Audit, Risk and Assurance Committee (Final Accounts) - Main Meeting

Tue 24 June 2025, 09:30 - 12:00

Agenda

1.
PRELIMINARY MATTERS

1.0 ARAC 202500624 Agenda - Final.pdf (3 pages)

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 20 May 2025

Attached *Chair*

ARAC 20250624 1.4 Minutes.pdf (8 pages)

1.5.
Committee Action Log and Matters Arising

Attached *Chair*

ARAC 20250624 1.5 Action Log.pdf (4 pages)

2.
Items for APPROVAL/RATIFICATION/DECISION

2.1.
Update on Financial Control Procedures

Attached *Director of Finance and Procurement*

ARAC 20250624 2.1 FCPs Report June 25.pdf (4 pages)

3.
ITEMS FOR DISCUSSION

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

To Follow *Director of Corporate Governance*

- ARAC 20250624 3.1 Cover Report Annual Report ARAC final accounts.pdf (11 pages)
- ARAC 20250624 3.1a Final DRAFT Performance Report 2024.25.pdf (53 pages)

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

To Follow *Director of Corporate Governance*

- ARAC 20250624 3.2 Final Draft Accountability Report 2024.25.pdf (107 pages)

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

Attached *Director of Finance and Procurement*

- ARAC 20250624 3.3 Audit, Risk and Assurance report on Final Annual Accounts 2024-25.pdf (4 pages)
- ARAC 20250624 3.3a Appendix 1 - adjustments actioned.pdf (2 pages)
- ARAC 20250624 3.3b ABULHB 2024-25 Final Annual Accounts.pdf (79 pages)

3.4.
To Audit Wales, Audit of Accounts (ISA 260) including Letter of Representation

Attached *Audit Wales*

- ARAC 20250624 3.4 4926A2025_ABUHB_Audit_Accounts_2024-25_final.pdf (35 pages)

3.5.
To Agree a recommendation to the Board in respect of the audited annual report and accounts

Oral *Chair*

3.6.
To Receive the Counter Fraud Functional Standard Return Declaration

Attached *Head of Counter Fraud*

- ARAC 20250624 3.6 ARAC Cover Paper - Counter Fraud Functional Standard Return 24-25.pdf (4 pages)
- ARAC 20250624 3.6a CFFSR24-25.pdf (24 pages)

3.7.
To Receive the Counter Fraud Services in NHS Wales Operational Performance Report for Q4 of 2024/25

Attached *Head of Counter Fraud*

- ARAC 20250624 3.7 NHS Wales Counter Fraud Operational Report 2024 2025 Q4 Final.pdf (46 pages)

3.8.
To Receive the Post Payment Verification Annual Report, including, the Annual Workplan for 2025-26

Attached *Post Payment Verification Manager*

- ARAC 20250624 3.8 PPV Board and Committee End of Year Report 24-25.pdf (4 pages)
- ARAC 20250624 3.8a ABuHB End of Year PPV Report 2024-2025.pdf (1 pages)
- ARAC 20250624 3.8b PPV SBAR.pdf (2 pages)
- ARAC 20250624 3.8c PPV Appendix 1 Acrobat Document.pdf (2 pages)
- ARAC 20250624 3.8d PPV Appendix 2 Acrobat Document.pdf (3 pages)

ARAC 20250624 3.8e PPV Appendix 3 .pdf (2 pages)

3.9.
To Receive the Committee Risk and Assurance Report

Attached *Director of Corporate Governance*

ARAC 20250624 3.9 Risk and Assurance Cover Report.pdf (7 pages)
ARAC 20250624 3.9a Appendix A - Strategic Dashboard and Risk Assessments.pdf (45 pages)

3.10.
To Receive the Annual Head of Internal Audit Opinion (including Specialised)

Attached *Head of Internal Audit*

ARAC 20250624 3.10 ABUHB FINAL HIA Opinion and Annual Report 2024-25.pdf (29 pages)

3.11.
To Receive the Internal Audit Progress Report

Attached *Head of Internal Audit*

ARAC 20250624 3.11 ABUHB June 2025 Audit Committee Progress Report.pdf (10 pages)

3.12.
To Receive Internal Audit Review Reports

3.12.1.
Job Planning – Limited Assurance

Attached *Head of Internal Audit*

ARAC 20250624 3.12.1 Final ABUHB 2425 Job Planning Report.pdf (12 pages)

3.12.2.
Contract Management -Advisory

Attached *Head of Internal Audit*

ARAC 20250624 3.12.2 ABUHB-2425-03-Contract Management Final Advisory Report for Client.pdf (10 pages)

3.12.3.
Performance Management Framework – Reasonable

Attached *Head of Internal Audit*

ARAC 20250624 3.12.3 ABUHB-2425-05 Performance Framework Final Report for Client.pdf (10 pages)

3.12.4.
High Priority Recommendations – Advisory

Attached *Head of Internal Audit*

ARAC 20250624 3.12.4 ABUHB 2425 FINAL Follow Up Report for Client.pdf (3 pages)

3.13.
To Receive External Audit Progress Report

Attached *Audit Wales*

ARAC 20250624 3.13 3997A2024 Audit Risk and Assurance Committee Update - June 2025.pdf (12 pages)

3.14.
To Receive the Audit Wales Planned Care report

Attached *Audit Wales*

ARAC 20250520 3.14 4621A2024 ABUHB Tackling the Planned Care Challenges.pdf (50 pages)

3.15.
To Receive the Clinical Audit Activity Annual Report 2024 - 2025

Attached *Assistant Director for Quality and Patient Safety*

ARAC 20250624 3.15 Final SBAR Clinical Audit Activity Report and Plan June 2025.pdf (7 pages)
ARAC 20240624 3.15a Final Anual Audit Activity Report 2024.2025.pdf (135 pages)

3.16.
To Receive the Clinical Audit Activity Annual Report 2024 - 2025

Attached *Assistant Director for Quality and Patient Safety*

ARAC 20250624 3.16 Final Clinical Audit Plan 2025.26.pdf (23 pages)

4.
Items for INFORMATION

4.1.
Committee Programme of Business 2025/26

Attached *Director of Corporate Governance*

ARAC 20250624 4.1 Audit, Risk and Assurance Committee Forward Work Plan Cover Report.pdf (3 pages)
ARAC 20250624 4.1a ARA Committee Work Programme 2025-26 Final - Copy.pdf (7 pages)

4.2.
Internal Audit Final 2025/26 Audit Workplan

Attached *Head of Internal Audit*

ARAC 20252624 4.2 ABUHB FINAL Internal Audit Plan 2025-26.pdf (26 pages)

5.
OTHER MATTERS

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

Oral *Chair*

5.2.
Any Other Urgent Business

Oral *Chair*

5.3.
Date of the Next Meeting: Thursday 18th September 2025

Oral *Chair*

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

AUDIT, RISK & ASSURANCE COMMITTEE AGENDA	
Date and Time	**Tuesday 24th June 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 20 May 2025	Attached	Chair
1.5	Committee Action Log and Matters Arising	Attached	Chair
2	**ITEMS FOR APPROVAL/RATIFICATION/DECISION**		
2.1	Update on Financial Control Procedures	Attached	Director of Finance and procurement
3	**ITEMS FOR DISCUSSION**		
3.1	To Review the Health Board's Annual Report (Overview & Performance Section) **(Part 1)**	Attached	Director of Corporate Governance
3.2	To Review Final Accountability Report, including Annual Governance Statement **(Part 2)**	Attached	
3.3	To Review Final Annual Accounts and Financial Statements **(Part 3)**	Attached	Director of Finance and procurement
3.4	To Review Audit Wales, Audit of Accounts (ISA 260) including Letter of Representation	Attached	Audit Wales
3.5	To Agree a recommendation to the Board in respect of the audited annual report and accounts	Oral	Chair



3.6	To Receive the Counter Fraud Functional Standard Return Declaration	Attached	Head of Counter Fraud
3.7	To Receive the Counter Fraud Services in NHS Wales Operational Performance Report for Q4 of 2024/25	Attached	Head of Counter Fraud
3.8	To Receive the Post Payment Verification Annual Report, including, the Annual Workplan for 2025-26	Attached	Post Payment Verification Manager
3.9	To Receive the Committee Risk and Assurance Report	Attached	Director of Corporate Governance
3.10	To Receive the Annual Head of Internal Audit Opinion (including Specialised)	Attached	Head of Internal Audit
3.11	To Receive the Internal Audit Progress Reports	Attached	
3.12	To Receive Internal Audit Review Report	Attached	
3.12.1	Job Planning – Limited Assurance	Attached	
3.12.2	Contract Management -Advisory	Attached	
3.12.3	Performance Management Framework – Reasonable	Attached	
3.12.4	High Priority Recommendations – Advisory	Attached	
3.13	To Receive External Audit Progress Report	Attached	Audit Wales
3.14	To Receive the Audit Wales Planned Care report	Attached	Audit Wales Chief Operating Officer



3.15	To Receive the Clinical Audit Activity Annual Report 2024 - 2025	Attached	Assistant Director for Quality and Patient Safety
3.16	Agree the Clinical Audit Plan 2025 - 2026	Attached	
4	**ITEMS FOR INFORMATION**		
4.1	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: Thursday 18th September 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 20 May 2025
VENUE	Microsoft Teams

PRESENT	Iwan Jones Dafydd Vaughan Neil Patrick	Independent Member, Committee Chair Independent Member Independent Member
IN ATTENDANCE	Rani Dash Rob Holcombe Robert Jones Lucy Windsor Gareth Lavington Stephen Chaney Eifion Jones Gareth Lewis Sara Utley Julie Rees - Tracey Daszkiewicz Jennifer Winslade Danielle Jackson -	Director of Corporate Governance Executive Director of Finance and Procurement Assistant Finance Director Head of Corporate Risk and Assurance Head of Counter Fraud Head of Internal Audit, NWSSP Deputy Head of Internal Audit, NWSSP Head of Financial Services & Accounting Performance Audit Lead, Audit Wales Finance Audit Lead, Audit Wales Executive Director of Public Health (*Item 3.5*) Excutive Director of Nursing (*Item 3.6*) Secretariat
OBSERVING		
APOLOGIES	Richard Clark Hannah Evans	Independent Member, Vice Chair Executive Director of Strategy, Planning and Peformance. (*Item 3.1*)

Minute Reference	Preliminary Matters
ARAC 2005/01	**Welcome and Introductions** The Chair welcomed everyone to the meeting.
ARAC 2005/02	**Apologies for Absence** Apologies for Richard Clark – Independent Member, Vice Chair Were noted.
ARAC 2005/03	**Declarations of Interest** There were no declarations of interest raised to record.

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ARAC 2005/04	**Minutes of the previous meeting** The minutes of the meeting held on the 22 April 2025were agreed as a true and accurate record.
ARAC 2005/05	**Committee Action Log** The Committee reviewed the action log, noting actions completed, actions in progress, and actions not yet due. Rob Holcombe (RH), Director of Finance and Procurement informed the Committee that the outstanding action had now been completed, following a meeting with the Director of Strategy, Planning & Partnerships it was agreed that a report focusing on the progress of future projects would be presented at the next Committee meeting to provide assurance. **ACTION: Director of strategy, Planning and Partnerships.** The Committee expressed further concerns regarding the Records Management Internal Audit report presented at the previous meeting, with particular emphasis on Recommendation 6. The Committee requested that the management responses be reviewed at the Board development session scheduled for the 25th June 2025 to ensure they adequately address the identified risks, associated with the safe storage of records during the digitalisation of records project. It was agreed that the updated report would be returned to the next scheduled Committee for assurance that the concerns had been addressed. **ACTION: Director of Corporate Governance, Head of Internal Audit and Director of Digital.** The Committee **AGREED** that completed actions could be removed from the Action Log.
	ITEMS FOR APPROVAL / RATIFICATION / DECISION
ARAC 2005/06	**To Receive the Audit Recommendation Tracking report and Approve the Quarter 4 Closing Position.** Lucy Windsor (LW), Head of Risk and Assurance provide an overview of the report. It was reported that to provide the committee with a clear end-of year-position and allow directors the opportunity to close all possible recommendations, updates were requested on all live recommendations with a view to progress remaining audits to a new digital tracking system, AMaT. Iwan Jones (IJ), Committee chair raised concerns that 57% of the recommendations contained within the tracker had exceeded their original implementation date and questioned to what extent the responsible directors were being held to account for the delay in completion of outstanding recommendations.

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	Rani dash (RD), Director of Corporate Governance informed the Committee that a deep dive of audit recommendations was scheduled to be presented at the next Executive Committee meeting to encourage a focused discussion and reinforce the importance of actively progressing recommendations raised within audits. **ACTION: Director of Corporate Governance.** RD also advised that a review of the Performance Management and Accountability Framework is ongoing, with the intention of incorporating a governance and leadership domain. This addition aimed to provide deeper oversight and visibility, enabling more effective accountability of responsible individuals. The Committee **APPROVED** the: • Completion of 35 recommendations; • 24 revised implementation deadlines. The Committee **NOTED** the: • 8 Overdue against their agreed implementation dates; •22 Not Yet Due against their agreed implementation dates.
ARAC 2005/07	**To Review the Health Board's Annual Report (Overview & Performance Section) (Part 1)** Rani Dash (RD), Director of Corporate Governance, presented a summary of Part 1 of the Health Boards Annual Report 2024/25, noting that draft versions had been provided to Welsh Government and feedback would be incorporated into the final version presented to the Committee and Board in June 2025 ahead of formal submission on the 30th June 2025. Iwan Jones (IJ), Committee queried how the figures would be validated to ensure a consistent approach throughout. RD confirmed that the performance data would be validated against the integrated performance report presented to the Board, and the financial data would be validated against financial and workforce data aligned to the remuneration and staff report. Julie Rees (JR), Finance Audit Lead, confirmed that the financial figures were undergoing review to ensure alignment and consistency and at present there were no areas of concern. The committee **NOTED** the report for assurance.

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ARAC 2005/08	**To Review Draft Accountability Report, including Annual Governance Statement (Part 2)** Rani Dash (RD), Director of Corporate Governance, provided an overview of Part 2 of the Health Board's Annual Report 2024/25. Iwan Jones (IJ), Committee Chair, questioned the consistency of data between figures presented in Part 2 and Part 3 of the report. RD confirmed that work had been ongoing between the Corporate Governance Team and the Finance Department to develop a more coherent approach to the presentation of figures, with the aim of ensuring consistency across all three parts of the Annual Report. Neil Patrick (NP), Independent Member, asked whether Audit Wales had provided a view on the Health Board's progress in relation to the Well-being of Future Generations (Wales) Act, specifically Section 9. Sara Utley (SU), Performance Audit Lead, confirmed that the Act had been addressed within the Structured Assessment 2024. She noted that a recommendation had been made for the Health Board to publish its well-being objectives and confirmed that the statement within the Annual Report accurately reflected the Health Board's current position. The committee **NOTED** the report for assurance.
ARAC 2005/09	**To Review Draft Annual Accounts and Financial Statements (Part 3)** Robert Holcombe (RH), Executive Director of Finance and Procurement, provided the Committee with an overview of Part 3 of the Health Board's Annual Report 2024/25, noting that all accounts had been prepared in accordance with national financial reporting standards. It was reported that: • The statutory target for the revenue resource limit had not been achieved, with a deficit of £7.1 million recorded for 2024/25. As a result, the three-year rolling target had also not been met. • The Public Payment Policy target of 95% had been achieved. • The closing cash limit fell within the £6.0 million threshold set by Welsh Government. The committee **NOTED** the report for assurance.
ARAC 2005/10	**To Receive the Counter Fraud Annual Report.** Gareth Lavington (GL), Head of Counter Fraud, provided the Committee with a summary of the work undertaken by the Counter Fraud department during the 2024/25 financial year.

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	It was reported that 84 investigations had been completed over the year, in addition to 200 National Fraud Initiative (NFI) investigations. As a result of these, 36 sanctions had been applied, with a total recovery of £135,000—of which £121,000 related to salary overpayments. It was noted that training packages had been developed and rolled out to support staff and managers in identifying and addressing fraud. This initiative was progressing well and would continue to be pursued. Rob Holcombe (RH), Director of Finance and Procurement, informed the Committee that the Welsh Government Directions were under review. He also provided an update on the newly established Task and Finish Counter Fraud Improvement Group, noting that its current focus was on improving joint working, capturing lessons learned, and proposing additional CPD opportunities for counter fraud professionals across Wales through the English Counter Fraud System. Iwan Jones (IJ), Committee Chair, suggested that future reports include comparisons with previous years. GL agreed to incorporate this in future reports and explained that, due to the introduction of a new reporting format, it had not been possible to include such comparisons in the 2024/25 report. The Committee **NOTED** the report for assurance.
ARAC 2005/11	**To receive Audit Wales' report on No time to lose: Lessons from our work under the Well-being of Future Generations Act.** Sara Utley (SU), Performance Audit Lead, provided the Committee with an overview of the Audit Wales review of the Well-being of Future Generations (Wales) Act. It was reported that the Act had gained prominence; however, there remained areas requiring further development, as it was not yet driving the level of change originally intended at the time of its implementation. While no Health Board-specific actions were identified in the report, the Act had been addressed within the Structured Assessment 2024. A number of recommendations were directed at Welsh Government. A formal response was still outstanding and would be shared with the Committee once received. Tracy Daszkiewicz (TD), Director of Public Health and Strategic Partners, informed the Committee that a recent action summit

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	had been held to launch an updated version of the Wellbeing Future Generations Act following a review process. She reassured the Committee that the Health Board and Public Health Services remained focused on aligning their work with the seven principles outlined in the Act. The Committee **NOTED** the report for assurance.
ARAC 2005/12	**To Receive Aneurin Bevan Quality Governance Follow up Report.** Sara Utley (SU), Performance Audit Lead, provided the Committee with an overview of the Audit Wales Audit Quality Governance Follow-Up Report. It was reported that the audit focused on reviewing progress made against the recommendations outlined in the original Quality Governance Audit conducted in 2022. While progress had been made, it was noted that additional time would be required to fully implement the remaining actions. Key areas identified for further improvement included the need to better understand why staff felt they were treated unfairly when raising concerns, and why there was a perception that appropriate action was not taken in response. Jennifer Winslade (JW), Director of Nursing, welcomed the report and informed the Committee that the Quality Management System had been redesigned to ensure it is robust and fit for purpose. The Committee **NOTED** the report for assurance.
ARAC 2005/13	**To Receive the Internal Audit Progress Report** Stephen Chaney (SC), Head of Internal Audit, reported on the progress of the Internal Audit Plan for 2024/25. The Committee **NOTED** the report for assurance.
ARAC 2005/14	**To Receive Internal Audit Draft Opinion** Stephen Chaney (SC), Head of Internal Audit, reported on the Head of Internal Audit Draft Opinion noting that the expected outcome was positive, with a Reasonable Assurance Rating anticipated for the Health Board. The Committee **NOTED** the report for assurance.

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ARAC 2005/15	**To Receive the Internal Audit 2025/26 audit plan including the three-Year Plan.** Stephen Chaney (SC), Head of Internal Audit, provided an overview of the Internal Audit Plan for 2025/26, as well as the Internal Audit Three-Year Plan. It was reported that adjustments had been made to reflect feedback received at the previous Committee meeting. These included: • The inclusion of the Welsh Intensive Care Information System; • An extension of the Standing Orders compliance review to consider the risk associated with Independent Members' availability; • An expanded scope of the Director Review to include capacity planning; and • An extension of the Six Goals Programme audit to assess the effectiveness of actions taken. The Committee **NOTED** the report for assurance.
ARAC 2005/16	**To Receive Internal Audit Review Reports.** Stephen Chaney (SC), Head of Internal Audit, presented findings from the following audit; **Health Board Managed Practices – Reasonable Assurance** The review examined the letting of a group of five Health Board managed GP practices to a single partnership in early 2024, one commencing on 1 January 2024 and four on 1 April 2024, which were subsequently returned to Health Board management in 2025. The purpose of the review was to ensure that appropriate processes had been followed. SC advised that a number of additional recommendations were identified to help the Health Board manage broader risks. These have been outlined in a supplementary report, which will be published shortly. Dafydd Vaughn (DV), Independent Member, inquired whether the failure to adhere to the six-week application submission deadline had impacted the procurement process. SC confirmed that the issue had been considered extensively but was ultimately deemed not to have affected the overall process. Rani Dash (RD), Director of Corporate Governance, informed the Committee that the topic of managed practices was scheduled for

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	discussion at the upcoming Board meeting on 21 May 2025. She suggested that a lessons learnt report be considered as part of that discussion. The Committee **NOTED** the report for assurance.
	ITEMS FOR INFORMATION
ARAC 1211/17	**Committee Programme of Business 2025/26** Lucy Windsor (LW), Head of Corporate Risk and Assurance, provided an update on the Committee Programme of Business 2025/26. The Committee **NOTED** the report for information.
	Other Matters
ARAC 2005/18	**Items to be Brought to the Attention of the Board and Other Committees** • Quality Governance Follow up Report to Patient Quality, Safety and Outcomes Committee and People and Culture Committee. • Audit Wales' report on No time to lose: Lessons from our work under the Well-being of Future Generations Act to Partnerships, Population Health and Planning Committee.
ARAC 2005/19	**Any Other Urgent Business** • Nothing reported.
ARAC 2005/20	**Date of the next meeting** • Tuesday 24th June 2025

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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 – Clinical Audit	Provide a summary of progress against national and local audit alongside the next report provided to the Audit Committee.	Medical Director	October 2025	**Not Due**



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

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
April 2025	**ARAC 2204/15** Grange University Hospital Emergency Department Extension – Internal Audit Report	Schedule a meeting to discuss the GUH ED Extension Audit to identify strategies for improvement and prevent similar issues in future projects.	Director of Finance and Procurement	20 May 2025	**Completed** Meeting taken place between the Director of Finance and Director of Strategy, Planning and Partnerships to discuss, Director of Strategy, Planning and Partnerships to discuss agreed to progress through the capital planning process.
May 2025	**ARAC 2005/05** Action Log	Provide the Committee with an update in relation to the checklist for future projects to prevent reoccurring issues being raised in future audits.	Director of Strategy, Planning and Partnerships	18th September2025	**Not Due**
May 2025	**ARAC 2005/05** Action Log	Review and update the management responses to ensure they accurately reflect the scope of the	Director of Corporate Governance/Director of Digital and Head of Internal Audit	4th September2025	**In progress** The Director of Corporate

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Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
		recommendations and return to the Committee for assurance.			Governance has initiated a review which will be discussed at the Board development session on the 25th June. Following amendment the updated report will be returned to the Committee.
May 2025	**ARAC 2005/06 Audit Recommendation Tracking report**	Provide the Committee with a verbal update following the audit recommendations tracker report being presented to the Executive Team on the 5th June.	Director of Corporate Governance	24th June 2025	**Completed** Paper received at executive committee on the 6th June, Verbal update provided to the next committee meeting.

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ANEURIN BEVAN UNIVERSITY HEALTH BOARD
ACTION LOG

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

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

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	24 June 2025
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Financial Control Procedures (FCPs)
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Robert Holcombe, Director of Finance, Procurement and Value Based HealthCare
SWYDDOG ADRODD: **REPORTING OFFICER:**	Robert Jones, Assistant Director of Finance (Financial Systems and Services)

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

Er Gwybodaeth/For Information

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report provides a status update of any revisions to the Financial Control Procedures.

Cefndir / Background

Financial Control Procedures are reviewed, as a minimum, on a 3 yearly basis.

All FCPS are currently within the 3 year review period and remain relevant.

Asesiad / Assessment

The following FCPs will be reviewed and are scheduled to be presented at the Audit, Risk and Assurance meeting on 4th September 2025.

- Budgetary Control
- Losses and Special Payments
- Stores and Stocks

The table below provides the summary position of all Financial Control Procedures

FCP	Year Due	Approved	Committee Approved	Review Date	Notes
Budgetary Control Policy & Procedure	25/26	Y	Aug-22	02-Aug-25	Scheduled for Sep 25
Losses and Special Payments	25/26	Y	Oct-22	06-Oct-25	Scheduled for Sep 25
Stores & Stocks	25/26	Y	Oct-22	06-Oct-25	Scheduled for Sep 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	
Approval of Orders over £100K	27/28	Y	Apr-25	22-Apr-28	
Overseas Visitors	27/28	Y	Apr-25	22-Apr-28	
Digital Procurement	27/28	Y	Apr-25	22-Apr-28	
Charitable Funds	27/28	Y	Apr-25	22-Apr-28	

Argymhelliad / Recommendation

The Audit, Risk and Assurance Committee is asked to note the status of the Financial Control Procedures.

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. N/A
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Finance
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:	FCP – Financial Control Procedure
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**
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. N/A

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	24 June 2025
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Annual Report and Accounts 2024/25
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

In respect of the Annual Report and Accounts 2024/25, this paper presents to the Board the final draft audited versions of:

1) The Performance Report (Part 1)
2) The Accountability Report (Part 2), including:
   a) A Corporate Governance Report
   b) A Remuneration and Staff Report
   c) A Parliamentary Accountability and Audit Report.

for consideration and approval prior to being submitted to Welsh Government on 30th June 2025, in-line with HM Treasury Requirements.

Following presentation of the draft documents to the Audit, Risk and Assurance Committee on 20th May 2025, the final draft versions incorporate comments and feedback received from Welsh Government; Audit Wales; and Board Members, including those comments made by the Audit, Risk and Assurance Committee when reviewing the drafts.

Page numbers contained in the documents will be added once the 3 reports have been combined in to one consolidated document for submission.

Part 3 of the Annual Report and Accounts 2024/25 are the Financial Statements 2024/25, and these are provided to the Audit, Risk and Assurance Committee under separate cover.

Cefndir / Background

NHS Bodies are statutorily obliged to prepare their annual report and accounts in compliance with the determination and directions given by Welsh Ministers and the approval of the Treasury.

The Manual for Accounts, issued by Welsh Government, has been prepared to ensure that those determinations and directions are consistent with the 2024-25 Government Financial Reporting Manual (FReM) which sets out the accounting guidance applicable to bodies within the Resource Accounting Boundary. In setting the requirements of the FReM the government is advised by an independent body, the Financial Reporting Advisory Board (FRAB). NHS bodies are required to follow FReM guidance except where a divergence has been formally agreed with the Treasury.

The Manual provides principles–based guidance to NHS bodies on how to prepare and complete their annual report and accounts and financial returns. Application of the principles to the individual circumstances of a NHS body is a matter between the body and its external auditors.

The Annual Report and Accounts as a whole must be fair, balanced and understandable and the Accountable Officer takes personal responsibility for it and the judgments required for determining that it is fair, balanced and understandable.

Asesiad / Assessment

Annual Report and Accounts – Requirements for 2024/25

As set out in the Manual for Accounts, NHS bodies are required to publish, as a single document, a three-part Annual Report and Accounts which includes:

- The Performance Report, which must include:
  - An overview.
  - Performance analysis

- The Accountability Report, which must include:
  - A Corporate Governance Report.
  - A Remuneration and Staff Report.
  - Senedd Cymru/Welsh Parliament Accountability and Audit Report.

- The Financial Statements, including:
  - The Audited Annual Accounts 2024/25.

The detailed structure of the Annual Report and Accounts 2024/25, is set out at Annex A.

For the 2024-25 reporting period the deadlines for submission are:

Annual Reports 2024/25 - Key Dates	**2025**	
Draft Accounts to WG	**Fri**	**2-May**
Draft Performance Report Overview, Accountability Report and Remuneration Report to WG	**Fri**	**9-May**
Draft Reports to ARA Committee Members	**Tues**	**13-May**
ARA Committee meeting to Consider Draft Accounts and Draft Accountability Report	**Tues**	**20-May**
Final Accounts & Accountability Report to Audit Committee Members	Tues	17-June
ARA Committee meeting to Consider Final Accounts, and Accountability Report	Tues	**24-June**
Board meeting to approve Final Accounts and Accountability Report	Wed	**25-June**
Certification by Auditor General		
Final Annual Report Deadline for Submission to WG – Annual Report and Accounts as a single unified document	Mon	**30 June**
Annual General Meeting – to receive the Annual Report and Accounts	Wed	24 Sept

Part One – The Performance Report 2024/25

The purpose of the performance section of the annual report is to provide information on the Health Board, its main objectives and strategies and the principal risks that it faces. The requirements of the performance report are based on the matters required to be dealt with in a Strategic Report as set out in Chapter 4A of Part 15 of the Companies Act 2006, as amended by SI 2013, No. 1970. The main features of the performance report should flow from the organisation's agreed plan and demonstrate how the Health Board has delivered against that plan in the year of reporting.

The performance report must provide a fair, balanced and understandable analysis of the Health Board's performance, in line with the overarching requirement for the annual report and accounts to be fair, balanced and understandable.

The performance report, once approved by the Board, shall be signed and dated by the Accountable Officer (the Chief Executive Officer).

The Draft Performance Report was considered by the Audit, Risk and Assurance Committee on 20th May 2025, where comments and feedback were provided to inform the Final Draft version, as attached. In addition, Audit Wales (External Audit), has reviewed the draft performance report for consistency with other information in the financial statements (Part 3). Feedback and amendments received from Audit Wales have been factored into the Final Draft.

Part 2 – The Annual Accountability Report 2024/25

The purpose of the accountability section of the annual report is to meet key accountability requirements to the Welsh Government. The requirements of the accountability report are based on the matters required to be dealt with in a Directors' Report, as set out in Chapter 5 of Part 15 of the Companies Act 2006

and Schedule 7 of SI 2008 No 410, and in a Remuneration Report, as set out in Chapter 6 of the Companies Act 2006 and Schedule 8 of SI 2008 No 410.

The Accountability Report is required to have three sections:

- **Corporate Governance Report**

  The purpose of the Corporate Governance Report is to explain the composition and organisation of the Health Board's governance structures and how they support the achievement of the entity's objectives.

  As a minimum, the corporate governance report must include:
  - The Directors' Report;
  - The Statement of Accounting Officer's responsibilities; and
  - A Governance Statement.

    The Governance Statement is a key feature of the organisation's Annual Report and Accounts. It demonstrates publicly the management and control of resources and the extent to which the body complies with its own governance requirements, including how they have monitored and evaluated the effectiveness of their governance arrangements. It is intended to bring together in one place in the annual report all disclosures relating to governance, risk and control.

- **Remuneration and Staff Report**

  The remuneration and staff report sets out the organisation's remuneration policy for directors and senior managers, reports on how that policy has been implemented and sets out the amounts awarded to directors and senior managers and where relevant the link between performance and remuneration.

- **Senedd Cymru/Welsh Parliament Accountability and Audit Report**

  The Parliamentary Accountability Report contains disclosure on the following:
  - Regularity of expenditure
  - Fees and charges
  - Public Sector Information Holders only - a statement is required if the entity has not complied with the cost allocation and charging requirements set out in HM Treasury guidance
  - A brief description of the nature of each of the organisation's material remote contingent liabilities (that is, those that are disclosed under Parliamentary reporting requirements and not under IAS 37) and, where practical, an estimate of its financial effect. (This is included in the Annual Accounts [Part 3]).

The Accountability Report, once approved by the Board, shall be signed and dated by the Accountable Officer (the Chief Executive Officer), the Chair and the Director of Finance.

The Draft Accountability Report was considered by the Audit, Risk and Assurance Committee on 20th May 2025 where comments and feedback were provided to inform the Final Draft version, as attached. In addition, Audit Wales (External Audit), has reviewed the draft Accountability report for consistency with other information in the financial statements (Part 3). Feedback and amendments received from Audit Wales have been factored into the Final Draft. Welsh Government has also reviewed the draft accountability report and were content that the Health Board had made the appropriate level of disclosure against the requirements in Chapter 3 of the Manual for Accounts.

Material changes made since the first draft are highlighted in yellow within the attachment to support committee members in undertaking their final review.

Attachment One provides an overview of the comments received and changes made.

