits for gynaecological, lower gastrointestinal, skin, and urological cancers, and sarcoma, and August 2024

	Performance against the 75% target	Median waiting times	75th percentile waiting times
Skin (excluding BCC)	80%	35 days	61 days
Sarcoma	20%	No data	No data
Urological	40%	86 days	132 days
Gynaecological	35%	83 days	115 days
Lower gastrointestinal	45%	70 days	106 days

Source: DHCW, Suspected Cancer Pathway – Closed Pathways Dataset on StatsWales (data on performance against the 75% target) and DHCW data on the Suspected Cancer Dashboard (data on median and 75th percentile waits).

Note: Median waiting time is point where half the people have had their treatment and the other half are still waiting. The 75th percentile represents the time when 75% of people have had their treatment but 25% are still waiting.

While diagnostic waits are getting shorter, waits between diagnosis and starting treatment are getting longer

1.12 Health board, NHS Executive and Welsh Government officials told us that delays at diagnostic stage are one of the main reasons for poor performance against the 62-day cancer target. Median waits from first suspicion of cancer to first diagnostic test have fallen from 20 days in February 2021 to 16 in August 2024. Depending on the type of cancer, patients usually face another wait between having a diagnostic test and finding out whether they have cancer (diagnosis). Median waits from first suspicion to actual diagnosis increased from 26 days in February 2021 to 36 in January 2022 but fell to 27 in August 2024[14].

1.13 Our analysis[15] points to problems between diagnosis and starting treatment. Between February 2021 and August 2024, median waits from diagnosis to treatment increased by 38% from 21 days to 29. Waits between diagnosis and treatment vary between tumour sites, with patients with lower gastrointestinal and breast cancers waiting longer than those with other cancer types in August 2024[16] (**Exhibit 9**).

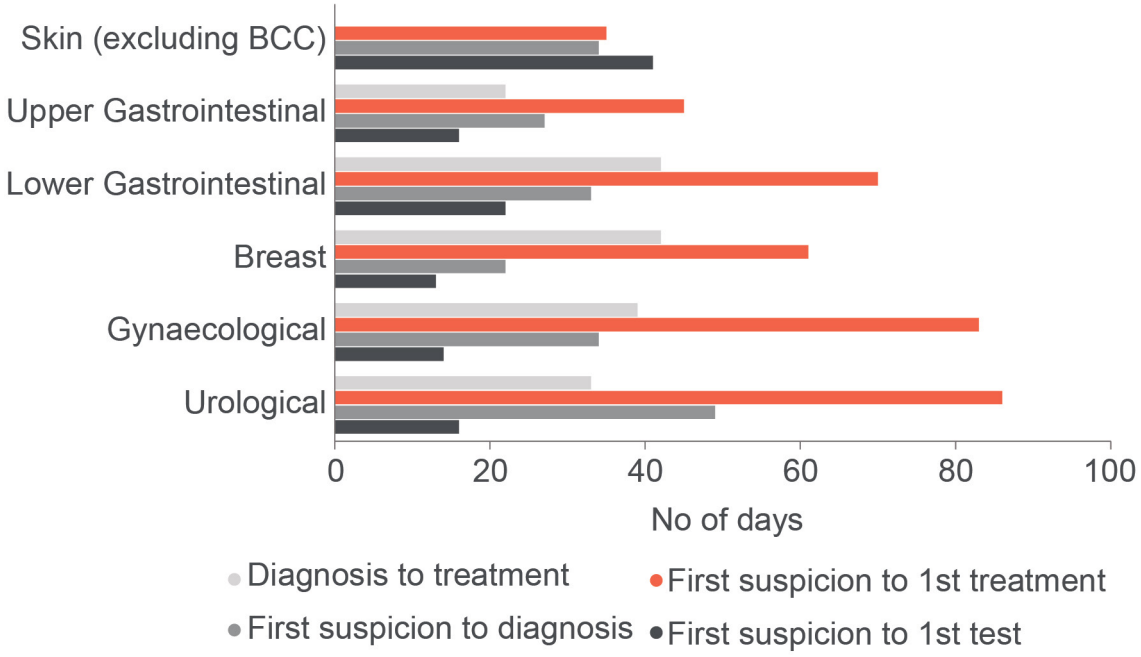
1.14 There are also considerable variations in waits at other stages of the pathway across tumour sites. For instance, in August 2024, the median wait for urological cancers was 16 days from first suspicion to diagnostic test, 49 days from first suspicion to diagnosis, and 86 days from first suspicion to the start of treatment. By comparison, the median wait for skin cancers was 41 days from first suspicion to diagnostic test and 34 days from first suspicion to diagnosis, and 35 days from first suspicion to the start of treatment (**Exhibit 9**).

14 **Appendix 2, Exhibit 28** gives median waits from first suspicion to diagnosis over time.

15 Of DHCW data from the Suspected Cancer Pathway Dashboard. DHCW only publishes median waits for the tumour sites included in **Exhibit 9.**

16 The Welsh Government does not publish median waits for all tumour sites.

Exhibit 9: median wait from first suspicion of cancer to first test, diagnosis and starting first treatment, August 2024



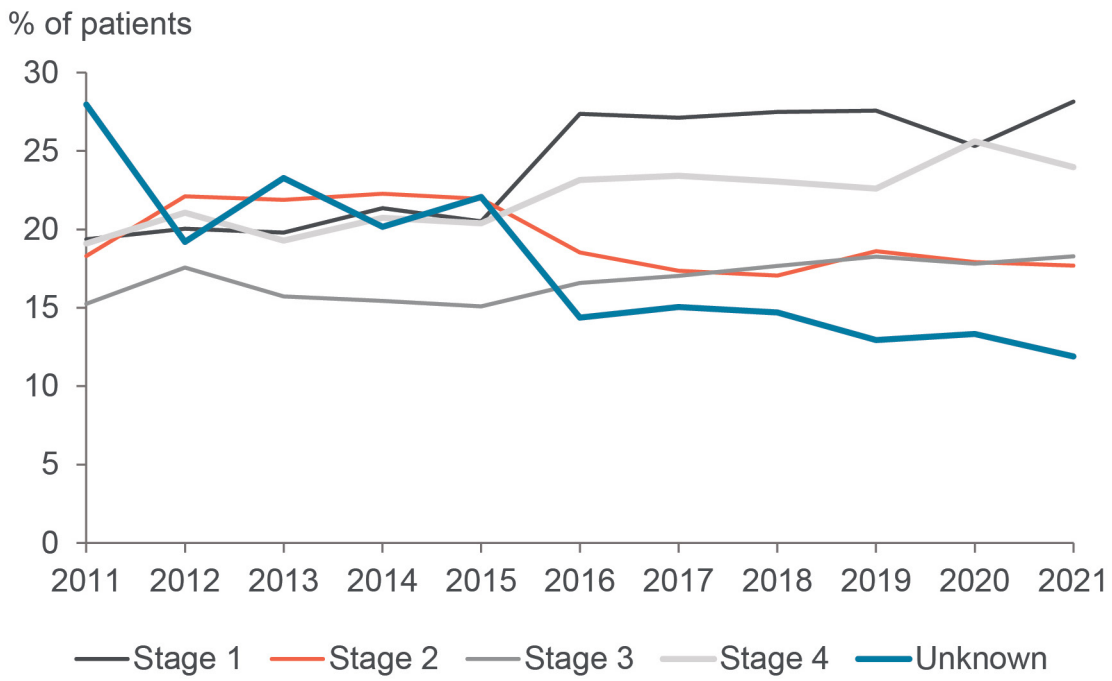
Source: DHCW data from the Suspected Cancer Pathway Dashboard

A significant minority of people are being picked up with late-stage cancer which impacts their likelihood of survival

1.15 Survival decreases as stage at diagnosis advances for all cancer types[17]. In 2021, 24% of cancer patients were diagnosed at stage four and 18% at stage 3 (**Exhibit 10**). The increase in the proportion of cancer patients diagnosed at stage 1 between 2011 and 2021 corresponds with a fall in patients diagnosed at stage 2 and patients whose stage is unknown at diagnosis. With the exception of an increase in 2020, the proportion of cancer patients diagnosed at stage 4 has ranged between 19% and 24% during the same period. Positively, the overall proportion of cancer patients whose stage at diagnosis was 'unknown' has significantly decreased since 2011.

17 WCISU, Cancer Survival in Welsh Residents Diagnosed Between 2002 and 2020, November 2023.

Exhibit 10: proportion of cancer patients by stage at diagnosis, 2011 to 2021



Source: WCISU cancer incidence data

Note: Our analysis is based on WCISU cancer incidence data which does not include 'non-stageable' cancer, non-melanoma skin cancer, and some rare cancer types.

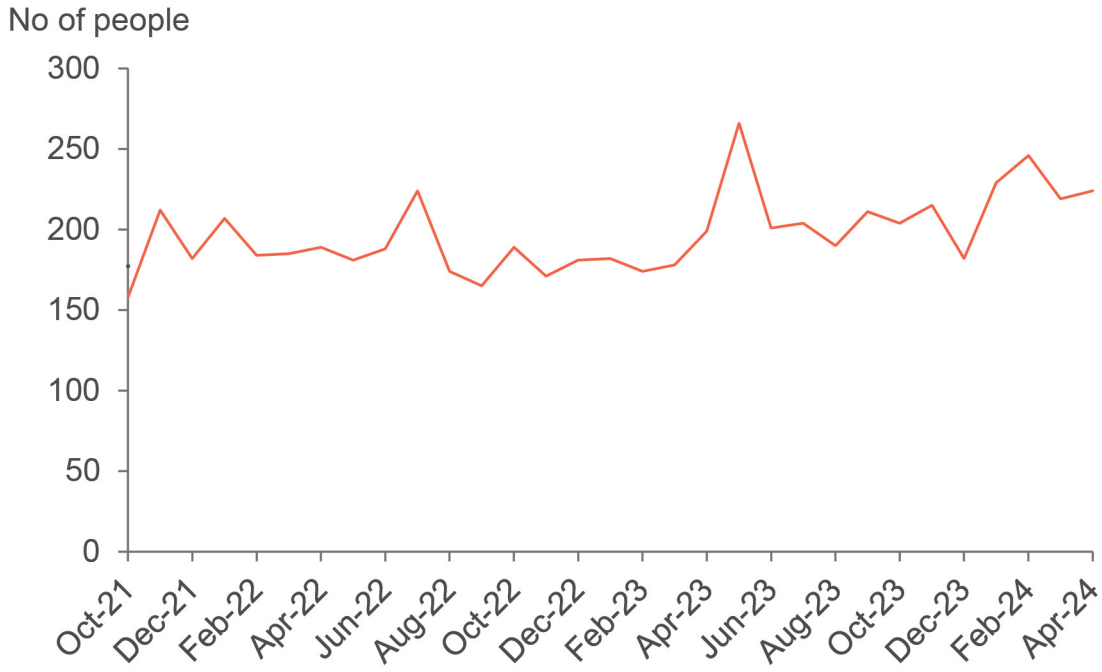
1.16 Some cancers are more likely than others to be diagnosed at a late stage, particularly asymptomatic cancers. In 2021, patients with gall bladder, pancreatic, and lung cancer were more likely than other cancer patients to be diagnosed at stage four[18]. 48% of lung cancer patients were diagnosed at stage four in 2021 (1,175 people). To illustrate the importance of early diagnosis, five-year survival for lung cancer diagnosed during 2016-2020 is 55% at stage one, 30% at stage two, 13% at stage three, and just 3% at stage four[19].

1.17 Although the numbers are relatively small, the number of people whose suspected cancer was identified via emergency departments has increased by over 40% from October 2021 to April 2024 (**Exhibit 11**).

18 74% of patients with gall bladder cancer and 52% of patients with pancreatic cancer were diagnosed at stage 4 in 2021.

19 WCISU, Cancer Survival in Welsh Residents Diagnosed between 2002 and 2020, November 2023.

Exhibit 11: number of urgent suspected cancer referrals via emergency departments from October 2021 to April 2024.



Source: Audit Wales analysis of DHCW Suspected Cancer Pathway Data – closed pathways by source of suspicion.

1.18 Research by the International Cancer Benchmarking Partnership[20] found that countries with higher rates of cancer diagnosis after emergency presentation had poorer survival rates[21]. It explained that Wales and Scotland have some of the highest rates amongst comparable countries. Our own analysis found that suspected cancer patients referred from emergency departments were more likely than those referred via other routes to die before being diagnosed or starting treatment[22]. While some caution is needed due to the small numbers, there is an upwards trend in patients referred from emergency departments dying before treatment or diagnosis.

20 The Partnership brings together international clinicians, policymakers and researchers to identify best practice and support improved cancer outcomes for patients.

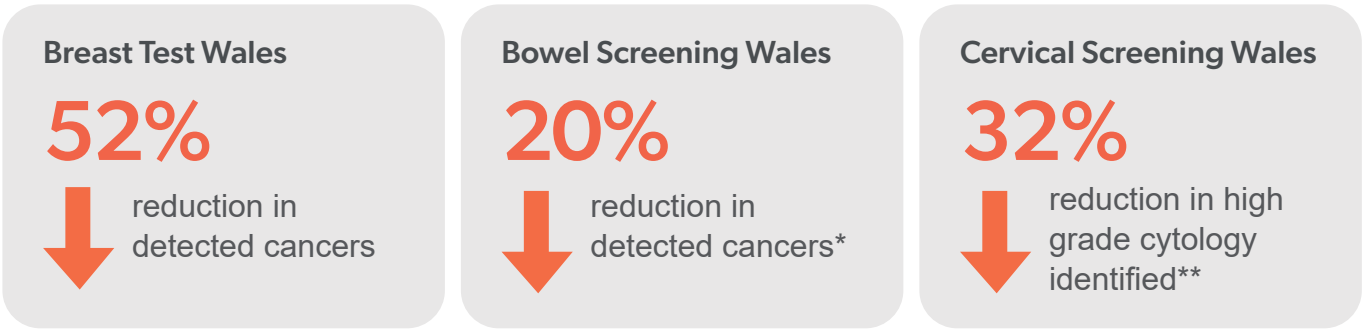
21 Abd Elkader, Alv, R; Barclay, M; Johnson, S; McPhail, S; Swann, R, Risk Factors and Prognostic Implications of Diagnosis of Cancer Within 30 Days After and Emergency Admission (Emergency Presentation): An International Cancer Benchmarking Partnership Population Based Study, 2022.