Argymhelliad / Recommendation

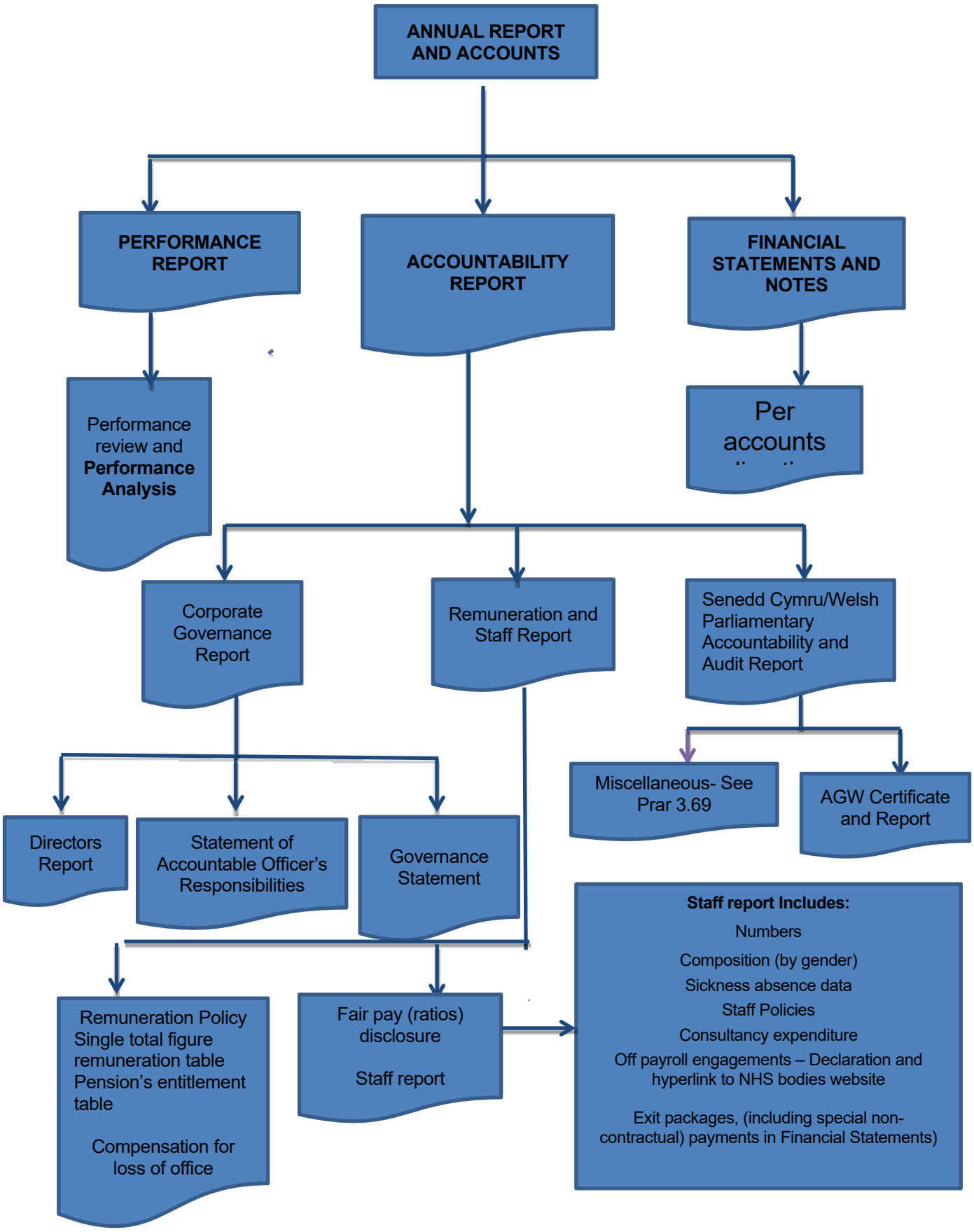
The Audit, Risk and Assurance Committee is asked to CONSIDER and REVIEW the Final Draft versions presented prior to being submitted for formal approval by the Board on 25th June 2025.

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

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	

Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Not Applicable Choose an item.


ANNUAL REPORT AND ACCOUNTS
PERFORMANCE REPORT
ACCOUNTABILITY REPORT
FINANCIAL STATEMENTS AND NOTES
Performance review and **Performance Analysis**
Per accounts
Corporate Governance Report
Remuneration and Staff Report
Senedd Cymru/Welsh Parliamentary Accountability and Audit Report
Directors Report
Statement of Accountable Officer's Responsibilities
Governance Statement
Miscellaneous- See Prar 3.69
AGW Certificate and Report
Remuneration Policy
Single total figure remuneration table
Pension's entitlement table
Compensation for loss of office
Fair pay (ratios) disclosure
Staff report
Staff report Includes:
Numbers
Composition (by gender)
Sickness absence data
Staff Policies
Consultancy expenditure
Off payroll engagements – Declaration and hyperlink to NHS bodies website
Exit packages, (including special non-contractual) payments in Financial Statements)

Page/reference	Comment	Response
Accountability Report		
Audit Wales Comments		
	General comment - presentational updating from 23-24	Document reviewed and years corrected / updated
Page 48, Audits	Substantial assurance: To be updated for 24-25 reports? Most already reported in 23-24s ARA	Section split (in line with subsequent sections) to identify Reports included within the 2023/24 Internal Audit Plan, and reported in the Annual Governance Statement 2023/24, reported to the Audit, Risk and Assurance Committee in 2024/25 and those included in the 2024/25 Internal Audit Plan
Page 55,	Structured Assessment: Also include a direct link to the annual audit report This report summarises the findings from our 2024 audit work at Aneurin Bevan University Health Board undertaken to fulfil our responsibilities under the Public Audit (Wales) Act 2004.	Link and explanation added to the report
ARAC Comments		
Page 17	ARAC – was not quorate for one meeting	This has been reflected in the table at Attachment One: Quoracy of Meetings
Page 17	Committee overview: RATS not included	Overview of RATS Committee added
Page 55	Audits: Should there be a list of audits not completed in 24/25 and carried forward to 2025/26	List has been added
Page 61	Iwan Jones is Welsh Language Champion	Table amended
Page 63	Quoracy of meetings: ARAC not quorate for one meeting	Table amended
	Structured Assessment findings on WBFGA to be included	Added to report
Welsh Government Comments		
Page 13	re the committee meeting, is this the only standing order not complied with?	Review of compliance with SOs added
Remuneration and Staff Report		

Audit Wales Comments		
	The audited sections in the Remuneration and Staff report need to be clearly identified as such (MfA, Chap 3, 3.52 - below)	'Audited position' added to relevant sections
	the Health Board needs to include expenditure on consultancy and temporary staff. You have a table on consultancy but not temporary staff (MFA Chap 1, Annex 5 defines temporary)	Table added
ARAC Comments		
	Staff Numbers – inconsistency in report	Amended calculation of 'total years' to provide consistency in numbers. Agreed with Audit Wales.
Annual Report/Performance Report		
Audit Wales Comments		
Page 2	23-24 references to be updated for 24-25 and section changes.	All years changed to 2024/25.
Page 3	The performance report should be signed and dated by the Accountable Officer (para 3.9 MFA ref) - need to add a signing point on page 50	Add Signature line to end of report
	Please confirm what figures have been used to = £15.8m?	Information provided to Audit
	Request audit trail please on number of staff employed in March 2025	Information provided to Audit.
Page 7	Comment for consideration - From a public point of view I think the colours might be confusing - Its RAG rating but its not clearly red, amber and green? Could you be clearer on which targets have been achieved and which have not.	RAG Removed- this was from last years report as this section of the report hadn't been updated in the draft provided to WAO
Page 12	Comment - did you want to be clearer on the ministerial priorities in relation to planned care and the HB performance - also charts could	Updated- this was from last years report as this section of the report hadn't been updated in the draft provided to WAO

	include comparators to enable better scrutiny?	
Page 14	Comment - I find these charts a little difficult to read	Updated- this was from last years report as this section of the report hadn't been updated in the draft provided to WAO
Page 27	Unclear if the MFA high level over-view requirements (3.44-3.49) are being sufficiently addressed in this section? eg no TCFD statement, commentary on Net Zero Carbon baselining and targets, use of resources table.	Section updated
Page 35	I note the recent media coverage in relating to Dylan Cope - I know that the HB has agreed to work with the UK Sepsis Trust - which I assume is the same aspect described here? Did you want to reflect further on the HB learning following the inquest	Not appropriate to comment on individual cases in an overarching performance report
Page 36	This could do with a comparator and maybe a link to explain RAMI?	RAMI explainer added
Page 37	I think this acronym needs to be expanded - sorry if I have missed it there are quite a few in this section.	LFER Learning from Events Report. Updated.
Page 41	Did you want to provide an update on progress in delivery of the clinical audit plan.	Clinical Audit included in Accountability Report
Page 43	MFA requirements to be considered here: Has the body either included its Well-Being Statement, or a link to a published statement? Has the organisation reflected upon their Well-Being objectives in the Performance Report?	The wellbeing statement is included
Page 44	Is this section to be updated for 24-25?	Updated Equality, Diversity & Inclusion Section provided by Sarah Simmonds 9. Equality Diversity Inclusion.docx
Page 50	Note 3.3 'other exp' s/b £14,310m to be consistent with 23-24. Total is correct, balancing figure is non pay exp.	Revised table included
Comments from ARAC members		

Page 1	2024/25?	Years updated.
Page 3	There are different figures published in the financial and accountability reports? These may be point in time but should we be consistent?	Drafting issues to be corrected in final draft
Page 6	Should we match figures in finance and accountability reports?	Figures checked
	2024/25?	
Page 33	We had one never event reported to board in November 2024 – seemed to suggest that was a theatre event – if not are we being "economical" with how we report	Confirmed with Quality & Safety team this Never Event did not relate to a theatre procedure
Page 38	This whole section feels out of date and refers to last year – is this due for updating?	Well-Being of Future Generations information provided by Public Health Well-Being of Future Generations Act annual Report update 2024-25.docx
	24/25? Etc.	References to last year updated
	Already 2 years in – are we not more interested in how it's going?	This is reported via PSB not health board
Page 41	Again refers to 2023/4 – are we giving a summary of previous year in which case the "has" is superfluous but what have we done 24/25?	Well-Being of Future Generations information provided by Public Health Well-Being of Future Generations Act annual Report update 2024-25.docx
Page 44	No Section 10	Drafting issues to be corrected in final draft
	Should be section 11?	Drafting issues to be corrected in final draft
Page 46	Section 12?	Drafting issues to be corrected in final draft
Page 47	Section 13?	Drafting issues to be corrected in final draft
.	ensure that up front within the performance report there is greater emphasis on achievements in year as well as reinforcing this within the conclusion section.	Increased successes in Exec summary

Aneurin Bevan University Health Board Annual Report and Annual Accounts 2024/2025

Our Annual Report is a suite of documents that tell you about our organisation, the services and care we provide and what we do to plan, deliver and improve healthcare for you. It provides information about how we performed in 2024/25, what we have achieved, how we plan to continue to improve next year and our plans for the future. This report also explains how important it is for us to work with you and listen to your views, to better deliver services that meet your needs, as close to your home as possible.

Our Annual Report for the period 1st April 2024 to 31st March 2025 includes:

- Our **Performance Report** which details how we have performed against our targets and the actions planned to maintain or improve our performance.

- Our **Accountability Report** which details our key accountability requirements and provides information about how we manage and control our resources, identify and respond to our risks, and comply with our own governance arrangements.

- Our **Financial Statements and Annual Accounts** which detail how we have spent our money and met our obligations.

Contact Us

You can contact the Health Board using the details below:

Aneurin Bevan University Health Board
Headquarters, St Cadoc's Hospital
Lodge Road, Caerleon, Newport, NP18 3WQ
Telephone; 01633 436700 or email abhb.enquiries@wales.nhs.uk
http://twitter.com/aneurinbevanhb
https://www.facebook.com/AneurinBevanHealthBoard

Section One – The Performance Report	
1. Overview from the Chief Executive **2. Reporting Requirements** **3. Aneurin Bevan University Health Board** **4. Annual Plan 2024/25 – Performance against trajectories** **5. Delivering the IMTP Priorities 2024/25** **6. Integrated Medium Term Plan 2024/25– Priority Programmes** **7. Integrated Medium Term Plan 2024/25 – Quality and Safety** **8. Well Being of Future Generations** **9. Equality, Diversity and Inclusion** **10. Welsh Language Requirements** **11. Financial Management and Performance** **12. Conclusion and Forward Look**	
Section Two – The Accountability Report	
Corporate Governance Report • **Directors Report** • **Statement of Accountable Officer's Responsibilities** • **Annual Governance Statement**	
Remuneration and Staff Report	
Parliamentary Accountability and Audit Report	
Section Three – The Financial Statements	
The Audited Annual Accounts 2024/25	

Part 1:
Performance Report

1st April 2024 –
31st March 2025

1. Overview from the Chief Executive

The last year marked one of steady progress for the organisation, with reductions in very long waits for patients, improvement in Emergency Care performance and the delivery of new developments which will bring care closer to home, such as the 19 Hills Health and Wellbeing Centre. Despite this progress the Health Board remains in Level 4 for finance, strategy and planning and level 5 for performance and outcomes related to urgent and emergency care pathways at The Grange University hospital emergency department. The organisation is committed to achieving the financial and operational performance required to support de-escalation and the progress made in the last year, shows the organisation is on track to achieve this.

There have been many achievements and improvements in performance, across the breadth of the Health Board's priorities. Much has been delivered over the past 12 months including:

- Strengthened focus on Quality, Safety and Patient Experience. Improving Quality metrics with Health Board's Risk Adjusted Mortality Index (RAMI) reducing and lowest in Wales;
- The Health Board delivered and sustained zero patients waiting over 156 weeks;
- Significantly reduced the 104 week position from 4,086 in March 2024 to 288 by year end;
- Significant reduction in diagnostics 8 week target from 4,209 in March 2024 to 1,155 by year end;
- Reduced the 52 week outpatient position from a high of 17,611 in November to 14,265 by year end across all RTT Specialties;
- Led work to eliminate 104 weeks waits for Cataracts across the South East Wales Region;
- Mental Health Part 1 and Part 2 across both Adults and CAMHS, recovered and sustained since December;
- CAMHS Neurodevelopmental RTT compliance has also seen a significant improvement delivering a year end position of 81.9% and meeting the national standard;
- Pathway of Care Delays (POCDs) reaching a year end position of 171 from 262 in September 2024, in addition to substantial reduction in the numbers of days attributable to the delays;
- Single Cancer Pathway (SCP) compliance of 67.5% for March 2025 demonstrates positive progress and is the highest value over the past 24 months. In addition, backlog reduced from high of 469 in May to 275 in March 2025 & 89% of patients diagnosed within 28 days. Significantly reduced waits of over two years across all specialties;

- Delivering financial target;
- Undertook widespread public engagement to inform a new Organisational Strategy to be published in July 2025;
- Opened the first phase of the 19 Hills Wellbeing Centre in Newport with further progress on the Primary Care Estate Plan;
- Variable Pay reduced by approximately £15.8m from 2023/24 to 2024/25 and increased the total number of substantive staff through innovative approaches to recruitment and retention;
- Increasing number of Patient Experience Surveys with latest quarter reporting 88% reporting satisfaction;
- Refreshed Joint Strategic Needs Assessment – progress with Preventable Premature Mortality Work and Women's Health Plan.

This report sets out the progress the organisation has made in 2024/25.



Workforce

The Health Board employs 13,424 WTE (17,111 people; March 2025) and is the largest employer in Gwent. This is an increase of 343 WTE from last year, mainly in Nursing and Midwifery (187.58 WTE), Estates and Ancillary (62.59 WTE), and Health Care Support Workers (HCSW) (43.94 WTE). Administration decreased by 80.08 WTE (2.8%). Estates and Ancillary increased core staffing by 6.17% to reduce reliance on agency usage.

The workforce demographic remains stable, with 20% of staff over 55 and 32% over 50 years old. Turnover reduced from 9.2% to 8.64%, while sickness increased from 6.10% to 6.44%, with stress, anxiety, and depression accounting for 33% of absences.

The organisation has significantly reduced Registered Nurse vacancies by 53% and Medical and Dental vacancies by 40% over the last two years. However, vacancies persist in some medical specialties (e.g., Ophthalmology, General and Acute Medicine, Psychiatry, Public Health), Therapies, and Pharmacy. The organisation will continue recruitment and retention campaigns to address these. Long-term vacancies remain in non-clinical roles like Mechanical and Craftsperson positions.

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

There are 1,370 WTE colleagues in independent GP Practices, with a high reliance on locum GPs and many GPs over 55 years old.

People Plan 2022 – 2025 – Putting People First: The next iteration of the organisation's People Plan (2025/26 - 2028/29) is in development and will involve full engagement with staff, Trade Unions and Partners. The Plan will address workforce challenges and support the Health Board's Long-Term Strategy and Ministerial Targets, focusing on:

- Staff Health & Wellbeing
- Employer of Choice
- Workforce Sustainability and Transformation

The priorities align with the commitments of Health Education and Improvement Wales (HEIW), Social Care Wales (2022), A Healthier Wales, and the National Workforce Implementation Plan (2023). Our Plans are also driven by Welsh Health Circulars 2024/031 and 2024-17.

Actions in the People Plan during 2024/25 have positively impacted key workforce performance indicators, including:

- Turnover dropped from 11.36% to 8.64%.
- Performance Appraisal (PADR) increased from 73.46% to 75.15% with a new process and manager training.
- Launched the Speaking up Safely process.
- Time to hire remains below the 71-day target at 64 days.
- Recruited 74 International Nurses.
- Reduced HCSW vacancies by 60 WTE and RN vacancies by 128 WTE.
- Reduced Medical vacancies by 57 WTE in the last two years.
- Variable Pay reduced by a further circa £15.8m from 2023/24 to 2024/25
- Refreshed a new Strategic Equality Plan focusing on Equality, Diversity, and Inclusion.
- Increased Welsh language translation, learning opportunities and reporting of competencies.

- Continued our work in line with Gwent Strategic Workforce Action Plan and roll out of our Integrated Schools Programme for Health and Social Care.
- Launched a bespoke Leadership Development Programme for aspiring and current Directorate Managers.
- Launched a Talent Management and Succession Planning Framework and Training Programme.
- Agreed a programme of work to positively recognise staff contribution and commitments with a range of formal and informal ways to show appreciation.

Finance

The Health Board faced a significant underlying deficit post the covid-19 pandemic (in excess of £100m) but has stepped up to the challenge and has achieved unprecedented levels of savings over the last 3 years delivering a total of £111.6m to 31st March 2025 (58% of which are recurrent).

In 2024/25 we developed a Three-year route map to sustainability based on the strategic aims of the Board, which has been used as the reference document to drive financial improvement and service sustainability planning via a Value & Sustainability Board.

Specific to the Health Board are the challenges and unique opportunities of a new system of working designed through the Clinical Futures Strategy aims and driven by the opening the Grange University Hospital. Leveraging the full benefits of this system change will be key to achieving sustainable services and financial opportunities. Improving efficiency through pathway redesign, better clinical and cost effectiveness, patient outcomes and driving value will be a key part of the route map to sustainability, generating either financial or performance benefits, which will need to be carefully balanced.

We have developed our approach to sustainability through the consideration of strategic priorities and Value & Sustainability themes, which will be used to programme manage the overall savings plan. Themes include; Workforce, Continuing Health Care, Medicines Management, Non-Pay, Service Redesign, Prevention and Digital.



In December 2024, the Health Board received a letter from Welsh Government which notified the Health Board of additional funding totalling £40.5m; £9.5m issued recurrently to support ongoing operational pressures, and a further £31m also issued on a recurrent basis but conditional on the Health Board delivering against objectives specified within the letter. As a result of this new recurrent funding, the Health Board was issued a revised control total of £7.356m and aimed to meet this target as a minimum, whilst continuing to identify opportunities to improve the position further.

The full-year financial outturn position at month 12 of 2024/25 was a deficit of £7.185m, with a total savings of £45.5m achieved. This position achieved and improved upon the Welsh Government's control total (£7.185m) by £171k.

2. Reporting Requirements

The purpose of the Performance Section of this Annual Report 2024/25, as set out in the guidance provided in the NHS Wales 2024/25 Manual for Accounts, is to provide information on Aneurin Bevan University Health Board, its main objectives and strategies and the principal risks that it faces. The requirements are based on the matters required to be dealt with as set out in Chapter 4A of Part 15 of the Companies Act 2006, as adapted in the Financial Reporting Manual and NHS Wales Guidance Manual.

The main features of the Performance Report flow from the organisation's agreed plan and demonstrate how the Health Board has delivered against these.

It should be noted that the Duty of Quality came into legal force in April 2023 in line with the Health and Social Care (Quality and Engagement) (Wales) Act 2020. These reports will be prepared and published separately to this Performance Report. Further information is available in the Annual Accountability Report, Page XX.

3. Aneurin Bevan University Health Board

Aneurin Bevan University Health Board was established in October 2009 and achieved 'University' status in December 2013. The Health Board's principal role is to ensure the effective planning and delivery of our local NHS system, within a robust governance framework, to achieve the highest standards of patient safety and public service delivery, improve health and reduce inequalities and achieve the best possible outcomes for our citizens, and in a manner that promotes human rights. To fulfil this role, we are required to work with our Partners and Stakeholders in the best interests of the population we serve.

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

The Population Needs Assessment for the region can be found here: Gwent Joint Strategic Assessment - Aneurin Bevan University Health Board

The Health Board employs 13,424 WTE as at the end of March 2024 and is the largest employer in Gwent. The workforce is ageing, as is the demographic profile of our population and the health inequalities of our population are also found within our workforce and 80% of our staff live within our communities. Therefore, it is essential that staff health and wellbeing is a key priority and a feature of our preventative plans.

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

Detail on how the Health Board is governed is set out within the Accountability Report (Section 2 of the Annual Report and Accounts 2024/25).

4. Annual Plan 2024/25 – Performance against trajectories

The Health Board's performance reporting is aligned to the commitments made in the 24/25 Annual Plan, which are split between two components:

- **Cabinet Secretary Priorities**
  - Enhanced Care in the Community *(1 measure),*
  - Primary and Community Care *(2 measures),*
  - Urgent and Emergency Care *(2 measures),*
  - Planned Care and Cancer *(4 measures),*
  - Mental Health, including CAMHS *(2 measures).*

- **System Change Themes**
  - Embedding Prevention and Population Health in all that we do *(5 measures),*
  - Progressing Place Based Models of Care and sustainability in Primary and Community Services *(6 measures),*
  - Improving our Urgent and Emergency Care System focusing on experience, access and discharge pathways *(11 measures),*
  - Continuing to prioritise Cancer, Urgent and the longest waiting patients for Planned Care *(7 measures),*
  - Improving our Mental Health Services *(7 measures).*

A summary of the Health Board's Annual Performance is detailed below by System Change Theme, with the relevant, corresponding Cabinet Secretary Priorities included.

Performance by System Change Theme

Embedding Prevention and Population Health in all that we do

5 Annual Plan Measures: 1 meeting trajectory/4 not meeting trajectory

There are 3 measures relating to vaccinations;

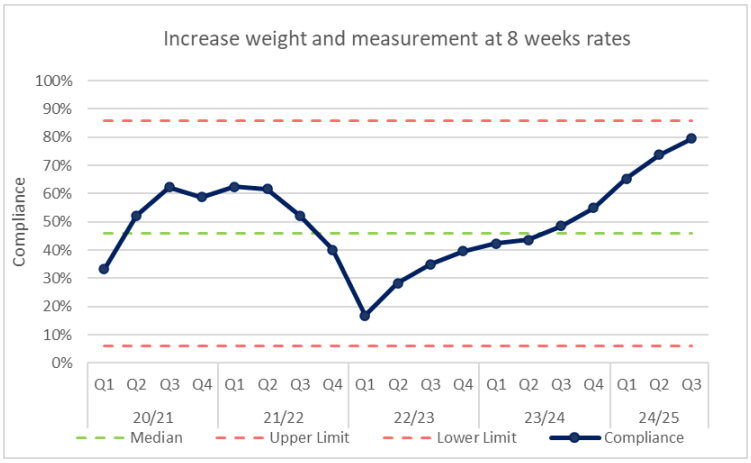
- Performance for the percentage of children who are up to date with the scheduled vaccinations by age 5 has improved through the year to the latest reporting period (Q4) at 86.5%, although this remains short of the national target (95%).
- The percentage of children receiving the HPV vaccination by the age of 15 has remained relatively static through to the latest reporting period Q4 at 66.1% against an Annual Plan trajectory of 91.1%.
- Influenza vaccinations amongst adults aged 65 years and over through the Winter campaign fell marginally shortly of the national target of 75% at 72.9%, however the Health Board's performance was higher than the all Wales performance of 70.3% for this cohort, and the second highest performing Health Board overall.

There are local initiatives in place to boost vaccination uptake. Neighbourhood Care Networks (NCNs) are implementing locally focused initiatives to encourage vaccination. These initiatives are tailored to address specific Community needs and include targeted Outreach Programs, Educational Campaigns, and Partnerships with local organisations to build trust and awareness.

School Health Nurses are also playing a pivotal role in our vaccination efforts. They are currently executing a robust Vaccination Plan that includes dedicated MMR (Measles, Mumps, and Rubella) Catch-up Clinics. These clinics are being held in Vaccination Centres and through Pop-up Clinics, making it easier for students to receive their vaccinations. By integrating these efforts within the school environment, we are ensuring that children have convenient access to essential vaccines, thereby reducing the risk of outbreaks and promoting overall public health.

The Health Board is committed to addressing vaccine inequity through our comprehensive Vaccine Inequity Strategy. This Strategy is informed by feedback from the NHS Executive and focuses on developing actions that ensure equitable access to vaccines for all populations. Our efforts include identifying and removing barriers to vaccination, such as transportation issues, language barriers, and misinformation. By working closely with Community Leaders and leveraging data to guide our actions, we aim to create a more inclusive and equitable Vaccination Program.

There are two Annual Plan measures relating to new born babies. The percentage in receipt of a physical examination at 6 weeks is 90.14% as of the latest reporting period (Feb '24) which is marginally behind the Annual Plan year end trajectory of 92.7%.



For the measure to increase rate of weight and measurement for babies at 8 week, the Health Board has seen significant improvement over the course of the past three years, which continued through 2024/25 to date, recording a historical high of 79.5% as of the latest reporting period (Q3).

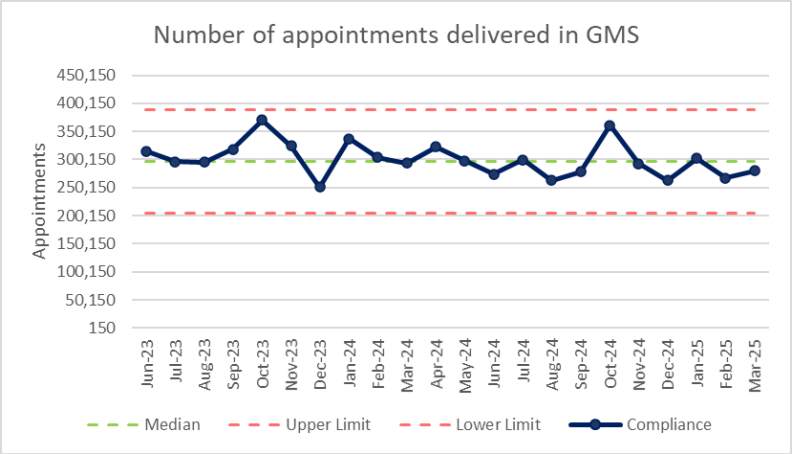
<u>Progressing Place Based Models of Care and sustainability in Primary and Community Services</u>

2 Cabinet Secretary Measures: 1 meeting trajectory/1 awaiting year end position

6 Annual Plan Measures: 2 meeting trajectory/3 borderline/1 not meeting trajectory

There are two Cabinet Secretary Priorities within this theme. The first is with regards to General Medical Services (GMS) and for 100% of Practices within the Health Board to achieve core access standards, and this has now been confirmed as achieved. The second relates to the percentage of contract fulfilled for General Dental Services (GDS). Year-end reporting is not yet available, however 62% of the contract value had been delivered as of the end of Q2.

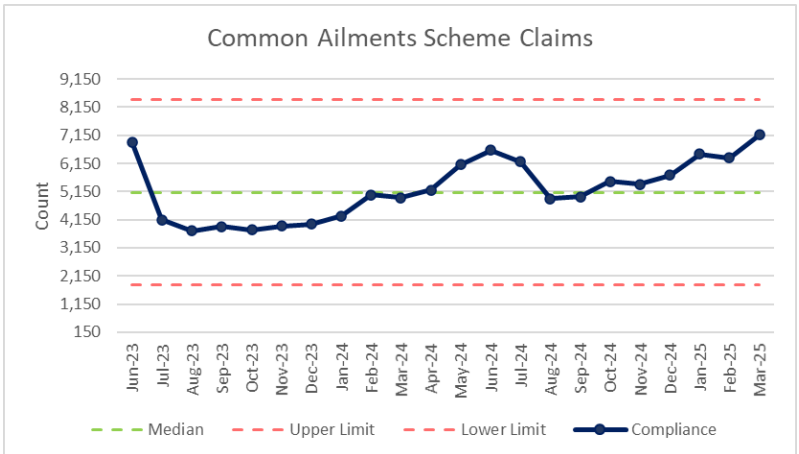
In relation to the number of appointments delivered in General Medical Services (GMS), the Health Board was close to meeting the total number set in the Annual Plan of



3,695,987. Despite not meeting the full annual target, we successfully delivered 94.7% of the total GP appointments planned, which is reflective of our commitment to providing accessible healthcare services and maintaining high performance levels. The Primary Care Contracting Team play a crucial role in managing GMS contracts. They ensure that any concerns are promptly addressed by raising them directly with the Contractors. This proactive approach helps in maintaining strong relationships and ensuring compliance with contractual obligations. Contracts are continuously monitored to ensure they meet all requirements. In 2024/25 3 Practices moved to Health Board management: Aberbeeg, Brynmawr and Blaenavon on 1 March 2025. This included 63 staff TUPE'd, with additional support put in place for staff wellbeing and the establishment of Patient participation panels. The action and support received positive feedback on the turnaround in short time frames, which continues in to 2025/2026.

The number of patients accessing NHS Optometry Services was 242,439, well ahead of the Annual Plan trajectory of 168,851. The Health Board successfully implemented new and revised Clinical Pathways, specifically Welsh General Ophthalmic Services (WGOS) 4 and 5. All providers have transitioned to WGOS 4 provision, ensuring a standardised and improved approach to clinical care. The Primary Care Contracting Team has monitored contracts to ensure all Optometry Practices meet the required standards of performance, including WGOS activity. This oversight guarantees that Practices adhere to high-quality standards and deliver consistent, reliable care to patients. The Health Board has actively supported the rollout of digitisation across services. This support for digitisation has improved data management, accessibility, and overall efficiency in service delivery.

The number of consultations undertaken by Community Pharmacy under the Common Ailments Scheme (CAS) also far exceeded the Annual Plan trajectory of 47,250, at 70,9637. All Community Pharmacies are now signed up to the CAS, resulting in a notable increase in the number of consultations in the final quarter of the year at almost 20,000. This expansion has improved access to care for common ailments, providing patients with more convenient and timely treatment options. A new system is being developed to provide all GMS



Practices with access to live service provision data in their area. This system will cover CAS, flu, and other services, enhancing the ability of GMS Practices to coordinate and deliver comprehensive care. The number of Pharmacies commissioned for the Independent Prescribing Service has increased from 46 in Q2 to 55 at the end of the year, reflecting our commitment to expanding the scope of Pharmacy Services and improving patient access to prescribed medications.

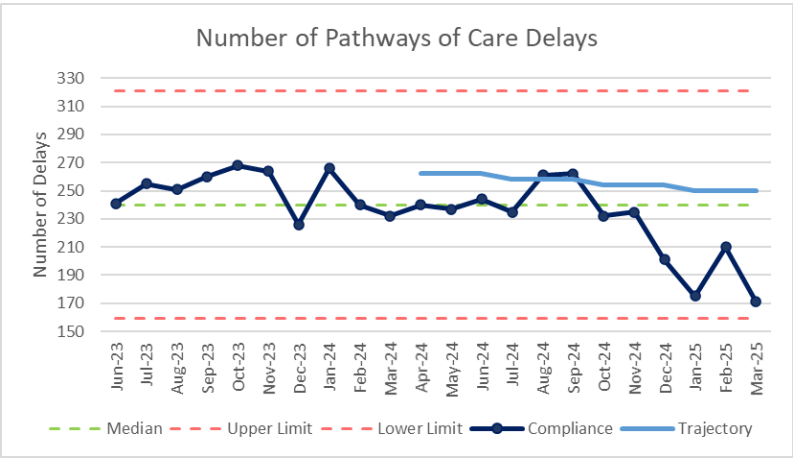
For the number of Units of Dental Activity (UDA) delivered performance was at 597,933 which reflects97.1% of the total planned . There were 50 UDA Practices at the beginning of the year, with 25 of these Practices opting for contract reform. Following Contract Terminations, there were successful re-commissioning of Services, ensuring continuity and quality of care. Our usual contract monitoring processes remain in place, ensuring that all Practices meet the required standards of performance.

Performance of Palliative Care referrals assessed within 2 days has averaged 96% across the course of the year against a 95% target, with the latest reporting period (January) recording 94.4%. The proportion of GP referrals made to rapid response as a total of all medical assessments has been below the Annual Plan trajectory of 10.15% throughout the course of the year, averaging 8%. The expansion of the Community Resource Team (CRT) Rapid Medical Model is now fully embedded and operating as business as usual, and a new Standard Operating Procedure (SOP) was implemented in September to reduce variation and ensure a more equitable service across all CRT Rapid Teams. While GP referrals to Rapid have remained relatively static, there is an increasing trend of referrals from front door and back door services.