22 Based on our analysis of on our analysis of DHCW Suspected Cancer Pathway Data. In April 2024, 4% of suspected cancer patients referred from an emergency department died before starting treatment or finding out they did not have cancer compared to 1% of all suspected cancer referrals.

There is scope to increase uptake of screening to detect cancers earlier

1.19 Screening plays a vital role in early detection. Public Health Wales NHS Trust (PHW) runs Wales's three cancer screening programmes: Breast Test Wales, Bowel Screening Wales and Cervical Screening Wales. The Trust estimates that brief pauses to its screening programmes[23] at the start of the pandemic reduced the number of detected cancers in 2021 compared to previous years (**Exhibit 12**).

Exhibit 12: reduction in cancers detected via screening, from April 2020 to March 2021 compared to the previous year



Source: PHW, Update on Population Based Screening Programmes in Wales to the Quality, Safety and Improvement Committee, June 2021

Note: * from April 2020 to February 2021.

**abnormal cells with the potential to develop into cervical cancer.

1.20 Whilst bowel screening is achieving its uptake standards, there are opportunities to increase screening uptake for the breast and cervical screening programmes which were both below the standard in August and April 2024 respectively (**Exhibit 13**). In 2022, the Trust reported differences in screening uptake for all three programmes depending on age, the health board area people live in, and whether the area is deprived or not[24]. It is working to address inequity in screening uptake via its Screening Equity Strategy but has not published a progress report on screening equity since June 2022.

23 Audit Wales, A Review of Arrangements to Recover Screening Services at Public Health Wales NHS Trust, August 2023, provides more information the pause and recovery screening services including performance measures, eligibility and coverage standards for each programme.

24 Public Health Wales NHS Trust, Screening Division Inequities Report 2020-21, June 2022.

Exhibit 13: screening coverage against target, April and August 2024

	Eligibility	Standard	Uptake
Breast Test Wales	Women aged 50 to 70 years invited for screening every three years	70%	68%*
Bowel Screening Wales	People aged 50 to 74 years invited for screening every two years	60%	65%**
Cervical Screening Wales	Women and people with a cervix aged 25-64 years invited for screening every 5 years if Human papillomavirus (HPV) negative or more frequently if HPV positive	80%	69%***

Source: Audit Wales, based on information and wording from PHW, October 2024.

Note:

*Rolling annual rate at August 2024
**Average over the previous year at August 2024
***Age appropriate coverage at April 2024

1.21 Referrals from breast and bowel screening programmes were amongst the most likely to go on to start cancer treatment (92% and 28% respectively in 2023-24 compared to 12% overall)[25]. However, there is no national data on the timeliness of subsequent cancer diagnosis and treatment for people referred from breast or cervical screening. From July 2023 to July 2024, just 21% of eligible people referred from bowel screening were offered a colonoscopy by the relevant health board within four weeks of phoning to book[26]. The target is 90%. Waiting times for colonoscopies varied between health boards from four to 14 weeks.

25 Based on our analysis of DHCW Suspected Cancer Pathway Data. We have excluded cervical screening referrals from our analysis due to low numbers. Less than 5 people are referred with suspected cancer following cervical screening each month.

26 Public Health Wales NHS Trust, October 2024.

Survey data suggests that patients are generally satisfied with their cancer care, though the latest survey pre-dates the recent decline in performance

1.22 Data on patient experience is collected via the annual Wales Cancer Patient Experience Survey commissioned by the Cancer Network and Macmillan Cancer Support. The most recent data is from 2021 and pre-dates the downturn in performance against the 62-day target.

1.23 The vast majority of cancer patients who responded to the survey rate their overall care highly. The average rating for overall care was 9 out of 10 across Wales, based on 5,859 responses. The positive results reflect the hard work and compassionate care of the many staff working across the NHS to care for and support cancer patients. 87% of respondents said that the different professionals treating and caring for them worked well together to give them the best possible care either ‘always’ or ‘most of the time’. The survey does not ask patients how they felt about the overall length of time they waited from first suspicion to starting treatment.

Outcomes for cancer patients are generally improving but lag behind comparable countries and are worse for people living in deprived areas

1.24 Cancer is the leading cause of death[27] in Wales, accounting for 25% of all deaths in 2022. Lung, bowel, and prostate cancer account for the largest proportions of cancer deaths[28]. The number of cancer deaths has increased from 8,295 in 2002 to 9,154 in 2022 and is projected to increase by 27% by 2040 (based on 2021 levels)[29]. The rise in cancer deaths is primarily explained by the changing age structure of the population. The age standardised rate[30] of cancer deaths has generally decreased since 2011 although there was a slight increase in 2022 (**Exhibit 14**).

1.25 The cancer death rate in Wales compares poorly to other UK nations and internationally[31]. Wales has had the second highest age standardised cancer death rate in the UK almost consistently since 2010 (**Exhibit 14**). The OECD compared age standardised cancer death rates in 2023, based on 2021 data. It placed the UK 35th out of 45 countries[32].

27 In 2022, 24% of deaths were caused by diseases of the circulatory system, 12% by diseases of the respiratory system, 10% by dementia and Alzheimer's, and 29% by other causes.

28 WCISU cancer mortality data.

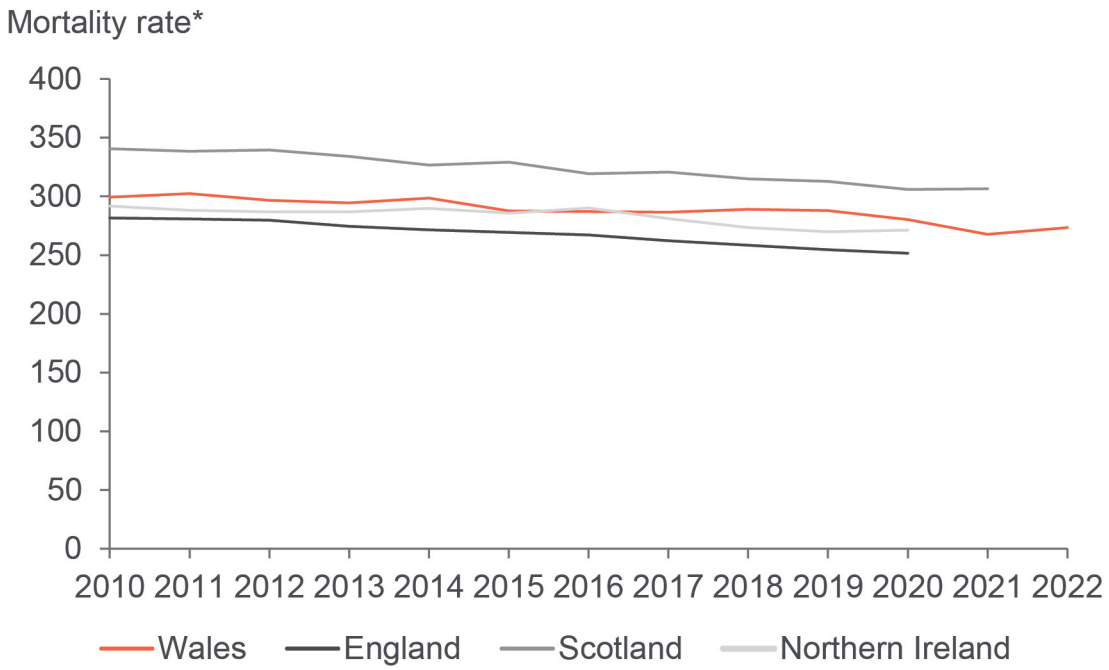
29 National Strategic Clinical Network for Cancer, A Cancer Improvement Plan for NHS Wales 2023-26, 2023.

30 Deaths per 100,000 of the population taking account of differences in the age structure of different parts of Wales.

31 Many factors affect cancer incomes including the relative wealth and spending on healthcare in each country, underlying population health, and deprivation.

32 OECD, Health At A Glance 2023: OECD Indicators, OECD, 2023.

Exhibit 14: age standardised cancer mortality rates in UK countries (excluding non-melanoma skin cancer), 2010 to 2022



Source: WCISU cancer mortality data

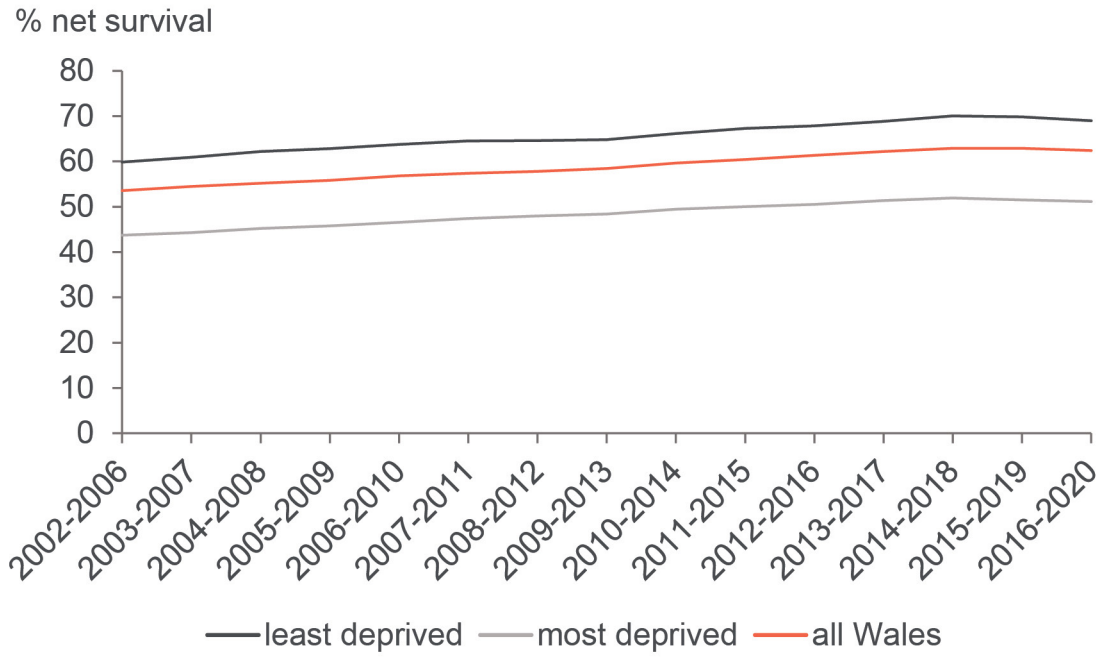
Note: *per 100,000, adjusted to reflect the age of the population

1.26 Cancer survival[33] improved between 2002 and 2020. 54% of patients diagnosed with cancer from 2002-2006 survived their cancer at five years compared to 62% of patients diagnosed between 2016 and 2020. There is not yet data available to track the impact of the pandemic on survival rates. Differences in data collection methods makes it difficult to compare overall survival figures across UK countries.

1.27 There is a significant deprivation gap in survival rates. While 69% of cancer patients living in the most affluent parts of Wales survive cancer at five years, that falls to 51% for those in the most deprived areas (**Exhibit 15**). Worryingly, the deprivation gap has widened from a difference of 16 percentage points for people diagnosed between 2002-06 to 18 percentage points for people diagnosed between 2016-20.

33 Cancer mortality figures show the number of deaths where cancer was the underlying cause whilst survival figures show how many people who have had cancer are still alive after a certain period of time so it takes several years for accurate data to be published.

Exhibit 15: percentage unstandardised rolling net survival at five years comparing most and least deprived areas with the all Wales figure for patients diagnosed in the periods 2002-2006 to 2016-20 (excluding non-melanoma skin cancer).



Source: WCISU cancer survival data

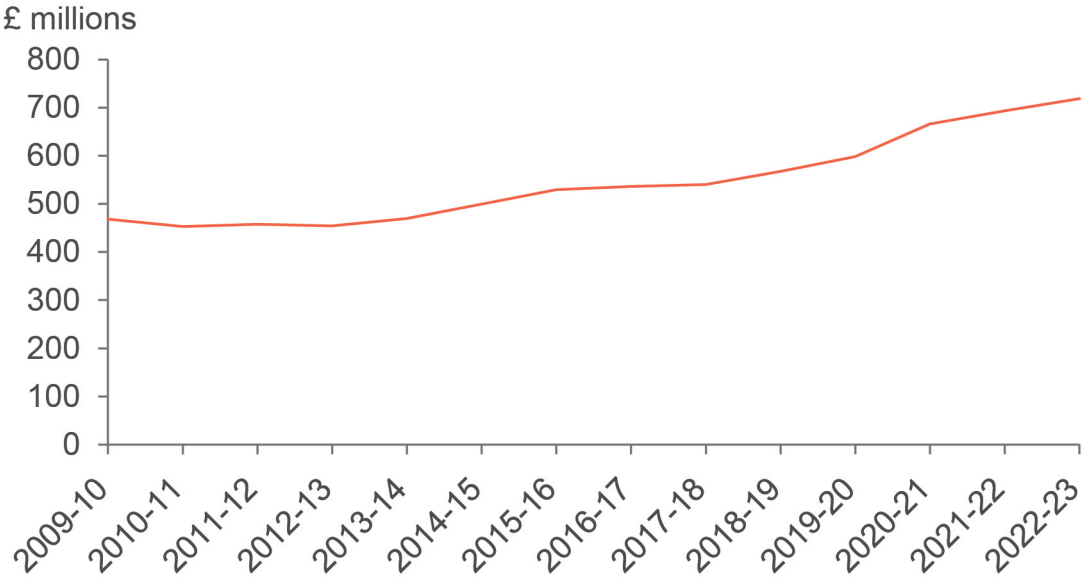
Spending on services to diagnose, treat and support cancer patients has risen faster than overall NHS spending but there are gaps in staffing capacity

Real terms spending on services to diagnose, treat and support cancer patients has grown more than overall growth in NHS Wales spending but there are significant cost pressures on those services

1.28 Real terms spending on services to diagnose, treat and support cancer patients increased by 54% from just over £450 million in 2009-10 to almost £720 million in 2022-23 (**Exhibit 16**). This increase is considerably greater than the overall 33% real terms growth in NHS Wales spending[34]. As a proportion of overall NHS spending, spending on services to diagnose, treat and support cancer patients has increased slightly from 7% in 2009-10 to 8% in 2022-23. Increased spending does not necessarily translate to additional capacity or activity. There are lots of cost pressures on services including rising workforce costs associated with pay growth and the use of agency staff; rising costs of existing drugs; new drugs and new technologies to improve treatment.

34 Based on revenue spending in the Welsh Government's NHS expenditure by programme budget category data on StatsWales for consistency with cancer spending figures. The NHS Finances Data Tool on our website is based on published Welsh Government budgets and gives a slightly different figure.

Exhibit 16: real terms NHS spending on cancer, 2009-10 to 2022-23



Source: Welsh Government, NHS Expenditure by programme budget category and year, 'cancer and tumours', on StatsWales.

Note: Real terms figures are adjusted to take account of inflation. We used HM Treasury GDP deflators at market prices and money for 2022-23, March 2024.

The Welsh Government confirmed that this data is based on NHS Wales patient activity costs including staff, consumables, medicines and overhead costs such as estates, catering, HR and finance costs.

1.29 In 2022-23 NHS Wales spent £230 per head of the population on services to diagnose, treat and support cancer patients[35]. Spend per head ranged from £206 in Cardiff and Vale to £270 in Swansea Bay University Health Board. An examination of the reasons behind differing spending figures across health board areas was outside the scope of this review but it is likely to reflect different local models of care and population factors including demography and deprivation.

1.30 Despite improvements in cancer waiting times being one of the key priorities for NHS Wales, the prospects for spending on services to diagnose, treat and support cancer patients are uncertain. UK public finances are under pressure. NHS bodies in Wales are already under financial strain, with six out of seven health boards overspending in 2023-24 and most projecting deficits for 2024-25. It is unclear whether they will be able to prioritise services for urgent suspected cancer patients to increase activity sufficiently to meet demand and reduce waiting times. Health boards are also under pressure to prioritise other parts of the system where performance is poor, including long waits for unscheduled care and for planned care.

35 There is no comparable data from other UK or comparable countries.

Workforce capacity is a significant challenge and there is an absence of information on the availability and condition of equipment

1.31 Despite spending increases, workforce capacity remains a significant challenge and workforce shortages are reducing service capacity[36]. HEIW's Education and Training Plan 2025-26[37] describes 'significant national shortages and longstanding gaps' in specialist professional roles impacting diagnostics, cancer, emergency care and mental health. It highlights particular shortages in dermatologists, clinical oncologists, consultant urology surgeons, and histopathologists. It cites pressure from increasingly complex cancer reporting and the evolving field of geonomics on histopathology, and demand from cancer patients on urology.

1.32 The Royal College of Radiologists describes shortfalls of 34% and 12% in the radiology and clinical oncology workforces, likely to deteriorate to 38% and 28% respectively by 2028[38]. We also heard that there are shortages of medical physicists, specialist and district nurses, and in the geonomics, Systemic Anti-Cancer Therapy and radiotherapy workforce.

1.33 HEIW set out its plans to address workforce shortages in its Education and Training Plan and Integrated Medium-Term Plan 2024-27. In line with its commitment in the Cancer Improvement Plan, HEIW has published its workforce plans for pharmacy and for geonomics, and intends to publish its plan for nursing in early 2025. The Ten-Year Workforce Strategy for Health and Social Care 2020 sets out the broader strategic approach.

1.34 As well as sufficient staff, NHS Wales needs sufficient equipment to deliver timely and effective diagnosis and treatment. The NHS Executive is building up a picture of capacity associated with the age and availability diagnostic imaging equipment including the age and availability of equipment. We heard anecdotal evidence that Wales has fewer imaging machines than comparable countries, and that some machines are old and prone to breaking down. Whilst it was beyond the scope of this review examine those claims, we did hear that limitations in access to diagnostic equipment are putting pressure on staff, affecting recruitment and retention, and restricting HEIW's ability to offer training places for diagnostic students[39].

36 Audit Wales, Workforce Data Briefing, 2023, sets out broad workforce issues, with many affecting services for cancer patients where services are not specific to cancer patients (such as diagnostics and surgery).

37 The Plan sets out commissioning and training recommendations for the health professional workforce in Wales.

38 Royal College of Radiologists, Radiology Workforce Census 2023, June 2024.

39 It is exploring using simulated training environment as an alternative.

Strategic direction

02

2.1 This part of the report looks at national strategic direction and leadership to improve cancer care in Wales. **Appendix 1** explains key elements of the strategic approach and broad roles and responsibilities for cancer services.

What we looked for

We looked for evidence of a clear strategic direction for improving cancer outcomes and services, and for reducing demand for cancer services by preventing cancer occurring in the first place. We also looked for evidence of appropriate and clear leadership structures to direct, oversee and support improvement and tackle barriers at a national level.

There is a lack of clarity on the status of the Cancer Improvement Plan and how it aligns with other cancer improvement initiatives

The Cancer Improvement Plan has not been sufficiently integrated into the wider strategic approach for improving cancer services

2.2 The Welsh Government set out its vision of what 'good' cancer services should look like in the Quality Statement for Cancer (2021). The Statement is generally high-level but is underpinned by tumour specific national optimal pathways. The pathways set out what should happen at different stages of the patient journey according to professional guidance. The Welsh Government instructed health boards to start embedding the pathways by September 2022[40]. When it published the Statement, the Welsh Government said that the Cancer Network would develop a rolling, three-year plan to achieve the national vision.

40 Via Welsh Health Circular (2022) (021).

Exhibit 17: vision set out in the Quality Statement for Cancer

The Cancer Quality Statement sets out that its ultimate aim is to improve population survival and reduce cancer mortality rates. It identifies key areas for action:

- that cancer is effectively prevented where possible,
- that cases of cancer are detected at earlier more treatable stages,
- that complex treatment pathways are optimised, while throughout people are properly supported and co-produce their care.

The statement sets out a series of attributes, indicating what good quality care looks like, under six headings:

- Equitable
- Safe
- Effective
- Efficient
- Person centred
- Timely

Source: Welsh Government Quality Statement for Cancer, 2021.

2.3 In 2023, the Network published A Cancer Improvement Plan for Wales 2023-26 (the Plan) at the request of then Minister for Health and Social Services. The Plan encompasses a broad range of cross-sector actions to improve cancer patient outcomes and reduce health inequalities. It's three year horizon was deliberately aligned to local health board planning cycles. However, this means the Plan lacks focus on longer-term actions to build sustainable cancer services. It also lacks detail on prevention, palliative and end-of-life care, and on services for children and young people and does not cover the full range of ambitions in the Quality Statement.

2.4 The then Minister used the Plan to set the new expectation that by March 2026, 80% of patients would start their first treatment within 62 days. The Minister announced publication of the Plan in an oral statement, describing it as a collective NHS Wales approach to delivering the policy intentions in the Quality Statement for Cancer. The Welsh Government told us that it is not a Welsh Government Plan. It considers that it does not require a national plan to implement the Quality Statement because health boards and trusts are responsible for implementing the vision through their own local plans.

2.5 Nonetheless, the Plan exists at the request of the Minister and many of its actions require national direction and leadership to support successful implementation. This would include consideration of the funding needed to support the Plan's actions and using national planning and performance management frameworks to clarify requirements around the Plan's delivery (**recommendation 1**).

2.6 The Cancer Improvement Plan commits the Welsh Government to monitoring delivery of the Plan through its existing performance arrangements. However, during our fieldwork, Welsh Government officials told us that such monitoring was not taking place. Since then, at the then Minister's request, the Cancer Network has collated a retrospective progress 'update' on delivery of the Plan. However, the Welsh Government is not routinely monitoring implementation in line with its commitment in the Cancer Improvement Plan.

New national initiatives to improve cancer services have merit but stakeholders are confused about how they link to the Cancer Improvement Plan

2.7 Since publication of the Plan in 2023, the Welsh Government and NHS Executive have set up new programmes aiming to improve cancer services (**Exhibit 18**). While there are merits in each programme, stakeholders are unclear about how they align with the Cancer Improvement Plan.

Exhibit 18: new programmes to improve cancer services

Programme	Description
Cancer: Improving Outcomes initiative	The Welsh Government commissioned Life Science Hub Wales to develop the initiative, which is aimed at focusing innovation on key problem areas and removing the barriers to delivering innovation at pace.
National Cancer Recovery Programme	The NHS Executive set up the programme, which is aimed at reducing long waits to achieve a target that 80% of suspected cancer patients start treatment within 62 days by 31st March 2026.

Source: Audit Wales.

2.8 The NHS Executive is currently finalising arrangements for its National Cancer Recovery Programme. The Programme focuses on five specific tumour sites[41] with some cross-cutting actions to improve more general services to diagnose and treat cancer patients. Rather than large-scale, whole-system transformation, the Programme aims to improve performance and improve compliance with the National Optimal Pathways within existing budgets.

2.9 The Welsh Government has repurposed Cancer Network funding to provide £2 million per annum for 2024-25 to 2026-27 for the NHS Executive to implement the Programme. Around half of this funding will pay for staff costs in line with the Programme aims around encouraging improvement within existing budgets. NHS Executive officials told us that the Programme may identify improvement opportunities which would then be costed and developed into business cases for additional Welsh Government funding.

41 Breast, gynaecological, lower gastrointestinal, skin, and urological cancers.

Many NHS bodies and third sector partners are confused about the strategic direction

2.10 NHS and third sector organisations told us they are confused about the strategic direction for cancer services in Wales. Some all-Wales NHS bodies have embraced the commitments in the Plan (for example **paragraph 1.33**). Others have rejected actions attributed to their organisation and saw some actions in the Plan as irrelevant (for example **paragraph 2.37**).

2.11 Health boards have developed local initiatives to improve diagnosis, treatment and support for cancer patients but it is not clear how they link to the Cancer Improvement Plan. During our fieldwork it was apparent that NHS bodies were not clear about the status of the Plan and how it should be shaping their activities. NHS and third sector bodies told us that the development of the new initiatives and programmes so soon after the publication of the Cancer Improvement Plan has increased their confusion about the strategic direction.

National leadership, decision-making and oversight arrangements are not effective and there is an over-reliance on narrow performance management

There is a lack of clarity as to who is responsible and accountable for driving system wide improvement to cancer services

2.12 The Welsh Government established the NHS Executive to drive improvements in the quality and safety of care. It brings together existing improvement organisations to better coordinate and drive improvements to the quality and safety of care[42]. However, officials in NHS bodies and third sector representatives we interviewed, were confused about the differing roles of the Welsh Government and NHS Executive. We also heard that there was confusion about the different roles and functions within the NHS Executive. At the time of our review, three NHS Executive functions had responsibility for driving cancer improvement:

- the Strategic Planned Care Programme had responsibility for supporting improvement in the timeliness of cancer diagnosis and treatment;
- the Performance Assurance Directorate provided direct support to NHS bodies to improve cancer performance; and
- the Cancer Network worked with clinicians, health professionals, and third sector and patient representative organisations to improve outcomes and care for cancer patients.

2.13 We found a general consensus, including within the Welsh Government and NHS Executive, that the Executive is not yet providing the intended strong leadership to drive improvement. Many NHS and third sector bodies described arrangements after the establishment of the Executive as a 'step backwards' or 'worse than ever.'

42 The NHS Wales Delivery Unit, the NHS Wales Finance Delivery Unit, the NHS Wales Health Collaborative; and Improvement Cymru.

2.14 Stakeholders raised various concerns about the national leadership and accountability arrangements for cancer services including:

- the Cancer Network lacking the authority to make decisions and commit the level of resources needed to secure change;
- lack of integration of the Cancer Network within the NHS Executive's leadership and with the wider NHS, and gaps in arrangements to share frontline insight from clinicians;
- third sector bodies are struggling to know who to engage with and how to share important intelligence and more generally feeling under-appreciated for the extensive support they provide to the system[43] and individuals and their families (**recommendation 2**);
- overlap and duplication between the cancer recovery work carried out by the Strategic Planned Care Programme and the intervention work led by the Performance Assurance Directorate; and
- lack of communication between the Welsh Government and NHS Executive to assess whether funding for additional capacity is being allocated to areas of greatest need.

2.15 Since our fieldwork the NHS Executive has established a Network Clinical Leadership Group to support closer working between clinicians and wider NHS Executive senior leadership. Whilst this is a positive development, wider action is needed to strengthen national leadership arrangements. The gaps, lack of clarity and duplication described above have led to a situation where many stakeholders from inside and outside of the NHS told us: 'we don't know who is in charge' (**recommendation 2**). The Senedd Health and Social Care Committee's report on gynaecological cancers[44] raised similar concerns and called on the Welsh Government to be 'more accountable' for driving improved cancer services.

43 The third sector has a wealth of knowledge and insight and provides funding for some services in Wales (such as the Teenage Cancer Trust cancer ward in Cardiff). We also found examples of third sector organisations attracting private sector funding to drive innovation, and developing data resources which are now used by NHS Wales.

44 Welsh Health and Social Care Committee, Unheard: Women's Journey through Gynaecological Cancer, December 2023.

National decision-making and leadership arrangements are not sufficiently robust to systematically identify and prioritise opportunities to improve cancer services

2.16 Cancer treatment is an area of significant innovation, with opportunities to improve outcomes and efficiency. We identified examples of Welsh Government investment and decision making to improve cancer and planned care. For instance, it has worked with health boards and the NHS Executive to introduce rapid diagnostic centres; supported improvements to the bowel screening programme and is funding a new cancer centre for Velindre NHS Trust[45].

2.17 However, the Welsh Government recognises that it lacks a robust approach to identifying, assessing and prioritising such opportunities. Current arrangements need strengthening to ensure there is sufficient capacity to assess and prioritise initiatives for funding. Arrangements should address gaps in decision making structures to prioritise investment in areas such as digital, workforce and diagnostics (**recommendation 2**). **Exhibit 19** sets out two areas of opportunity to improve efficiency and outcomes, where decision making has been slow.

45 We are conducting a separate examination of decision-making relating to the development of the new Velindre Cancer Centre. We aim to publish that report in 2025.