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

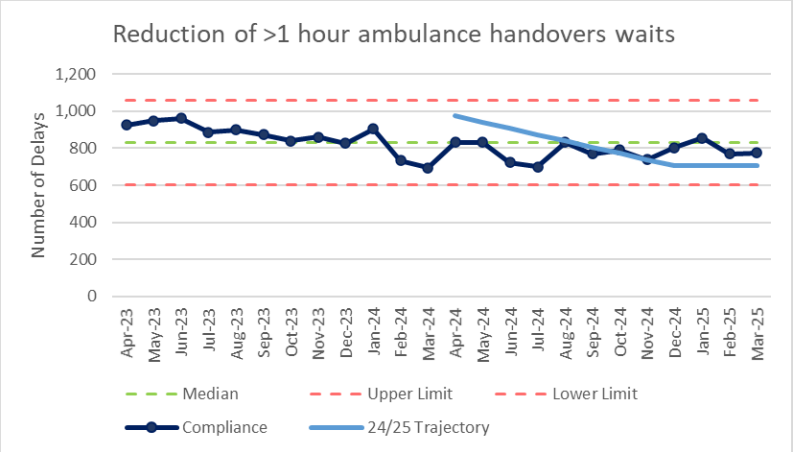
3 Cabinet Secretary Measures: 1 meeting trajectory/1 borderline/1 not meeting trajectory

11 Annual Plan Measures: 5 meeting trajectory/6 not meeting trajectory

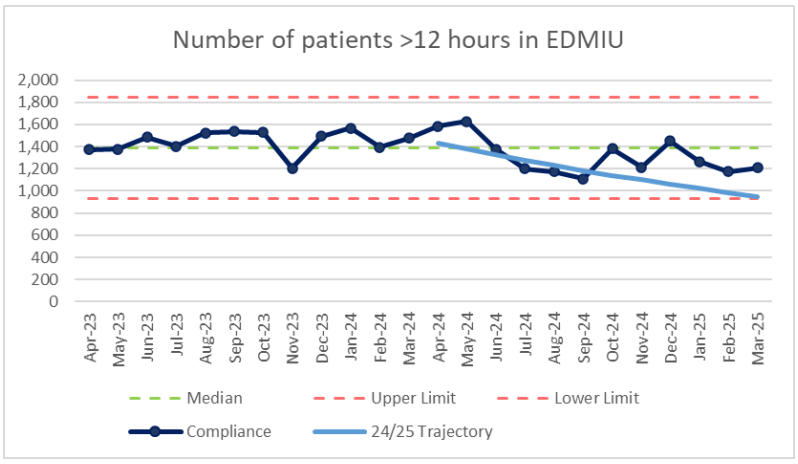


The Health Board has delivered significant progress against the Cabinet Secretary's Priority of the reducing the number of Pathway of Care Delays (POCDs). Sustained improvement in POCDs was observed through the second half of the year, culminating in a year-end position of 171 from a year-high position of 262 in September. Additionally, there was a significant reduction in the total number of days delayed, from a high of 10,531 to 6,912 at year end. This success enabled the Health Board to also meet its ministerial targets as outlined by the Care Action Committee (CAC). Central to this success has been the actions undertaken as part of the 50 day challenge. Initiated in November, this focused

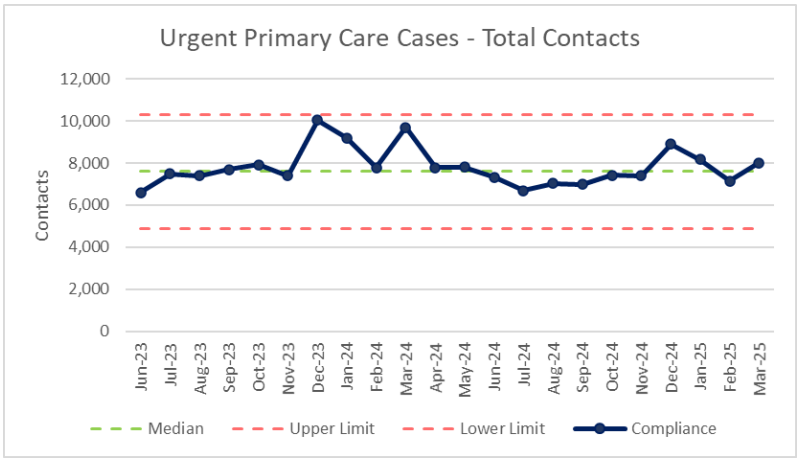
on enabling discharge and reducing POCD, in collaboration with Local Authority partners. The actions taken during this period have laid a strong foundation for continued improvements beyond the challenge timeframe. Hospital 2 Home has been further supported through the 50-day challenge, and saw a significant increase in number of patients supported through this pathway in January and continued elevated levels through the rest of Q4 and meeting its Annual Plan trajectory.



Across the measures within Urgent & Emergency Care (UEC), there has been expected seasonal variation which has impacted performance and reflects pressures faced by the health system particularly through the Winter period. Several key performance measures for Urgent Care peaked in January, as the system was subjected to the peak of Winter pressures, however they have since trended downwards from this point through the final two months of the year. End of year targets for the two key Cabinet Secretary Measures of >1hr Ambulance handovers and >12hr EDMIU attendances were not achieved, although 1hr Ambulances was borderline having reduced from a year high of 855 to 774 at year end. There are continued Improvement Plans in place through 2025/26 with performance ambitions linked to WG de-escalation criteria. Despite the challenges across several Annual Plan metrics relating to Ambulance handovers and patients waits in the Emergency Department (ED), >4hr performance across our EDMIUs was consistently at or slightly above the Annual Plan target of 75%.



A new General Internal Medicine Model was implemented at GUH in November, linked to a new Model of Care for General Medicine patients led by the Respiratory Team. This initiative aims to enhance patient care and streamline service delivery. The 'SDEC First' pilot has been initiated at GUH for the Acute Medical Unit (AMU) to help manage demand. . A Clinical Prioritisation Framework protocol has been drafted, led by the Medical Director. This framework will guide prioritisation decisions, ensuring that patients receive timely and appropriate care based on clinical need. Weekly enhanced monitoring meetings continue to oversee and support improvements across our services. These meetings are crucial for maintaining high standards of care and operational efficiency.

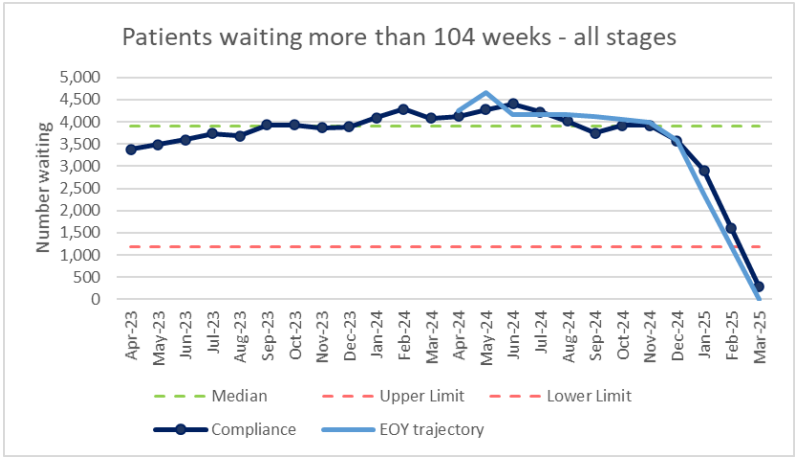


Demand for Urgent Primary Care (UPC) has been high throughout the course of the year, with contacts in excess of 200% of the forecast in the annual plan. UPC have also provided additional support for practices in escalation. With regards to performance against the three measures relating to Stroke, performance figures are reported through SSNAP. As of Q3, the Health Board is meeting its Annual Plan trajectories in two standards (% of unique Stroke patients given Thrombectomy, and % Stroke Patients Assessed by one of OT, PT, SALT within 24 hours). A Stroke Improvement Plan is in place bringing together the 53 recommendations from GIRFT, HIW and the Welsh Government, the workstreams include: imaging, staffing, rehab, prevention, patient flow, governance, education and training, community, acute stay, data capture and audit compliance. The Health Board also approved the complete ring-fencing of the Stroke Pathway (Hyper Acute Stroke Unit & Rehab) to improve the pathway and also to support changes in Prince Charles Hospital.

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

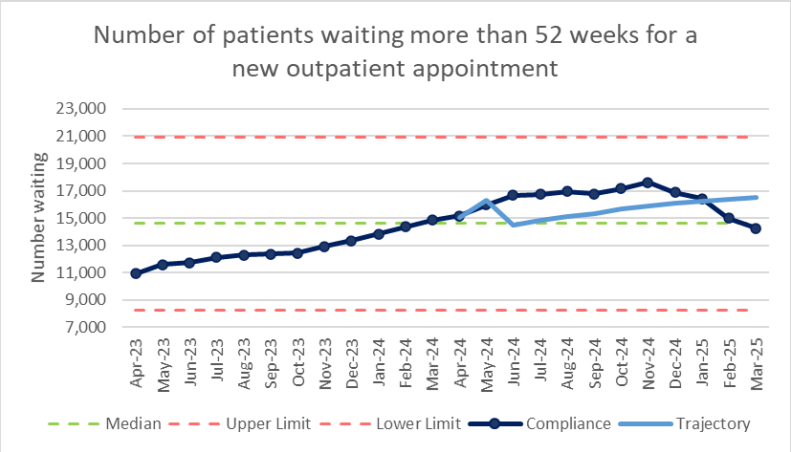
4 Cabinet Secretary Measures: 1 meeting trajectory/3 borderline

7 Annual Plan Measures: 3 meeting trajectory/4 not meeting trajectory



2024/25 saw the Health Board make significant progress with key priorities across Planned Care, Diagnostics and Cancer performance. This year, the Health Board made significant strides with the Cabinet Secretary Priority of reducing the number of patients waiting more than 104 weeks for referral to treatment (RTT), delivering substantial progress through strategic initiatives and targeted funding. At the end of Q1, the Health Board had 4,408 patients waiting over 104 weeks for RTT, marking the highest point in the year. This situation highlighted the urgent need for intervention and improvement. The number of patients waiting began to decrease over the next two quarters, reflecting the Health Board's efforts to address the backlog and improve patient access to treatment. The Health Board received targeted funding from the Welsh Government across three key specialties: Ear, Nose & Throat (ENT), Ophthalmology, and Trauma & Orthopaedics. This funding was crucial in supporting ambitious plans to reduce waiting

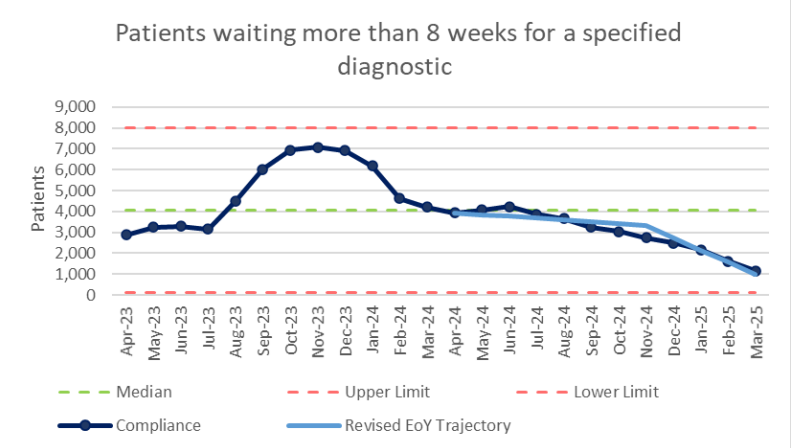
times and deliver a position as close to zero as possible by the end of the year. At year end the Health Board successfully reduced the number of patients waiting over 104 weeks to 288. This represents excellent progress and a significant achievement. Notably, the specialties of Ophthalmology-Cataracts and ENT achieved zero patients waiting over 104 weeks, demonstrating particular success in these areas.



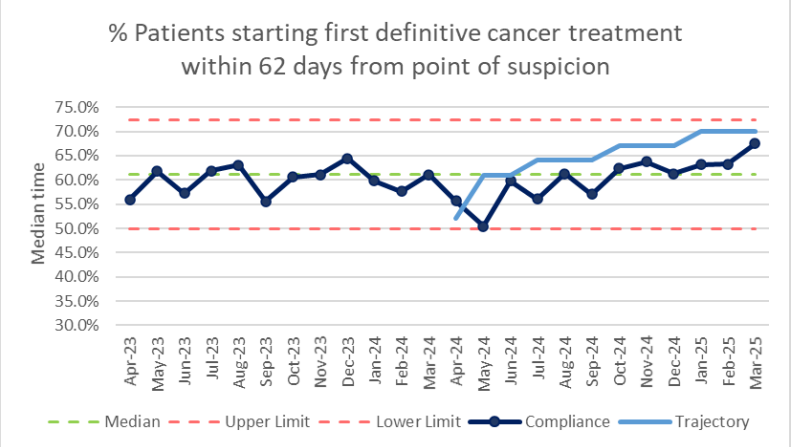
For the Cabinet Secretary Priority Measure of the number of patients waiting more than 52 weeks for a new Outpatient appointment, the Health Board delivered a lower closing position of 14,625 when compared to that at the beginning of 2024/25 (15,160) and delivering ahead of a trajectory of 16,500. Significant gains were delivered through the second part of the year, reducing the position by almost 3,000.

The Health Board also eliminated waits of over 156 weeks, having started the year with 52 patients breaching this measure to recording zero in the final two months of the year.

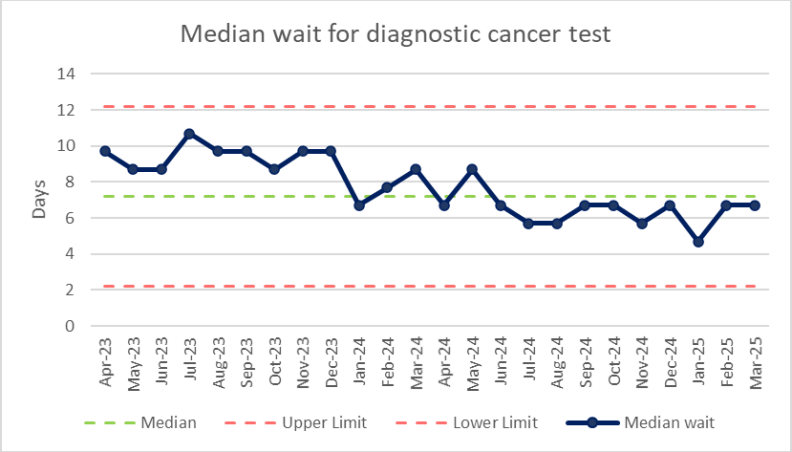
In respect of the number of patients waiting more than 8 weeks for a specified diagnostic, the Health Board was in receipt of Government funding across Endoscopy and Neurophysiology to deliver an improved year end position. With a target of 987, the final figure of 1,155 represented significant progress particularly when taken in the context of the previous two years and a Q1 2024/25 position of 4,221.



There has been a step forward with Cancer performance through 2024/25. For the Cabinet Secretary Priority of Single Cancer Pathway (SCP) compliance, which measures the percentage of people starting their first definitive treatment within 62 days from point of suspicion, the Health Board's performance through the first half of the year was subject to monthly fluctuations and behind trajectory. In the second half of the year performance was more stable,



and a further step forward was taken in March to deliver a year end position of 67.5%. Whilst this is marginally behind a trajectory of 70%, it is the highest monthly performance over the past 2 years and consolidates an improvement trend delivered over the course of the year, having been as low as 50.4% in May '24.

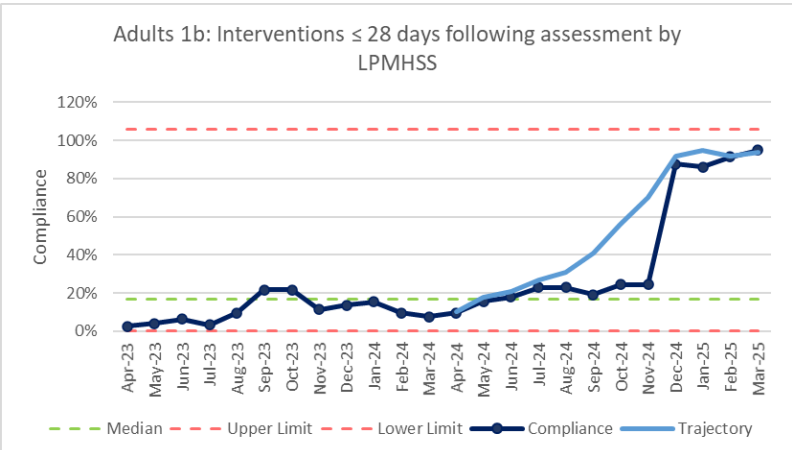


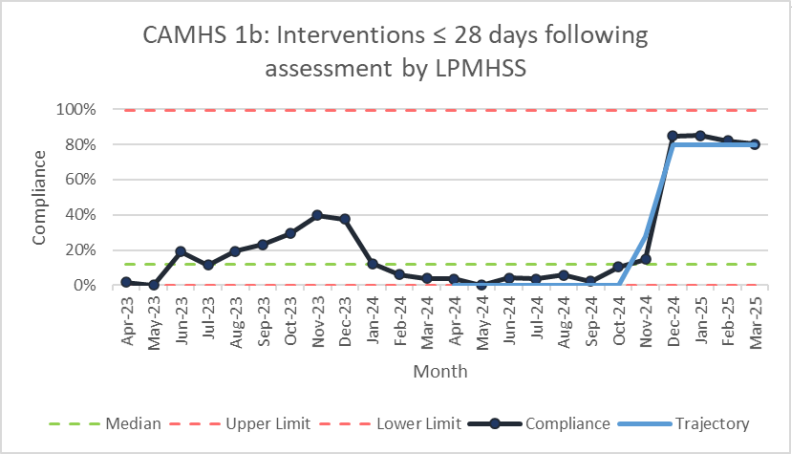
The 62 and 104 day backlogs for SCP have also seen substantial reductions over the year and, whilst slightly higher than annual plan trajectories, have stabilised over the past quarter and are in line with expected levels when taken in the context of the SCP census. Tumour Site Specific Task and Finish groups have been instrumental in delivering improvements in Cancer performance, as has Divisional scrutiny to improve compliance and maintain attentive focus of management of patients going through the pathway.

Improving our Mental health services

2 Cabinet Secretary Measures: 2 meeting trajectory

7 Annual Plan Measures: 6 meeting trajectory/1 not meeting trajectory





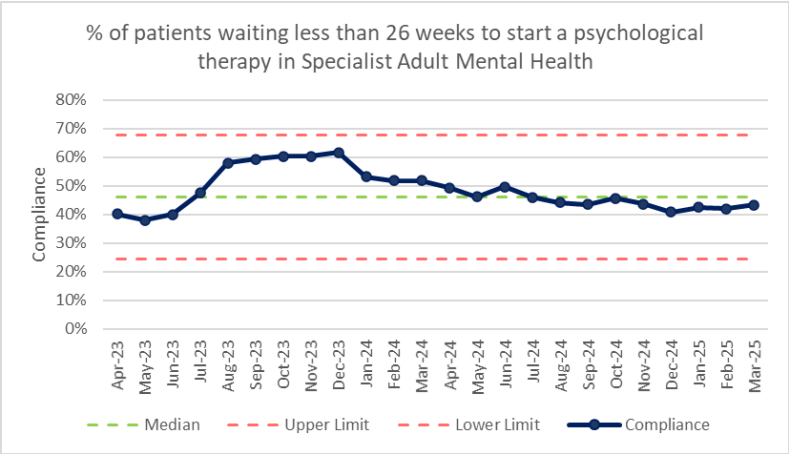
The Health Board has been successful in delivering significant improvements across several measures through the course of 2024/25. For the two Cabinet Secretary Priorities for Part 1B across Child and Adolescent Mental Health Services (CAMHS) and Adults, which measures the percentage of Therapeutic interventions started within 28 days following an assessment by Local Primary Mental Health Services (LPMHSS) for people aged under 18 years, and then adults above 18 years, the Health Board had submitted ambitious improvement trajectories within the Annual Plan for both measures. Following significant focussed efforts from the respective Divisions, this

improvement was realised at the end of Q3 and sustained throughout the remainder of the year with both measures meeting the national standard of 80%. CAMHS performance closed the year at 80.3%, with Adults recording a closing position of 95%. The Adult waiting list has also seen substantial reduction through the course of 2024/25, from a high of 2,760 in July to 215 as of the end of the year. The CAHMS waiting list is also greatly reduced, from 584 in April 2024 to a year end position of 74.

For the Annual Plan Measure for Part 1A within Adults, which was to increase in to national target for Adult MH (assessment completed within 28 days), again significant improvement was delivered through the second part of the year with the national standard being met for the final five months of 2024/25 and recording a year end performance of 96%.

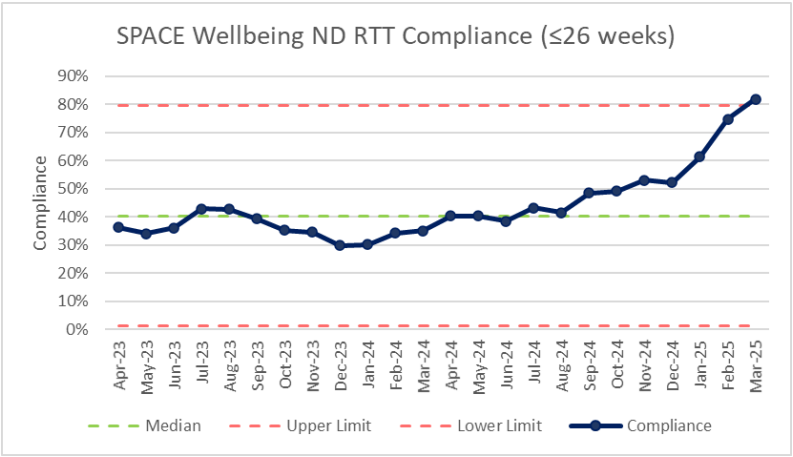
The waiting list also reduced from 1,320 at the beginning of the year, decreasing for six consecutive months from August to February before increasing slightly in March to achieve a year end position of 581. For Part 1A in CAMHS, performance had been excellent through 2024/25, however there was a decrease in March to 77.2%, which ends the year just below the national standard (80%). This is due to issues with the clinical system and therefore the ability to accurately capture pathway data. To mitigate, there is a forensic approach to waiting list management and to develop a Recovery Plan. The waiting list reduced through the first half of the year before increasing again, however the closing position of 224 is still lower than the opening one (250). Robotic Process Automation (RPA) was implemented in 2024/25 to help support the management of referrals and has resulted in taking ~3 days off the referral process between GPs and the PCMH team, which has been an enabler in improving performance across Part 1A.

For the Annual Plan Measure for Part 2 within Adults, which was to maintain rates for the number of individuals with a valid care and treatment plan (CTP), performance had been strong throughout the year however there was a significant decrease in December to 68.4%, due to issues with the recording of data on clinical systems. There is an action plan in place to ensure compliance returns, and compliance has increased slightly over the final part of the year to close on a position of 71% which is ahead of the Annual Plan trajectory (68.3%). For CAMHS Part 2, performance increased in the second part of the year and was maintained at or very close to 100% for 6 consecutive months, closing the year at 98.2% and above the national standard.



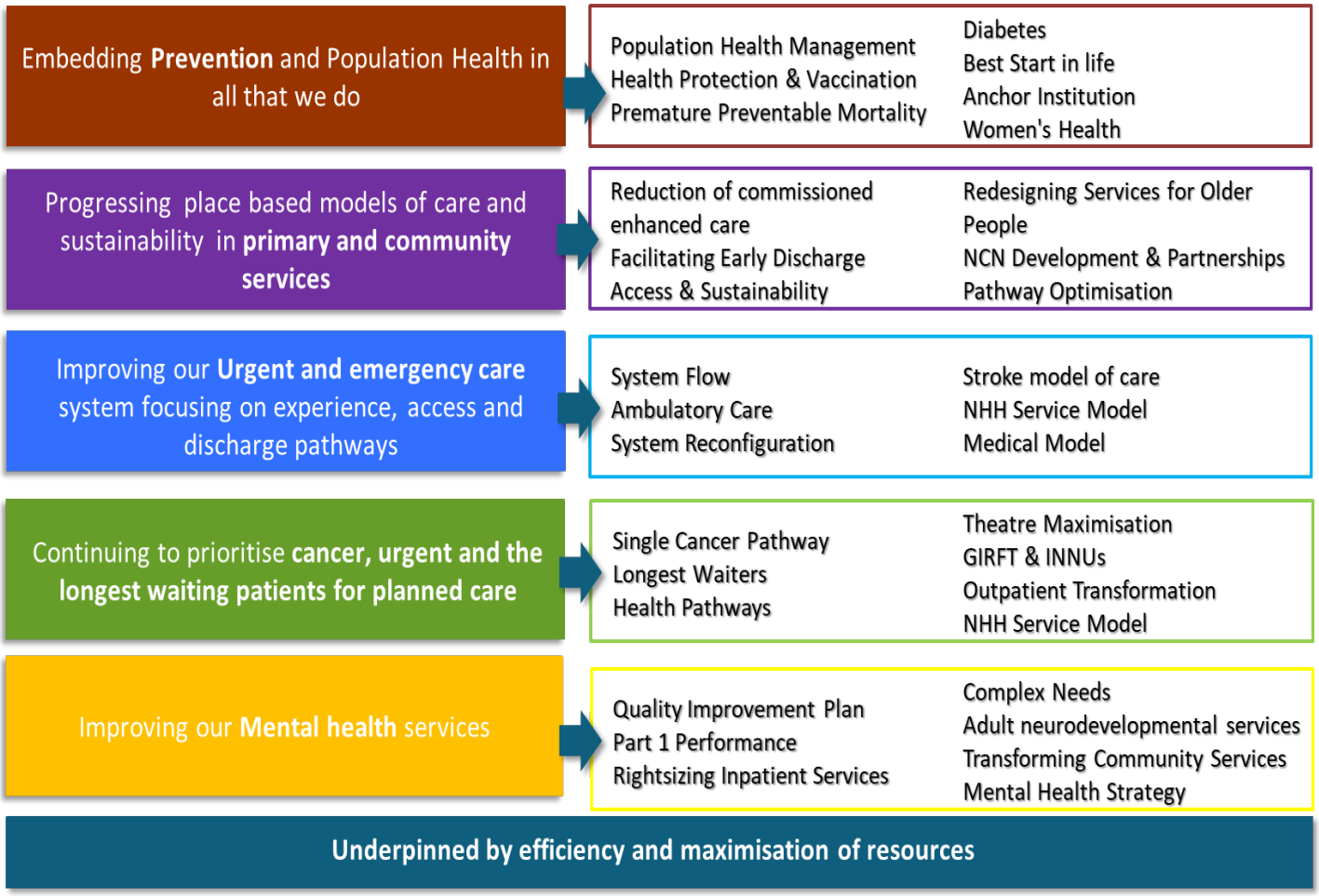
Performance for the percentage of patients waiting less than 26 weeks to start a Psychological Therapy in Specialist Adult Mental Health has been challenged through the course of the year, having trended slightly downwards from an opening position of 49.3% to a closing one of 43.2%. This is below the Annual Plan trajectory of 70%. The number of patients waiting also remains relatively flat at ~1,200, although the longest waiters have reduced slightly. This measure is an area of focus for 2025/26 following the delivery of improvements for Part 1, with a plan in place for 2025/26 to focus on data validation and pathway improvements.

Neurodevelopmental (ND) assessments for those aged 0-18 years are another improvement area for the Health Board. The Annual Plan Measure is compliance for the percentage of people assessed within 26 weeks, and our submitted trajectory was to achieve 57% compliance. Following some additional funding, the Service were able to utilise this to improve performance by having a dedicated ND Clinician to support through Q4, and holding additional clinics held at evenings and weekends. This delivered significant improvements over the final part of the year, with the closing position reaching 81.9% and meeting the national standard. The longest waits have also now reduced to under 52 weeks.



5. Annual Plan 2024/25 – Deliver of System Change

This chapter of the report updates on delivery against the five system change themes and the key priorities outlined in our Annual Plan 2024/25.



Embedding **Prevention** and Population Health in all that we do

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

Under the system change theme of embedding prevention and population health in all that we do there were 7 key areas we committed to delivery against in our Annual Plan for 2024/25.

1. Population Health Management,
2. Health Protection & Vaccination,
3. Premature Preventable Mortality, Cardiovascular & Cancer,
4. Diabetes,
5. Best Start in Life,
6. Anchor Institution,

7. Women's Health,

We made the following key achievements against these areas;

Priority	Achievements
Population Health Management	A pilot GP practice has been identified in Monmouthshire to further progress this work throughout 2025/26.
Health Protection & Vaccination	Work continues to address vaccine inequity through our Vaccine Inequity Strategy with actions being developed based on NHS Executive Feedback.
Premature Preventable Mortality	Hypertension Programme was designed and began implementation through GP Practices focusing on case finding patients.
Diabetes	The Diabetes Prevention Model now running in 6 areas across three Neighbourhood Care Networks with 2 in Blaenau Gwent, 3 in Caerphilly and 1 in Newport.
Best Start in Life	Good progress has been made bringing a breadth of detailed information together to produce the Best Start in Life Joint Strategic Needs Assessment in Partnership.
Anchor Institution	Anchor institutions has been a fundamental part of our organisational strategy development articulating our joint commitments across Gwent.
Women's Health	A successful Women's Health Conference was held with dedicated sessions and feedback on how to develop our Women's Health Plan with targeted action in 2025/26.

Looking forward to 2025/26 we have set out the below as areas of focus for embedding prevention and population health in all that we do;

- **Resilient Communities & Health Protection:** Deliver the National Immunisation framework for Communities and accelerate action to embed community interventions that tackle the wider determinants of health recognising the local need and deprivation.

- **Best Start in Life:** Using the evidence developed in the Joint Strategic Needs Assessment to produce the Early Years Delivery plan with partnership commitment to deliver the actions.

- **Women's Health:** Working in partnership and understanding the gap in provision for Women implement the first Women's Health Hub in Gwent.

- **Preventable Premature Mortality:** Support our population to prevent premature mortality through targeted implementation of the Diabetes Prevention Programme and Hypertension Programme.

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

Over the last few decades, we have seen significant, disproportionate, growth in Hospital-Based Services compared with Prevention, Primary Care and Community Services. It is important, now more than ever, to deliberately redirect resources towards helping people in Gwent maintain good health and well-being, so they can lead fulfilled and healthier lives for longer.

Under the system change theme of progressing Place Based Models of Care and sustainability in Primary and Community Services, there were 7 key areas we outlined we would deliver against in our annual plan for 2024/25;

1. Reduction of commissioned Enhanced Care,
2. Access & Sustainability for General Medical Services,
3. Access & Sustainability for General Dental Services,
4. Maximise Community Pharmacies,
5. Maximise Community Optometry,
6. NCN Development & Partnerships including ACD Programme,
7. Pathway Optimisation.

Priority	Achievements
Reduction of commissioned enhanced care	Review of high-cost placements has been undertaken and publication is expected in July. The Teams continue to support patients that have potentially prevented a re-admission to an Acute Hospital by managing their complex needs at home.
Access & Sustainability for General Medical Services	100% of our GP Practices achieving core access standards in December 2024. Continued monitoring processes in place and support continues with practices to ensure appropriate contract monitoring and achievement of the contractual requirements. 3 practices moved to Health Board management: Aberbeeg, Brynmawr and Blaenavon on 1 March 2025
Access & Sustainability for General Dental Services	Exceeded national target for percentage of contract value fulfilled with 62% already delivered at the halfway point of the year. The enabling work to deliver Dental Services, as part of the 19 Hills Health and Wellbeing Centre development is ongoing. The Dental Practice will move into 19 Hills in June 2025.
Maximise Community Pharmacies	All Community Pharmacies are now signed up to the Common Ailments Scheme (CAS). CAS claims in the final quarter of the year were the highest of the year at almost 20,000. 55 Pharmacies have now been commissioned to undertake Independent Prescribing by the end of March 2025, which has increased from 39 in April 2024.
Maximise Community Optometry	All 5 providers of Ophthalmic Diagnosis and Treatment Centre provisions transitioned to national standards and provision in line with the National Glaucoma Pathway.

NCN Development & Partnerships incl ACD Programme	We have continued to deliver the Accelerated Cluster Development Programme building maturity in our Integrated Service Partnership Boards (ISPB). Local priorities are in place within each ISPB and during 2025/26 Q1-Q2 they will be developing implementation plans to further progress Place Based Care.
Pathway Optimisation	Clinical Implementation Groups have been established to prioritise pathway development and redesign activities.

Looking forward to 2025/26, we have set out the below as areas of focus for progressing Place Based Models of Care and sustainability in Primary and Community Services;

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

- **Access & Sustainability:** Ensure sustainable GP Services across Gwent and implement of new pathways for Primary Care Optometry Services. In addition, increase the number of Pharmacies providing Pharmacist Independent Prescriber Service and services through Common Ailments Service**.**

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

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

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

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

A strategic, coordinated approach is essential to manage growing demand and ensure the hospital system can deliver timely, high-quality care. By focusing on improving Ambulance handovers, reducing prolonged stays, and addressing care delays, the system can continue to make meaningful progress in enhancing patient outcomes and operational efficiency.

Under the system change theme of improving our Urgent and Emergency Care System focusing on experience, access and discharge pathways, there were 7 key areas we would deliver against in our annual plan for 2024/25;

1. System Flow,
2. System Reconfiguration,
3. Enhanced Monitoring,
4. Redesigning Services for Older People (Goal 1),
5. Urgent and Acute Transformation,
6. (Goals 2,3 &4),
7. Nevill Hall Hospital (NHH) Service Model.

Priority	Achievements
System Flow	Partnership continues through our collaborative with Welsh Ambulance Services Trust to embed alternative pathways. Progress has been made in reduction in handover delays, however further work required for long waits seen over Winter.
System Reconfiguration	System reconfiguration completed to consolidate changes on our St Woolos Hospital site and deliver the Respiratory Model changes for Service sustainability.
Enhanced Monitoring	Robust assurance in place thoroughly a monthly scorecard and Executive Lead Whole System Safety Flow Meetings in place on a weekly basis to address continued pressures in supporting timely Ambulance handovers.
Redesigning Services for Older People (Goal 1)	Successfully extended hours of our Community Resource Teams supporting care closer to home now fully operational. Implemented the first phase of our Acute Frailty Response Team.
Urgent and Acute Transformation (Goals 2,3 &4)	Same Day Emergency Care (SDEC) has continued to grow and at Grange University Hospital and now routinely sees over 230 patients and within Ysbyty Ystrad Fawr SDEC sees more than 70 patients per week.

Facilitating Early Discharge (Goals 5&6)	50-day challenge actions commenced in November with strong focus on enabling discharge and reducing Pathway of Care Delays working in partnership with Local Authorities. Work and actions will continue beyond the challenge period. Hospital 2 Home saw a significant increase in number of patients supported through this pathway in January and continued elevated levels through the rest of Q4.
NHH Service Model	Work continues on the clinical service models with table top exercises undertaken with Clinicians and Stakeholders to inform future Medical Service Model across all sites.

Looking forward to 25/26 we have set out the below as areas of focus for improving our Urgent and Emergency Care System focusing on experience, access and discharge pathways;

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

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

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

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

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

Planned Care and Cancer Services represent not just operational priorities, but fundamental components of a responsive and resilient healthcare system. By focusing on reducing waiting times, streamlining pathways, and enhancing patient outcomes, we can continue to adapt to rising demand while upholding our commitment to delivering equitable and effective care.

Under the system change theme of continuing to prioritise Cancer, Urgent and the longest waiting patients for Planned Care, there were 7 key areas we outlined we would deliver against in our annual plan for 2024/25;

1. Single Cancer Pathway,
2. Longest Waiting Patients,
3. Health Pathways,
4. Theatre Maximisation,

5. Getting it Right First Time (GIRFT) & Interventions Not Normally Undertaken (INNUs),
6. Outpatient Transformation,
7. Diagnostics 8 Week Wait.

Priority	Achievements
Single Cancer Pathway	Our year-end position for Single Cancer Pathway of 67.5% is the highest over the past 2 years. Tumour Site Specific Task and Finish groups have been instrumental in delivering improvement in the backlog position, as has Divisional scrutiny to improve compliance and maintain attentive focus of management of patients going through the pathway.
Longest waiting patients	One of the few Health Boards in Wales to eliminate patients waiting over 156 weeks for treatment. We finished the year with 288 waiting for 104 weeks. Whilst not quite achieving the ambition of zero, huge progress has still been made when considering that the breach numbers were in excess of 4,000 in March 2024.
Health Pathways	Continued high utilisation of Health Pathways Platform: 2,936 page views in March 2025 and 103 localised pathways live at end of Q4.
Theatre Maximisation	Sustained improvement in scheduling Key Performance Indicators since baseline in April. Reviewed opportunities for increased day case activity to inform short-term opportunities and longer-term Theatre Service Model as part of Nevill Hall Hospital developments.
Getting it Right First Time (GIRFT) & Interventions not normally undertaken (INNUs)	Ongoing monitoring of INNUs with quarterly reviews to identify further opportunities in line with evidence-based interventions project work. Implemented Ophthalmology GIRFT recommendations by increasing volume through Optometry Pathways, including Diabetic Eye Screening.
Outpatient Transformation	Continue to demonstrate opportunities for efficiency through 52 week validation process and further roll out of digital solutions such as Consultant Connect.
Diagnostics 8 Week Wait	Radiology performance is currently at >95% being seen in <8 weeks and with the support of additional Welsh Government funding significantly reduced our Endoscopy waiting times.

Looking forward to 2025/26 we have set out the below as areas of focus for continuing to prioritise Cancer, Urgent and the longest waiting patients for Planned Care;

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

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

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

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

Improving our **Mental Health S**ervices

Demand for Mental Health Services is sharply increasing and we need to find ways of supporting people earlier within the community to better support crisis prevention and recovery. The vision is to provide high quality, compassionate, person-centred Mental Health and Learning Disabilities Services, striving for excellent outcomes for the people for Gwent. There are a number of national strategic drivers including the Strategic Programme for Mental Health and National Programme for Suicide and Self harm Prevention.

Under the system change theme of improving our Mental Health Services there were 7 key areas we outlined we would deliver against in our annual plan for 2024/25;

1. Quality Improvement Plan,
2. Recovering Part1 Mental Health Performance,
3. Rightsizing Inpatient Services,
4. Complex Needs,
5. Neurodevelopmental Services,
6. Transforming Community Services,
7. Mental Health Strategy.

Priority	Achievements
Quality Improvement Plan	Continued focus on quality improvement through the Embedded Programme management arrangements.
Recovering Part1 MH Performance	For Adults, assessment completed within 28 days the waiting list has reduced from 1,320 at the beginning of the year, reducing for six consecutive months from August to February before increasing in March to achieve a year end position of 581. For Children and Young People, waiting list for interventions completed within 28 days has also seen significant reduction through the course of the year to date, from 584 in April to a year end position of 74.
Rightsizing Inpatient Services	Service Models defined for Older Adults and Learning Disabilities and will be presented to Strategic Change Board in April and Adults working on developing their models following a number of rapid reviews.
Complex Needs	The Commissioning Team has reviewed the findings from the National Clinical Commissioning Unit and implementing recommendations within the Team.

Neurodevelopmental services	We are implementing an Integrated Referral Front Door designed to improve the initial patient and stakeholder experience. This streamlined referral process is a key component of the Model and will form the basis for a more equitable and efficient Diagnostic Pathway across all Adult Neurodevelopmental services. The organisation has achieved successful recovery of the under 18's 80% target and maintained this performance.
Transforming Community Services	Work has progressed for Adults and Older Adults building their Demand and Capacity Models taking learning from an NHS England approach to inform future Service direction.
Mental Health Strategy	Engagement with stakeholders is underway to support the development of a new mental health strategy which will also be informed by the new national strategy. .

Looking forward to 2025/26 we have set out the below as areas of focus for improving our Mental Health Services;

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

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

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

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

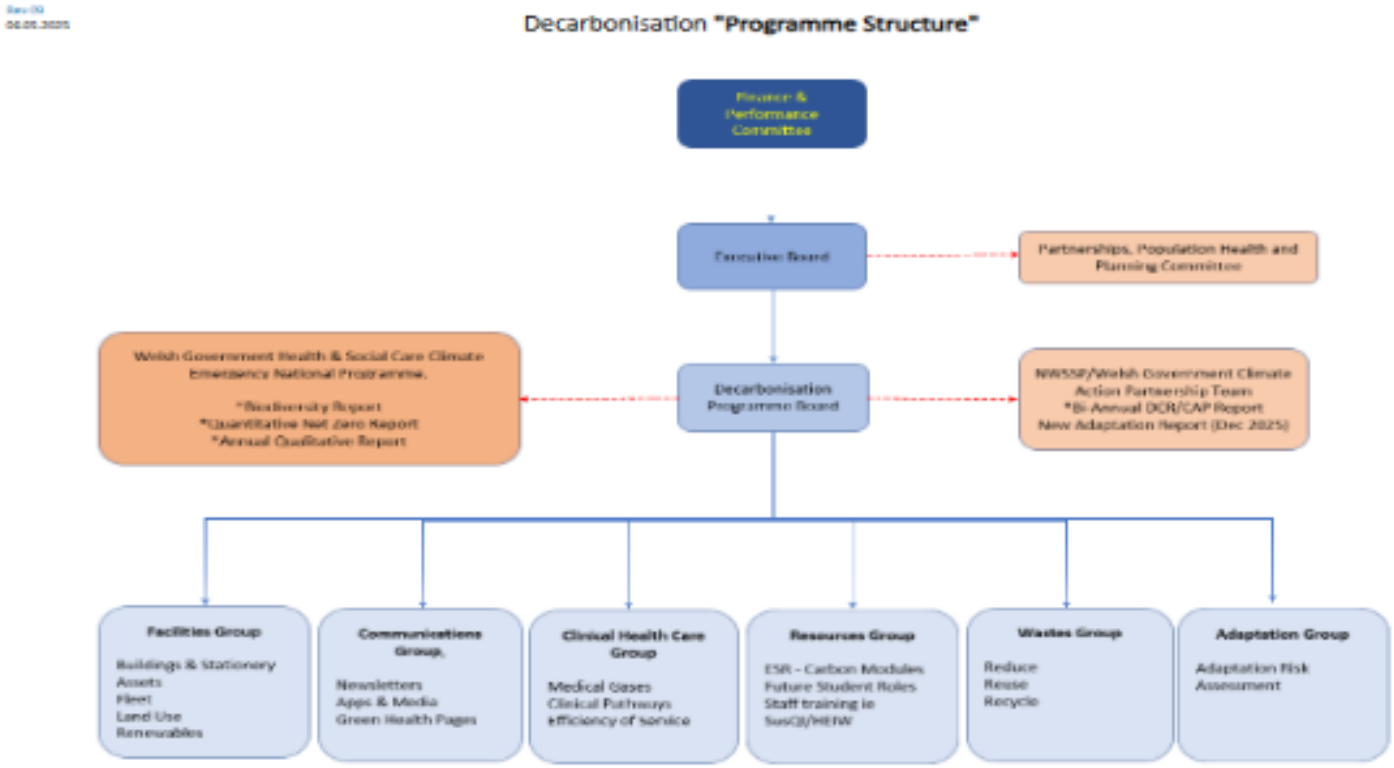
6. Sustainability and Carbon Reduction Plans



The Health Board continues to align its activities to complement and make progress towards the objectives and targets set out in the NHS Wales Decarbonisation Strategic Delivery Plan, published by Welsh Government in 2021. The Plan responds to the declaration of the climate emergency in 2019 and the ambition of Welsh Ministers for the Welsh public sector to be net zero by 2030.

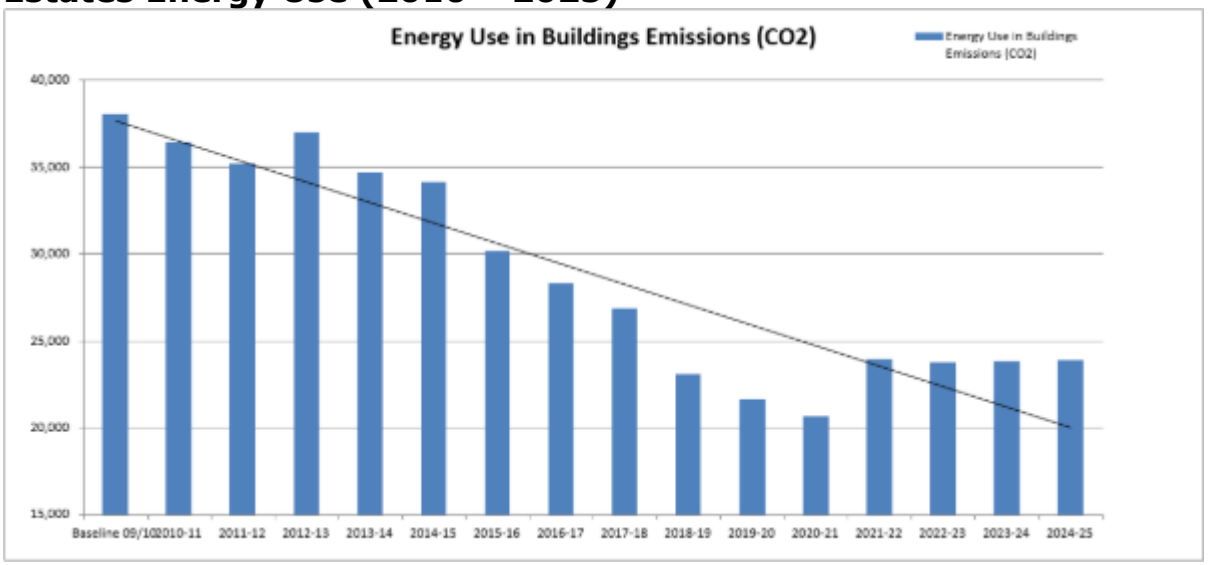
The Health Board has a well-established Decarbonisation Programme Board, which was established in 2022 with aim to develop future schemes that would help to reduce the organisations Carbon footprint over the next decade. The Board is chaired by the Executive Director for Finance and Procurement. Four working groups are now well established with a further introduction of working group 5 (Waste) each working group having a suite of the national initiatives assigned to them to take forward and develop associated projects. Through 2024/25, we have been proactively supporting the reporting to NWSSP/WG on the metrics/ DCR reporting submissions on the performance of the Decarbonisation Programme.

Governance & Reporting Structure



Estates, Land Use & Fleet

Estates Energy Use (2010 – 2025)



The 2024/25 annual energy performance compared to the previous year was a 0.4% reduction in electricity consumption. Gas consumption saw a marginal increase of 0.6%. Year on year water consumption reduced by 10.3%, as we were able to minimise leakage events throughout the year.

The Estates and Facilities Division have made considerable progress with its ReFit Energy Performance Contract development during 2024/25. This long-term partnership with Vital Energi has the potential to deliver significant investment in low-carbon and renewable energy projects across the main hospital sites and community premises in the coming years and through several phases of work. During the year the Project Team have worked hard to finalise the High-Level Appraisal Report and then the development of the subsequent Investment Grade Proposal, which is currently undergoing its finalisation.

Phase 1 of ReFit (over a 2-yr Period) is focussing on Royal Gwent, St Woolos Casnewydd Unit, Serennu Children's Centre, Nevill Hall, Chepstow Community Hospital and Grange University Hospital and will look to implement traditional energy efficiency measures such as LED lighting, pipework insulation, ventilation upgrades and improvements to Building Management Systems. There are also plans for significant solar PV generation at RGH, GUH, St Woolos Casnewydd, Serennu Children's Centre and Chepstow Community Hospital. Collectively, these projects are anticipated to save 817 tonnes of CO2 annually.

During Q4 of the year, bids were submitted to Welsh Government for Targeted Estates Funding (TEF). The Health Board was successful in obtaining £6.6m funding over 2 years for decarbonisation initiatives that include window replacements at Nevill Hall, as well as insulation and heat pump installation at some of the staff residences buildings at Nevill Hall, delivering an annual carbon saving of 168 tonnes.

Communications

The Communications Team have been supporting the Decarbonisation Agenda with newsletters, posters, advertisements on the web, video's and apps. Training opportunities and more recently the inclusion of the Green Champions within the Health Board. As part of a new initiative the Decarbonisation Board Members and the Communication Team will be looking to develop a Quarterly Post Board Review/Newsletter, which will provide a summary of the previous Quarter results and a view of what to expect in the next quarter.

Health Care Services

The **Clinical and Health Service Planning Team** within the Decarbonisation Programme has grown into a vibrant, collaborative network of sub-groups driving real change across Services. From promoting use of the Green Theatre checklist in Operating Theatres and exploring options to switch to digital consent in Endoscopy, to reducing waste in Supply Chains such as maternity packs and influencing prescribing habits in Respiratory Care, their work is making a measurable difference. The Team's commitment to shared learning and spreading innovation has seen their projects adopted widely across the Health Board and beyond.

The Health Board proactively reduced the carbon emissions due to waste of Nitrous Oxide gas by decommissioning piped manifold supply in all eLGH sites and switching to a local cylinder supply where needed. An audit is underway to understand the N2O usage in the Grange University Hospital and whether the manifold can be downsized.

The Annual Purchase Data from BOC Ltd reported a significant reduction in the Health Board's use of Nitrous Oxide.

As a result of the decommissioning of the manifolds and the change to cylinder use the health board has seen a reduction of more than 1.6 million litres of Nitrous Oxide being used, over the last two years.

The plan for the next year is to increase awareness of appropriate glove use and conduct glove audits to understand how staff are using the gloves and provide education, if used inappropriately.

Under the Clinical and Healthcare Planning group, there are five priorities for 2025-26:

1. Reduction in the waste of Medical Gases,
2. Reduction in the unnecessary use of Non-Sterile Gloves,
3. Increase numbers of Green Wards and Champions,
4. Reduction in waste in Sterile Packs,
5. Reduction in unnecessary Blood tests.

Resources Group

The Resources Group comprises of 3 elements of which the first is the introduction of a dashboard for measuring the carbon reduction on all aspects of the Decarbonisation Programme. The WG have announced that this will be possible from the information that has been produced through the previous DCR reporting to NWSSP. This will be available to all organisations from Mid-May and can form part of the Board reporting aspects of the highlight reports in the Resources Section of the Plan.

The second element is the digital space, which is moving at pace with around 40+ robotic interventions developed using the latest robotic interfaces in the Health Board. This is a different aspect to AI, as it does not provide the machine learning capability, but allows the individual systems to speak to each other hence saving manual administration activities.

The third element is the training aspects of everything we do to develop our staff across the Health Board, which during 2024/25 we have trained staff in SusQi with our ABCi support along with HEIW Carbon Literacy Training, Green Champion Training and this year we will be monitoring the uptake of the ESR Carbon Modules that were introduced recently.

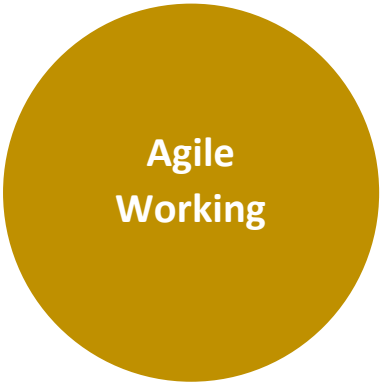
Waste

This group is a new initiative for the Decarbonisation Programme and will start to develop through 2025/26. The Health Board continues to work towards introducing more sustainable and resource efficient methods of processing waste generated from health care activities. The Health Board is working towards a zero-waste to landfill approach (this figure is not currently available), in collaboration with external Contractors. The vast majority of non-recyclable general waste now goes to energy-from-waste plants to generate sustainable electricity.

Inclusion of Adaptation January to December 2025.

The UK Climate Change Act 2008 provides a legal framework to cut UK greenhouse gas emissions and build the UK's ability to adapt to a changing climate. Responsibility for climate change adaptation is devolved, meaning national governments in Northern Ireland, Wales and Scotland are responsible for developing their own respective adaptation Programmes and Plans. The Decarbonisation Members are actively involved in supporting the new Adaptation Tool Kit, which started in January 2025 with a target date for submission by December 2025. This will be added to the Dashboard, which will be used to monitor our delivery from June 2025, the adaptation delivery is now a strategic part of our future reporting format to NWSSP/WG.

7. Agile Working



We understand the importance of agile and flexible working to staff wellbeing through giving greater autonomy of work and improving work life balance. During 2024/25, we continued to strengthen our Agile Working Strategy, building on areas of good practice underpinned by a set of principles. The Strategy has been delivered through a workplan aligned to the Estate Strategy and Digital Strategy and a Dashboard with measurable benefits of Agile/Hybrid working.

We have tested our Strategy this year through the delivery of a significant milestone in our Estate Strategy, the opening of Ty Gwent. The principles of working at Ty Gwent and the design of accommodation were based on agile working principles. A total of 570 staff were transferred to this new accommodation in late 2024. Whilst this was a new way of working for many staff, it has been well received and benefits delivered through improved team co-locations and staff feeling valued through the investment in improved accommodation. The opening of Ty Gwent released additional benefits because of reducing lease premises and reducing the Estate footprint.

We are in the process of resetting our workplan for 2025/26 building on intelligence gained through the agile working evidence base, benefit measures, collaboration with agile networks and engagement with services. In conjunction with this, we will continue to update supporting frameworks and policies. The emerging priorities and workplan will be aligned with the Estate Strategy and Digital Strategy, which continue to be the key enablers for the delivery of the Agile Strategy.

8. Quality and Safety

In 2024/25, we kept a strong focus on improving the quality and safety of care by putting our *Quality Strategy* and *Patient Experience & Involvement Strategy* into action. This work supports our legal responsibilities under the *Duty of Quality* and *Duty of Candour* - making sure we are always honest, open, and focused on doing what is right for patients. We updated our Implementation Plan to make sure we are on track to meet these key priorities.

Our Performance Report - used by the Patient Quality, Safety, and Outcomes Committee - has grown stronger over the past year. It now gives a clear picture of assurance, what we have learned, and where we can improve. It looks at everything from patient experience to safety, clinical outcomes, and how effectively we deliver care.

The Health Board uses the *Health and Care Quality Standards* to guide how we plan, deliver, and monitor Services. We have also strengthened our *Quality Outcomes Framework*, making sure it reflects the six key areas of quality and the tools that help us deliver it.

Our commitment remains clear: to provide safe, high-quality care that is built around patients, with learning and improvement at its core. This will continue throughout 2025/26.



Putting Quality at the Heart of Your Care

We are working hard to deliver safe, effective, and high-quality care that meets national priorities and tackles local challenges. Our focus is on what matters most - improving patient experience, learning from feedback, and making care better every day.

To do this, we're guided by six key areas, known as our *Pillars of Quality*: Patient and Staff Experience, Incident Reporting, Complaints, Concerns and Compliments, Health, Safety And Security, Infection Prevention and Control and Safeguarding. These pillars help us track our performance, learn from what's working well, and take action where improvements are needed. By strengthening our approach to quality, we aim to make sure every decision we make leads to better, safer care for everyone. Quality and safety are not just goals - they are part of everything we do.

Over the past year, the Health Board has made significant strides in improving patient care through the implementation of innovative feedback platforms, detailed monitoring of patient safety incidents, and a commitment to zero tolerance of preventable healthcare-associated infections. The introduction of CIVICA, an electronic feedback platform, has enhanced the collection and analysis of patient feedback, providing valuable insights into areas of positive performance and areas needing improvement.

The Patient Experience and Involvement Strategy makes a commitment to delivering Person-Centred Care that puts the people at its heart, to deliver a positive patient experience. The launch of the system to capture patient's experience across the Health Board (CIVICA), has provided the opportunity to receive direct patient feedback. Through this Strategy, the Health Board are committed to:

- Respecting people's **values**, preferences and expressed need;
- Improving **information** and education;
- Improving **access** to care;
- Improved provision of **emotional** support to relieve fear and anxiety;
- **Involving** family, friends and people who matter to the individual;
- Providing **continuity** and secure transition between healthcare settings;

- Providing **physical comfort**;
- Delivering **co-ordinated** care.

Goals and Objectives



Working Together for Safer, Better Care

We have continued to work closely with NHS Wales Boards, Trusts, and the NHS Wales Executive through the *Safer Care Partnership*. This national collaboration supports local Teams in delivering safe, reliable, and high-quality care. As part of this, we have refreshed our approach to quality improvement and strengthened our ability to deliver change. Several improvement projects are already underway, with more to come. National work continues around caring for deteriorating patients and using standardised early warning scores to keep people safe. Other focused areas include tackling deconditioning (loss of physical ability due to inactivity) and building a strong *Quality Management System* to guide everything we do. This will form part of our workplan for 2025/26.

Learning and Improving, Together

Over the past year, we have built a strong culture of learning and improvement across the Health Board. The *Patient Quality and Safety Learning and Improvement Forum* has been key to this, creating regular opportunities for teams to come together, share experiences, and drive change across services.

At the heart of this approach is our *Listening and Learning Framework*. This helps us identify and act on learning in a meaningful way—making sure good practice is shared, and improvements are embedded. We have also made great use of our *Learning*

Repository—a central place where knowledge is collected and shared to inspire innovation, shape improvements, and support excellence in care.

Throughout the next year, we will ensure these efforts are helping us to learn from experience, support staff, and deliver better outcomes for patients.

Driving Quality Through Action: What We've Achieved

We are proud of the strides we have made this year in improving care, improving people's experience, building staff skills, and creating a safer, more effective health system for all and will build on these in the next 12 months.

Quality Improvement – Building Skills, Changing Culture

We launched our Quality Improvement Capability approach, setting out a clear vision to become a truly learning organisation. Our first group of 31 Quality Improvement Coaches completed their training and are now helping us work towards an ambitious goal - a million minutes of coaching over the next four years. From better training to smarter tools, quality improvement is now firmly part of everyday practice across the Health Board.

Deteriorating Patients and Sepsis – Acting Fast, Saving Lives

In November 2024, we held a major workshop on Caring for Deteriorating Patients. This work supports national safety priorities, including the implementation of standardised Early Warning Scores, these help to identify acute deterioration, to suggest a point at which care needs to be escalated and to define a response to escalation triggers. This will involve implementing a standardised, national approach using evidence-based tools to ensure clarity, minimise risk and support improved patient outcomes. The use of All Wales Early Warning Scores such as National Early Warning Score 2 (NEWS2), Paediatric Early Warning Score (PEWS), Maternity Early Warning Scores (MEWS) and the Newborn Early Warning Track and Trigger 2 will help the workforce spot signs and serious illness earlier.

We are developing new Sepsis Monitoring Tools and staff education to boost early recognition and treatment. We have launched an internal Sepsis Awareness Campaign for staff over Winter. A public facing campaign is due to launch in Q1 of 2025, aimed at improving public awareness of signs and symptoms of sepsis and inform them when and where to seek help".

Human Factors – Learning from Practice

Our focus on Human Factors - how people interact with systems and environments - has grown across the Health Board. A major milestone was reached when our Theatre Safety Improvement Project was accepted for presentation at the International Forum on Quality and Safety in Quebec.

Infection Prevention and Control – Staying One Step Ahead

We've continued to tackle infections like C. difficile, Staph Aureus, and E. coli with strong monitoring, training, and evidence-based policies. Unfortunately, this has not led to the Health Board achieving the trajectory outlined by Welsh Government,

Ward/Team Accreditation – Recognising Excellence

Ward/Team Accreditation facilitates high standards through regular Senior Nurse visits and Clinical Audits. Implementation of our Ward/Team Accreditation Programme has been divided into three phases. Phase one is complete, with partial completion of phase 2 and is embedded in 78 clinical areas. So far, eight teams have received Bronze Awards for their quality and safety efforts.

- **Priorities for the next year:**

  - Completion of phase 2 & 3; extending accreditation to Teams including Health Visiting, District Nursing and Maternity Services.
  - Supporting Wards/Teams to move through the accreditation process – to include Phase 1 areas, who will all have achieved bronze level of accreditation, with more than 20 achieving silver and 5 achieving gold.

What We've Achieved This Year: A Look at Our Pillars of Quality

cross 2024/25, Aneurin Bevan University Health Board has continued to deliver safe, effective care while listening, learning, and improving. For the next year, we will be updating our objectives and milestone mapped to our pillars of quality. Here is how we have made a difference across the six key quality areas:

Patient and Staff Feedback – Listening, Learning, Improving

We introduced *CIVICA*, a Digital Feedback Tool, making it easier to understand how patients and staff feel about our services. So far, 91% of emotional responses have been positive. Feedback themes often highlight compassion, support and kindness.

We are actively working towards setting up *Patient Participation Panels*, strengthened our *PALS and Bereavement Services*, and launched a *"Big Conversation for Future Care Planning (FCP)* to involve the public in improving communication and information and planning for FCP services and ongoing involvement of the population.

Successes:

- Record-high Survey responses in February 2025.
- New SMS surveys launched in the Emergency Department to make it easier for the Public to provide feedback.
- More patients involved in shaping services, particularly around Dementia and Neurodiversity.
- Established Bereavement Collaboratives inclusive of people, staff and partners.

- Increased involvement of people living with Dementia and their carers through targeted community engagement.
- Developed public information on Treatment Escalation Planning including Easy Read that has been adopted across Wales.

Areas for further progress:
- Low uptake of QR code and paper surveys—SMS aims to boost this
- Divisional reporting in regard to 'you said, we did'.

Incident Reporting – Safer Care, Together

We remain committed to learning from incidents and reducing avoidable harm. Between April 2024 and February 2025, 504 moderate or above harm incidents were reported - a slight drop from the previous year.

Successes:
- No *Never Events* in Theatres since November 2023.
- Better reporting of early warning notifications to Welsh Government.
- 99% of falls were no or low harm.
- Risk-Adjusted Mortality Index (RAMI) remains stable at 101.91 - RAMI is a risk-adjusted mortality rate means that a mortality rate has been statistically adjusted to account for the predicted risk of death.
- The Health Board proactively reports and manages all patient safety incidents to reduce future risks and mitigate further recurrence.
- The Patient Safety Incident Policy promotes an open reporting culture that encourages staff to look critically at their own actions and those of their Teams, with an emphasis on learning and not blame.
- Learning is at the heart of all claims investigated by the Health Board, with local Divisional Teams responsible for the development of Learning from Events Reports, the assurance of actions taken, with support from the Divisional Senior Leadership Team and Divisional Director final approval and sign off.
- As of November 2024, Learning From Events Report (LFER's) are sent from Legal Services directly to the relevant Divisional Triumvirate teams to have ownership and oversight of the completion and return of the LFER with supporting evidence, within prescribed timescales. At the beginning of every month a spreadsheet is sent to each Division to assist with identifying and tracking any outstanding LFER's.

- **Organisational focus on Nutrition & Hydration:** The Health Board recognises the importance of appropriate Nutrition & Hydration (N&H) for better patient care and outcomes. Two Task and Finish Groups have undertaken a multidisciplinary approach to improving fluid balancing monitoring, as well as providing an Escalation Protocol for patients at risk through delays in artificial nutritional care. This and future work is supported by a refreshed N&H Steering Group. Food Standards and Clinical Standards Sub-Groups feed into the Steering Group to provide the operational influence.

- **Embedding Speaking Up Safely:** The Health Board is committed to embedding Speaking Up Safely as part of its culture.

- **Compliance in NRI's** increased from 29% in July 2024 to 77% in January 2025. However, by the end of the year, this figure had slightly decreased to 63%. This decline is partly due to vacancies, sickness, and the addition of new members to the divisional and Corporate PSI Teams. By the end of March 2025, the Corporate PSI Team was fully staffed, providing a greater opportunity to monitor and improve compliance once again.

Areas for further progress:

- Maintaining open reporting culture, while continuing to reduce harm.
- Balancing Safety Intelligence: Incident Reports are just one part of the Assurance Framework and should be considered within the broader context of other sources of safety intelligence.
- Welsh Risk Pool financial penalties for late or outstanding assurance of learning.

Falls – Caring for those at Risk (Hospital Adult Inpatients)

We continue to strive for improvements in managing falls and falls-related injuries by adopting a multifaceted approach that considers both individual and environmental factors. Our goal is to minimize the risk of injury from falls and maintain quality of life.

Successes

- National Contributions: Contributed to the development of the Falls National Head Injuries Pathway and the National Inpatient Falls Network's work on sensor use, setting a national standard.
- Digital Integration:
  - Successful rollout of the Welsh Nursing Care Record (WNCR) Multi-Factorial Risk Assessment (MFRA) to Adult Inpatient Wards.
- Modified MFRA developed for use in Emergency Departments (ED), adopted in Assessment Units.
  - Training: Progress in developing a national approach to implementing ESR Modules for Mandatory Falls Training.
  - Review of Falls Incidents: Agreement to transition to a new approach to reviewing falls incidents by means of a Falls Strategic Oversight Panel (FSOP) with alignment to the National Audit of Inpatients Falls (NAIF) Annual Report 2024 to consider all falls with fractures and falls related Head Injuries.
  - Post-Fall Management: Successful procurement of additional Flat Lifting Equipment in support of improvements in Post Falls Care.
  - Initiatives:
    - Rollout of the SWARM's Methodology to further promote the MDT approach.
  - Implementation of the yellow wristband initiative to visually indicate patients at risk of falls.

Areas for further progress:

- Development of a Fall's Dashboard representing real-time activity.
- Strengthening assurance controls to mitigate falls risk by enhancing data availability related to WNCR-MFRA, DECI, One Patient One Audits and Ward Accreditation.
- The required successful digital integration of an immediate Post Falls Risk Assessment, as part of WNCR once ratified nationally.
- Compliance with reporting Falls Incidents under RIDDOR.
- Ongoing work in relation to admission avoidance for those who have experienced a fall in the Community setting.
- Expanding the opportunities for falls prevention and management within falls resources available to the Health Board.

Complaints, Concerns & Compliments – Listening to Every Voice

We are resolving more complaints earlier and capturing more compliments than ever before.

Successes:

- 67% early resolution rate for Complaints.
- Greater than 9 months+ reduced by 72% in the last 12 months Deep dives into Divisions have led to significant reductions in the number of open formal concerns.
- Reduced number of formal Complaints thanks to improved early resolution.
- Compliments now tracked in both CIVICA and Datix systems.

Areas for further progress:

- Continued effort needed to further reduce formal Complaint volumes.
- Formal Complaints compliance still below target.
- Consistent communication with Complainants.

Health, Safety and Security – A Safe Environment for All

We've seen big improvements in safety compliance and contributed to national work on reducing Violence and Aggression.

Successes:

- *RIDDOR compliance* improved from 68.4% to 86.4%.
- Developed a *Violence Prevention & Reduction Strategy.*
- Improved *Fire Safety and Manual Handling Training*
- *New Patient Safety Bedside Boards in ward areas.*

Areas for further progress:

- Manual Handling Compliance still below target—training ongoing.
- Fire response changes require ongoing staff engagement.

Infection Prevention and Control – Staying Ahead of the Curve

We have taken a zero-tolerance approach to Healthcare-Acquired Infections (HCAIs), using data and focused action to drive change.

Successes:

- Targeted actions for *C. difficile, Staph aureus*, and *E. coli.*
- Strong focus on *hand hygiene and environmental cleaning.*
- Infection-Specific Working Groups created QI projects.
- Refreshed intranet as an additional resource for staff.
- Webinars for specific focus for education.
- Divisional Dashboard for timely surveillance.

Areas for further progress:

- Ongoing work needed to reduce infection rates in some areas.
- Human factors and non-adherence to Infection Prevention Fundamentals of Care.
- Condition of some of our hospital premises.
- High prevalence of Winter virus, escalation process in development in collaboration with PHW Colleagues.
  Balancing whole systems risks for patient placement and enhanced cleaning, a review of the process will be undertaken for 2025/26.