Exhibit 19: potential innovations where decision making has been slow

Programme	Description
Digital cellular pathology	During our review, NHS bodies and third sector organisations cited frustration with the speed of national decision making on the use of digital cellular pathology. Betsi Cadwaladr University Health Board was a pioneer of the approach and transformed its pathology service in 2014. Laboratories could scan and upload images onto digital systems to be analysed remotely rather than transporting samples between locations. Alongside a broader transformation programme*, the approach dramatically improved the timeliness of pathology results and helped the health board recruit and retain staff because it facilitated flexible working arrangements. The National Pathology Programme has been working with the Welsh Government and health boards to develop a consistent all-Wales approach to digital cellular pathology since 2019. Despite general consensus on the benefits of the approach, progress has been restricted by uncertainty about who would fund modern scanning equipment and digital storage. Health boards have been reluctant to commit funds without clarity on the Welsh Government's financial contribution. Despite investing in other aspects of digital cellular pathology, at the time of our review, the Welsh Government was not clear about whether it would fund the equipment and storage to establish an all-Wales approach. The National Pathology Programme was still working with health boards to agree a business case share ongoing annual costs of around £3 million for the scanning equipment and storage. Wales now lags behind the rest of the UK for digital cellular pathology capacity, making it a less attractive employment option for newly qualitied pathologists in an already competitive market.

Programme	Description
Lung Screening	In 2019, the Cancer Network started exploring evidence on the effectiveness lung screening. It concluded that screening could increase the percentage of cancers identified at an early stage and had the potential to reduce lung cancer mortality by 20%. The work informed a pilot lung health check programme in Cwm Taf Morgannwg University Health Board, which started in 2022 and was funded by third sector organisations and private industry. The UK National Screening Committee recommended that UK nations develop targeted lung screening for people aged 55-74 years with a history of smoking in June 2022. Despite an endorsement from the Wales Screening Committee in November 2022, the Welsh Government did not task PHW with developing options for a national programme until July 2023. The Welsh Government has asked PHW to provide interim proposals on a national lung screening programme by May 2025. If PHW meets the 2025 deadline, it will have taken three years from the UK National Screening Committee's recommendation just to develop interim proposals. Finalising proposals and implementing a national programme would take more time after this point (**recommendation 5**).

Source: Audit Wales.

Note: *The digital cellular pathology approach was part of a wider transformation programme including combining regional services into a single Betsi Cadwaladr University Health Board Cellular Pathology Service.

2.18 We also heard concerns about the Welsh Government's ability to secure the benefits from its investment in capacity and new ways of working. In particular, stakeholders frequently cited an incoherent approach that has seen the Welsh Government invest in the training and recruitment of radiologists only for many to be unable to find work in NHS Wales (**Exhibit 20**).

Exhibit 20: investment in training and radiologists

A National Imaging Academy opened in 2019, as a result of the Welsh Government providing £3.4 million to HEIW to establish the facility to help meet identified workforce gaps in respect of radiologists and imaging professionals.

However, many of the newly qualified radiologists are leaving Wales because, despite workforce gaps there are no jobs for them. Some health boards told us that financial pressures have led to recruitment freezes which limited their ability to recruit diagnostic staff. We also heard that weaknesses in health board workforce planning including projections of future need and slow recruitment processes were part of the problem*.

The NHS Executive's National Diagnostics Implementation Plan** contains a weak commitment to work with HEIW to 'advocate' for commitment to employment from health boards when requesting training numbers. It is unclear what role the Welsh Government intends to play in ensuring the benefits of its investment in training the future workforce are not lost to Wales (**recommendation 7**).

Source: Audit Wales

Notes:

* Our review of workforce planning made specific recommendations to health boards to improve workforce planning. Individual reports for each NHS body are available on our website www.Audit.Wales.

** NHS Executive, National Diagnostic Implementation Plan 2023-25.

2.19 Regional working across health board areas can help to share capacity and bolster fragile services. Health boards are developing regional approaches in some areas that can increase capacity in the system[46]. The NHS Executive is also developing plans for two regional diagnostic hubs in South Wales to provide additional shared diagnostic capacity for the region. However, the overall pace of regional collaboration is slow. Whilst there is a clear onus on health boards to take forward regional working, there is also a need for national leadership and co-ordination from the Welsh Government and the NHS Executive. In that regard the recent creation of a dedicated senior role within the NHS Executive to support regional working is a welcome development. However, success will also depend on action to tackle barriers to regional working such as a lack of integration between digital systems making it difficult to share waiting lists across health boards[47] (**recommendation 6**).

Welsh Government oversight is narrowly focussed on the 62-day target

2.20 The Welsh Government's NHS Performance Framework (2024-25) sets out the measures (but not the targets) against which NHS bodies are accountable. The 62-day measure is the main cancer specific measure. There is a measure on the timeliness of colonoscopy for bowel screening referrals (**paragraph 1.21**) but no measures for breast or cervical screening referrals. Previous performance frameworks[48] included coverage measures for all three cancer screening programmes. There is also a measure for uptake of the human papillomavirus (HPV) vaccine (**paragraph 2.24**).

2.21 The Performance Framework does not include any measures on cancer incidence, mortality and survival rates. It does not clearly link to the six quality attributes set out in the Quality Statement for Cancer and the Framework makes no reference to compliance with the National Optimal Pathways that underpin the Quality Statement. While the Welsh Government has made the NHS Executive responsible for monitoring compliance with the pathways it is still developing methods for doing so.

46 Including developing regional approaches to diagnostics and treatment in North, Southeast and Southwest Wales using Welsh Government planned care recovery funding.

47 Welsh Health and Social Care Committee, Unheard: Women's Journey through Gynaecological Cancer, December 2023.

48 NHS Wales Performance Framework 2022-23.

2.22 There is a well-established framework for oversight of NHS bodies' planning and performance through activities such as scrutiny of NHS bodies' annual or medium-term plans, monthly Integrated Quality, Planning and Delivery meetings and twice yearly Joint Executive Team meetings between Welsh Government, the NHS Executive and individual NHS bodies. In addition, monthly cancer performance meetings provide a specific focus on the diagnosis and treatment of cancer patients. Collectively this represents a significant volume of performance management activity and includes positive developments around collaboration and information sharing between the Welsh Government and NHS Executive. However, the focus is largely on short-term delivery of the 62-day cancer performance target, rather than broader system change and wider delivery of the vision in the Quality Statement (**recommendation 3**).

The strategic approach lacks a coherent focus on cancer prevention, and is undermined by gaps in data and fragmented digital services

There is no coherent strategic approach to prevention, even though many cancers are preventable and doing so could save lives and reduce demand for NHS services

2.23 The Cancer Improvement Plan states that 38% of cancers each year in Wales are preventable. There are considerable opportunities to tackle lifestyle factors which increase the risks of some cancers. Many of the lifestyle risk factors for cancer are similar across major conditions accounting for the majority of planned and emergency care in the UK. Data from PHW's Public Health Outcomes Framework[49] showed that in 2022-23, 13% of adults in Wales smoked; 17% drank more alcohol than recommended guidelines[50]; and only 36% of working age adults were a healthy weight[51].

2.24 There are also opportunities associated with increasing the uptake of the human papillomavirus (HPV) vaccine. Since its introduction in 2008, the vaccine has reduced cancer rates by almost 90% in women in their 20s and is expected to save hundreds of lives a year in the UK[52]. PHW reported that 74% of children in school year 9 during 2023-24 had the vaccine. There was considerable variation in uptake ranging from 60% in Cardiff and Vale University Health Board to 88% in Swansea Bay. Changes in eligibility for the vaccine make it difficult to compare changes in uptake over time[53].

49 Public Health Wales NHS Trust Observatory, Public Health Outcomes Framework.

50 Based on adults who reported drinking over 14 units of alcohol per week.

51 Smoking and alcohol consumption data uses age standardised rates to account for differences in age structures of different parts of Wales. Data on healthy weight is age specific.

52 Public Health Wales NHS Trust: immunisation and vaccines.

53 Public Health Wales, Vaccine Uptake in Children in Wales, Quarterly Report January to March 2024, May 2024.

2.25 The World Health Organisation states that prevention offers the most cost-effective long-term strategy for managing cancer[54]. The Welsh Government's Science Evidence Advice[55] agrees that there are considerable opportunities to reduce the burden of disease on the NHS by preventing cancer and other major conditions. It identifies scope for long-term financial savings and calls for 'drastic action' to address increases in lifestyle risk factors, making many suggestions to reshape services around prevention.

2.26 The Welsh Government's NHS Planning Framework 2024-27 refers health boards to the Science Evidence Advice, explaining that it expects to see evidence of prevention in health boards plans. However, the Welsh Government does not go further in encouraging and leading health boards to develop local preventative initiatives.

2.27 Preventing cancer would also reduce demand on NHS capacity. **Exhibit 21** sets in crude terms what impact a 10%, 20% and 38% reduction in cancer cases could have, based on 2022-23 activity levels. The potential annual financial savings from the reduction in bed days would be in the order of £8.2 million to £31.4 million[56]. There could also be significant savings from reducing outpatient appointments and drugs costs. However, there would also be costs associated with activity to prevent cancer.

54 World Health Organisation, Health Topics – Cancer Prevention.

55 Welsh Government, Science Evidence Advice – NHS in 10+ Years – An Examination of the Projected Impact of Long-Term Conditions and Risk Factors in Wales', September 2023.

56 Savings calculation based on £500 per day cost of an NHS bed in Wales.

Exhibit 21: potential capacity gains associated with preventing cancer occurring in the first place based on 2022-23 activity

				
2022-23	**90,532** finished consultant episodes	**84,583** admission episodes	**164,971** bed days	**10,864** regular attenders*
-10% 	**81,479** finished consultant episodes (9,053 reduction)	**76,125** admission episodes (8,458 reduction)	**148,474** bed days (16,497 reduction)	**9,778** regular attenders (1,086 reduction)
-20% 	**72,426** finished consultant episodes (18,106 reduction)	**67,666** admission episodes (16,917 reduction)	**131,977** bed days (32,994 reduction)	**8,691** regular attenders (2,173 reduction)
-38% 	**56,130** finished consultant episodes (34,402 reduction)	**52,441** admission episodes (32,142 reduction)	**102,282** bed days (62,689 reduction)	**6,736** regular attenders (4,128 reduction)

Source: Audit Wales analysis of DHCW data from the Patient Episode Database for Wales, Headline Figures and Primary Diagnosis Datasets, Welsh Providers

Note:

*Our analysis is indicative of potential capacity gains based on averages. We calculated potential gains associated with a 38% reduction in activity based on the assertion in the Cancer Improvement Plan that 38% of cancers each year are preventable.

*Regular attenders are patients who are admitted to hospital on a regular basis to receive treatment.

2.28 Despite compelling evidence and it being a long-standing ambition, the Welsh Government has yet to translate broader aims on prevention into more concrete and cohesive policy approaches aimed at shifting the balance of care towards prevention (**recommendation 4**). In particular:

- it has never set out a clear, over-arching strategic approach to achieving this shift across the many public sector bodies whose priorities, choices and behaviours would need to change;
- it has a piecemeal approach with individual strategies on healthy weight and tobacco control[57] but no plan related to the health impacts of alcohol use; and
- the Future Generations Commissioner, amongst others, criticised the Welsh Government for cutting its preventative health improvement budgets in 2024-25[58].

There are gaps in the availability and quality of data to understand how well cancer care is being provided

2.29 Good quality data is essential for the planning, delivery and improvement of cancer care. The NHS Executive has improved the timeliness and accessibility of performance data in an unpublished interactive dashboard used by health boards, the Executive, and the Welsh Government. DHCW publishes a different Suspected Cancer Pathway Dashboard with less detailed information[59].

2.30 However, there are gaps in published data right across the patient pathway (**Exhibit 22**). The Welsh Government publishes data on 'closed' pathways showing how many patients were treated within 62 days but does not publish 'open' pathway waits to show how many patients are currently waiting for treatment.

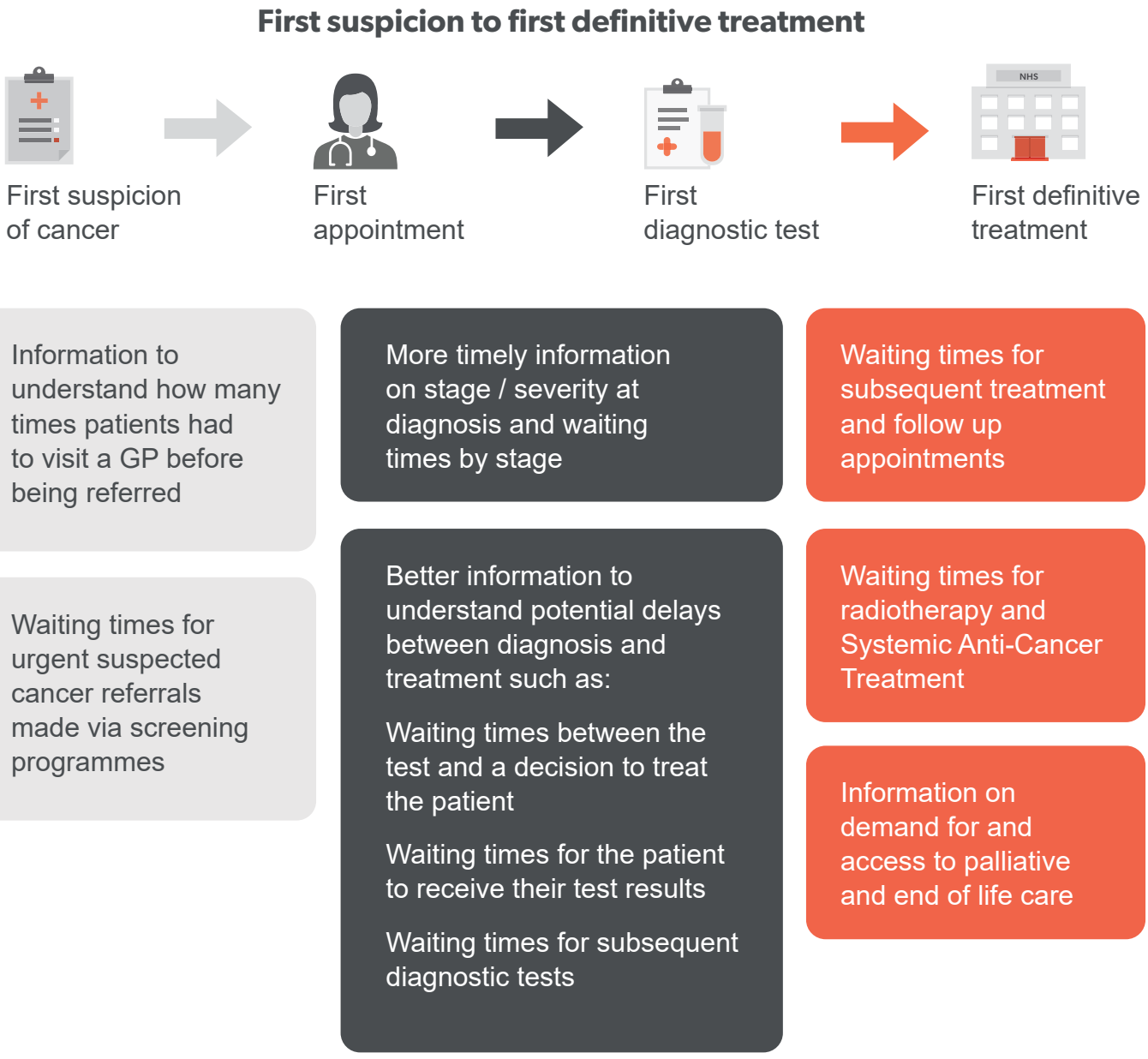
2.31 Much of the available data focusses narrowly on the period between referral and diagnosis or first treatment. There is no national data on the activity and timeliness leading up to a referral. There is also no available data on activity after the first treatment starts (see **paragraph 1.6**), including follow-up tests, ongoing treatment and access to palliative and end-of-life care (**recommendation 9**).