Safeguarding – Protecting the Vulnerable

We have formalised and strengthened our safeguarding processes internally within the Health Board, alongside strengthening our relationships with Local Authorities, Police and Probation as our statutory partners.

Successes:

- Increased compliance with Level 1 and 2 Adults and Children Safeguarding Training to be consistently above 80%, though further work is required to reach the target of 90%.
- Mandating of Level 3 Training Safeguarding Adults and Children via ESR.
- Worked with Divisions to develop processes to ensure that progress of complex investigations is monitored and escalated, whilst ensuring that early learning is identified and embedded into practice.
- Re - launched *Strategic Safeguarding Group, whilst implementing* Subgroups to oversee and deliver improvements in key priority areas.
- Developed a Rollout Plan and implemented its first stages to ensure that the Datix Safeguarding Module is utilised for case management and monitoring of actions.

Areas for further progress:

- Expanding safeguarding efforts to keep pace with growing need.
- Meeting the demand in regard of Level 3 Safeguarding Training.
- Monitoring and improving quality of safeguarding referrals.

Learning from Deaths – Turning Reflection into Safer Care

At Aneurin Bevan University Health Board, we believe that every life matters — and every death offers a vital opportunity for learning and improvement. Over the past year, we have strengthened our approach through the development of a comprehensive Learning from Deaths Framework, supported by a detailed report capturing key mortality metrics and insights.

Our Risk Adjusted Mortality Index (RAMI) improved, positioning the Health Board as the best-performing in Wales. Crude mortality rates remained steady, while specific mortality rates for conditions such as Myocardial Infarction (heart attacks) and Stroke showed a noticeable decline, reflecting better recognition, response, and management in these critical areas.

The Medical Examiner Service expanded to include Primary Care, Paediatrics, Neonates, Maternity, and Gynaecology. The referrals made, contributing to a growing understanding of care pathways and areas for improvement. Themes identified through these reviews were shared via newsletters and briefings, ensuring learning is disseminated across Teams and embedded into practice.

Importantly, the Health Board recorded a reduction in confirmed suicides. This reflects ongoing efforts to improve Mental Health support and early intervention. Enhanced reporting processes also helped improve the identification of deaths in patients with Learning Disabilities, ensuring that no voices are missed in our mission to learn and improve.

Clinical Effectiveness

Ensuring clinical care is consistently safe, effective, and evidence-based is central to the Health Board's vision. Over the last year, we have actively participated in the National Clinical Audit Programme, using its findings to benchmark the quality of care we provide and identify areas for focused improvement.

Each national audit undertaken has offered valuable insights into our strengths and areas for development. These have been discussed in detail by the Clinical Standards and Effectiveness Group and reported through to the Patient Quality, Safety, and Outcomes Committee, ensuring clear oversight and accountability.

As part of this work, we have developed and implemented an Annual Clinical Audit Plan, ensuring that our participation in national and local audits remains structured and purposeful. Local actions and recommendations have been shaped from the results, helping us refine practice, raise standards, and deliver better outcomes for our patients.

This ongoing focus on clinical effectiveness ensures we continue to improve, respond to evidence, and provide the highest quality care to the communities we serve.

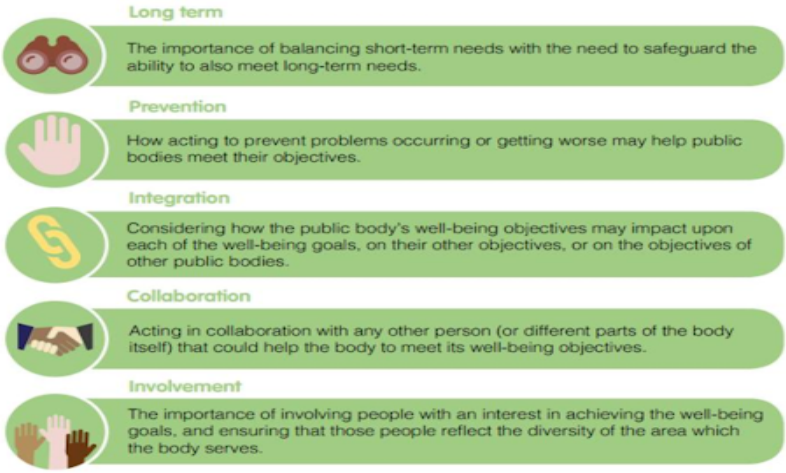
These achievements reflect our unwavering commitment to quality, safety, and patient-centred care which we will build on annually. By embedding learning and improvement at every level, we are creating a stronger, safer health system for everyone.

9. Well-Being of Future Generations

The Wellbeing of Future Generations (Wales) Act (2015) ('the Act') has the central aim of improving the social, economic, environmental and cultural wellbeing of Wales, whilst also reducing health inequalities through long term prevention and the delivery of sustainable, outcome focused services. The Act has seven wellbeing goals and five ways of working which help organisations understand how they can work more sustainably together to meet the duties of the Act.

The seven wellbeing goals **The five ways of working**





Source: Future Generations Commissioner for Wales

Gwent Well-being Plan

During 2024/25, Aneurin Bevan University Health Board worked closely with Partners in Gwent Public Services Board to turn the findings of the Gwent Well-Being Assessment into a Well-Being Plan, which will improve the social, economic, environmental and cultural wellbeing of citizens in Gwent. Using the five ways of working, Public Services Board Partners have worked together to develop a plan which will deliver ambitious and transformational change that cannot be achieved by individual organisations alone. The plan will cover the five-year period 2023-28, and is based on two strategic objectives and five steps. These are:

Gwent Well-being Plan strategic objectives:

1. We want to create a fairer, more equitable and inclusive Gwent for all.
2. We want a climate-ready Gwent, where our environment is valued and protected, benefitting our well-being now and for future generations.

Gwent Well-being Plan steps:

1. Take action to reduce the cost-of-living crisis in the longer term.
2. Provide and enable the supply of good quality, affordable, appropriate homes.
3. Taking action to reduce our carbon emissions, help Gwent adapt to climate change, and protect and restore our natural environment.

4. Take action to address inequities, particularly in relation to health, through the framework of the Marmot Principles.
5. Enable and support people, and communities to be resilient, connected, thriving and safe.

During 2024/2025 the Aneurin Bevan University Health Board continued to work closely with Gwent Public Services Board Partners, establishing an up-to-date picture of delivery across Gwent against the recommended actions from the Building a Fairer Gwent Report, monitoring progress against the Marmot recommendations amongst PSB Partner organisations.

The Marmot recommendations were categorised into the four Areas of Focus for the PSB to monitor progress and identify any gaps or opportunities for regional delivery against each of the Area of Focus:-

1. That every child has the best start in life (agreed as the initial Area of Focus).
2. That everyone lives in a place they feel safe.
3. That everyone has the same economic chances.
4. That everyone lives in a climate-ready community where their environment is valued and protected.

As part of the ongoing collaboration between Gwent Public Services and Public Health Wales (PHW), significant progress has been made in developing the regional area of focus on ensuring the Best Start in Life for children and families across Gwent.

PHW is leading this priority area, with current work centred on:

- Agreeing a shared definition of what constitutes a "Best Start in Life," ensuring all partners are aligned in their understanding and approach.
- Identifying key workstreams that will underpin delivery, aligned with this shared definition.

A Distributed Leadership Model is being developed to support this work. This model will enable the appointment of workstream leads who will establish Task Groups and develop detailed delivery plans. A core principle of this work is the realisation of children's rights, which will underpin all aspects of planning and delivery.

Progress monitoring and assessment have been crucial in tracking the implementation of the Marmot recommendations. The Gwent Strategic Well-being Action Group (GSWAG) engaged Local Authorities and the Health Board to ensure comprehensive monitoring. The Gwent Joint Strategic Assessment (JSA) Team committed to providing baseline and trend data to monitor progress, inviting partners to flag any data gaps for inclusion in the JSA.

Initial findings indicated progress in early years health, such as the Healthy and Sustainable Pre-School Scheme, and education, including efforts to address school absences. However, overall progress has been mixed, highlighting several opportunities for improvement.

The Gwent PSB agreed the following:

1. Note the initial findings from the Regional Assessment of progress towards the year one Marmot recommendations relating to the Best Start in Life Area of Focus and provide feedback on the approach taken.
2. Ensure the collation of further intelligence/updates from your Partner Organisations on the outlined recommendations for Best Start in Life.
3. Consider where regional influence and coordination from the PSB can add most value in supporting progress against the Best Start in Life Marmot recommendations in the short, medium and long-term.
4. Agree a PSB member to lead and shape the delivery of the Marmot approach recommended in the Building a Fairer Gwent report for Best Start in Life.
5. Agree to lead the next regional assessment of progress towards the year one Marmot recommendations and shaping delivery relating to:
    a. Climate-Ready Communities
    b. Economic Chances
6. Safe Places.
7. PSB members to deliver approach within their own partner organisation to support PSB collective agreement to become a Marmot region.

The two-year tenure of Cllr. Sean Morgan as Chair of Gwent Public Services Board (PSB) ended in December 2024 and Cllr. Anthony Hunt, Leader of Torfaen County Borough Council, has now taken over the role of Chair. Tracy Daszkiewicz (Executive Director for Public Health & Strategic Partnerships) has been appointed to the role of Vice-Chair, enabling the Gwent-wide partnership to continue to address inequity and the wider determinants of health as part of 'Building a Fairer Gwent'.

Aneurin Bevan University Health Board Wellbeing Objectives

The development of our new Strategy Gwent 2035 champions population health and puts the Wellbeing of Future Generations at the heart of everything we do to improve the health of our population through partnerships. The development of a new Strategy has provided a unique opportunity to look to the future with communities in order to determine: what matters to them; and how we can work in partnership to improve wellbeing through Place Based Care. Under the Wellbeing of Future Generations Act (2015), the Health Board has a statutory responsibility to set and publish wellbeing objectives and these are proposed to be our new strategic aims as set out below:

Our Aims	
Better Health	Together we will support people to be healthy, active and happy.
Better Care	Together we will deliver what matters to people, supporting our staff to thrive and achieving quality, kind and sustainable care.
Better Lives	Together we will create strong, safe and connected communities.

During 2024/25, Aneurin Bevan University Health Board has continued to maintain a life course approach to its wellbeing objectives, as it continues to endeavour to reduce health inequalities and improve population health. Unlike a disease-oriented approach, which focuses on interventions for a single condition often at a single life stage, the life course approach considers the critical stages, transitions, and settings where large differences can be made in promoting or restoring health and wellbeing of both current and future generations. Adopting the life course approach means identifying opportunities for minimising risk factors and enhancing protective factors through evidence-based interventions at important life stages, from the perinatal period through early childhood to adolescence, working age, pre-conception and the family-building years, and into older age. It also capitalises on the potential to deliver an intergenerational approach to health improvement and reduce health inequalities from generation to generation and improve conditions of daily life. Our health services are there to provide universal coverage to everyone throughout the life course, whilst also recognising that we need to provide more support to those in greatest need.

This approach requires holistic, long-term, policy and investment strategies and engagement that promote better health outcomes for individuals and greater health equity in the population. Aneurin Bevan University Health Board is confident this approach can achieve high returns for health and sustainable development, both by limiting ill health and the accumulation of risk throughout life and by contributing to social and economic development.

The five ways of working set out in the Act have continued to be demonstrated by Aneurin Bevan University Health Board in 2024/25. Through the regional partnership arrangements of the Regional Partnership Board and Public Services Board, integration has been demonstrated through joint approaches to Wellbeing, Health and Social Care delivery. Aneurin Bevan University Health Board's Communications Team have undertaken a number of public involvement and engagement activities during 2024/25. Through work on the Well-being Plan and Area Plan, Aneurin Bevan University Health Board has worked in partnership to establish a long-term vision for wellbeing in Gwent. Through 'Building a Fairer Gwent', Aneurin Bevan University Health Board has worked in partnership to deliver an approach to prevention embedded in the social determinants of health. Finally, the work of both Gwent Regional Partnership Board and Gwent Public Services Board demonstrate how Aneurin Bevan University Health Board is working in collaboration to achieve gains for the population of Gwent that cannot be delivered by individual organisations alone.

Putting Neighbourhoods and Place at the heart of the Health and Social Care System

Over the last 10-15 years the healthcare system has struggled to meet the rising demand and needs for Health and Care Services, due to factors such as an ageing population, increasing complexity, workforce supply challenges and the widening gap in healthy life expectancy. The Health Board and its Partners are working together to break down traditional barriers between Organisations, Teams and Funding Streams to put neighbourhoods and place at the heart of the Health and Social Care System. This aims to support a rapid shift towards prevention, early intervention and self-care, focusing on what matters to people and communities. The approach will place a greater

emphasis on physical and mental well-being within the context of people's day-to-day lives and on reducing health inequalities.

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

- Building resilient and connected communities;
- Prevention and earlier intervention;
- Reducing health inequalities;
- Collaborative working to establish effective and efficient Multi-Disciplinary Teams;
- Providing are closer to home and streamlining access to Specialist Care;
- Reducing preventable admissions and optimal hospital discharge through a Home First approach.

The Place Based Care model in the Health Board is based on a continuum from building resilient communities through to intermediate care service to prevent avoidable admissions and support timely discharge (see below).



The Integrated Wellbeing Network programme (see above) is funded by the RPB to:

- Engage communities and build capacity for community-led approaches to health improvement and reducing inequities.
- Map and organising community asset so they are clearly accessible to the public and professionals.
- Bridge, link and co-ordinate wellbeing assets in each neighbourhood.
- Supporting individual and group behaviour change to help people prevent health problems and live well with long term conditions.

The Neighbourhood Care Networks (see above) are focussed on four priority areas:

- Multidisciplinary working for people with complex needs, including but not exclusively, people with moderate or severe frailty.
- Reducing premature mortality and morbidity through prevention and management of Diabetes and Cardiovascular risk factors, initially Hypertension Case Finding and management.
- Connecting people to Non-Medical Activities, Groups and Services in their community which can address their practical, social and emotional needs.

- Equity of access to Supplementary Services particularly for Inclusion Health groups.

At the heart of the proposed approach is bringing together Public Health, Primary Care and Community Services to create Integrated Neighbourhood Teams serving populations of around 20-30,000 people. Doing this is a key part of the plan for improving health outcomes for the population and tackle inequalities as set out in Building a Fairer Gwent (Marmot Report). The principles underpinning Integrated Neighbourhood Teams is rooted in a shared ownership for the health and well-being of the local population and brings together Professionals and Practitioners that have a high level of interaction with each other and the local population. It will require a culture of collaboration with time and space to build trusted relationships, solve problems and agree more effective ways of working. This will replace complex referral and administrative systems that can often create barriers, with a more rapid, relationships-based approach to providing health, care and well-being support.

The Health Board and Partners will be developing plans to advance Place Based Care in each Borough through Integrated Services Partnership Boards, in conjunction with the local Integrated Wellbeing Networks and NCNs.

Improving access to Healthier Food Especially for our Youngest Children

Gwent Public Health Team are working with Partners across Gwent to take a 'whole system approach' to healthy weight and identify the most impactful levers for 'system change'. A 'whole system approach' presents an opportunity to work with Communities and Partners at a local level to tackle and prevent the underlying causes of Obesity, complimenting work being undertaken nationally by Public Health Wales and Welsh Government. Across Gwent our aims are to:

1. **Embed Healthy Weight Ambitions and Goals within Local Strategic Partnerships and Pans**

   We are working to maximise opportunities for planning policy to contribute to the creation of healthier environments by contributing to the Replacement Local Development Plans. We are also working with Food Partnerships to embed healthy weight into council food strategies and programmes and have gathered views from residents across Gwent as part of a Great Weight Debate.

2. **Increase Access to Healthier Food for Early Years Children and their Families**

   We are working with Stakeholders across Gwent to create a framework for action for healthier food in childcare settings. We are supporting childcare settings to create opportunities for children to explore a range of foods via sensory food play and the engagement of parents. We recognise the challenge of eating well for families when they are out and about around Gwent. To address this we are exploring opportunities for promoting access to healthier food in Public Sector Venues, such as Leisure Centres, visited by early years children and their families.

3. Support ABUHB to become an Exemplar Health Promoting Health Board

We recognise the potential for the Health Board act as an exemplar on Public Sector Catering and are exploring opportunities to increase access to healthier foods in our own catering.

For further information, please visit:
Gwent Regional Partnership Board https://gwentrpb.wales/
Gwent Public Services Board http://www.gwentpsb.org/en/

10. Equality, Diversity and Inclusion

The Health Board published its Strategic Equality Action Plan for 2024 – 2028 in March 2024, in line with the Public Sector Equality Duty (2011), demonstrating its commitment to advancing Equality, Diversity, and Inclusion (EDI) and fulfilling its statutory responsibilities under the Equality Act (2010) and the Human Rights Act (1998).

Our Strategic Equality Plan update published in March 2025 highlights the progress made in embedding equitable, inclusive, and person-cantered approaches across the organisation in Year 1 of our new plan.

Key achievements during **2024/25** include:

- Commencement of Engagement with Staff, Patients and the Public to coproduce an Aneurin Bevan LGBTQ+ Action Plan.

  Further Expansion of Staff Diversity Networks and Advisory Boards, with Executive Sponsors and Chairs playing a more active role in shaping strategic EDI initiatives, including the publication of the Strategic Communications Framework for Staff Networks.
- Continued Implementation of the Health Board's Anti-Racism Action Plan, aligning with the Welsh Government's Anti-Racist Wales Action Plan. With key achievements around the introduction of our Reverse Mentorship Scheme, our IMG Induction for Internationally Educated colleagues, working with HEIW and the BMA around Improving Employee Experience for our Black and Ethnic Minority Groups and the achievement of Diverse Cymru Cultural Competence Certificate across a number of teams.

- Enhanced accessibility and inclusion initiatives, including the continued Health Board- wide rollout of the SignLive service, providing real-time British Sign Language (BSL) interpretation for Deaf patients, families and staff.

- The creation of Visually Better Spaces in clinical spaces including the Eye Clinic in the Royal Gwent Hospital.

- The continued roll out of our bespoke Visual Awareness Training to colleagues across the Health Board.

- The roll out of our Health and Well-Being Passport for Staff developed in collaboration between our Equality, Diversity and Inclusion Disability Lead, Occupational Health and Trade Union Representative.

- The delivery of Widening Access projects such as the Skills Surgery, a project introducing Year 6 students to careers in Health. Delivered to two Primary Schools, Ysgol Gymraeg Bro Helyg in Blaenau Gwent and Pill Primary School in Newport.

The key achievements in Year 1 of our Strategic Equality Plan demonstrates the Health Board's ongoing dedication to fostering an inclusive and equitable workplace and healthcare environment. EDI and Human Rights remain key Executive and Board-level priorities, with a continued focus on monitoring, measuring, and driving sustainable progress in addressing health and workplace inequalities.

11. Welsh Language Regulations

The Health Board has published its Annual Report for 2024/25 on its website in both Welsh and English. This addresses the statutory duty of Aneurin Bevan University Health Board to provide an annual account to the Welsh Language Commissioner on compliance with its Welsh Language Standards under the Welsh Language (Wales) Measure 2011. The report has been prepared in accordance with Welsh Language Standard 120. The report shows our progress and work in this field. It notes key achievements as well as our strategy and plans for the future.

https://abuhb.nhs.wales/files/key-documents/other-reports/welsh-language-standards-annual-report-2023-2024-pdf/ English

https://bipab.gig.cymru/ffeiliau/key-documents/adroddiad-blynyddol-safonaur-gymraeg-2023-2024-pdf/ Welsh

Some of the notable points from the report include:

- Establishment of a Welsh Language tutor to work with staff who lack confidence in using the Welsh language skills they have. We have also further developed our training offer to all staff with a new system that better matches the learning offered with the needs of the individual.

- We have worked with our colleagues in Health Education and Improvement Wales as well as our partners in Careers Wales to offer appropriate information around career opportunities in Welsh to our future workforce. This includes the development and delivery of our 'Syrjeri Sgiliau – Skills Surgery' programme designed for Primary School children.

- Working with our colleagues across the Workforce and Organisational Development directorate we have delivered bespoke training around Welsh language service delivery in induction programmes such as the Health Care

Support Workers Clinical Induction. We've also delivered training to leadership programmes such as the 'Leadership Development Programme and the 'Nursing & Midwifery Academy'.

- New resources have been generated to support our frontline staff who do not have Welsh language skills to utilise common basic Welsh phrases with patients.

- Working closely with our Digital, Data and Technology Division we have ensured that any new technologies procured are fully functional for our Welsh speaking service users.

As a Health Board we work collaboratively with our colleagues across NHS Wales and have established a 'Welsh Language Leads' group to identify areas for collective work. We work closely with Welsh Government and maintain a strong positive relationship with the Welsh Language Commissioners office as we strive to deliver the best care to our Welsh speaking service users.

12. Financial Management and Performance

The Annual Accounts 2024/25, at Section 3 of the Annual Report and Accounts 2024/25, Page XX, sets out the detailed accounts for the full year to 31 March 2025 for Aneurin Bevan University Health Board. These accounts are prepared under International Financial Reporting Standards (IFRS).

The Health Board has two statutory financial duties:

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

Revenue Resource Performance

Aneurin Bevan University Health Board has not met its financial duty to break-even against its Revenue Resource Limit over the 3 years 2022-23 to 2024-25.

For the period 2024-25, the Board reported an overspend of £7,185K, as shown in the table below:

3 Year Revenue Breakeven Duty	2022-23	2023-24	2024-25	Total
Underspend Against Allocation	-36,842	-49,766	-7,185	-93,793

Capital Resource Performance

In addition to a revenue resource limit the Health Board has a capital resource limit (CRL) that sets the target for capital expenditure. The target of £70.475m was met in 2024/25 with a small underspend of £66K. The target is measured over a 3 year period as shown below:

3 Year Capital Resource Duty	2022-23	2023-24	2024-25	Total
Underspend Against Allocation	43	41	66	150

Long-term Expenditure Trends, 2019-2020 to 2024-2025

3. Analysis of gross operating costs

	£'000	£'000	£'000	£'000	£'000	£'000
3.1 Expenditure on Primary Healthcare Services	**2019-20**	**2020-21**	**2021-22**	**2022-23**	**2023-24**	**2024-25**
General Medical Services	103,343	108,993	112,524	116,217	122,671	132,671
Pharmaceutical Services	22,900	27,109	25,082	25,273	25,756	29,224
General Dental Services	36,608	33,079	38,030	39,817	39,870	44,444
General Ophthalmic Services	8,911	8,734	9,343	8,866	10,659	15,075
Other Primary Health Care expenditure	2,872	2,289	2,487	2,612	4,373	4,729
Prescribed drugs and appliances	102,280	106,852	106,282	114,331	121,947	125,771
Total	276,914	287,056	293,748	307,116	325,276	351,914

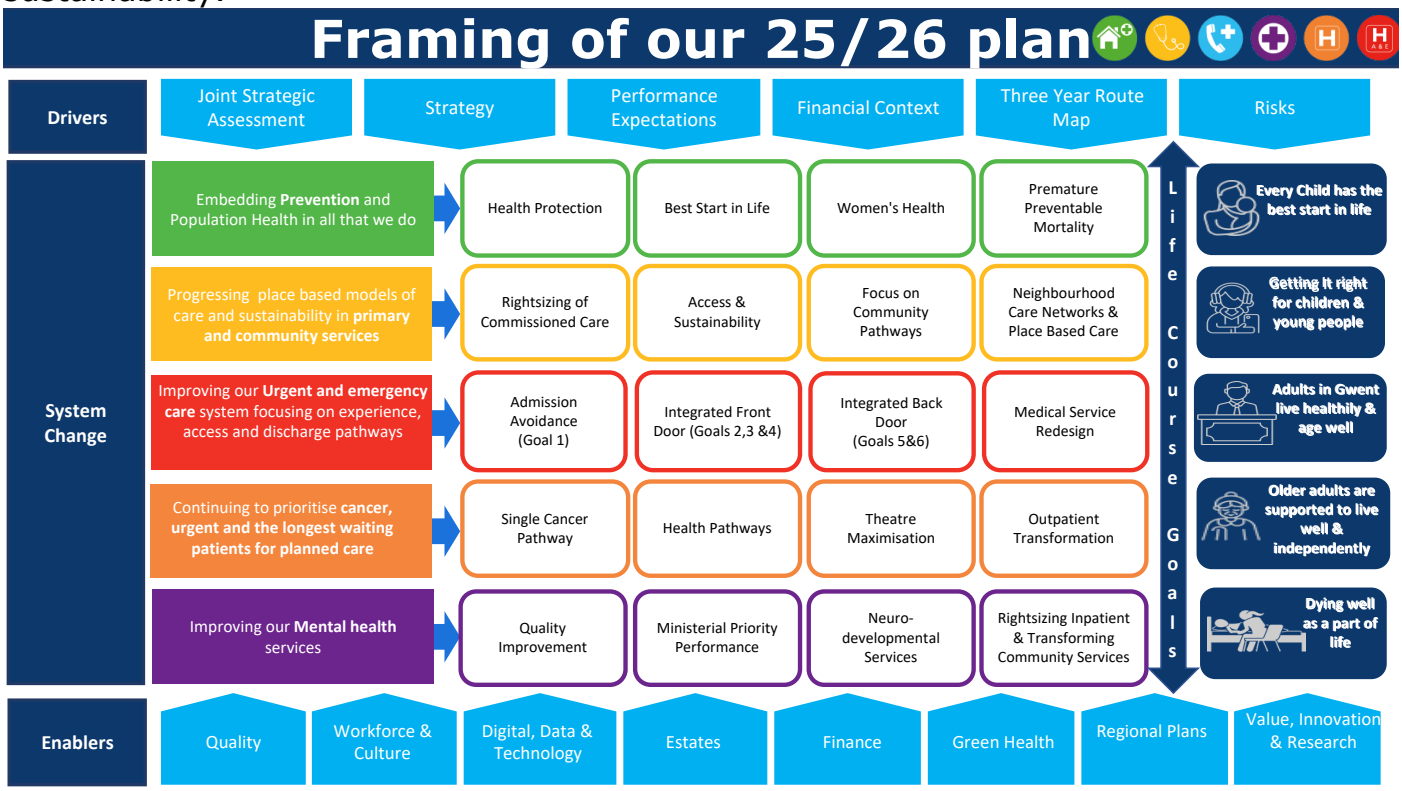
	£'000	£'000	£'000	£'000	£'000	£'000
3.2 Expenditure on healthcare from other providers	**2019-20**	**2020-21**	**2021-22**	**2022-23**	**2023-24**	**2024-25**
Goods and Services from Other NHS bodies	103,179	103,278	117,637	117,587	129,254	133,420
Goods and services from WHSSC / EASC	144,458	161,384	177,035	198,320	208,640	218,320
Continuing Care	71,005	81,347	83,675	86,006	99,136	99,904
Other	61,107	71,795	85,054	72,240	71,368	75,559
Total	379,749	417,804	463,401	474,153	508,398	527,203

3.3 Expenditure on Hospital and Community Health Services

	£'000	£'000	£'000	£'000	£'000	£'000
	2019-20	**2020-21**	**2021-22**	**2022-23**	**2023-24**	**2024-25**
Staff Costs	579,760	671,972	714,255	762,081	821,197	888,882
Non Pay	152,277	172,611	191,827	200,118	206,261	221,025
Depreciation and Impairments	23,197	96,361	31,056	30,804	59,994	49,908
Losses, special payments and irrecoverable debts	3,154	1,886	2,831	1,526	3,217	3,065
Other operating expenses	7,990	8,526	11,009	9,538	14,599	14,310
Total	766,378	951,356	950,978	1,004,067	1,105,268	1,177,190

13. Conclusion and Forward Look

The organisation is rightly proud of its achievements in 2024/25, significant progress has been made as the organisation strives to come out of areas of escalation. Importantly the organisation has set out a clear path to sustainability with a financial roadmap and plans to deliver improvement in performance and quality. Notably the organisation has a strong track record of planning and delivery, achieving much of the ambitions set out in the Annual Plan. Looking forward the IMTP set out the organisations plans for 2025/26 and beyond as the organisation continues on its path to sustainability.



Part 2:
Accountability Report

1st April 2024 –
31st March 2025

INTRODUCTION TO THE ACCOUNTABILITY REPORT

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

This Accountability Report has three sections:

1. Corporate Governance Report

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

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

2. Remuneration and Staff Report

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

3. Senedd Cymru/Welsh Parliament Accountability and Audit Report

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

A: THE DIRECTORS' REPORT

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

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

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

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

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

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

Further detail on the Board's membership and composition during 2024/25 is available within Section C: The Annual Governance Statement.

Board Members' Interests

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

The document, which can be accessed in the link below, shows details of directorships of other organisations or other interests that have been declared by the members of the Board of Aneurin Bevan University Health Board, and staff across the organisation, in line with the Standards of Business Conduct Policy, as at the 31st March 2025. This information is available on the Health Board's Internet site and can be accessed by following this link.

Personal Data Related Incidents

Information on personal data related incidents formally reported to the Information Commissioner's Office and "serious untoward incidents"

involving data loss or confidentiality breaches are detailed on page 47 of the Annual Governance Statement at Section C.

Environmental, Social and Community Issues

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

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

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

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

The Board's Annual Report for 2024/25 and Integrated Medium Term-Plan (IMTP) 2022-25 (approved by the Board March 2023) sets out the Board's strategic priorities which have been set within the context (environmental, social and community issues) in which the Health Board is operating within.

The Performance Report (Part A) of the Annual Report and Accounts 2024/25 provides greater detail in relation to the achievements of the Health Board in delivering the IMTP during 2024/25.

Statement for Public Sector Information Holders

In-line with the disclosure requirements set out by the Welsh Government and HM Treasury, the Health Board confirms that it has complied with the cost allocation and charging requirements set out in HM Treasury guidance during the 2024/25 year.

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

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

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

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

As Accountable Officer, I confirm that the Annual Report and Accounts 2024/25 as a whole is fair, balanced and understandable. I take personal responsibility for the Annual Report and Accounts and the judgements required for determining it as fair, balanced and understandable.

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

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

_____

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

SECTION B(2): STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS FOR 2024/25

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

In preparing those accounts, the directors are required to:

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

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

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

By Order of the Board

Signed:

Ann Lloyd, Chair
Dated:

Nicola Prygodzicz, Chief Executive
Dated:

Robert Holcombe, Director of Finance and Procurement
Dated:

C: ANNUAL GOVERNANCE STATEMENT 2024/25

SCOPE OF RESPONSIBILITY

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

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

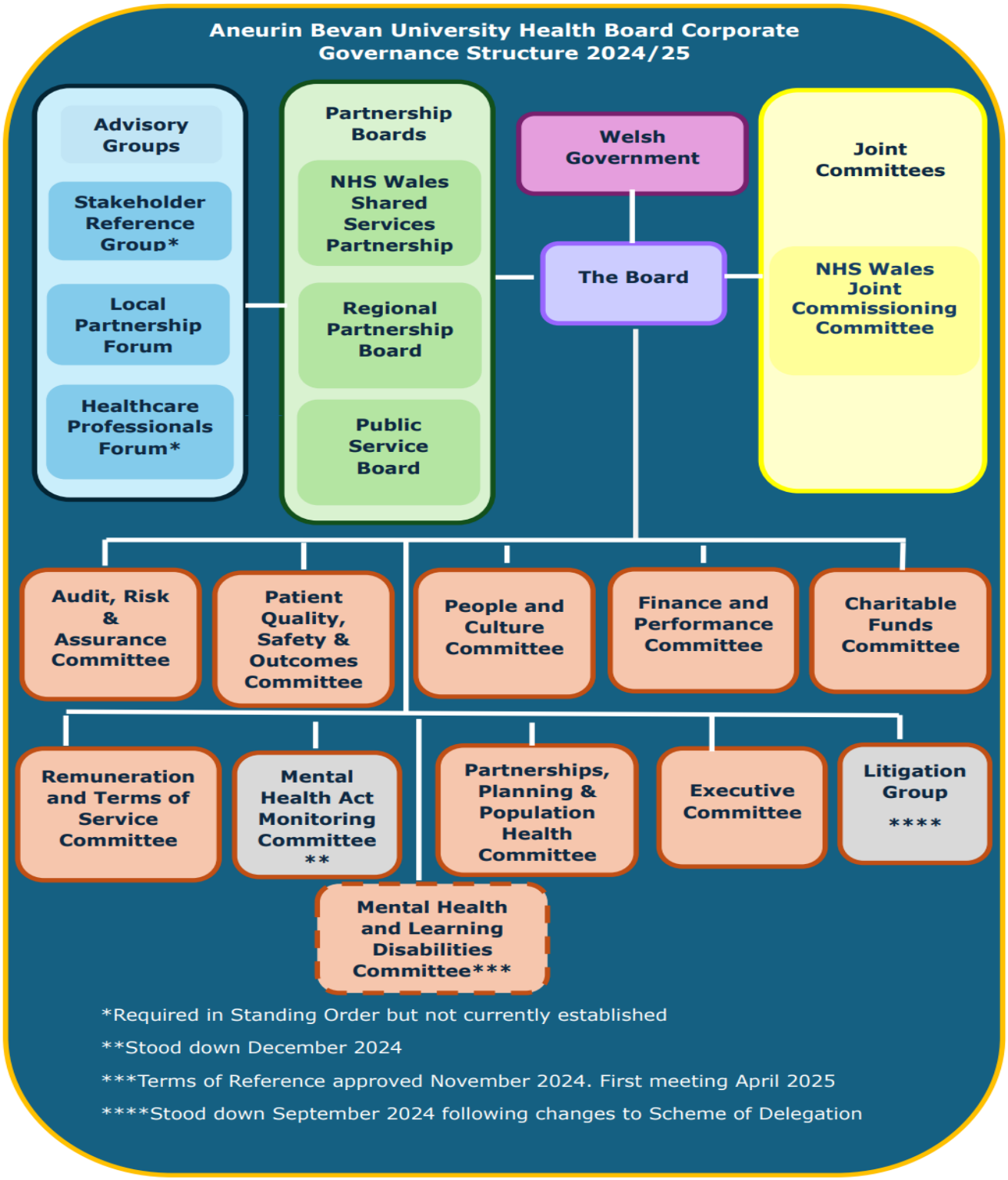
Welsh Government's Escalation and Intervention Arrangements for NHS Wales sets out the collective arrangements in place between the Welsh Government and external review bodies for identifying and responding to serious issues affecting NHS service delivery, quality and safety of care, and organisational effectiveness. As at 31st March 2025, Aneurin Bevan University Health Board was in 'Targeted Intervention' for planning and finance and 'Enhanced Monitoring' for performance and outcomes related to urgent and emergency care pathways as a result of extended waits for patients in ambulances and emergency department clinical assessment at the Grange University Hospital. The Performance Report (Part 1) of the Annual Report and Accounts for 2024/25 provides greater detail on the Health Board's performance and improvement actions in these areas.

OUR GOVERNANCE AND ASSURANCE FRAMEWORK

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

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

The diagram below outlines the corporate governance structure in place during 2024/25:



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

Membership of the Health Board and its Committees

Attachment 1 provides the Board's membership during 2024/25 and attendance at Board meetings for this period. The membership of the Board and changes during 2024/25, are outlined in Table 1 below:

Name	Designation	Dates (If not full year)
Executive Directors		
Nicola Prygodzicz	Chief Executive	
Hannah Evans	Director of Strategy, Planning and Partnerships	
Rob Holcombe	Director of Finance and Procurement	
Dr James Calvert	Medical Director / Deputy Chief Executive	
Sarah Simmonds	Director of Workforce and OD	
Jennifer Winslade	Director of Nursing	
Peter Carr	Director of Allied Health Professions and Health Sciences	
Tracy Daszkiewicz	Director of Public Health	
Leanne Watkins	Chief Operating Officer	
Independent Members		
Ann Lloyd	Chair	
Pippa Britton	Vice Chair	Until 30/11/2024
Louise Wright	Independent Member (Trade Union)	
Richard G Clarke	Independent Member (Local Authority)	
Professor Helen Sweetland	Independent Member (University)	
Paul Deneen	Independent Member (Community)	
Iwan Jones	Independent Member (Finance)	
Dafydd Vaughan	Independent Member (Digital)	
Neil Patrick	Independent Member (Community)	From 01/04/2024
Penny Jones	Independent Member (Community)	
Martin Blakebrough*	Independent Member (Third Sector)	Until 08/06/2024

Name	Designation	Dates (If not full year)
Directors in Attendance**		
Paul Solloway	Director of Digital	
Special Advisors to the Board***		
Phil Robson	Special Advisor to the Board	
Associate Members******		
Vacant	Chair, Stakeholder Reference Group	
Vacant	Chair, Health Professionals Forum	
Vacant	Director of Social Services	
Director of Corporate Governance********		
Rani Dash	Director of Corporate Governance	

***** Absent in agreement with Chair and Welsh Government (effective 01/09/23 to 08/06/2024)*

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

****The Board has discretion to appoint Special Advisors to support it in achieving its responsibilities. Special Advisors are not Board Members and therefore attend meetings of the Board in an ex-officio capacity without voting rights.*

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

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

The Role of the Board

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

The Board is made up of individuals from a range of backgrounds, disciplines and areas of expertise. The Board comprises the Chair, Vice Chair and nine other Independent Members and the Chief Executive and eight Executive Directors. There are also Associate Independent Member positions, Special Advisors and other senior managers who routinely attend

Board Meetings. The full membership of the Board and their lead roles are outlined in **Attachment 1**.

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

In summary, the Board:

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

Committees of the Board

Section 3 of Aneurin Bevan University Health Board's Standing Orders provides that "*The Board may and, where directed by Welsh Government must, appoint Committees of the Health Board either to undertake specific functions on the Board's behalf or to provide advice and assurance in the exercise of its functions*". In line with these requirements, the Health Board had in place a Committee Structure for 2024/25.

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

During 2024/25, the following Committees were in place:

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

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

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

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

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

Conducting Business with Openness and Transparency

Members of the public have been able to attend all Board meetings in person during 2024/25. In addition, the Microsoft Teams link is also published with the agenda and on social media channels to enable members of the public to observe the meeting in real time if they are unable to attend in person. All Board meetings in 2024/25 were recorded and published to the Health Board's You Tube Channel within 24 hours for public viewing.

During 2024/25, the Board's committees have continued to meet virtually and, due to capacity constraints, the Health Board has not been able to stream these in real-time for the public's viewing. Work is underway to address this in 2025/26 to ensure that the Health Board's business operates with full transparency and openness.

As the Health Board has not been able to allow the public to attend all meetings of its committees during 2024/25, the Health Board has not complied with its Standing Orders in this regard.

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

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

- ❖ All Board and Committee meeting agenda packs have been published to the Health Board's website in advance of meetings;
- ❖ Meetings of the Board have been recorded and published to the Health Board's You Tube Channel within 24 hours;
- ❖ The Health Board's Annual General Meeting in September 2024 was livestreamed, with in person attendance also permitted.

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

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

Items considered by the Board in 2024/25

During 2024/25, the Board held 6 scheduled meetings, as well as its Annual General Meeting on 10th September 2024 and an extraordinary meeting in April 2024 to discuss proposals for the Emergency Medical Retrieval and Transfer Service.

All the meetings of the Board in 2024/25 were appropriately constituted and quorate. The key business and risk matters considered by the Board during 2024/25 are outlined below.

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

Business Cases:	**Plans/Strategies/Policies/Service Change**
• Approved a Business Justification Case for a **Central Decontamination Unit at the Royal Gwent Hospital** • Approved the Business Justification Case (BJC) for a **South-East Wales Radio pharmacy** • Approved the **Urgent and Emergency Care Business Cases: The Grange University Hospital (GUH) Transfer Lounge and Increase in Emergency**	• Approved the **proposed budget delegations** for 2024/25 • Noted progress in the implementation of the **Nursing, Midwifery and SCPHN Workforce Strategy 2023-26** • **Approved** the **Three-Year Route Map to Service and Financial Sustainability** acknowledging the

Department (ED) Consultant Establishment

- Approved the Business Case for the **addition of a second MRI scanner at the Grange University Hospital (GUH)**
- Approved the Business Case for an **Electronic Prescribing Medicines Administration (EPMA) System**
- **Approved** the **expansion of the Multiple Sclerosis Team** to support the implementation of Fampridine and Siponimod drugs as well as ensuring that all MS patients received an annual review.

Governance and Assurance

- Received assurance in respect of arrangements for compliance with the **Nurse Staffing Levels (Wales) Act.**
- Approved the **Annual Report and Accounts 2023-24.**
- Approved the **Charitable Funds Annual Accounts and Annual Report 2023-24**
- Received the following **Annual Reports**:
  - Health and Safety
  - Gender Pay and Ethnicity Pay Gap
  - People Plan Annual Review
  - Welsh Language
  - Annual Quality Report
- Received the **Audit Wales Annual Audit Report and Structured Assessment.**

Routine Business

- Ratified actions taken by the Chair, on behalf of the Board, to seal documents affixing the Health Board's Common Seal.
- Considered and discussed the Health Board's financial performance and the related risks being managed by the organisation.
- Considered the Board's performance against key local and national targets need for regular progress reports and further engagement to address delays in transfers of care and ensure effective resource allocation.
- Received updates on the **Nevill Hall Development Programme**
- Update on **Community Therapy MSK Transformation**
- Progress and next steps on the development of the refreshed **digital, data, and technology strategies**
- Endorsed the approach to developing a **Quality Assurance Framework for Commissioned Services**
- Approved the **Winter Plan 2024/25**
- Update on **planned care performance** and endorsed the deployment of additional funding received from Welsh Government to make further improvements
- Development of proposals under the **ReFit framework** for invest to save capital funding to enhance the Health Board's estate, reduce carbon emissions and reduce costs associated with energy.
- Endorsed the **approach to Quality Improvement**
- Approved and adopted the **Compassionate Leadership Pledge**
- Approved a 12 month extension on the temporary **Stroke reconfiguration** and the consolidation of services across the Hyper Acute Stroke Unit (HASU) at the Grange University Hospital and one stroke rehabilitation site at Ysbyty Ystrad Fawr (YYF)
- Review of **Children and Young People's Services**
- Received the **Statutory and Mandatory Training Report** and endorsed the actions to improve compliance
- Update on the **NHS Wales Electronic Prescribing & Medicines Administration programme** (ePMA)

and the actions being taken forward to improve performance. • Considered performance against the Health Board's Quality Outcomes Framework. • Received assurance reports from the Committees and Advisory Groups of the Board. • Received update reports from the Executive Team in respect of key issues locally, regionally and within NHS Wales. • Reviewed the Corporate Risk Register and sought assurance on the management of mitigating actions.	and the implementation across the Health Board.

Patient Experience and Public Engagement

In March 2023, the Board approved its Patient Experience & Involvement Strategy. The Strategy's goals and objectives are to improve services and their effectiveness and safety and to improve people's experiences. It encompasses the Health Board's intent to engage patients, families, carers, staff and the wider community, with a commitment to listen to feedback, learn and therefore improve healthcare across all of our services.

The Board has remained committed to hearing and learning from the experience of staff and patients. During 2024/25 the Board received patient/staff stories in respect of:

Respecting patient's wishes at end of life, improving communication with families and our bereavement offer - reflecting upon the end of life and bereavement services over the past year, with the work culminating in the production of the Bereavement collaborative report.

Hospital to Home Pilot - aims to facilitate earlier discharges for clinically optimised patients, reducing hospital bed occupancy and associated risks.

Arts Therapies - the role of arts therapies within the Health Board, particularly focusing on art, music, and drama therapies for individuals who struggle with traditional talking therapies

Children's Rights and Participation in Action - an insight into work to embed children's rights and the work of the Child and Adolescent Psychology Service

My Medical Record within the Urology Service - an insight into the adoption of the MyMedical Record (MyMr) application to support patients manage their prostate cancer.

Throughout 2024/25, **Llais, Gwent Region** attended meetings of the Board to provide an overview of recent issues of concern and positive observations or public feedback being addressed by Llais in relation to the planning and delivery of health services in Gwent.

Items considered by Committees of the Board

During 2024/25, Board Committees considered and scrutinised a range of reports and issues, in line with the matters delegated to them by the Board. These included a range of internal and external audit reports and reports from other review and regulatory bodies, including Healthcare Inspectorate Wales.

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

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

Audit, Risk and Assurance Committee		
Roles and Responsibilities	The Committee has been established to enable the scrutiny and review of matters related to audit, financial accounting, assurance, and risk management, to a level of depth and detail not possible in Board meetings. The purpose of the Committee is to support the Board and Accounting Officer by reviewing the comprehensiveness and reliability of assurances on governance, risk management, the control environment and the integrity of financial statements and the annual report. Full Terms of Reference	
Chair	Iwan Jones, Independent Member (Finance)	6/6
Members and Attendance	Richard Clark, Independent Member Neil Patrick, Independent Member – from May 2024 Dafydd Vaughan, Independent Member	2/6 5/5 5/6
Regular Executive Attendance	Rob Holcombe, Director of Finance and Procurement	6/6
No Meetings per year	6	
Items Considered	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. • Responses from Welsh Government on the Questions set out in the	

	Audit Wales Community Pharmacy Data Matching Report. • Review of Audit Recommendation Tracking Process. • Reviewed the Standards of Business Conduct Policy • Review Audit Enquires to those charged with Governance and Management The Committee reviewed and approved the audit strategies and plans from Audit Wales and Internal Auditors, NWSSP Audit & Assurance Services, and received audit reports produced in support of them during 2024-25. In approving the strategies and plans, the Committee ensured that they were robust and linked to the health board's risk profile. During the year the Committee received Internal Audit reports in line with the agreed programme for 2024-25, including the management response from the relevant Executive Director. Further information is available in the Audit, Risk and Assurance Committee Annual Report 2024/25	

Patient Quality, Safety and Outcomes Committee		
Roles and Responsibilities	The scope of the Patient Quality, Safety and Outcomes Committee encompasses all areas of patient experience, quality and safety relating to patients, carers and service users, within directly provided services and commissioned services. Full Terms of Reference	
Chair	Pippa Britton - until December 2024 Helen Sweetland, Independent Member - from December 2024	5/5 1/1
Members and Attendance	Helen Sweetland, Independent Member Paul Deneen, Independent Member Penny Jones, Independent Member Louise Wright, Independent Member – until May 2024	4/5 6/6 6/6 1/1
Regular Executive Attendance	Jennifer Winslade, Director of Nursing James Calvert, Medical Director Peter Carr, Director of Allied Health Professions and Health Science	6/6 5/6 6/6
No Meetings per year	6	
Items Considered	Among the key issues considered by the Committee during 2024-24, as outlined in the Committee's Work Programme, the following were also considered: • Regular Committee Risk Reports detailing the key risks allocated to the Committee • Covid-19 Nosocomial Investigation Report • Listening and Learning Framework • Primary Care Quality Report • Commissioning Assurance Framework	

	• Quarterly reporting on the Performance of Patient Quality and Safety Outcomes, including: – Duty of Candour triggers – Infection Prevention and Control – Enhanced Monitoring – Falls – Health, Safety and Security – Complaints, Concerns and Compliments – HIW Inspections • Annual Reports: – Pharmacy and Medicines Management – Volunteering – Hospital Transfusion Committee – Putting Things Right – Human Tissue Act – Organ Donation – Dementia Care – Falls and Bone Health Management – Health and Safety Compliance – Radiation Protection Committee – Research and Development – Infection Prevention, Decontamination, and Antimicrobial Stewardship – Safeguarding Further information is available to the Patient Quality, Safety and Outcomes Committee Annual Report 2024/25

Partnerships, Population Health and Planning Committee		
Roles and Responsibilities	The purpose of the Partnerships, Population Health and Planning Committee is to seek assurance on: • The robustness of the Health Board's approach, systems and processes for developing strategies and plans, including those developed in partnership; • Plans and arrangements for the following matters are adequate, effective, and robust and achieving intended outcomes: Joint committee and partnership planning; Engagement and communication; and Civil Contingencies and Business Continuity; • That partnership governance and partnership working is effective and successful; and that those arrangements in place to improve population health and wellbeing are robust and effective and delivering intended outcomes. Full Terms of Reference	
Chair	Ann Lloyd, Chair	4/4
Members and Attendance	Dafydd Vaughan, Independent Member Richard Clark, Independent Member Penny Jones, Independent Member (From 01.07.24)	3/4 2/4 3/3

Regular Executive Attendance	Hannah Evans, Director of Strategy, Planning and Partnerships Tracy Daszkiewicz, Director of Public Health	3/4 4/4
No Meetings per year	4	
Items Considered	Among the key issues considered by the Committee during 2024-25, as outlined in the Committee's Work Programme, the following were also considered: • An overview of the work of the **Gwent Public Service Board (PSB)**, including the alignment of PSB priorities with that of the Marmot principles and actions. • An overview of the Health Boards **Long Term Strategy Development for 'Strategy 2035'.** • An update on progress of **Regional Planning** including the development of a regional acute clinical strategy between Aneurin Bevan, Cwm Taf Morgannwg and Cardiff & Vale University Health Boards. • An overview of meetings of the **Regional Partnership Board**, including discussion around topics raised as a concern. • Updates on the **Health Protection and Vaccination Programme**; with a focus on the distribution of a new respiratory vaccination rolled out in September 2024, and catch-up work undertaken into HPV in school aged teenagers. • Committee Risk Report • An overview of the **Nevil Hall Hospital Strategic Outline Case**, with emphasis on work ongoing to develop the new Nevil Hall Hospital clinical service model, including future service models around Enhanced Local General Hospital (eLGH) Further information is available in the Partnerships, Population Health and Planning Committee Annual Report 2024/25	

People and Culture Committee		
Roles and Responsibilities	The purpose of the People and Culture Committee is to provide assurance to the Board on: • all matters relating to staff and workforce planning of the Health Board; • plans to enhance the environment that supports and values staff in order to engage the talent and nurture the leadership capability of individuals and teams working together to drive the desired culture throughout the Health Board to deliver safer better health care; • the direction and delivery of Organisational Development and other related frameworks to drive continuous improvement and to achieve the objectives of the Health Board. Full Terms of Reference	
Chair	Louise Wright, Independent Member (Trade Union)	3/3
Members and Attendance	Paul Deneen, Independent Member Helen Sweetland, Independent Member	3/3 3/3

	Penny Jones, Independent Member	1/3
Regular Executive Attendance	Sarah Simmonds, Director of Workforce and OD	3/3
No Meetings per year	3	

Items Considered	Among the key issues considered by the Committee during 2023-24, as outlined in the Committee's Work Programme, the following were also considered:
	• Key matters relating to Employee Relations and suspensions over 4 months.
	• Annual Reports:
	  • Medical Revalidation
	  • Job Planning including Medical E-Systems
	  • Nursing, Midwifery and SCPHN Workforce
	• Progress with the implementation of the Health Board's People Plan 2022/25
	• Progress in relation to Equality, Diversity and Inclusion across the Health Board
	• Results of the Health Board's Staff Experience Survey and the NHS Wales Survey
	• Compliance with the Welsh Language Standards "More than just words"
	• Talent Management and Succession Planning Framework
	• Regular review of the workforce dashboard including sickness absence, turnover and performance reviews
	
	Further information is available in the People and Culture Committee Annual Report 2024/25	

Finance and Performance Committee		
Roles and Responsibilities	The purpose of the Finance & Performance Committee is to provide assurance to the Board on the achievement of the Board's aims and objectives as set out in its Integrated Medium-Term Plan. In doing so, the Committee will seek assurance that there is: • ongoing development of an improving performance culture which continuously strives for excellence and focuses on improvement in all aspects of the health board's business, in line with the Board's Performance Management Framework; • that arrangements for financial management and financial performance are sufficient, effective and robust; • that services are improving efficiency and productivity and financial plans are being delivered; • there is timely and appropriate access to health care services to achieve the best health outcomes within agreed targets, for directly provided and commissioned services; and	

	• risks are suitably identified, mitigated, residual risks controlled, and corrective actions are taken as required to sustain or improve performance. Full Terms of Reference	
Chair	Richard Clark, Independent Member	4/4
Members and Attendance	Iwan Jones, Independent Member Dafydd Vaughan, Independent Member Helen Sweetland, Independent Member Neil Patrick, Independent Member	4/4 2/4 3/4 4/4
Regular Executive Attendance	Rob Holcombe, Director of Finance and Procurement Hannah Evans, Director of Strategy, Planning and Partnerships	4/4 4/4
No Meetings per year	4	
Items Considered	Throughout 2024/25, the Committee has maintained oversight of the Health Board's escalation and intervention arrangements, including the Health Board's escalation status as set by Welsh Government (as at 31st March 2025, Health Board was in 'Targeted Intervention' for planning and finance and 'Enhanced Monitoring' for performance and outcomes related to urgent and emergency care pathways as a result of extended waits for patients in ambulances and emergency department clinical assessment at the Grange University Hospital). Among the key issues considered by the Committee during 2024-25, as outlined in the Committee's Work Programme, the following were also considered: **Financial Management and Performance** • Routine monitoring of the financial position of the Health Board through the provision of quarterly financial performance reports and specific focussed reports on efficiency and savings opportunities and delivery. • Value and Sustainability updates outlining the savings positions aligned to divisional reported schemes and Value and Sustainability Board theme areas • Quarterly updates on efficiency opportunities **Organisational performance and management:** • Digital, Data and Technology reports highlighting successful projects such as completion and installation support of Body Cam security • Information Governance and SIRO reports providing assurance on Cyber Security and Information Governance • Update on application of Health Board's Performance Management Framework, providing an overview of the Performance and Accountability Framework 6 monthly reviews for all nine operational directorates • Quarterly performance and activity reports • Overview of three impairments in relation to large capital schemes completed in 2023/24 – The Bevan Health and Wellbeing Centre, Endoscopy Unit and the Breast Unit at Ysbyty Ystrad Fawr	

	• Estates compliance overview with a focus on risks and mitigating actions • Freedom of Information Act Performance reports Further information is available in the Finance and Performance Committee Annual Report 2024/25	

Charitable Funds Committee		
Roles and Responsibilities	The purpose of the Charitable Funds Committee is to ensure the stewardship and effective management of funds which have been donated, bequeathed and given to the Aneurin Bevan Health Charity for charitable purposes by making and monitoring arrangements for the control and management of the Health Board's Charitable Funds. Full Terms of Reference	
Chair	Paul Deneen, Independent Member	4/4
Members and Attendance	Neil Patrick Independent Member Richard Clark, Independent Member Nicola Prygodzicz, Chief Executive Robert Holcombe, Director of Finance and Procurement	4/4 3/4 3/4 4/4
No Meetings per year	4	
Items Considered	• The Committee considered and endorsed the Charitable Funds Accounts and Annual Report 2023/24 • Received the Audit Wales – Audit of Accounts Report 2022/23 • Throughout the year the Committee received the Finance report on the current financial position for each quarter, providing Members with assurance of income, total spend, donations, grant income and total losses. • The Committee approved several small grants throughout the year and received updates on projects previously agreed. • The Committee received regular updates on spending plans over £25k • The Committee received an annual update on CCLA investment funds, which included an overview of the communities the funds had been invested in. Further information is available in the Charitable Funds Committee Annual Report 2024/25	

Mental Health Act Monitoring Committee		
Roles and Responsibilities	The purpose of the Mental Health Act Monitoring Committee is to advise and assure the Board and the Accountable Officer by critically monitoring and reviewing the way in which the Health Board discharges its functions and responsibilities under the Mental Health Act 1983 (the MH Act). It supports the Health Board in discharging its accountabilities and responsibilities for the achievement of the Health Board's objectives and organisational requirements in accordance with the standards of good governance determined for the NHS in Wales.	
Chair	Pippa Britton, Vice Chair (until December 2024)	1/1
Members and Attendance	Paul Deneen, Independent Member	1/1
Regular Executive Attendance	Leanne Watkins, Chief Operating Officer	1/1
No Meetings per year	4 (1 held in 2024/25, please see note below)	
Items Considered	The Committee received a quarterly report which provided assurance to the Committee on the compliance with the legislative requirements of the Mental Health Act. A **Power of Discharge Sub-Committee** has been established as a formal sub-committee of the MHAMC. The membership of this Committee is comprised of Associate Hospital Managers and provides advice and assurance that the processes associated with the discharge of patients from compulsory powers, used by the Sub Committee, are being performed correctly and in accordance with legal requirements. The Sub-Committee reports routinely to the Committee for assurance and developmental purposes. Note: In November 2024, the Board approved revised Terms of Reference to enable a broader focus on all aspects of the Health Board's activities in relation to mental health, learning disabilities and child and adolescent mental health services. As a result, the Mental Health Act Monitoring Committee was stood down and a Mental Health and Learning Disabilities Committee established. The first meeting of the new Committee was held on 9th April 2025. In the interim, the Mental Health Act Compliance Report was presented to the Patient Quality, Safety and Outcomes Committee in February 2025.	

Remuneration and Terms of Service Committee		
Roles and Responsibilities	The Committee considers and approves the remuneration and terms of service for the Chief Executive, Executive Directors and other very senior staff within the framework set by the Welsh Government, on behalf of the Board. The Committee seeks assurance in respect of objectives for Executive Directors and other Very Senior Managers and the associated performance assessment; agreeing actions on behalf of the Board where required. Full Terms of Reference	
Chair	Ann Lloyd, Chair	1/1
Members and Attendance	Pippa Britton, Vice Chair (Until December 2024) Iwan Jones, Independent Member Louise Wright, Independent Member	1/1 1/1 1/1
Regular Executive Attendance	Sarah Simmonds, Director of Workforce and OD	1/1
No Meetings per year	Quarterly, as required	
Items Considered	The Committee received updates on: • Chief Executive and Executive Director Performance • Executive and Senior Manager Secondments • Settlement Agreements • Progress with AFC non pay collective agreement and other pay related issues (national discussions)	

Board Development and Briefing

Board members took part in a number of development and briefing sessions through 2024/25. Topics covered at these sessions included:

- ❖ Long Term Strategy Development
- ❖ Charity Trustee Training
- ❖ Service Development Business Cases
- ❖ Health and Safety Training
- ❖ Corporate Manslaughter Training
- ❖ Health Pathways Overview
- ❖ Estates Strategy
- ❖ Speaking Up Safely
- ❖ Social Partnership and Public Procurement (Wales) Act Training
- ❖ Cyber Security Awareness

Self Assessment and Evaluation

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

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

In order to support the ongoing development of the Health Board, the Health Board are working with the Good Governance Institute (GGI) to develop and roll out a board development programme during 2025/26.

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

In addition to these core components, GGI colleagues met with each member of the Board during February/March 2025 to inform a baseline position of the Board's development programme.

The outputs of the baseline position and a discussion with board members regarding opportunities for targeted development will be held in April 2025

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

Compliance with Standing Orders

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

Section 5 – Advisory Groups	*The LHB's Advisory Groups include a Stakeholder Reference Group, Healthcare Professionals' Forum and Local Partnership Forum.* [Local Partnership Forum is established]

Section 7 - Meetings	*The availability of papers in English and Welsh languages and in accessible formats, such as Braille, large print, easy read (where requested or required) and in electronic formats;*
Section 7 - Meetings	*The LHB shall encourage attendance at its formal Board meetings by the public and members of the press as well as LHB officers or representatives from organisations who have an interest in LHB business.* (noting that the SOs, as far as they are applicable, also apply to meetings of any formal Committees established by the Board)

Actions will be put in place to address each of these areas during 2025/26.

ADVISORY GROUPS AND JOINT COMMITTEES

Advisory Groups

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

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

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

Stakeholder Reference Group (SRG)

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

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

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

In view of these evolving engagement arrangements and given that the Stakeholder Reference Group last met in October 2021, a decision was taken to disband the SRG in its current form in October 2022, whilst the Health Board reviews and redesigns the role and constitution of the Group, ensuring it is fit for purpose and fully effective. A proposal for re-establishment of the SRG will be considered by the Board in 2025.

In the meantime, the Health Board continues to work alongside partners to engage and involve people who others are also seeking to engage. This enables strong partnership working, the sharing of resource and the ability to collaborate regarding joint solutions to challenges shared. Many organisations have been extremely generous in enabling our participation in their existing activities. The Health Board has previously attended:

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

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

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

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

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

The TUPF is the formal mechanism for the Health Board and Trade Union/Professional Organisation Representatives to work together to improve health services. It is the forum where key stakeholders will engage with each other to inform, debate and seek to agree local priorities on workforce and health service issues. The TUPF is co-chaired by the Chair of Staff Representatives and the Chief Executive of the Health Board. Members are Staff Representatives (including the Independent Member for Trade Unions), the Executive Team and Chief Executive, the Director of

Corporate Governance, the Assistant Directors of Workforce and OD and the Head of Workforce Governance. The Forum meets 6 times a year and the Board receives an Annual Report on the work of the Forum.

Healthcare Professionals' Forum (HPF)

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

The Health Board is currently developing its Quality Management System and as a part of this a review and design of the Healthcare Professional's Forum will be undertaken, ensuring it is fit for purpose and fully effective and does not duplicate other aspects of the Health Board's clinical engagement mechanisms. A proposal for re-establishment of the HPF will be considered by the Board in 2025.

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

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

NHS Wales Joint Commissioning Committee

As set out within the Health Board's Standing Orders, during 2024/25, the Board was required to establish the NHS Wales Joint Commissioning Committee.

The National Health Service Joint Commissioning Committee (Wales) Directions 2024 (the Directions) came into force on 7th February 2024 which provide that the Local Health Boards in Wales will work jointly to exercise functions relating to the planning and securing of services specified within the Directions or as identified by the Local Health Boards. Specifically, these are: (a) specialised services for: (i) cancer and blood disorders, (ii) cardiac conditions, (iii) mental health and vulnerable groups, (iv) neurosciences, and (v) women and children; (b) services where there is agreement

between the Local Health Boards that they should be arranged on a regional and national basis; (c) emergency medical services; (d) non-emergency patient transport services; (e) emergency medical retrieval and transfer services; (f) NHS 111 services; (g) sexual assault referral centres; and (h) other services as directed by the Welsh Ministers.

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

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

Statutory and Strategic Partnerships

Gwent Regional Partnership Board

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

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

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

The Regional Integration Fund (RIF) is hosted by Aneurin Bevan University Health Board on behalf of the Gwent Regional Partnership Board and is a standing agenda item on the Regional Partnership monthly meetings. All matters in relation to the RIF are discussed and approved within the partnership forum. Information is cascaded throughout the partnership structures for transparency. Where needed, the RPB accommodates

special meetings to sign off RIF investment plans where meetings schedules do not align with reporting or development timeframes.

Aneurin Bevan University Health Board Members included in the membership of the Regional Partnership Board are:

- Ann Lloyd, Health Board Chair
- Nicola Prygodzicz, Chief Executive
- Tracy Daszkiewicz, Director for Public Health
- Hannah Evans, Director of Strategy, Planning & Partnerships
- Phil Robson, Special Advisor to Health Board

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

Gwent Public Services Board

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

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

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

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

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

NHS Wales Shared Services Partnership

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

As a hosted organisation, NWSSP operates under the legal framework and Establishment Order of Velindre University NHS Trust. The Managing Director is the designated Accountable Officer for Shared Services in line with The Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012 and is accountable to the Director General/CEO

of NHS Wales, Health Boards, Special Health Authorities and Trusts through the Shared Services Partnership Committee (the Partnership Committee). The Partnership Committee meets bi-monthly and is chaired by Professor Tracy Myhill OBE. The membership is comprised of representatives from each NHS organisation, including Aneurin Bevan University Health Board.

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

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

Partnership working with other Health Boards

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

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

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

Directed by the Cabinet Secretary for Health and Social Care, in Quarter 3 of 2025/26, Aneurin Bevan University Health Board, Cardiff and Vale University Health Board, and Cwm Taf Morgannwg University Heath Board will establish a Joint Regional Committee to exercise the facilitation and oversight of regional planning to drive effective collaboration and regional working.

THE PURPOSE OF THE SYSTEM OF INTERNAL CONTROL

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

The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place for the year ended 31 March 2025 and up to the date of approval of the annual report and accounts.

Capacity to Handle Risk

As Chief Executive and Accountable Officer, I hold overall responsibility for risk management and provide regular reports to the Board on its effectiveness across the Health Board. My advice to the Board is informed by executive officers and insights from the Board's Committees, particularly the Audit, Risk, and Assurance Committee and the Patient Quality, Safety, and Outcomes Committee. This ensures a well-rounded approach to risk oversight, integrating both strategic and operational perspectives.

Risk management is embedded within the Health Board's governance structure. The Executive Committee serves as a key forum for executive directors to discuss and escalate risks. This enables continuous monitoring of the organisation's risk profile and ensures that emerging risks are actively managed and reported to the Board and its Committees.

The Director of Corporate Governance leads the Health Board's risk management framework, overseeing the development of systems and processes that support a proactive and structured approach to risk identification, mitigation, and review. Responsibility for specific risks is delegated to relevant Directors, ensuring expert oversight and accountability. For example:

- Patient safety risks are managed by the Medical Director, the Director of Nursing and the Director of Allied Health Professionals and Health Science.
- Operational risks fall under the purview of the Chief Operating Officer
- Workforce-related risks are overseen by the Director of Workforce and Organisational Development.
- Digital-related risks are overseen by the Director of Digital

This structured approach ensures that risks are managed effectively at all levels of the organisation, safeguarding both service quality and organisational resilience.

Risk Management Framework

The Health Board employs a robust risk management framework, integrating systematic identification, assessment, and mitigation processes.

The current Risk Management Framework (RMF) was approved by the Board in January 2024 and as required by the Model Standing Orders, undergoes an annual review. This year's (2025) review resulted in minimal changes; however, key updates have been incorporated to ensure staff assess the intent behind risks, whether malicious or non-malicious. This distinction determines the timeframe over which the risk's potential impact should be considered, in alignment with the National Security Risk Assessment (NSRA):

- **Malicious risks:** Assessed over a 2-year period.
- **Non-malicious risks:** Assessed over a 5-year period.

The updated Risk Management Framework was presented to the Audit Risk and Assurance Committee in April 2025 for review and feedback, prior to its submission to the Board for approval in May 2025.

The Chief Executive has overall accountability for risk management, with delegated responsibilities assigned to senior leadership teams and operational managers as appropriate. Staff are equipped with risk management training tailored to their roles, ensuring that decision-making aligns with the Board's risk appetite. This includes:

- Comprehensive induction training on risk awareness for new employees.
- Ongoing professional development in risk assessment methodologies.
- Periodic risk scenario exercises and workshops to enhance preparedness for Major Incidents and Business Continuity Incidents.

Risk Profile, Strategic Risk and Assurance Register

The Board maintains an integrated risk management approach by linking risk assessment to the Integrated Medium-Term Plan (IMTP). This provides a structured mechanism for monitoring high-impact risks and ensure that mitigation strategies are aligned with strategic objectives.