57 Welsh Government, Healthy Weight Healthy Wales, 2019 and Welsh Government, A Smoke Free Wales – Our Long-term Tobacco Control Strategy, 2022.

58 The budget for health improvement and healthy living reduced by £3.8 million bringing the total budget to £10.8 million; the substance misuse action plan fund by £2.5 million bringing the total budget to £47.5 million); and the health promotion budget fell by £710,000 to £12.2 million.

59 DHCW's dashboard uses data which has been validated to identify errors but the internal NHS Executive dashboard is unvalidated performance data.

Exhibit 22: gaps in data at different stages of the cancer pathway



Source: Audit Wales

2.32 There is very limited data to track progress against the ambitions in the Quality Statement. Against the overarching ambition of prevention and early detection, we found limited information on the causes of growing demand that can be used to prevent or detect cancer early amongst those most at risk. For instance, little is known about why some people are presenting at a more advanced stage, or as an emergency. There is also limited information about the demographic profile and location of people with unhealthy lifestyles. A new project led by WCISU has the potential to improve national intelligence on cancer risk factors. It will link Cancer Registry data to Census 2021 information via the SAIL databank to explore the influence of factors like ethnicity, income and educational status on cancer outcomes[60].

2.33 There is also very limited information to understand how equitable cancer support services are. For example:

- the Welsh Government requires heath boards to record the ethnicity of cancer patients[61] but compliance is extremely low. We were unable to analyse waiting list and timeliness trends by ethnicity because over two thirds of the pathways had no information on patient ethnicity.
- DHCW reports performance against the 62-day target by sex but there is little information to understand patient experience and outcomes by sex. The Senedd inquiry into gynaecological cancers found that women can experience many barriers to accessing cancer treatment but there is little information to understand how many women are affected[62].
- there is insufficient public data to understand potential differences in the timeliness of cancer diagnosis and treatment across Wales, particularly for people living in Powys. Timeliness data for Powys residents treated by other Welsh health boards is included in data for those health boards. The data is not disaggregated to show timeliness for Powys residents or the residents of the health board providing treatment[63]. There is also a lack of data on Welsh patients from any health board who are treated by NHS England (**recommendation 10**).
- there is also little information to understand equity of provision for children and young people. DHCW groups all data for under 30-year-olds together in the Suspected Cancer Dashboard data whereas other patients are grouped ten-year age bands. Under 16-year-olds are excluded from the Macmillan cancer patient experience survey.

60 The project aims to report its findings in late 2024.

61 Under Data Standards Change Notices from 2020 onwards (DCSN 2020/21 and DSCN 23/45). The Notices mandate compliance with data standards.

62 Welsh Parliament Health and Social Care Committee, Unheard: Women's Journey Through Gynaecological Cancer, December 2023.

63 Other published NHS Wales data does include distinct health board 'residence' and 'provider' performance data. For instance the Referral for Treatment data on StatsWales.

2.34 There are problems with the quality of some of the available data. WCISU officials told us Wales is a year behind England in publishing Cancer Registry data because a high volume of errors in the source data is creating extra work for its staff. NHS bodies told us that poor compliance with data standards by NHS staff inputting patient information is creating data errors. We found that there is confusion around who is responsible for improving compliance (**recommendation 8**). We have not specifically reviewed data quality as part of this review but have uncovered several inaccuracies in published data and bespoke analysis provided by DHCW.

Digital systems are fragmented and progress implementing the new cancer information system has been slow

2.35 Progress in updating the core digital system for cancer patients has been extremely slow. The previous system (Canisc) was constructed using a programming language in 1997 which Microsoft stopped supporting in 2014. Following our 2018 report on NHS Wales informatics systems[64], the Senedd Public Accounts Committee inquiry raised serious concerns about slow progress replacing Canisc[65]. It took a further five years to implement the first phase of the new cancer information system. DHCW told us that the pandemic has added to delays. The Welsh Government has recently confirmed funding for the second phase of the programme, aimed at improving integration and digital processes and dealing with requests for specific changes from individual NHS bodies.

2.36 More broadly, NHS bodies told us that lack of integrated digital systems is consuming valuable staff time because they are using manual 'workarounds' to transfer patients across the different patient administration systems. The process is frustrating staff and diverting their time from seeing patients. It also carries risks to patient safety because details could be transferred incorrectly or not at all. DHCW is responsible for delivering national digital systems for NHS Wales but not their local configuration. DHCW described considerable barriers to getting those systems to join up. In particular, there are numerous examples of NHS bodies either procuring their own digital systems rather than using the national products, or adapting the national products which limits interoperability.

2.37 The Cancer Improvement Plan committed PHW, the Cancer Network and DHCW to developing a cancer version of the national Digital and Data Strategy for Wales by the end of June 2023. No such plan had been created at the time of our review and we found confusion about the commitment to create one in the first place. DHCW told us there is no need to create a separate digital cancer plan because the overarching Digital and Data Strategy sets out the system wide approach to improve digital provision.

64 Wales Audit Office, Informatics Systems in NHS Wales, 2018.

65 National Assembly for Wales Public Accounts Committee, Informatics Systems in NHS Wales, 2018.

Appendices

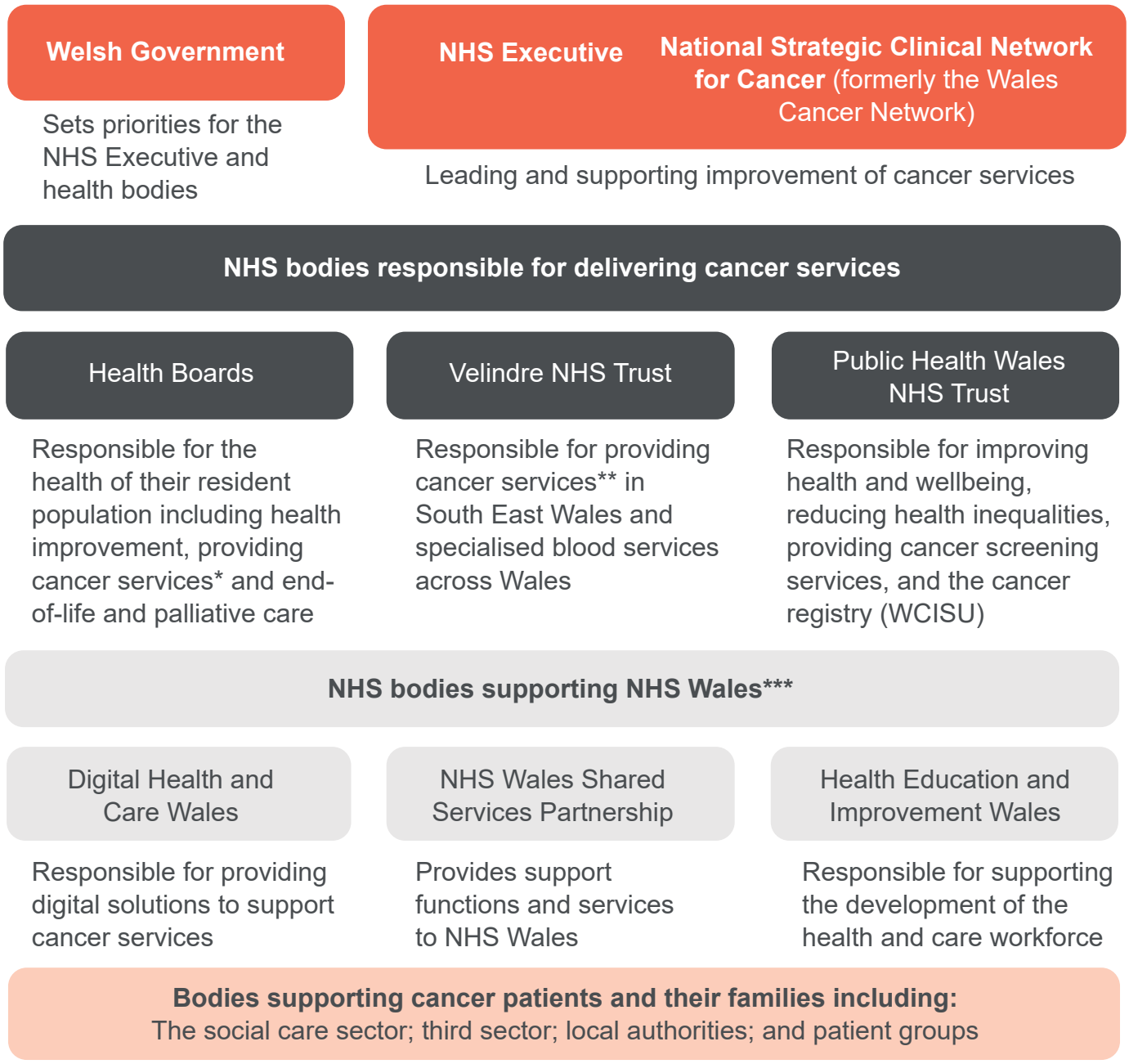
1 Strategic context

2 Additional data analysis

3 About our work

1 Strategic context

Exhibit 23: broad roles and responsibilities for cancer services in Wales



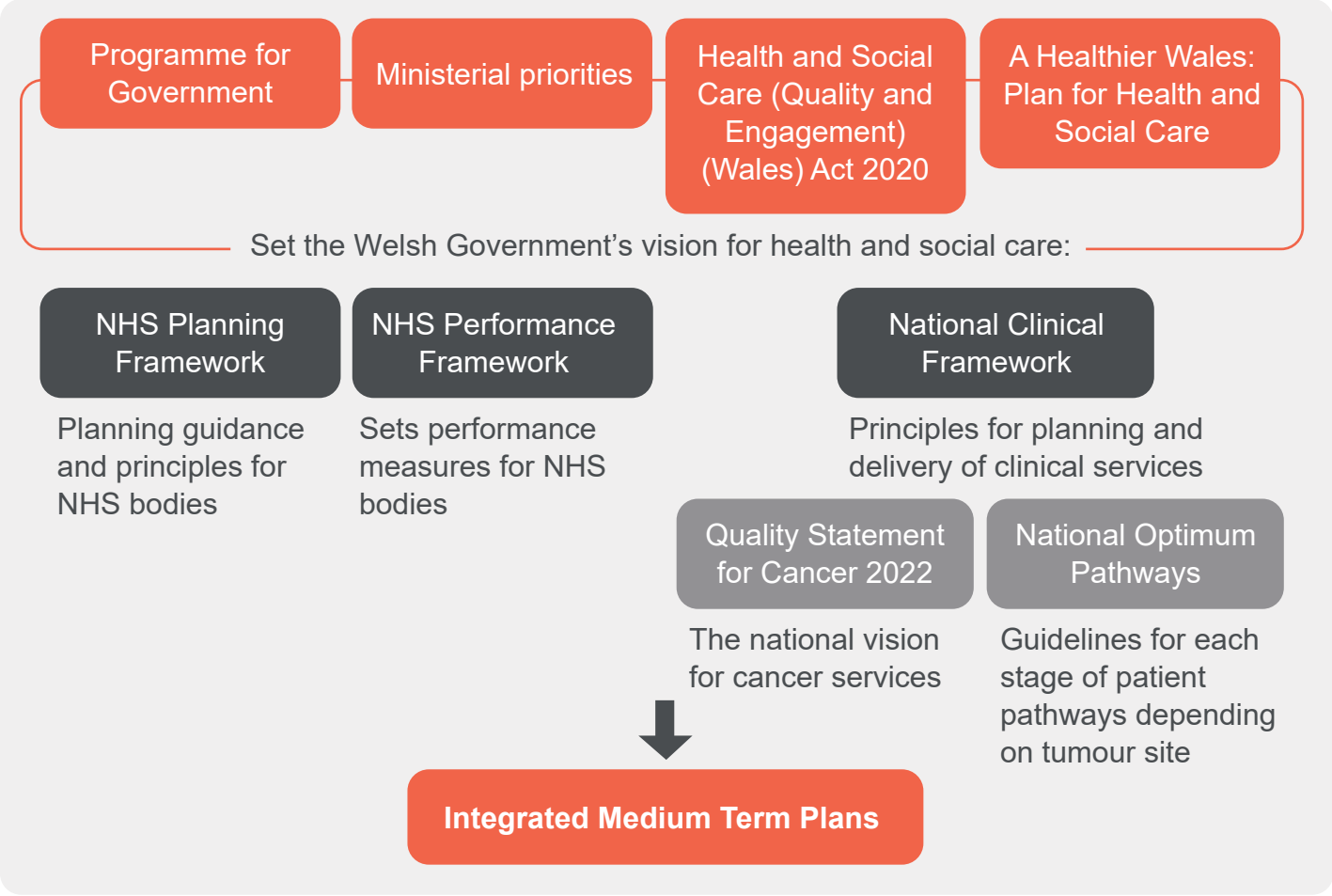
Source: Audit Wales

Note:

*Including diagnostic tests; treatment; and support and advice for patients. The level and type of services provided differs between health boards because some services are provided by other healthcare providers. For instance, Powys Teaching Health Board provides some diagnostic services but commissions other cancer services from other NHS providers in England and Wales.

**Including chemotherapy; radiotherapy; and support and advice for patients.
***There are also organisations and groups responsible for research, development and innovation including: Geonomics Partnership Wales; Health and Care Research Wales; Life Sciences Hub Wales; and the Wales Cancer Research Centre.