Significant risk areas identified during the reporting year include:

- Operational resilience amid external pressures, such as increased demand for healthcare services in response to workforce shortages and recruitment challenges.

- Cybersecurity threats, due to dated systems posing operational vulnerabilities, staff vigilance of potential cyber threats.

- Financial pressures, due to increase in costs and limitations impacting delivery of efficiency savings.

- Compliance with meeting national environmental goals within its regulatory responsibilities.

Each identified risk is assigned a designated risk owner, ensuring accountability and oversight at the appropriate governance level.

The Director of Corporate Governance submits a comprehensive Strategic Risk Report at every Board meeting, along with tailored reports for each Board Committee. These Committee reports include in-depth risk assessments specific to the areas for which each Committee is responsible, in line with its Terms of Reference.

To promote transparency and accountability, the Strategic Risk Report is published in the public domain. This ensures openness around the key strategic risks identified by the Health Board as potential obstacles to achieving its strategic priorities.

As of the end of March 2025, the Strategic Risk Register contained **Nine** active principal risks with **21** (threats) sub-risks. These represent the most significant threats to the successful delivery of the Health Board's strategic objectives. Each risk is evaluated and categorised according to its likelihood of occurrence and potential impact, as outlined below.

Risk Level & Score	Number of Risks	Number of Risks outside of Appetite
Extreme (15 – 25)	**8**	**1**
High (9 – 12)	**9**	**4**
Moderate (5 –8)	**4**	**-**
Low (1 – 4)	**-**	**-**

The highest risk included on the Strategic Risk Register has a score of **16**

(L4 x I4) and is owned by the Director of Finance and Procurement (SRR 001G) and is concerned with safeguarding the financial sustainability of the Health Board.

The infographic below depicts the Health Board's current risk exposure to the 21 strategic sub-risks, demonstrating that the majority of the strategic risks are concentrated in the central line of the risk matrix indicating a high level of risk exposure.

Risk Scoring Matrix					
Likelihood	**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%)					

A copy of the latest Strategic Risk Report, presented to the Board in May 2025, is available on the Health Board's website. The risks contained within this report have undergone thorough scrutiny, challenge, and review by the designated Executive Risk Owners. In addition, a robust assessment of the Health Board's internal control systems has been completed, alongside an evaluation of all sources of assurance related to each risk.

Ongoing work is being undertaken to strengthen assurance over risks currently operating outside the Board's defined risk appetite. This includes conducting targeted deep dives into these risks and developing action plans to enhance control measures and reduce the likelihood and/or impact of adverse events.

Recent enhancements to the risk assessment template, along with the implementation of a risk dashboard, have significantly improved the Board's visibility of how current risk profiles align with its strategic objectives and the Board's appetite for risk in achieving them. The revised reporting format used for both Committees and the full Board offers a high-level summary of the risks under their oversight, clearly indicating:

- Whether each risk is being managed within the agreed risk appetite
- Where risks are outside of appetite, whether appropriate mitigation plans are in place to address them

While progress has been made, the Board acknowledges that further work is needed to enhance both risk control and assurance mechanisms across the full spectrum of strategic risks.

Accordingly, a high-level summary of the overall assurance level the Board can draw from this iteration of the Strategic Risk Report is provided below:

Overall Assurance on the Management of Risk		
Nil	**Satisfactory**	**Considerable**
	X	

As a result, the Board can take a satisfactory level of assurance that the strategic risks recorded on the Strategic Risk Register (as at May 2025) which reflect the most significant threats to the delivery of the IMTP are being effectively managed.

Furthermore, the internal control systems in place to manage these risks are assessed as satisfactory.

Risk Appetite Determination

The Health Board establishes its risk appetite through a structured assessment process, balancing the need for innovation with patient safety, financial sustainability, and regulatory compliance. The Health Board's Risk appetite was approved by the Board in January 2024 through strategic discussions that consider operational challenges, stakeholder expectations, and emerging trends.

The Board ensures a proportionate approach to risk-taking, allowing for flexibility where necessary while maintaining strict controls in critical areas such as patient care, clinical safety, and financial governance.

The table below summarises the Health Board's position on its appetite for risk and the level of tolerance it is willing to accept. The full Risk Appetite Statement is available here.

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

Strategic Risks Outside of the Health Board's Defined Threshold as at 31st March 2025

All five strategic risks outlined below exceed the Health Board's defined threshold and fall under the category of Safety and Compliance, a domain in which the Health Board has a minimal risk appetite, with a threshold set at a score of 8 or lower. These risks are currently being managed using the 5T's risk control framework: Tolerate, Treat, Transfer, Terminate, or Take the opportunity. This structured approach ensures each risk is assessed and addressed with appropriate action in line with the Board's governance and safety priorities.

Risk ID	Sub Risk Description	Current Score	Treatment of the Risks
SRR 001I	Due to a failure to implement the required performance improvements in some areas of the organisation in line with the Health Board's Performance Management Framework domains of Quality and Safety, Operational Delivery, and Finance.	12	**Treat** the residual risk, but also **Take the Opportunity** to redesign and strengthen services for long-term sustainability.
SRR 002A	Due to the presence of Reinforced Autoclaved Aeriated Concrete (RAAC) within structures	15	**Tolerate** the risk until it can be **Terminated.**
SRR 002B	Due to significant levels of backlog maintenance and structural impairment.	12	**TREAT** the risk through proactive estate investment and maintenance planning.
SRR 004B	Due to ineffective and insufficient arrangements across all service areas to respond to a Business Continuity or Critical Incident	12	**TREAT** the risk by developing, standardising, and testing effective Business Continuity and Critical Incident Response Plans.
SRR 010	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.	12	**Treat** the residual risk, but also **Take the Opportunity** to improve staff safety culture.

Risk & Assurance Related Internal Audit Reviews

The Board's Internal Audit Work Plan is developed with careful consideration of the key risks that could impact the achievement of the Health Board's strategic and operational objectives, as well as its long-term sustainability. Any risks identified through the audit process are reviewed by the Head of Corporate Risk and Assurance to determine whether they should be incorporated into the appropriate risk register strategic, corporate, or operational to ensure they are subject to effective monitoring and management

The Audit, Risk and Assurance Committee received one risk management audit with a reasonable assurance rating from the 2024/25 Internal Audit Plan. 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 report issued in April 2025 concluded that divisional management demonstrated effective risk escalation processes, supported by current policies and procedures. Clear guidance was provided on identifying and escalating key risks, with appropriate use of judgement. Risks were well-documented, tracked, and escalated to the relevant governance bodies with feedback recorded and acted upon in a timely manner.

Overall assurance levels were rated as **Substantial to Reasonable** with four medium recommendations for action.

Public and Stakeholder Involvement in Risk Management

Public stakeholders play a crucial role in shaping risk management strategies. Engagement mechanisms include:

- Public consultations to gather community perspectives on service delivery risks.
- Collaboration with patient advocacy groups such as Llais to address concerns related to clinical and operational risks.
- Partnerships with external agencies, including regulatory bodies, emergency services, and local authorities, ensuring a coordinated response to shared risks.

These collaborative efforts have strengthened the Board's ability to anticipate and respond to risks effectively, fostering transparency and public trust.

Addressing Weaknesses in the Risk Environment

Where weaknesses in the risk environment have been identified, the Health Board has taken decisive actions to strengthen controls. Measures include:

- Enhanced governance processes, ensuring clearer oversight of risk mitigation efforts.

- Investment in digital transformation, reducing reliance on outdated systems that pose operational vulnerabilities.

- Strengthened audit and assurance mechanisms, providing greater scrutiny and accountability in high-risk areas.

By adopting these measures, the Health Board ensures continuous improvement in risk management, supporting the delivery of high-quality, safe, and sustainable healthcare services.

Emergency Planning

In accordance with the statutory duties of the Civil Contingencies Act (2004) and Emergency Planning Guidance issued by Welsh Government the Health Board have in place emergency plans, business continuity arrangements, health protection response plans and supporting documents. These plans were considered by the Board's Partnerships, Population Health and Planning Committee in July 2024.

The Major Incident Plan was Exercised fully in June 2024 with lessons identified through debrief processes and there is ongoing refinement to departmental plans and action cards. There has additionally, in accordance with the Act, been collaborative planning and exercising with Local Resilience Forum partners throughout the year aligned to the LRF Risk Register, and shared and collaborative response to incidents.

THE CONTROL FRAMEWORK

Patient Safety, Quality, Experience and Learning

As an NHS Wales organisation, there are clear expectations set out for the quality standards we must maintain as set out through the:

- Health and Social Care (Quality and Engagement) (Wales) Act 2020, including the Health and Care Standards;
- A Healthier Wales;
- Core Commissioning Requirements.

In 2023 the Health Board published and implemented the Quality Strategy and the Patient Experience and Involvement Strategy. These strategies are shaped by the experiences of patients, families, carers, staff, and communities, focusing on improvement, planning, and assurance where it matters most. They align with the Duty of Quality objectives, Health and Care Standards and support our responsibilities under the Duty of Candour. Both Strategies set out the Health Board's goals to enhance clinical effectiveness, safety, and service user experience. They reflect our commitment to meaningful engagement, listening to feedback, learning from it, and driving improvement across all services.

The Health Board has made several notable achievements in relation to the Quality Strategy, particularly focusing on **insight, involvement and improvement**. These include:

- Development of the Quality Management System which sets out the Assurance Framework to enable the delivery of safe high-quality care.

- Improved understanding of patient safety by drawing insights from multiple sources of patient safety information, including incident reports, medical examiners' reviews, and patient feedback. This comprehensive data collection has enabled more informed decision-making and targeted interventions.

- Implementation of data analytics has allowed the Health Board to monitor performance effectively. For example, there is now an ability to track and report on various quality metrics, ensuring continuous improvement in service delivery. This includes implementation and refining of a Quality Outcomes Framework (QOF) to systematically measure and enhance healthcare quality.

- Introduction of the CIVICA Citizen Feedback System which has significantly increased the volume of feedback from patients and staff. This system has facilitated the collection of valuable insights, which are used to make informed changes and improvements.

- Prioritised person-centered care by involving patients, relatives, carers, and system partners in the planning and delivery of care. This approach has led to an overall satisfaction score of 88%, which is above the benchmark of 85%.

- Promoted a culture of openness and transparency, by encouraging staff to report incidents and concerns without fear of blame. This has fostered a supportive environment where continuous learning and improvement are prioritised.

- Established several quality improvement programmes, including those within the Safe Care Collaborative, which focuses on key safety priorities. These programs provide structured support for teams to implement changes, leading to effective and sustainable improvements.

- Developed continuous learning and development by providing structured training programs, learning from feedback and incidents, direct coaching, and support for improvement initiatives. This has ensured that staff have the necessary skills and opportunities to drive effective change.

- Promoted a whole systems approach to quality, encouraging collaboration across different departments and services. This integrated approach has ensured that improvements are sustainable and have a broad impact on patient care.

Clinical Audit Programme

The Health Board's Annual Clinical Audit Plan is developed and updated each year which provides timelines of audit publications for the year ahead. The Health Board actively participates in the National Clinical Audit Programme. By using its findings, the Health Board benchmarks the quality of care provided and identify areas for focused improvement. Each national audit offers valuable insights into strengths and areas for development. These insights are discussed by the Clinical Standards and Effectiveness Group and reported to the Board's Patient Quality, Safety, and Outcomes Committee, ensuring clear oversight and accountability. These can be seen in our Annual Audit report. Actions for improvement arising from Clinical Audit are recorded on the Health Board's Audit Management and Tracking (AMaT) system.

Information Governance

Information is a critical asset, essential for both the clinical management of individual patients and the efficient management of services and resources. Information Governance (IG) involves establishing high

standards for handling this information and equipping the organisation with the necessary tools to achieve these standards.

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

Throughout 2024/2025, the Health Board continued to enhance its forums to address information governance requirements consistently. These forums facilitate processes and communications to ensure compliance with Data Protection obligations. Dashboards are produced to support and assist in training compliance, complaint handling, incident, and breach management. Annual reports detailing progress are disseminated to relevant divisions and boards.

At the request of the DPO, the organisation underwent a consensual audit by the Information Commissioner's Office (ICO), focusing on Information Security, Requests for Access and Information Risk Management. The audit resulted in a "Reasonable score" for each aspect. Following a subsequent review, the ICO deemed the audit engagement complete after evaluating the actions taken in response to their recommendations.

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

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

In 2024/2025, there was a 12.5% increase in the number of Subject Access Requests (SARs), rising from 6,724 in 2023/2024 to 7,568 in 2024/2025. There was also a 4% increase in IG incidents reported by staff, from 531 incidents in 2023/2024 to 555 incidents in 2024/2025.

There were 11 complaints made to the Information Commissioner's Office (ICO), with 9 not upheld and 2 pending a final outcome at the time of writing.

In 2024/2025, the Health Board reported no serious lapses in data security to the ICO.

Quality of Data

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

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

The Corporate Governance Code

The Corporate Governance Code currently relevant to NHS bodies is 'The corporate governance in central government departments: code of good practice' (published 21 April 2017). The Health Board, like other NHS Wales organisations, is not required to comply with all elements of the Code, however, the main principles of the Code stand as they are relevant to all public sector bodies. The Corporate Governance code is reflected within key policies and procedures. Further, within our system of internal control, there are a range of mechanisms in place that are designed to monitor our compliance with the Code. These include Self-assessment; Internal and External Audit; and Independent Reviews.

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

Planning Arrangements

The Health Board's Annual Plan: Three Year Intent 2024/25 ("The Plan"), together with supporting templates and appendices, was approved by the Board in its meeting on the 27th of March 2024. The submission recognised the significant challenges and risks going forward and the financial context within which the Health Board is operating to deliver the plan. The Duties of Quality and of Candour and a refocusing of the Health Board's ambition

with respect to prevention were at the forefront of the Annual Plan, alongside the need to drive efficient and effective in year service delivery.

The Plan outlined an end of year outturn of a £48.9m deficit, notwithstanding a significant savings programme and a high-level line of sight towards a balanced position within three years.

Following correspondence from Welsh Government, the Health Board updated its Annual Plan for 2024/25 and re-submitted this by 31st May 2024.

On 26th July 2024 the Health Board received correspondence from Welsh Government which confirmed that the Health Board had been unable to submit a balanced integrated medium-term plan (IMTP) for 2024-27 in line with section 175(2A) of the National Health Service (Wales) Act 2006 (as amended by NHS Finance (Wales) Act 2014) and in accordance with the NHS Planning Framework. The Health Board's Annual Plan with a forecast deficit was noted by Welsh Government alongside a number of accountability conditions issued:

- Ensure delivery of performance in line with expectations;
- Continue to review and take action to reduce the deficit and maximise your savings plan in year and deliver on the escalation framework and de-escalation requirements;
- Continue to adopt the Value and Sustainability Board programme, maximise opportunities for efficiency and productivity;
- Progress regional solutions, working collaboratively with partners; and
- Agree LTAs with other organisations, working collaboratively to avoid arbitration.

In December 2024, the Health Board received a letter from Welsh Government which notified the Health Board of additional funding totalling £40.5m; £9.5m issued recurrently to support ongoing operational pressures, and a further £31m also issued on a recurrent basis but conditional on the Health Board delivering against objectives specified within the letter. As a result of this new recurrent funding, the Health Board was issued a revised control total of £7.356m and aimed to meet this target as a minimum, whilst continuing to identify opportunities to improve the position further.

Throughout the year the Board and its Finance and Performance Committee has maintained a focus on overseeing delivery of the commitments set out by the Health Board within the Annual Plan for 2024/25.

MANDATORY DISCLOSURE STATEMENTS

Equality, Diversity & Human Rights

It is a key priority for the Health Board to become a truly inclusive organisation which celebrates its diverse workforce, and where staff feel they are treated equally regardless of their ethnic background, gender, religion, sexual orientation, disability or age.

The Health Board published its Strategic Equality Action Plan for 2024 – 2028 in March 2024, in line with the Public Sector Equality Duty (2011), demonstrating its commitment to advancing Equality, Diversity, and Inclusion (EDI) and fulfilling its statutory responsibilities under the Equality Act (2010) and the Human Rights Act (1998). The Strategic Equality Plan Update published in March 2025 highlights progress made in embedding equitable, inclusive, and person-centered approaches across the organisation in Year 1 of the new plan.

The key achievements in Year 1 of our Strategic Equality Plan demonstrates the Health Board's ongoing dedication to fostering an inclusive and equitable workplace and healthcare environment. EDI and Human Rights remain key executive and board-level priorities, with a continued focus on monitoring, measuring, and driving sustainable progress in addressing health and workplace inequalities.

The Health Board has a statutory duty to publish the organisation's Gender Pay Gap data annually based on snapshot as at the 31st March each year with a reporting deadline of the 30th March of the following year. The Health Board submitted its data as at the 31st March 2024 on time and by the 30th March 2025.

The Health Board has seen a decrease in the Pay Gap percentage for average hourly rates from 25.37% in March 2023 to 24.71% in March 2024 which is a move in the right direction. The average hourly rate remains static at 9.56% in March 2023 and 9.68% in March 2024.

In addition to our annual reporting cycle, governance arrangements for ED&I ensure the Board and its People and Culture Committee receives regular assurance that the Health Board is meeting its Public Sector Equality Duty (PSED) requirements.

Pensions Scheme

I can confirm that as an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employers' contributions and payments into the Scheme are in accordance with Scheme rules and that the member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations. Further detail in this regard is included within the provisions note within the 2024/25 Financial Statements (Note 20).

Carbon Reduction Delivery Plans

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

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

The organisation completed the initial presentation on Adaptation by Welsh Government on the 2nd May 2025 and are now completing the planned adaptation tool kit in readiness for submission to the Welsh Government in December 2025. Public Health Wales are helping to co-ordinate the upcoming literacy sessions through the summer 2025 and we have started to share best practice in the approach of the adaptation process with our local councils.

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

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

The Health Board's Counter Fraud Team undertake proactive/preventative work with the intention of safeguarding the organisation from economic crime. Further information on the valuable work undertaken is available in the Counter Fraud Annual Report 2024/25.

Ministerial Directions & Welsh Health Circulars

The Welsh Government has previously issued Non-Statutory Instruments and reintroduced Welsh Health Circulars (WHCs) in 2014/15. Details of these and a record of any ministerial directions given is available on the Welsh Government website. A full detail of the WHCs and Ministerial Directions issued to the Health Board in 2024/25 and the Health Board's responding action is included at **Attachment 2**.

There was one Ministerial Direction issued in December 2019, to address the operational challenges arising as a consequence of pension tax arrangements. Further detail in this regard is included in provisions within the 2024/25 Financial Statements (Note 20).

Modern Slavery Act 2015 – Transparency in Supply Chains

The Health Board is fully committed to the Welsh Government Code of Practice Ethical Employment in Supply Chains. This has been established

by the Welsh Government to support the development of more ethical supply chains to deliver contracts for the Welsh public sector and third sector organisations in receipt of public funds.

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

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

NWSSP Procurement Services has:

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

NWSSP Procurement Services will continue to:

- Conduct appropriate and targeted engagement with our bidders, to ensure that the way in which we work does not contribute to the use of illegal or unethical employment practices within the supply chain;
- Maintain and share knowledge of ethical employment issues and themes, ensuring continuing support of fair and decent work;
- Leverage our tender processes to encourage our suppliers to sign up to the commitments of Ethical Employment in Supply Chains Code of Practice and also to the TISC register, to publicise their commitments and their Modern Slavery/Ethical Employment Statements;
- Assess our expenditure to identify areas of high risk, and continue to address any issues of modern slavery, human rights abuses and/or unethical employment practice.

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

REVIEW OF EFFECTIVENESS OF SYSTEM OF INTERNAL CONTROL

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

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

During 2024/25, the Board's Audit, Risk and Assurance Committee and, Patient Quality, Safety and Outcomes Committee played a key role in monitoring the effectiveness of internal control and the process for risk management. During 2024/25 work has continued to embed the Risk Management Framework approved by the Board in January 2024. The Board's Quality Strategy, approved in March 2023 and updated in February 2024, will ensure that the work of all regulators, inspectors and assurance bodies is mapped and evidenced in our assurance framework so that the Board is fully aware of this activity and the level of assurance it provides. We will also continue to strengthen arrangements for monitoring and reporting progress in implementing recommendations arising from the work of auditors.

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

INTERNAL AUDIT

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

The overall opinion by the Head of Internal Audit on governance, risk management and control, is a function of this risk-based audit programme and contributes to the picture of assurance available to the Board in

reviewing effectiveness and supporting our drive for continuous improvement.

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

The assurance sections that follow provide a brief summary of the scope of the Internal Audit Reviews that have been completed and received by the Committee during the financial year 2024-25.

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.
Reports included within the 2023/24 Internal Audit Plan, and reported in the Annual Governance Statement 2023/24, reported to the Audit, Risk and Assurance Committee in 2024/25:
Unified Breast Unit at Ysbyty Ystrad Fawr (2023/24) 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)** This internal audit was undertaken to provide an opinion over the effectiveness of the Health Board's treasury financial controls. **Early Supported Discharge – Stroke (2023/24)** 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)**

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.

Reports included within the 2024/25 Internal Audit Plan:

Declarations of Interest (2024/25)
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.

Reports included within the 2023/24 Internal Audit Plan, and reported in the Annual Governance Statement 2023/24, reported to the Audit, Risk and Assurance Committee in 2024/25:

Asset Management (2023/24)
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)
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)
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)
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)
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)
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.

Directorate Review – Theatre Stock (2023/24)
This internal audit was 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)
This internal audit was 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)
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)
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.

Reports included within the 2024/25 Internal Audit Plan:

IMTP – Service Delivery Plans (2024/25)
This internal audit was undertaken to provide an opinion over the controls to ensure the delivery of IMPT/ Strategic Objectives.

Facilities Stock (2024/25)
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)
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)
To provide an opinion over the arrangements in place within Aneurin Bevan University Health Board for providing care to asylum seekers and refugees, including that applicable guidance is being adhered to.

Intelligence Led Organisation (2024/25)
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)
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)
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)
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.

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

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

Reports included within the 2023/24 Internal Audit Plan, and reported in the Annual Governance Statement 2023/24, reported to the Audit, Risk and Assurance Committee in 2024/25:

Bevan Health and Wellbeing Centre (2023-24)
The audit sought to review the delivery and management arrangements in place to progress the Bevan Health & Wellbeing Centre.

The audit recognised the significant delays to the delivery of the project (currently circa 49.6 weeks) which are attributed to the Supply Chain Partner (SCP) and the corresponding delay in achieving the anticipated business case objectives.

The project faces significant challenges going forward as the contractor is likely to be operating at a loss – accordingly, maintaining reasonable performance from the SCP through existing project management tools will be essential through to completion and handover

A management action plan is in place to respond to the recommendations.

Financial Controls – RPB (2023-24)
This review tested the compliance with the Model Standing Orders Reservation and Delegation of Power / Standing Financial Instructions (SFIs) / Financial Control Procedures (FCPs) of the Health Board, regarding Regional Partnership Board (RPB) payments made on behalf of the RPB, by the Health Board.

The audit found that the financial framework, for the management of RPB activities is, in principle, aligned to the Health Board's approach to ordering, receipting and payments of purchases. However, a lack of a documented record of roles and responsibilities throughout that process, specific to the RPB, was noted.

In addition, detailed sampling of payment transactions identified examples of compliance issues with the FCPs and SFIs, partly due to the non-standard nature of the funding transactions, and opportunities for operational effectiveness to be improved.

Decarbonisation (2023-24)
This audit was undertaken to determine if the Health Board was adhering to the Welsh Government's requirements for the achievement of net zero carbon emissions.

The audit determined that the Health Board is unlikely to reach the Welsh Government (WG) target of 34% carbon emissions reduction by 2030. The audit found that this is not due to poor governance or an unwillingness from the organisation to achieve the target, but rather the Health Board faces similar issues as other NHS Wales organisations, with a lack of funding to implement the necessary steps to achieve the WG target.

Furthermore, 67% of the Health Board's overall emissions sit within its procurement processes, which is managed by NHS Wales Shared Services Partnership (NWSSP) and therefore, outside of its direct control.

Positively, there has been clear progress and development of the internal controls since our previous audit. This included a clearly defined governance framework and a well-developed decarbonisation action plan (DAP) monitoring process.

Reports included in the 2024/25 Internal Audit Plan:

Records Management (2024/25)
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.

The Audit, Risk and Assurance Committee has raised concerns about the pace of the digitisation project and the risks it poses, and has escalated this to the Board to enable a discussion on how records are kept safe while awaiting digitisation.

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.

Reports included within the 2023/24 Internal Audit Plan, and reported in the Annual Governance Statement 2023/24, reported to the Audit, Risk and Assurance Committee in 2024/25:

Follow-up of High Priority Recommendations (2023-2024)
The review sought to assess whether high-level internal audit recommendations have been implemented and the completeness and accuracy of the updates provided to the Committee via the Audit Recommendation Tracking Tool (the 'Tracker')

Flexible Working (2023-24)
This audit assessed the Health Board's progress in embedding flexible working practices and the identification of good practice.

Reports included in the 2024/25 Internal Audit Plan:

None

The following reports included in the 2024/25 Internal Audit Plan have been deferred to 2025/26:

- Welsh Intensive Care Information System
- Capital Systems/Major Project Provisions (not separately provided)
- NHH Regional Satellite Centre

Monitoring and Implementation of Audit Recommendations

The Audit, Risk and Assurance Committee monitors the implementation of audit recommendations. In April 2022, the Committee adopted a standard

operating procedure (SOP) outlining the internal and external recommendation tracking process. This SOP provides rationale for how tracking recommendations benefits the organisation.

During 2024/25, significant and sustained progress has been made in strengthening the management of audit recommendations. A focused effort has been made to ensuring timely implementation, with particular attention given to longstanding recommendations (pre-2022). This targeted approach has contributed to a more robust and accountable system of oversight. The Audit, Risk and Assurance Committee receives regular updates at each meeting on the status of both internal and external audit recommendations.

To provide assurance to the Committee and the Board, Internal Audit conducts an annual review of how audit recommendations have been implemented, specifically high priority recommendations to ensure they are addressed in an appropriate and timely manner. The review assesses the risk to the Health Board if the implementation of high-priority recommendations is delayed. This review is underway at the time of writing.

As of the final meeting of the 2024/25 financial year, the Audit Recommendations Tracker recorded 69 outstanding recommendations across 38 audit reports. These 69 recommendations are broken down and set out below, demonstrating a continued focus on implementation of recommendations to ensure improvements in quality, safety and governance across the Health Board.

Number of Live Recommendations on the Tracker by Priority Rating				
High	**Medium**	**Low**	**Advisory**	**Total**
15	**32**	**12**	**10**	**69**

Head of Internal Audit's Opinion for 2024/25

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

The overall opinion is based primarily on the outcome of the work undertaken during the 2024/25 audit year. We also consider other information available to us such as our overall knowledge of the organisation, the findings of other assurance providers and inspectors, and the work we undertake at other NHS Wales organisations. The Head of Internal Audit considers the outcomes of the audit work undertaken and

exercises professional judgement to arrive at the most appropriate opinion for each organisation.

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

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

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

EXTERNAL AUDIT: AUDIT WALES STRUCTURED ASSESSMENT

The Audit Wales 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.

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."

The Structured Assessment also considered whether the Health Board had a sound approach to setting its well-being objectives in accordance with the sustainable development principle in the Well-being of Future Generations Act. The Assessment found that, while the Health Board worked well with partners to assess and understand its population needs, it needed to review its well-being objectives and ensure their delivery features more explicitly in corporate plans.

The report recommended that the Health Board needed to take the opportunity presented through the development of its new long-term strategy to more fully integrate the requirements of the Well-being of Future Generations (Wales) Act 2015 across the organisation and set well-being objectives, which the Health Board will now take forward.

The Annual Audit Report for the Health Board is available on the following link. This report summarises the findings from Audit Wales' 2024 audit work at Aneurin Bevan University Health Board undertaken to fulfil their responsibilities under the Public Audit (Wales) Act 2004.

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

CONCLUSION

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

During 2024/25, the Health Board proactively identified areas requiring improvement and requested that Internal Audit undertake detailed assessments in order to manage and mitigate associated risks. Work will continue in 2025/26 to ensure implementation of recommendations arising from audit reviews, in particular where a limited assurance rating is applied. Work will also continue in 2025/26 to further embed and mature risk management and assurance arrangements at a corporate and operational level. Implementation of further improvements identified by the External Audit will see a further strengthening of the Board's effectiveness and the system of internal control in 2025/26.

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

It is disappointing that in 2024/25, the Health Board has remained under enhanced escalation and intervention arrangements in some areas with Welsh Government. Significant progress has been made, and we will continue to progress at pace towards sustainable improvements that enable de-escalation to routine monitoring arrangements.

It is widely known that the demands on the health and care system remain significantly pressured, increasing health inequalities, and sustained economic and cost of living challenges. The health and care landscape in Gwent is rapidly changing. The COVID-19 Pandemic and Cost of Living

Crisis have exacerbated pre-existing health inequalities; in 2024, women in Monmouthshire can expect to live 14 more healthy life years than women in Blaenau Gwent. In addition to this, there are now more people over the age of 65 living in Gwent than ever before – and fewer young people too. This pattern is set to continue in the future which will have a significant impact on healthcare provision and the overall healthcare workforce over the coming years. In 2025/26 we will therefore launch a new long-term strategy which will articulate our joint commitments with the population of Gwent through to 2035.