Exhibit 24: key elements of the strategic approach to cancer services in Wales



Wales Cancer Network: Cancer Improvement Plan 2023

A collective plan for NHS Wales to improve services for cancer patients

NHS Executive: National Cancer Recovery Programme 2024

National programme to improve cancer services

Life Sciences Hub Wales: Cancer: Improving Outcomes Initiative

A Welsh Government commissioned programme, aimed at delivering innovation at pace.

Broader Welsh Government Strategy including:

Diagnostics, Recovery and Transformation Strategy for Wales 2023-25

Digital and Data Strategy for Health and Social Care in Wales 2023

National Workforce Implementation Plan: Addressing NHS Wales Workforce Challenges 2023 and A Healthier Wales: Our Workforce Strategy for the Health and Social Care Workforce, 2020 (commissioned by the Welsh Government from Health Education and Improvement Wales)

Healthy Weight, Healthy Wales, 2019 including a 2022 to 2024 delivery plan

A smoke-free Wales: Long-term tobacco control strategy, 2022 including a 2022 to 2024 delivery plan

Source: Audit Wales

2 Additional data analysis

Data on demand for cancer services

Exhibit 25: Patients who were treated by source of suspicion, monthly average across 2023-24

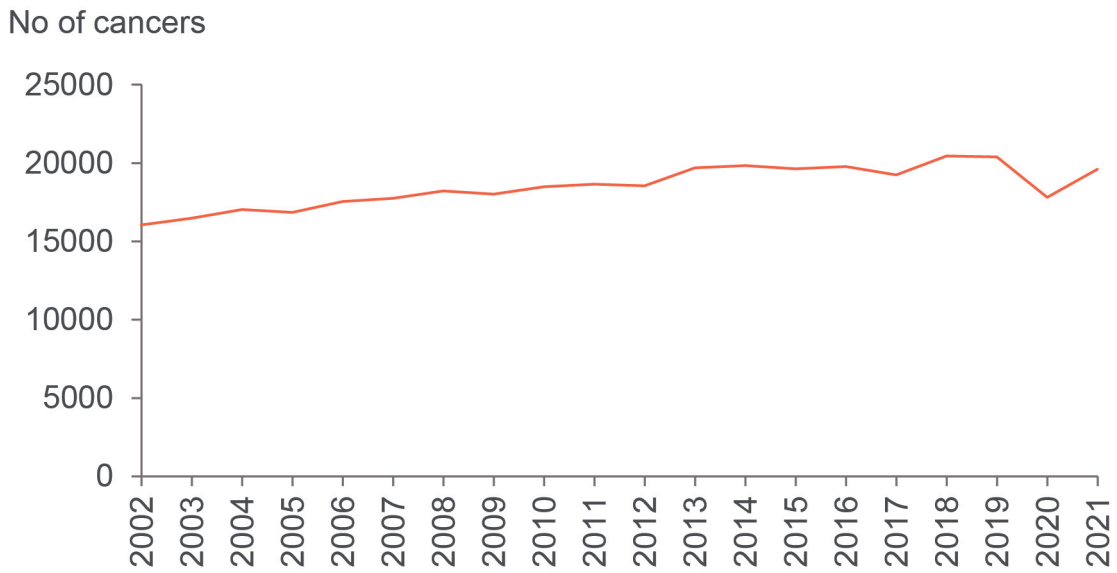
Source of suspicion / referral	% overall suspected cancer referrals	% of patients starting treatment as a proportion of referrals by source of suspicion
GP	**80%** (12,635 people)	**8% of GP referrals** (975 people)
Internal secondary care	**10%** (1,570 people)	**17% of internal secondary care referrals** (266 people)
Following a diagnostic test	**6%** (911 people)	**37% of referrals following a diagnostic test** (341 people)
Bowel screening	**1%** (120 people)	**28% of bowel screening referrals** (33 people)
Breast screening	**1%** (106 people)	**92% of breast screening referrals** (98 people)
Cervical screening	**<1%***	**50% of cervical screening referrals***
Emergency department	**1%** (214 people)	**38% of emergency department referrals** (81 people)
Other primary care professional	**1%** (120 people)	**5% of referrals from other primary care professionals***
Other health professional	**<1%** (66 people)	**15% of referrals from other health professionals***
Consultant from another health board	**<1%** (38 people)	**21% of referrals from external consultants***

Source: Audit Wales analysis of DHCW Suspected Cancer Pathway Data – closed pathways by source of suspicion.

Note: A small number of patient pathways did not have data on the source of suspicion / referral.

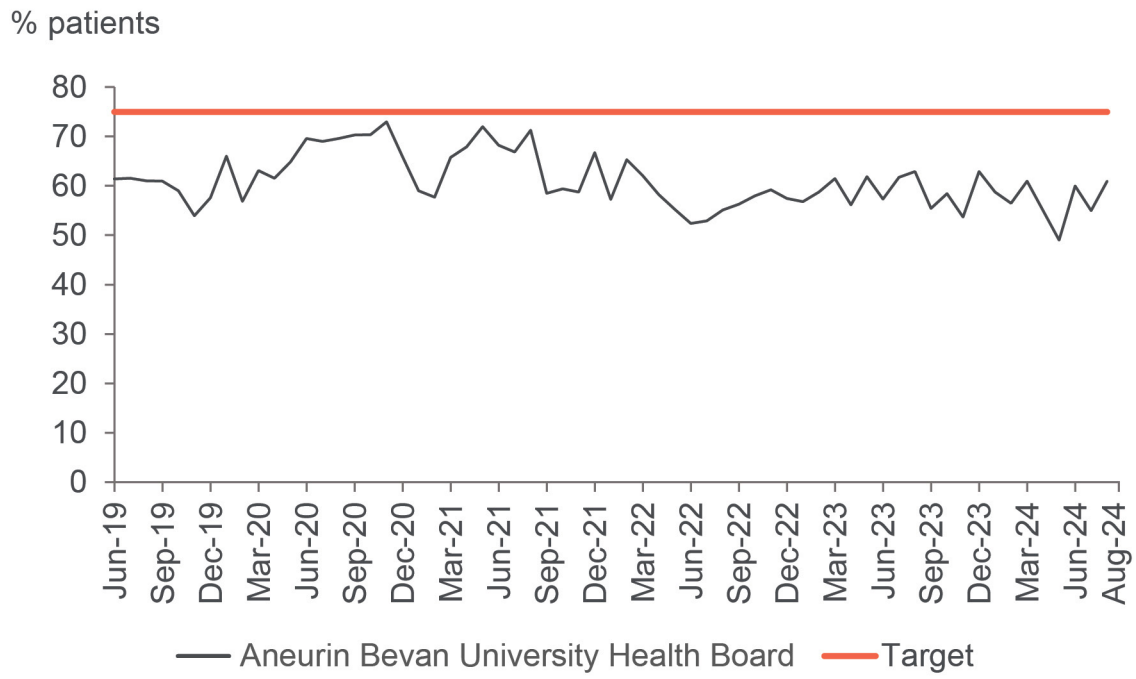
*Where there are 10 people or less.

Exhibit 26: number of newly diagnosed cancers in Wales (excluding non-melanoma skin cancer), 2002-2021



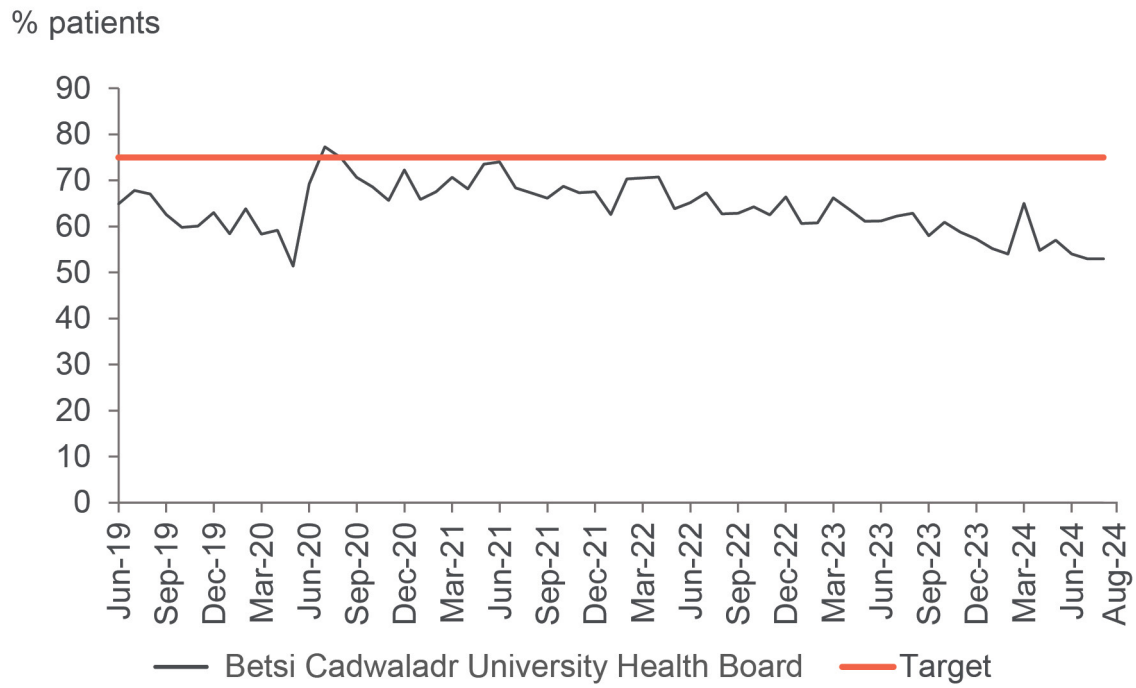
Source: WCISU cancer incidence data

Exhibit 27a: performance against the 62-day target by Aneurin Bevan University Health Board, June 2019 to August 2024



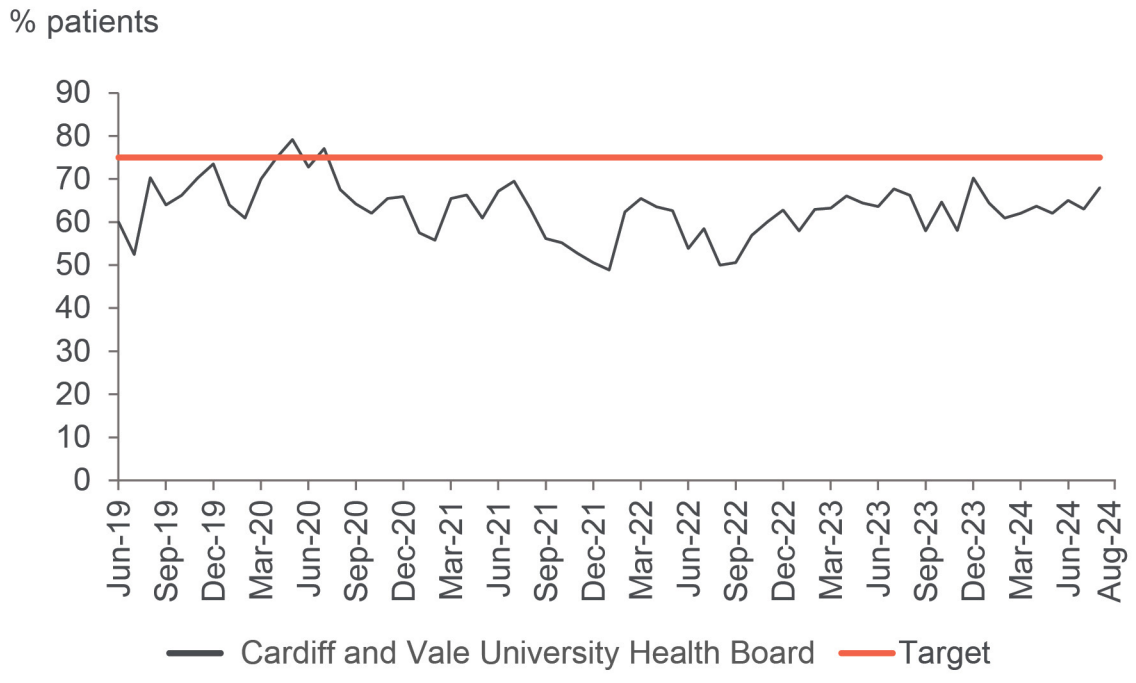
Source: DHCW, Suspected Cancer Pathway – Closed Pathways dataset, on StatsWales.

Exhibit 27b: performance against the 62-day target by Betsi Cadwalladr University Health Board, June 2019 to August 2024



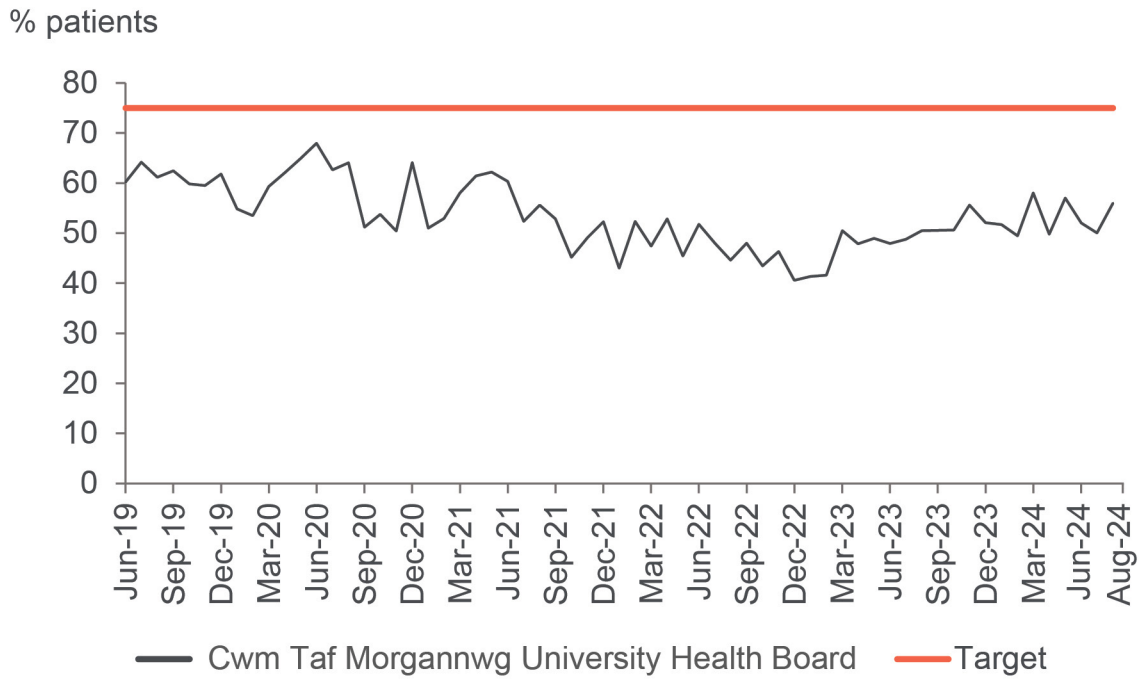
Source: DHCW, Suspected Cancer Pathway – Closed Pathways, on StatsWales.

Exhibit 27c: performance against the 62-day target by Cardiff and Vale University Health Board, June 2019 to August 2024



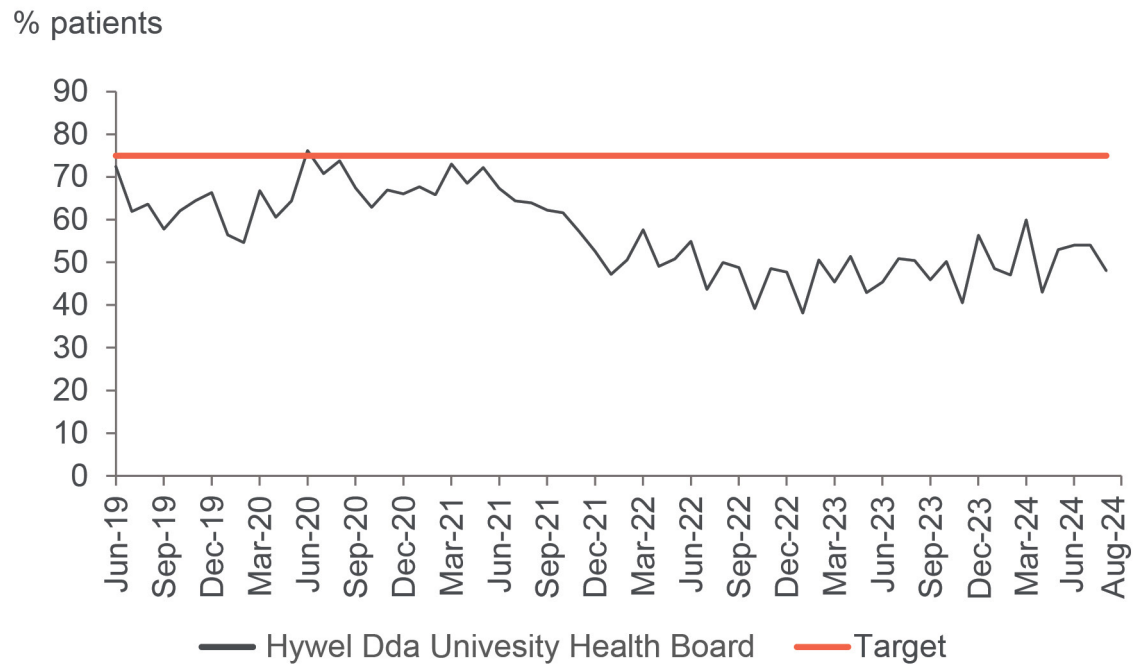
Source: DHCW, Suspected Cancer Pathway – Closed Pathways dataset, On StatsWales.

Exhibit 27d: performance against the 62-day target by Cwm Taf Bro Morgannwg University Health Board, June 2019 to August 2024



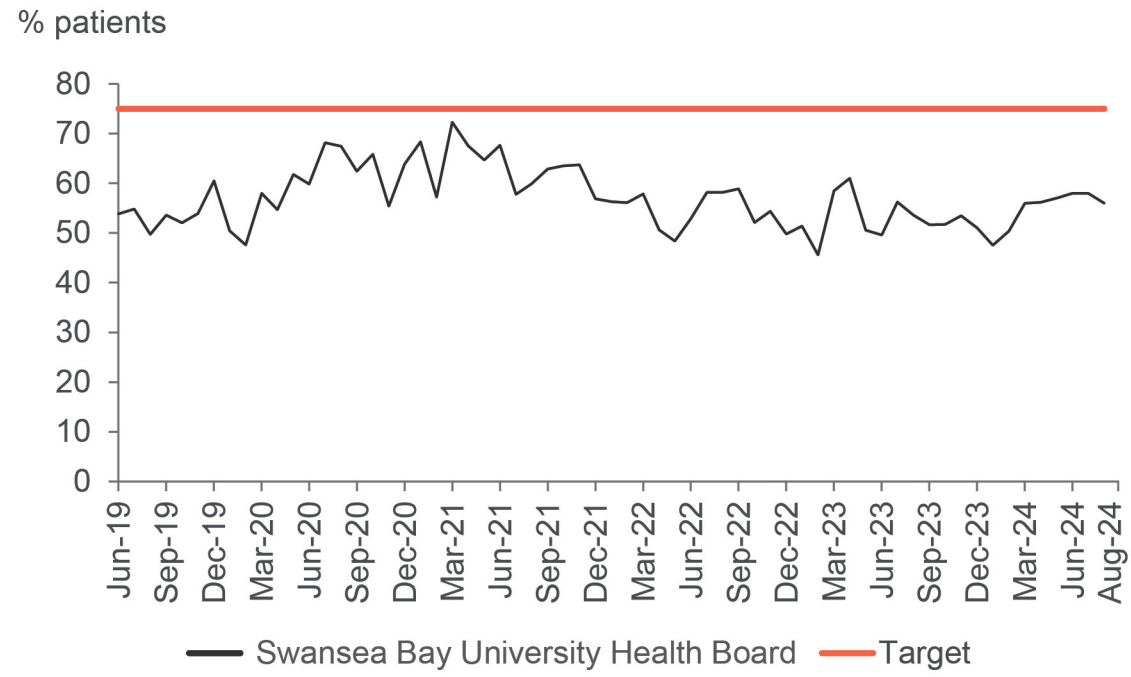
Source: DHCW, Suspected Cancer Pathway – Closed Pathways dataset, on StatsWales.

Exhibit 27e: performance against the 62-day target by Hywel Dda University Health Board, June 2019 to August 2024



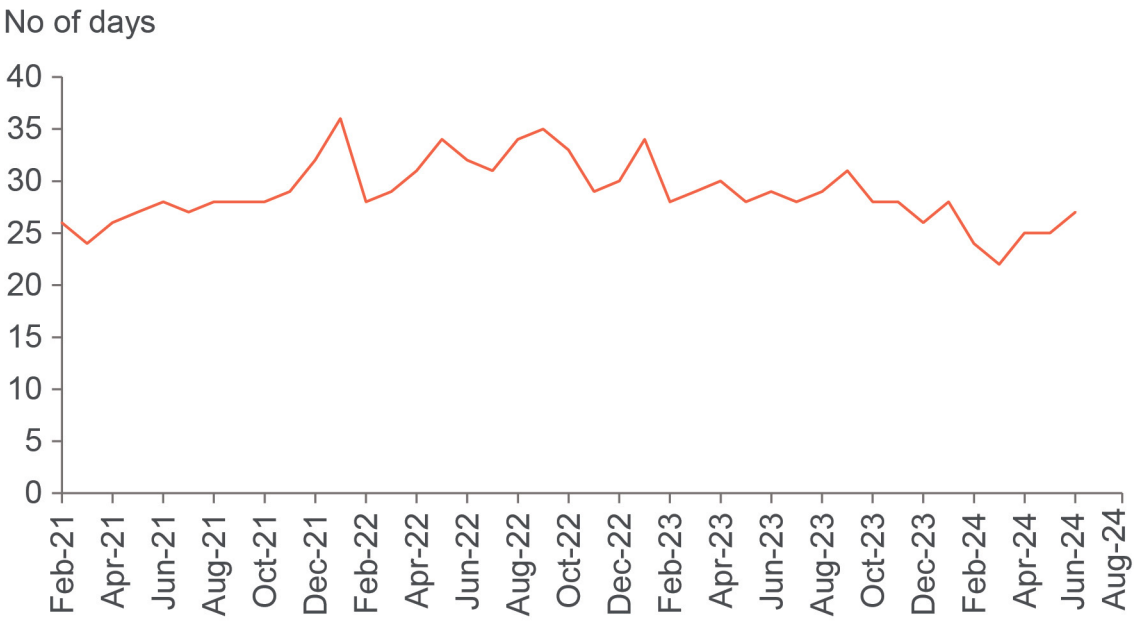
Source: DHCW, Suspected Cancer Pathway – Closed Pathways dataset, on StatsWales.

Exhibit 27f: performance against the 62-day target by Swansea Bay University Health Board, June 2019 to August 2024



Source: DHCW, Suspected Cancer Pathway – Closed Pathways dataset, on StatsWales.

Exhibit 28: median waits from first suspicion to diagnosis, February 2021 to August 2024



Source: DHCW data from the Suspected Cancer Pathway Dashboard

3 About our work

Audit question, scope and criteria

We chose to focus on the national strategic approach to improving the timeliness of cancer diagnosis and treatment because we identified significant systemic challenges facing cancer services during our scoping. This review focuses on the Welsh Government and NHS Executive (and its National Strategic Clinical Network for Cancer) as system leaders, recognising that health boards and trusts have responsibility for the operational delivery of different aspects of cancer services. We will consider the merits of further work focusing on NHS bodies' approach to delivering cancer services in our 2025-26 work programme.

We developed our audit criteria based on learning from our previous audits of planned care[66] and local health audit work, analysis of key strategic documents[67], and research from relevant organisations on the challenges associated with cancer services in Wales.

66 Audit Wales, NHS Wales Waiting Times for Elective Care in Wales, 2015; Audit Wales, 10 Opportunities for Resetting and Restarting the NHS Planned Care System, 2020; and Audit Wales, Tackling the Planned Care Backlog in Wales, 2022.

67 Including Welsh Government, A Healthier Wales – a Long Term Plan for Health and Social Care, 2021; Welsh Government, Our Programme for Transforming and Modernising Planned Care and Reducing Waiting Lists in Wales, 2022, Welsh Government, The Quality Statement for Cancer, 2022, Welsh Government, Diagnostics Recovery and Transformation Strategy for Wales 2023 to 2025; and the National Strategic Clinical Network for Cancer, A Cancer Improvement Plan for NHS Wales 2023-26, 2023.

Audit methods

Document review

We reviewed relevant documentation including:

- documents setting out the national strategic approach. Key documents include the Quality Statement for Cancer, Cancer Improvement Plan, the Diagnostic Recovery and Transformation Strategy, National Clinical Framework, National Optimal Pathways and NHS planning and performance frameworks
- documents relating to the NHS Executive's national cancer recovery programme
- individual NHS body plans setting out their approach to delivering cancer services, and relevant board and committee papers on cancer performance
- papers from the Welsh Government's performance management meetings
- Public Health Wales NHS Trust information on the delivery of population screening servicesinformation on cancer data and population health including reports from the Welsh Cancer Surveillance and Intelligence Unit and the Welsh Government's Science Evidence Advice[68]
- the Senedd Health and Social Care Committee's report on its inquiry on gynaecological cancers[69] and supporting evidence

Semi-structured interviews

We interviewed officials from the following organisations:

- the Welsh Government;
- the NHS Executive including its National Strategic Clinical Network for Cancer;
- a sample of health boards including officials from Betsi Cadwaladr, Hywel Dda and Swansea Bay University Health Boards, and Powys Teach Health Board;
- officials from other NHS bodies including Digital Health and Care Wales, Health Education and Improvement Wales, Public Health Wales and Velindre NHS Trusts; and
- we also met with officials from the NHS Executive, Cardiff and Vale, Hywel Dda and Swansea Bay University Health Boards to inform our scoping.

68 Welsh Government, Science Evidence Advice – NHS in 10+ Years – An Examination of the Projected Impact of Long-Term Conditions and Risk Factors in Wales', September 2023.

69 Welsh Parliament Health and Social Care Committee, Unheard: Women's Journey Through Gynaecological Cancer, December 2023.

Workshop with third sector representatives

We held a workshop with representatives from the third sector on 1st May 2024 organised by the Wales Cancer Alliance[70]. We asked participants for their views of the strengths and weaknesses of the national strategic approach and invited further written responses with more detail on the same topic. We conducted follow-up interviews with some organisations for clarification where necessary. Representatives from the organisations below took part in the workshop:

- ALK Positive UK
- Association of the British Pharmaceutical Industry
- Blood Cancer UK
- Bowel Cancer UK
- Breast Cancer Now
- Cancer Research UK
- Fair Treatment for the Women of Wales
- Leukaemia Care
- MacMillan Cancer Support
- Marie Curie
- Prostate Cancer UK
- Royal College of Pathologists
- Royal College of Paediatrics and Child Health
- Royal College of Physicians
- Tenovus Cancer Care
- Young Lives vs Cancer
- We established an expert panel to inform our understanding of the systemic barriers to the timeliness of cancer diagnosis and treatment and provide critical challenge on our findings. The panel included representatives from Marie Curie, the Association of the British Pharmaceutical Industry, the Royal College of Physicians, and the Wales Cancer Alliance.

70 A coalition of charities working to prevent cancer, improve care, fund research and influence policy in Wales.

Data analysis

We reviewed data from different sources including:

- DHCW published data on open and closed cancer pathways, on StatsWales;
- DHCW published data on hospital admissions. We also requested data on discharge destinations of cancer patients admitted to hospital;
- we requested data from the Suspected Cancer Pathway dataset managed by DHCW that is not published elsewhere. We analysed data on performance against the Suspected Cancer Pathway target by ethnicity; source of suspicion ; and closed pathways by whether patients started treatment for cancer, were downgraded for not having cancer, or died before being downgraded or starting treatment; and
- Welsh Cancer Surveillance and Intelligence Unit data on cancer incidence, mortality and survival.

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We welcome correspondence and telephone calls in Welsh and English.

Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Management response form

Report title: Cancer Services in Wales: A review of the strategic approach to improving the timeliness of diagnosis and treatment

Completion date: 14/01/25

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R1	The Welsh Government should publicly clarify the status of the Cancer Improvement Plan and its links to the National Cancer Recovery Programme and the Cancer: Improving Outcomes initiative. As part of this the Welsh Government should clarify how it intends to hold NHS bodies to account for delivery of the Cancer Improvement Plan.	Accept. The Welsh Government will update the Quality Statement for Cancer to clarify the respective roles of the Cancer Recovery Programme, Cancer improvement Plan, and other important national work streams such as the Making it Happen initiative. This will include a description of accountability arrangements.	End quarter 1 2025-26	Sue Tranka Chief Nursing Officer
R2	The Welsh Government should set out a coherent model for system leadership in respect of cancer services that clarifies its own role and that of the NHS Executive and sets out how it will bring on board clinicians and other key stakeholders to build a common view of	Accept. The Welsh Government is in the process of finalising a revised governance and leadership model for cancer service development. This will include the introduction of a National Cancer Leadership Board	End quarter 4 2024-25	Nick Wood Deputy Chief Executive, NHS Wales

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	cancer service performance, quality and opportunities for improvement.	that will coordinate or lead on national actions. The NHS Executive will provide the clinical, third sector, and private sector input to its work. This model will continue to develop in response to the feedback of those directly involved and those involved through related leadership groups. These arrangements will be described in the updated Quality Statement for Cancer.		
R3	The Welsh Government should review its oversight and performance framework in respect of cancer services to focus on a broader range of issues, including a more explicit alignment to the ambitions and quality attributes set out in the Quality Statement for Cancer.	Accept. The NHS Performance Framework only includes the top-level strategic metrics for the NHS; it does not include all the metrics that are routinely applied in accountability processes. There are a broader set of metrics which sit outside the Framework. This includes component waits in the cancer pathway, access to treatment measures, data on care quality and outcome, screening and immunisation uptake, and patient outcomes. The broader set of metrics	End quarter 1 2025-26	Jeremy Griffith Director of Operations

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
		are used as part of routine accountability process as required. The updated Quality Statement for Cancer will include additional detail to explain how cancer service delivery will be measured.		
R4	The Welsh Government should develop a more coherent approach to population health improvement by setting out how it intends to use its Science Evidence Advice: NHS in 10+ Years to harness the opportunities associated with prevention to reduce the incidence of cancer and other major conditions.	The Welsh Government pursues an evidence-led approach to prevention and to reducing population-level risk for cancer and major conditions. There are established programmes for smoking prevention through the Smoke Free Wales Strategy and Tobacco Control Delivery Plan (with additional supportive legislation imminent) and on tackling overweight and obesity, through the Healthy Weight Healthy Wales strategy and delivery plan, including through the facilitation of physical activity. These programmes are under constant review and development as new evidence and technologies emerge. The NHS Planning Framework for 2025-28 has population health and prevention as one of the five	Establishment of preventing ill-health advisory group by end quarter 1 2025-26	Sioned Rees Director for Public Health Protection

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
		priority areas and this will support a further drive and focus on primary, secondary and tertiary prevention interventions in the plans of NHS organisations. We are also in the process of establishing a preventing ill-health advisory group under the Chief Medical Officer to support and harness opportunities to implement sustainable, evidence informed policies that focus on preventing ill-health and related inequalities. The initial focus will be on securing and measuring funding of ill-health prevention, strengthening the current architecture, progressing work on data, and supporting the cross-government role in prevention of ill-health. The establishment of this group will assist in providing sustained engagement and a coherent, coordinated approach to the development of appropriate policy and system responses.		

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R5	The Welsh Government should work with Public Health Wales to accelerate decision making for a national lung screening programme. It should clarify as soon as possible whether it will fund national lung screening for Wales and the timescale for implementing such a programme.	Accept. The Welsh Government has asked Public Health Wales to accelerate its work on scoping lung screening to permit a decision by Welsh Ministers on its introduction and funding. Public Health Wales is due to provide an interim report by end of March and a final report by end of September to permit Welsh Ministers to make a decision on introducing a national lung screening programme.	End quarter 2 2025-26	Sioned Rees Director for Public Health Protection
R6	As part of a wider approach to encourage greater regional working between health boards, the Welsh Government and the NHS Executive should work with the service to understand and help address any key barriers to delivering regional services. This should include working with DHCW to identify digital solutions to support shared waiting lists for	Accept. The Welsh Government will work with NHS organisations to support regional working for services, where appropriate, to address service fragility. This will include working with Digital Health and Care Wales on the development of digital solutions to permit shared waiting lists.	Ongoing	Mike Emery Chief Digital Officer

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	cancer diagnosis and treatment, where it is appropriate to do so.			
R7	The Welsh Government should work with the NHS Executive, HEIW and other NHS bodies to ensure there are employment opportunities for radiologists who have been trained in the National Imaging Academy.	Accept. The Welsh Government will work with health boards in Wales, which are responsible for planning their workforce, to enable employment of Imaging Academy graduates in line with local or regional workforce needs.	Quarter 2 2025-26	Helen Arthur Director of Workforce and Government Business
R8	The Welsh Government should clarify national roles and responsibilities for monitoring and ensuring compliance with its data standards including how it will hold NHS bodies to account for poor compliance.	Accept. Digital Health and Care Wales develop and design data standards, including minimum data sets for NHS Wales. DHCW advises the Welsh Government on what should be included and how they should be collected. Only the Welsh Government can mandate	Quarter 3 2025-26	Mike Emery Chief Digital Officer

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
		requirements through national policy, planning guidance or Welsh Health Circulars. To ensure compliance, the Welsh Government expects organisations to audit themselves against the standards and DHCW to deliver a quality assurance and review process. Regulatory bodies such as Audit Wales and Healthcare Inspectorate Wales also have a role in auditing organisations against national standards. DHCW and regulatory bodies should report to the Welsh Government any significant failure to comply with national data requirements, so that these can be addressed with NHS organisations through accountability processes and meetings.		
R9	The Welsh Government should work with the NHS Executive (particularly the Cancer Network), DHCW and Public Health Wales NHS Trust to develop a more comprehensive set of publicly available data on cancer services, which as a minimum should include:	Accept in principle. The Welsh Government will develop a cancer data road map to improve the available data on cancer service delivery for use by the NHS, the Welsh Government, and the public. However, it may not be	Quarter 3 2025-26	Mike Emery Chief Digital Officer

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	• the number of people currently waiting for cancer diagnosis or treatment (open pathway data); • Performance against the 62-day target for the health board providing diagnosis and treatment and health board of residence, including people living Powys Teaching Health Board area; • Performance across the patient pathways including timeliness of diagnostic reporting across different tumour sites; timeliness from the decision to treat a patient to the start of that treatment (including surgery, radiotherapy and Systemic Anti-Cancer Therapy); and diagnosis and treatment of recurrent disease. Performance information should be provided at cancer sub-tumour level where possible; • Timeliness of diagnosis and treatment for patients referred from the breast and cervical screening programmes; and	possible to provide all of this data to the public for reasons of data accuracy, reporting burden on NHS services, and patient confidentiality. In addition, the barriers to providing data on treatment in England must first be understood before commitments can be made to publishing this data, but we support the principle of doing so, subject to their further analysis.		

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	• accurate information on equity of access, including ethnicity of cancer patients as well as the experiences of different patient groups (this should include children and young people).			
R10	The Welsh Government should work with DHCW and NHS England to share regular and consistent data on the timeliness of diagnosis and treatment for Welsh cancer patients treated by NHS England.	Accept. The Welsh Government will work with health boards, NHS England, and Digital Health and Care Wales to ensure relevant data on the diagnosis and treatment of Welsh residents seen in England is appropriately shared.	Quarter 4 2025-26	Mike Emery Chief Digital Officer

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	22 April 2025
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Audit, Risk and Assurance - Committee Forward Work Plan 2025/26
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Head of Corporate Governance/Head of Risk and Assurance.

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

The Audit, Risk and Assurance Committee is asked to consider and approve the draft Committee Forward Work Plan (Appendix 1). The Forward Work Plan has been developed with due regard to recommendations arising from the Committee's 2025/26 Self- Assessment, to support the Committee in its ability 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

In line with good governance practice, a Forward Work Plan has been developed to ensure that statutory requirements and key items of Committee business are appropriately scheduled throughout the year. The Work Plan serves as a proactive tool to inform, anticipate and guide Committee business, thereby supporting the agenda setting process.

Asesiad / Assessment

The Forward Work Programme is intended to support the Committee in overseeing and managing its programme of business. It outlines the scheduled timing of report submissions, highlights any deferred items, and records new requests for reports. The Plan also enables the Committee to monitor progress and review its workload at each meeting.

Between February and April, the following updates and/or changes have been made to the Forward Work Plan:

Items deferred on the Forward Work Programme:

- Compliance with Welsh Health Circulars (WHCs)

Additions to the Forward Work Programme:

- No additions to note.

Argymhelliad / Recommendation

The Committee is asked to:

- **APPROVE** the Forward Work Plan; and
- **NOTE** that it will be presented at each future Committee meeting for ongoing oversight.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	The monitoring and reporting of committee business is a key element of the Health Boards assurance framework
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Choose an item. 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	Not Applicable Choose an item. Choose an item. Choose an item.

Strategic Equality Objectives 2020-24	

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	N/A
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	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 2025/26

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 2024 and the Structured Assessment 2024 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’.

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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
			22nd April 2025	20th May *Draft Accounts*	24th June *Final Accounts*	4th Sept 2025	21st Oct 2025	16th Dec 2025	12th Feb 2026
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	√ (Draft)		√				
Corporate Governance, Risk & Assurance									
Review and report upon the adequacy of arrangements for declaring, registering, and handling interests	**An**	DofCG					√	√	
Receive full report of all offers of gifts and hospitality as declared	**An**	DofCG	√					√	
Compliance with Ministerial Directions	**BI**	DofCG	√					√	
Compliance with Welsh Health Circulars (WHCs)	**BI**	DofCG	√**D**	√				√	
Review of Standing Orders, Standing Financial Instructions, and Scheme of Delegation	**An**	DofCG							√
Compliance with regulatory requirements	**An**	DofCG							√
Audit Recommendations Tracking Report	**Qu**	DofCG		√**Q4**		√Q1	√Q2		√Q3
Annual Review of Risk Management Framework	**An**	DofCG		√					
Report on the Implementation of the Risk Management Framework	**BI**	DofCG					√		√
Committee Risk & Assurance Report	**SI**	DofCG	√		√	√	√	√	

DRAFT

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2025/26						
			Quarter 1			Quarter 2	Quarter 3		Quarter 4
			22nd April 2025	20th May *Draft Accounts*	24th June *Final Accounts*	4th Sept 2025	21st Oct 2025	16th Dec 2025	12th Feb 2026
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**	DofF&P & DofCG						√	
Review the Health Board's Annual Report (Overview & Performance Section) **(Part 1)**	**An**	DofCG		√	√				
Review Draft/Final Accountability Report, including Annual Governance Statement **(Part 2)**	**An**	DofCG		√	√				
Review Draft/Final Annual Accounts and Financial Statements **(Part 3)**	**An**	DofF&P		√	√				
Audit Enquiries to those charged with Governance and Management	**An**	DofF&P		√					
Audit Wales, Audit of Accounts (ISA 260) including Letter of Representation	**An**	AW			√				
Final Annual Accounts Memorandum	**An**	AW					√		
Receive the Annual Head of Internal Audit Opinion (including Specialised)	**An**	HofIA			√				
Agree a recommendation to the Board in respect of the audited annual report and accounts	**An**	Chair			√				
Counter-Fraud									
Review of the Counter Fraud, Bribery and Corruption Policy *(Feb 2026)*	**3-Yearly**	DofF&P	-	-	-	-	-	-	√
Receive the Counter Fraud Annual Report	**An**	HofCF		√					
Agree the Counter Fraud Annual Workplan	**An**	HofCF							√
Receive a Quarterly Report on Counter Fraud Activity	**Quarterly**	HofCF				√		√	

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2025/26						
			Quarter 1			Quarter 2	Quarter 3		Quarter 4
			22nd April 2025	20th May *Draft Accounts*	24th June *Final Accounts*	4th Sept 2025	21st Oct 2025	16th Dec 2025	12th Feb 2026
Agree the Counter Fraud Functional Standard Return Declaration	**An**	HofCF			√				
Receive the Post Payment Verification Annual Report, including, the Annual Workplan for 2025-26	**An**	PPV Manager			√				
Receive a Mid-Year update in respect of Post-Payment Verification Activity	**An**	PPV Manager					√		
Clinical Audit									
Receive the Clinical Audit Activity Annual Report 2024 - 2025	**An**	Medical Director			√				
Agree the Clinical Audit Plan 2025 - 2026	**An**	Medical Director			√				
Mid-year Report on the delivery of the Clinical Audit Plan	**An**	Medical Director					√		
Internal Audit (Including Specialised Audit) – NWSSP Audit & Assurance Services									
Agree the Internal Audit Annual Workplan	**An**	HofIA	√						
Receive Internal Audit Progress Reports	**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		√					
External Audit – Audit Wales									
Receive the External Audit Annual Audit Report	**An**	AW		√					
Agree the External Audit Annual Plan	**An**	AW		√					
Receive the draft external auditor's opinion on the quality account	**An**	AW						√	
Receive the 2025 Structured Assessment	**An**	AW					√		
Receive External Audit Progress Report 2025-26	**SI**	AW	√	√	√	√	√	√	√

DRAFT

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2025/26						
			Quarter 1			Quarter 2	Quarter 3		Quarter 4
			22nd April 2025	20th May *Draft Accounts*	24th June *Final Accounts*	4th Sept 2025	21st Oct 2025	16th Dec 2025	12th Feb 2026
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							
Total Items Scheduled (excluding preliminary items) -to be updated prior to each meeting			**13**	**13**	**17**	**12**	**16**	**14**	**8**
Audit, Risk and Assurance Committee Members to meet Independently with:									
External Audit Team	**BI**	Chair			√			√	
Internal Audit Team	**BI**	Chair		√			√		
Local Counter Fraud Team	**BI**	Chair	√			√			√

Lead Officer Key	
DofCG	Director of Corporate Governance
DofF&P	Director of Finance and Procurement
HofCF	Head of Counter Fraud
PPV	Post Payment Verification
HofIA	Head of Internal Audit
AW	Audit Wales
Chair	Chair

Frequency of Inclusion Key	
SI	Standing Item
AN	Annually
BI	Biannually
Quarterly	Quarterly

Schedule of Meetings Key	
√	Scheduled agenda item in FWP
√**R**	Received at the Scheduled meeting
D	Deferred from this agenda
√ **D**	Deferred Scheduled agenda item Received
W	Withdrawn from FWP
T	Transferred to another Committee

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IC	Matter discussed In Committee

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