Signed:

Nicola Prygodzicz
Chief Executive
Dated: XX 2025

Attachment One

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

Name	Designation	Dates (If not full year)	Attendance at Board Meetings	Champion Role
Independent Members				
Ann Lloyd	Chair		7 out of 7	
Pippa Britton	Vice Chair	Until 30/11/2024	4 out of 5	Mental Health
Louise Wright	Independent Member (Trade Union)		6 out of 7	Speaking Up Safely
Richard G Clarke	Independent Member (Local Authority)		4 out of 7	
Professor Helen Sweetland	Independent Member (University)		7 out of 7	Research
Paul Deneen	Independent Member (Community)		7 out of 7	Children and Young People
Iwan Jones	Independent Member (Finance)		6 out of 7	Welsh Language
Dafydd Vaughan	Independent Member (Digital)		7 out of 7	
Neil Patrick	Independent Member (Community)	From 01/04/2024	6 out of 6	Armed Forces
Penny Jones	Independent Member (Community)		7 out of 7	
Martin Blakebrough*	Independent Member (Third Sector)	Until 08/06/2024		
Executive Directors				
Nicola Prygodzicz	Chief Executive		7 out of 7	

Name	Designation	Dates (If not full year)	Attendance at Board Meetings	Champion Role
Hannah Evans	Director of Strategy, Planning and Partnerships		7 out of 7	Emergency Planning
Rob Holcombe	Director of Finance and Procurement		7 out of 7	
Dr James Calvert	Medical Director / Deputy Chief Executive		5 out of 7	Caldicot
Sarah Simmonds	Director of Workforce and OD		7 out of 7	Raising Concerns Welsh Language
Jennifer Winslade	Director of Nursing		7 out of 7	
Peter Carr	Director of Allied Health Professions and Health Sciences		5 out of 7	Fire Safety Violence and Aggression
Tracy Daszkiewicz	Director of Public Health		4 out of 7	
Leanne Watkins	Chief Operating Officer		7 out of 7	
Directors in Attendance				
Paul Solloway	Director of Digital		7 out of 7	
Director of Corporate Governance				
Rani Dash	Director of Corporate Governance		7 out of 7	

Membership and attendance at Committees of the Board is provided on pages XX

Quoracy of Meetings

	Quorate	Non-Quorate

Board	**10 April 2024**	**22 May 2024**	**17 July 2024**	**25 September 2024**	**26 November 2024**	**29 January 2025**	**26 March 2025**
Patient Quality, Safety and Outcomes Committee	**30 April 2024**	**4 June 2024**	**30 July 2024**	**2 September 2024**	**12 November 2024**	**20 January 2025**	
Audit, Risk and Assurance Committee	**22 April 2024***	**20 May 2024**	**24 June 2024**	**4 September 2024**	**21 October 2024**	**16 December 2024**	**12 February 2025**
Charitable Funds Committee	**3 July 2024**	**7 November 2024**	**13 January 2025**	**7 March 2025**			
Partnerships, Population Health and Planning Committee	**16 April 2024**	**1 July 2024**	**30 September 2024**	**28 January 2025**			
Mental Health Act Monitoring Committee	**4 June 2024**						
Finance and Performance Committee	**17 June 2024**	**9 September 2024**	**16 December 2024**	**17 February 2024**			
People and Culture Committee	**18 June 2024**	**15 October 2024**	**11 February 2025**				
Remuneration and Terms of Service Committee	**21 August 2024**						

* any decisions approved in principle and ratified at the following meeting

Attachment Two

Welsh Health Circulars

WHC No	Date Issued	Name of WHC	Rating
WHC/2024/001	10/01/2024	Changes to the way individuals who are at highest risk from Covid-19 access lateral flow tests	Complete
WHC/2024/002	05/03/2024	Standards for Competency Assurance of Non-Medical Prescribers in Wales	In Progress
WHC/2024/004	12/02/2024	Assurance of aseptic preparation of medicines in NHS Wales (Sterile preparation of medicine)	Complete
WHC/2024/005	01/02/2024	Private Obesity Surgery and the Welsh NHS	Complete
WHC/2024/006	22/03/2024	National Clinical Guidance for Stroke, for the UK and Ireland	In Progress
WHC/2024/007	09/04/2024	Guidelines for managing patients on the suspected cancer pathway	In Progress
WHC/2024/008	02/02/2024	Vaccination against measles - urgent action	In Progress
WHC/2024/009	08/02/2024	Covid 19 spring booster vaccination programme 2024	Complete
WHC/2024/010	27/02/2024	Welsh Sustainability Conference and Awards - New dates	Complete
WHC/2024/011	06/03/2024	Changes to dietary advice on feeding young children	Complete
WHC/2024/012	19/03/2024	Nursing Preceptorship & Restorative Clinical Supervision - A National Position Statement	In Progress
WHC/2024/013	11/04/2024	Governance on interim appointments to Executive and Senior Positions	Complete
WHC/2024/014	07/05/2024	Introduction of the Office of National Statistics' (ONS) Register of Geographic Codes (RGCs) as a foundational standard for use across NHS Wales Bodies	In Progress
WHC/2024/015	01/04/2025	People's Experience Framework and People's Experience Survey	In Progress
WHC/2024/016	12/04/2024	Healthy Child Wales Programme: for school aged children	In Progress
WHC/2024/017	28/03/2024	Implementation of the Non-pay elements of the 2022-24 Collective Agreement	Complete

WHC No	Date Issued	Name of WHC	Rating
WHC/2024/019	17/04/2024	Interim amendments to the Model Standing Orders for Local Health Boards and NHS Trusts in Wales	Complete
WHC/2024/020	13/05/2024	New Treatment fund: directions on the exemptions for health boards and trusts	Complete
WHC/2024/021	25/11/2024	Welcome to Wales: Policy Guidance Framework	Complete
WHC/2024/022	24/04/2024	Dispute Arbitration Process - Guidance for Disputed Debts (Invoices and service agreements) within NHS Wales: 2024/25-2026/27	Complete
WHC/2024/024	21/05/2024	Implementation on the agreed approach to preventing Violence and Aggression towards NHS staff in Wales	Complete
WHC/2024/025	04/06/2024	NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme for 2024/25	Complete
WHC/2024/026	22/05/2024	2024/25 LHB, SHA & Trust Monthly Financial Monitoring Return Guidance	Complete
WHC/2024/027	19/06/2024	All Wales Critical Care Escalation Guidance for the Management of Large Unplanned Increases in Demand	Complete
WHC/2024/028	12/06/2024	The National Influenza Immunisation Programme 2024-25	In Progress
WHC/2024/029	11/06/2024	Certification of Vision Impairment in Primary and Community Care	Complete
WHC/2024/030	03/07/2024	Published weight management medication pathway	In Progress
WHC/2024/031	17/06/2024	Agency workforce reduction programme and control framework 2024 to 2025	Complete
WHC/2024/032	25/06/2024	Introduction of RSV Vaccination programme	Complete
WHC/2024/033	02/08/2024	The Winter Respiratory Programme 2024/25	In Progress
WHC/2024/034	28/08/2024	Directions to apply the national Framework for the Commissioning of Care and Support in Wales: Code of Practice to local health boards and NHS Trusts - August 2024	In Progress

WHC No	Date Issued	Name of WHC	Rating
WHC/2024/035	17/09/2024	Standardising the management of acute deterioration	In Progress
WHC/2024/036	30/08/2024	Oxygen Cylinders: regulation 28 report and patient safety notice 041 reminder	Complete
WHC/2024/037	24/09/2024	Winter Respiratory Framework 2024 to 2025	In Progress
WHC/2024/038	20/09/2024	Healthcare associated infections and antimicrobial resistance goals 2024 to 2025	Complete
WHC/2024/039	03/10/2024	Pre-Transfusion Sample taking Compliance with the confirmatory sample rule	Complete
WHC/2024/040	03/10/2024	Adopting a patient and family initiated escalation approach	In Progress
WHC/2024/041	30/10/2024	Ambulance patient handover guidance	In Progress
WHC/2024/042	30/10/2024	Introduction of the 'Dictionary of Medicines and Devices' (DM+D) as a foundational standard in all NHS bodies in Wales.	In Progress
WHC/2024/043	14/11/2024	Pertussis Vaccine Offer for Healthcare Workers	In Progress
WHC/2024/044		Mandatory E-Learning Module - Anti-Racism	Complete
WHC/2024/045	18/11/2024	Spotting Sepsis in Children Awareness Leaflet	In Progress
WHC/2024/046	04/12/2024	Influenza (Flu) Vaccination mop up 2024 2025	In Progress
WHC/2024/047	18/12/2024	COVID-19 Spring Vaccination Programme 2025	In Progress
WHC/2024/050	20/12/2024	Infected Blood Inquiry: Implementation of Recommendation 8a and 8b	In Progress
WHC/2024/051	27/01/2025	Health Board allocations 2025 to 2026	Complete
WHC/2025/001	05/03/2025	NHS Wales Sustainability Conference and Awards 2025	Complete

WHC No	Date Issued	Name of WHC	Rating
WHC/2025/002	27/02/2025	**Timelines and Responsibilities for the Implementation of Early Warning Scores (EWS) to identify Acute Deterioration**	**In progress**
WHC/2025/004	14/04/2025	**National Clinical Audit Plan**	**Complete**
WHC/2025/005	07/03/2025	**Climate Emergency Spread & Scale Leadership Day & Adaptation**	**In progress**
WHC/2025/007	06/03/2025	Amendments following interim review to the Model Standing Orders for Local Health Boards, NHS Trusts and Special Health Authorities in Wales	**Complete**

Ministerial Directives

Date Issued	Ministerial Direction	Progress
29/04/2024	The Directions to Local Health Boards and NHS Trusts in Wales 2003 and the Managed Introduction of New medicines into the National Health Service in Wales Directions 2009 (Amendment)(Wales) Directions 2024	**Implemented**
19/04/2024	Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment)(No 2) Directions 2024	**Implemented**
24/06/2024	The Primary Medical Services (Directed Supplementary Services) (Wales) Directions 2024	**Implemented**
24/06/2024	The Primary Medical Services (Pertussis Immunisation for Pregnant and Post-Natal Women) (Directed Supplementary Services) (Wales) Directions 2024	**Implemented**
24/06/2024	The Primary Medical Services (Influenza and Pneumococcal Immunisation Scheme) (Directed Supplementary Service) (Wales) Directions 2024	**Implemented**
24/06/2024	The Primary Medical Services (Oral Anti-coagulation with Warfarin) (Directed Supplementary Services) (Wales) Directions 2024	**Implemented**
24/06/2024	The Primary Medical Services (Hormone Treatment Scheme for Adult Transgender Patients) (Directed Supplementary Service) (Wales) Directions 2024	**Implemented**
24/06/2024	The Primary Medical Services (Antivirals for Prophylaxis of Seasonal Influenza in Care Home Outbreaks) (Directed Supplementary Service) (Wales) Directions 2024	**Implemented**
24/06/2024	The Primary Medical Services (Type 2 Diabetes Mellitus Care Scheme for Adults) (Directed Supplementary Service) (Wales) Directions 2024	**Implemented**
05/07/2024	The Alternative Provider Medical Services (Wales) Directions 2024	**Implemented**

Date Issued	Ministerial Direction	Progress
23/08/2024	The Primary Care (Contracted Services: Immunisations) (RSV) Directions 2024	**Implemented**
28/08/2024	The Directions to Local Health Boards and NHS Trusts in Wales on the National Framework for Commissioning Care and Support 2024	**Implemented**
30/09/2024	Pharmaceutical Services (Clinical Services) (Wales) (Amendment) Directions 2024	**Implemented**
10/10/2024	The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 3) Directions 2024	**Implemented**
28/11/2024	Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 4) Directions 2024	**Implemented**
03/12/2024	The Local Health Board Medical Services (Wales) Directions 2024	**Implemented**
19/12/2024	The directed supplementary services directions and specification for complex multi-morbidity and frailty 2024	**Implemented**
10/02/2025	The Directions to Local Health Boards as to the General Dental Services Statement of Financial Entitlements (Amendment) Directions 2025	**Implemented**
10/02/2025	The Directions to Local Health Boards as to the Personal Dental Services Statement of Financial Entitlements (Amendment) Directions 2025	**Implemented**
10/02/2025	The Directions to Local Health Boards as to the General Dental Services Statement of Financial Entitlements (Amendment) (No.2) Directions 2025	**Implemented**
10/02/2025	The Directions to Local Health Boards as to the Personal Dental Services Statement of Financial Entitlements (Amendment) (No.2) Directions 2025	**Implemented**
11/02/2025	Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2025	**Implemented**
11/02/2025	Statement of general ophthalmic services remuneration and fee directions: 2025	**Implemented**
18/02/2025	The Directions to Local Health Boards as to the Personal Dental Services Statement of Financial Entitlements (Amendment) (No.3) Directions 2025	**Implemented**
18/02/2025	The Directions to Local Health Boards as to the General Dental Services Statement of Financial Entitlements (Amendment) (No.3) Directions 2025	**Implemented**
21/02/2025	Statement of general ophthalmic services remuneration and fee directions: 2025	**Implemented**
21/02/2025	The Directions to Local Health Boards as to the General Dental Services Statement of Financial Entitlements (Amendment) Directions 2025	**Implemented**
28/03/2025	The Wales Infected Blood Support Scheme (amendment) Directions 2025	**Implemented**

Attachment Three

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

Aneurin Bevan University Health Board Assessment 2024/25

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
2.1 2.2	Each organisation should have an effective board, which provides leadership for the business, helping it to operate in a business-like manner. The board should operate collectively, concentrating on advising on strategic and operational issues affecting the department's performance, as well as scrutinising and challenging departmental policies and performance, with a view to the long-term health and success of the Trust.	The Board meets in public on a bi-monthly basis. A forward work programme of Board Business is in place and approved on an annual basis. The work of the Board is guided and determined by its Standing Orders, Standing Financial Instructions and Schemes of Delegation. This provides the framework for delegation and decision making within the Health Board. The Board receives, as standing items to each meeting, finance, performance and corporate risk reports.	Comply	Board and Committee Minutes – demonstrate Scrutiny and support Audit Wales Structured Assessment 2024
2.3	The Board does not decide policy or exercise the powers of the ministers. The department's policy is decided by ministers alone on advice from officials. The board advises on the operational implications and effectiveness of policy proposals. The Board will operate according to recognised precepts of good corporate governance in business: • Leadership – articulating a clear vision for the department and giving clarity about how policy activities contribute to achieving this vision, including setting risk appetite and managing risk • Effectiveness – bringing a wide range of relevant experience to bear, including through offering rigorous challenge and scrutinising performance	The Board provides leadership and direction to the organisation and has a key role in ensuring that the organisation has sound governance arrangements in place. The Board seeks an open culture and high standards in the ways in which its work is conducted. Board Members share corporate responsibility for all decisions and undertake a key role in monitoring the performance of the organisation. Progress against the Health Board Integrated Medium Term Plan 2022-2025, which adopts a life course approach, is presented to the Board on a quarterly basis. The Health Board's Standing Orders and Standing Financial Instructions are designed to translate the statutory requirements into day to day operating practice, and, together with the adoption of a Schedule	Comply	Standing Orders and Standing Financial Instructions Audit Wales Structured Assessment 2024 IMTP Value and Behaviours Framework

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
	• Accountability – promoting transparency through clear and fair reporting. • Sustainability – taking a long-term view about what the department is trying to achieve and what it is doing to get there.	of Decisions reserved to the Board of Directors; a Scheme of Decisions to Officers and Others; and Standing Financial Instructions (SFIs), they provide the regulatory framework for the business conduct of the Health Board. These documents form the basis upon which the Health Board's governance and accountability framework is developed and, together with the adoption of the Health Board's Values and Behaviour Framework, is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.		
2.4 3.10	The Board should meet on at least a quarterly basis; however, best practice is that boards should meet more frequently. The Board advises on five main areas: • Strategic Clarity • Commercial Sense • Talented People • Results focus • Management information	The Board meets at least six times a year and in addition holds an Annual General Meeting. Discussions, actions and decisions of all meetings of the Board and its Committees are formally recorded as minutes or action notes. The Board's role, as set out in its Standing Orders, is to: • Set the strategic direction for the organisation • Hold the organisation to account for performance and delivery • Set the tone and culture of the Board and the organisation The Board's business is therefore structured in this way and encompasses the five main areas set out in point 2.4.	Comply	Standing Orders and Standing Financial Instructions Audit Wales Structured Assessment 2024 Board and Committee Agenda and Meeting Papers
2.7	The Board also supports the accounting officer in the discharge of obligations set out in Managing Public Money for the proper conduct of business and maintenance of ethical standards.	The Board approves the Accountability Report, following scrutiny by the Audit, Risk and Assurance Committee, on an annual basis which includes the Statement by the Accountable Officer assuring the Board on the System of Internal Control.	Comply	Accountability Report

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

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
		The Board is provided with a range of information including performance information at Board and Committee Meetings. The format and content of these is informed by national standards and requirements and also locally requested information. Independent Member membership on Board Committees are rotated at appropriate times to ensure there is mix and balance of experience across all meetings		
3.2	The roles and responsibilities of all board members should be defined clearly in the department's board operating framework.	The Board is constituted in accordance with the Health Board's Establishment Orders and Standing Orders	Comply	Health Board Establishment Orders Standing Orders
3.3	The Finance Director should be professionally qualified.	The Director of Finance and Procurement is professionally qualified	Comply	Recruitment and appointment documentation for the Director of Finance and Procurement
3.5	Independent Members will exercise their role through influence and advice, supporting as well as challenging the executive	The Structured Assessment 2024 highlights: *Board members hold open and frank discussions in Board and committee meetings on the Health Board's performance, finance, and quality challenges. Executive Directors are open about the Health Board's challenges and the priority areas for action and feel well supported by the entire Board in responding to them.*	Comply	Audit Wales Structured Assessment 2024 Independent Member Induction Pack

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
		There is a national programme of induction, in which all members are asked to participate. This is organised by Health Education and Improvement Wales. Tailored programmes of induction are in place new for Independent Members. A revised local induction programme has been developed and work continues to build a comprehensive programme for future use. There is also a programme of Board Development Sessions and Board Briefings and other training made available to the Board.		
3.15	The Board should agree and document in its board operating framework a *de minimis* threshold and mechanisms for board advice on the operation and delivery of policy proposals.	A forward work programme of Board Business is in place and approved on an annual basis. The Terms of Reference Operating Arrangements for the Board Committees articulate their remit. A forward work programme for each Committee is in place and approved on an annual basis.		Board Forward Work Programme Committee Forward Work Programmes Committee Terms of Reference
4.1	The Board should ensure that arrangements are in place to enable it to discharge its responsibilities effectively, including: 1. formal procedures for the appointment of new board members, tenure and succession planning for both board members and senior officials 2. allowing sufficient time for the board to discharge its collective responsibilities effectively 3. induction on joining the board, supplemented by regular updates to keep board members' skills and knowledge up-to-date	All Independent Member appointments including the Chair and Vice Chair are appointed by Welsh Government and the appointment processes are managed by the Public Appointments Department of Welsh Government. All Executive appointments, although internal appointments have external independent assessors on the panels and also Welsh Government representation. The Director of Corporate Governance monitors the terms of office of Independent Members to ensure succession planning is timely and managed in conjunction with the public appointments unit.		Terms of Reference and Operating Arrangements for Board and Committees Board and Committee Forward Work Programmes

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
	4. timely provision of information in a form and of a quality that enables the board to discharge its duties effectively 5. a mechanism for learning from past successes and failures within the departmental family and relevant external organisations 6. a formal and rigorous annual evaluation of the board's performance and that of its committees, and of individual board members 7. a dedicated secretariat with appropriate skills and experience	Agenda Setting meetings are held with the Chair, Chief Executive and Director of Corporate Governance to plan the agenda and ensure sufficient time is allocated to the right things at Board meetings. Board Induction programme in place (as previously referenced), supplemented by ongoing Board Briefing and Board Development sessions. The Chair undertakes regular one to ones and annual Personal Appraisal and Development Reviews with all Independent Members. Agenda and papers for Board meetings are published one week prior to the meeting. Report templates have been revised to ensure to support the provision of appropriate and relevant information. The Board's Quality Strategy and Quality Assurance Framework ensure learning as a key pillar of quality, embedded across the organisation. The Board undertakes an assessment of its effectiveness using the NHS England and NHS Improvement (NHSE and NHSI) Well-led Framework for Leadership and Governance Developmental Reviews. Committees undertook self assessments for 2024/25 during January which will inform the Board's end of year assessment.		

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
4.5	The terms of reference for the nominations committee will include at least the following three central elements: • scrutinising systems for identifying and developing leadership and high potential • scrutinising plans for orderly succession of appointments to the board and of senior management, in order to maintain an appropriate balance of skills and experience • scrutinising incentives and rewards for executive board members and senior officials, and advising on the extent to which these arrangements are effective at improving performance	The Terms of Reference and operating arrangements are based on the model Standing Orders and ensure that roles and responsibilities of Board Committees capture scrutiny and assurance roles. The Chair reviews the membership of Committees on an annual basis to ensure the appropriate balance of skills and expertise and support succession planning.	Comply	Terms of Reference for Board Committees Standing Orders
4.6	The attendance record of individual board members should be disclosed in the governance statement and cover meetings of the board and its committees held in the period to which the resource accounts relate.	The Annual Governance Statement provides details on the membership of the Board and Committee and the attendance record of individuals at these meetings.	Comply	Annual Governance Statement
4.10	Where necessary, board members should seek clarification or amplification on board issues or board papers through the board secretary. The board secretary will consider how officials can best support the work of board members; this may include providing board members with direct access to officials where appropriate.	Independent Members of the Board have direct access to members of the executive team in order to seek further information or clarification on issues as and when they arise. Regular Board Development sessions and Board briefings are also held to ensure that Board members are kept up to date on the breadth of issues. The Director of Corporate Governance acts as an independent voice within the organisation to advise and support the Board on governance matters and its approach to openness and transparency. The Director of Corporate Governance is responsible for developing the programmes of work for the Board and Committees of the organisation. Ensuring that agenda and papers are	Comply	Board Secretary role profile

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
		developed and reviewed prior to publication to ensure the quality or reports and maximum transparency and openness in the way in which the organisation conducts its business.		

4.11	An effective board secretary is essential for an effective board. Under the direction of the permanent secretary, the board secretary's responsibilities should include:
	
	• developing and agreeing the agenda for board meetings with the chair and lead non-executive board member, ensuring all relevant items are brought to the board's attention
	• ensuring good information flows within the board and its committees and between senior management and non-executive board members, including:
	  • challenging and ensuring the quality of board papers and board information
	  • ensuring board papers are received by board members according to a timetable agreed by the board
	  • providing advice and support on governance matters and helping to implement improvements in the governance structure and arrangements
	  • ensuring the board follows due process
	  • providing assurance to the board that the department:
	  • complies with government policy, as set out in the code
	  • adheres to the code's principles and supporting provisions on a comply or explain basis (which should form part of the report accompanying the resource accounts)
		The Director of Corporate Governance undertakes these roles as Board Secretary for the Health Board	Comply	Board Secretary role description
				
				Standing Orders

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
	• acting as the focal point for interaction between non-executive board members and the department, including arranging detailed briefing for non-executive board members and meetings between non-executive board members and officials, as requested or appropriate recording board decisions accurately and ensuring action points are followed up • arranging induction and professional development of board members (including ministers)			
4.14	Evaluations of the performance of individual board members should show whether each continues to contribute effectively and corporately and demonstrates commitment to the role (including commitment of time for board and committee meetings and other duties).	Individual annual assessment of Board Executive Directors is undertaken by the Chief Executive and Independent Members by the Chair, with the former reported to the Remuneration and Terms of Service Committee.	Comply	Appraisal documentation and process
4.15	All potential conflicts of interest for non-executive board members should be considered on a case by case basis. Where necessary, measures should be put in place to manage or resolve potential conflicts. The board should agree and document an appropriate system to record and manage conflicts and potential conflicts of interest of board members. The board should publish, in its governance statement, all relevant interests of individual board members and how any identified conflicts, and potential conflicts, of interest of board members have been managed.	Board Members complete annual Declarations of Interest and this register is available on the Health Board's website. Declarations of Interest in relation to items on the agenda are also sought at each Board and Committee meeting and are formally recorded within the minutes. Standards of Business Conduct for Employees in place (revised September 2024) and details responsibilities for declarations of interests.	Comply	Declarations of Interest Register Standards of Business Conduct for Employees Policy

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
5.1 5.8	The board should ensure that there are effective arrangements for governance, risk management and internal control for the whole departmental family. Advice about and scrutiny of key risks is a matter for the board, not a committee. The board should be supported by: • an audit and risk assurance committee, chaired by a suitably experienced non-executive board member • an internal audit service operating to Public Sector Internal Audit Standards1 • sponsor teams of the department's key ALBs	The Health Board has established an Audit, Risk and Assurance Committee, chaired by the Independent Member Finance lead. NWSSP Internal Audit Services are appointed as the Health Boards Internal Auditors The Health Board and its Committees monitor the management of risk considering the risks profile and actively engaging in its management.	Comply	Terms of Reference and Operating Arrangements for the Audit, Risk and Assurance Committee Accountability Report Audit Wales Structured Assessment
5.2 5.13	The board should take the lead on, and oversee the preparation of, the department's governance statement for publication with its resource accounts each year. The annual governance statement (which includes areas formerly covered by the statement on internal control) is published with the resource accounts each year. In preparing it, the board should assess the risks facing the department and ensure that the department's risk management and internal control systems are effective. The audit and risk assurance committee should normally lead this assessment for the board.	The Audit, Risk and Assurance Committee is responsible for reviewing the system of governance and assurance established within the Health Board and the arrangements for internal control, including risk management for the organisation and, in particular, advises on the Annual Governance Statement signed by the Chief Executive. The Governance Statement is included within the Accountability Report which is considered by the Audit, Risk and Assurance Committee prior to approval by the Board.	Comply	Accountability Report
5.3 5.10	The board's regular agenda should include scrutinising and advising on risk management.	The Health Board approve the Risk Management Framework. The Health Board and its Committees monitor the management of risk considering the risks profile and actively engaging in its management.		Board and Committee Agendas and papers Risk Management Strategy

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
		A Strategic Risk Register is maintained and considered at each Board Meeting, and by the Audit, Risk and Assurance Committee. Each Committee monitors risks associated with its portfolio and provides assurance reports on these to the Board.		Board Assurance Framework Strategic Risk Register
5.4 5.9 5.11 5.12 5.14 5.15	The key responsibilities of non-executive board members include forming an audit and risk assurance committee. The board and accounting officer should be supported by an audit and risk assurance committee, comprising at least three members. An audit and risk assurance committee should not have any executive responsibilities or be charged with making or endorsing any decisions. It should take care to maintain its independence. The audit and risk assurance committee should be established and function in accordance with the *Audit and risk assurance committee handbook.* The board should ensure that there is adequate support for the audit and risk assurance committee, including a secretariat function. The terms of reference of the audit and risk assurance committee, including its role and the authority delegated to it by the board, should be made available publicly. The department should report annually on the work of the committee in discharging those responsibilities	An Audit, Risk and Assurance Committee is established. The Terms of Reference and Operating Arrangements for the ARA Committee are clear in relation to authority and delegated responsibilities. These Terms of Reference are published on the Health Board's website. Full secretariat support is provided by the Corporate Governance Team. 5 Independent Members comprise the Audit, Risk and Assurance Committee. The Board Assurance Framework is scrutinised by the Audit, Risk and Assurance Committee.	Comply	Terms of Reference and Operating Arrangements for Audit, Risk and Assurance Committee Board Assurance Framework

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
	Boards should ensure the scrutiny of governance arrangements, whether at the board or at one of its subcommittees (such as the audit and risk assurance committee or a nominations committee). This will include advising on, and scrutinising the department's implementation of, corporate governance policy.			
5.5	The head of internal audit should periodically be invited to attend board meetings, where key issues are discussed relating to governance, risk management processes or controls across the department and its ALBs.	The role of Head of Internal Audit is clearly set out in the Health Board's Standing Orders. The Head of Internal Audit attends all meetings of the Audit, Risk and Assurance Committee. Audit Wales and Internal Audit have a routine invite to all Board and Committee meetings.	Comply	Standing Orders Terms of Reference for the Audit, Risk and Assurance Committee
5.6 5.7 5.10	The board should assure itself of the effectiveness of the department's risk management system and procedures and its internal controls. The board should give a clear steer on the desired risk appetite for the department and ensure that: • there is a proper framework of prudent and effective controls, so that risks can be assessed, managed and taken prudently • there is clear accountability for managing risks • Departmental officials are equipped with the relevant skills and guidance to perform their assigned roles effectively and efficiently.	The Health Board has an agreed Risk Management Strategy which articulates a clear risk escalation pathway. A Risk Management Community of Practice is in place, led by the Head of Corporate Services, Risk and Assurance.	Comply	Risk Management Strategy Strategic Risk Register

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
	The board should also ensure that the department's ALBs have appropriate and effective risk management processes through the department's sponsor teams Advising on key risks is a role for the board. The audit and risk assurance committee should support the board in this role.			

Remuneration and Staff Report 2024/25

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

This section of the Accountability Report meets these requirements.

The Remuneration and Terms of Service Committee

Remuneration and Terms of Service for Executive Directors and the Chief Executive are agreed, and kept under review, by the Board's Remuneration and Terms of Service Committee. The Committee also monitors and evaluates the annual performance of the Chief Executive and individual Directors (the latter with the advice of the Chief Executive). In 2024/25, the Remuneration and Terms of Service Committee was chaired by the Health Board's Chair, Ann Lloyd CBE, and the membership included the following Members:

- Pippa Britton, Vice Chair of the Board;
- Iwan Jones, Chair of Audit, Risk and Assurance Committee
- Louise Wright, Independent Member (Trade Union).

Meetings are minuted and decisions fully recorded.

Independent Member Remuneration

Remuneration for Independent Members is determined by the Welsh Government, along with the tenure of appointments. Details of Independent Members' remuneration for the 2024/25 financial year, together with comparators are given in Tables below.

Directors' Remuneration

Details of Directors' remuneration for the 2024/25 financial year, together with comparators are given in Tables below. The norm is for Executive Directors and Senior Managers salaries to be uplifted in accordance with the Welsh Government identified normal pay inflation percentage. In 2024/25, Executive Directors received a pay inflation uplift, in-line with Welsh Government's Framework.

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

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

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

Salary and Pension entitlements of Senior Managers Remuneration

		2024-25					2023-24				
Name	**Title**	**Full Year Equivalent Salary (bands of £5,000)** £000	**Salary (bands of £5,000)** £000	**Benefits in kind (to nearest £100)** £00	**Pension Benefits** £000	**Total (bands of £5,000)** £000	**Full Year Equivalent Salary (bands of £5,000)** £000	**Salary (bands of £5,000)** £000	**Benefits in kind (to nearest £100)** £00	**Pension Benefits** £000	**Total (bands of £5,000)** £000
Executive Directors											
Nicola Prygodzicz	Chief Executive	240 - 245	210 - 215	16	175	390 - 395	225 - 230	205 - 210	12	62	270 - 275
Dr James Calvert	Medical Director / Deputy Chief Executive	225 - 230	225 - 230	0	92	315 - 320	215 - 220	215 - 220	0	57	275 - 280
Robert Holcombe	Director of Finance and Procurement	165 - 170	165 - 170	0	68	235 - 240	160 - 165	160 - 165	0	0	160 - 165
Chris Dawson-Morris	Interim Director of Planning and Performance (Until 02.04.23)						125 - 130	0 - 5	0	0	0 - 5
Hannah Evans	Director of Strategy, Planning and Partnerships	155 - 160	155 - 160	0	38	190 - 195	145 - 150	145 - 150	0	82	230 - 235
Jennifer Winslade	Director of Nursing	155 - 160	155 - 160	12	20	175 - 180	145 - 150	145 - 150	7	0	150 - 155
Sarah Simmonds	Director of Workforce and Organisational Development	155 - 160	155 - 160	15	55	210 - 215	145 - 150	150 - 155	15	51	200 - 205
Peter Carr	Director of Therapies and Health Sciences	130 - 135	130 - 135	0	99	230 - 235	125 - 130	120 - 125	0	0	120 125
Dr Chris O'Connor	Interim Director of Primary, Community and Mental Health Services (Until 30.04.23)						135 - 140	10 - 15	0	0	10 - 15
Tracy Daszkiewicz	Director of Public Health and Strategic Partnerships	150 - 155	150 - 155	0	44	195 - 200	140 - 145	140 - 145	0	35	175 - 180
Chief Operating Officer											
Leanne Watkins	Chief Operating Officer (From 01.05.23) Director of Operations (Until 30.04.23)	155 - 160	155 - 160	17	59	215 - 220	145 - 150	150 - 155	17	121	270 - 275
Other Directors											
Rani Dash	Director of Corporate Governance	130 - 135	130 - 135	10	28	155 - 160	120 - 125	125 - 130	45	64	195 - 200
Paul Solloway	Director of Digital (From 28.06.23)	130 - 135	130 - 135	9	150	280 - 285	125 - 130	90 - 95	6	214	305 - 310

Special Advisor to the Board

Philip Robson	Special Advisor to the Board	15 - 20	15 - 20	0	0	15 - 20	15 - 20	15 - 20	0	0	15 - 20

Independent Members

Ann Lloyd CBE	Chair	65 - 70	65 - 70	0	0	65 - 70	65 - 70	65 - 70	0	0	65 - 70
Pippa Britton	Vice Chair (Until 30.11.24)	55 - 60	35 - 40	0	0	35 - 40	55 - 60	55 - 60	0	0	55 - 60
Martin Blakebrough	Independent Member (Third Sector) (From 03.05.23 Until 08.06.24)	15 - 20	0 - 5	0	0	0 - 5	15 - 20	10 - 15	0	0	10 - 15
Prof. Helen Sweetland	Independent Member (University)	15 - 20	5 - 10	0	0	5 - 10	0	0	0	0	0
Richard Clark	Independent Member (Local Authority)	15 - 20	15 - 20	0	0	15 - 20	15 - 20	15 - 20	0	0	15 - 20
Paul Deneen	Independent Member (Community)	15 - 20	15 - 20	0	0	15 - 20	15 - 20	15 - 20	0	0	15 - 20
Neil Patrick	Independent Member (Community) (From 01.04.24)	15 - 20	15 - 20	0	0	15 - 20					
Shelley Bosson	Independent Member (Community) (Until 31.03.24)						15 - 20	15 - 20	0	0	15 - 20
Penny Jones	Independent Member (Community) (From 15.01.24)	15 - 20	15 - 20	0	0	15 - 20	15 - 20	15 - 20	0	0	15 - 20
Dafydd Vaughan	Independent Member (Digital)	15 - 20	15 - 20	0	0	15 - 20	15 - 20	15 - 20	0	0	15 - 20
Iwan Jones	Independent Member (Finance)	15 - 20	15 - 20	0	0	15 - 20	15 - 20	15 - 20	0	0	15 - 20
Louise Wright	Independent Member (Trade Union)	0	0	0	0	0	0	0	0	0	0

	2024-25		2023-24	
	Pay	Ratio	Pay	Ratio
Band of Highest paid Director's Total Remuneration £000	240 - 245		225 - 230	
25th percentile pay £	29,484	8.2:1	28,581	8.0:1
Median pay £	37,030	6.5:1	35,922	6.3:1
75th percentile pay £	48,530	5.0:1	46,686	4.9:1

Salary has been reported as gross pay, which is before the deduction of any salary sacrifice schemes. During 2024-25 the following salary was sacrificed.

	Lease Car Scheme	Home Electronics Scheme	Pensions Advice
	£'000	£'000	£'000
Nicola Prygodzicz	9		<1
Jennifer Winslade	12		
Sarah Simmonds	8		<1
Leanne Watkins	11	1	
Rani Dash	9		
Paul Solloway	9		

The post of Special Advisor to the Board has been disclosed as it has been deemed to have an influence over board decisions.

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

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

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

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

Former Chief Executive Andrew Goodall has been seconded to Welsh Government since 8th June 2014. Welsh Government Accounts has disclosed remuneration received, the Health Board was reimbursed for the employment costs incurred. The salary for Andrew Goodall for 2024-25 was between £240,000 to £245,000 (£230,000 to £235,000 2023-24).

Salary and Pension entitlements of Senior Managers Pension Benefits

Name	Title	Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31 March 2025 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2025 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2025 £000	Cash Equivalent Transfer Value at 31 March 2024 £000	Real increase in Cash Equivalent Transfer Value £000	Employer's contribution to stakeholder pension £00
Nicola Prygodzicz	Chief Executive	7.5 - 10.0	15.0 - 17.5	85 - 90	225 - 230	1974	1650	188	0
Dr James Calvert	Medical Director / Deputy Chief Executive	5.0 - 7.5	2.5 - 5.0	95 - 100	255 - 260	2404	2114	117	0
Robert Holcombe	Director of Finance and Procurement	2.5 - 5.0	2.5 - 5.0	60 - 65	160 - 165	1474	1290	76	0
Hannah Evans	Director of Strategy, Planning and Partnerships	2.5 - 5.0	2.5 - 5.0	45 - 50	115 - 120	964	846	42	0
Jennifer Winslade	Director of Nursing	0.0 - 2.5	0.0	60 - 65	155 - 160	1449	1316	27	0
Sarah Simmonds	Director of Workforce and Organisational Development	2.5 - 5.0	0.0 - 2.5	40 - 45	100 - 105	852	736	48	0
Peter Carr	Director of Therapies and Health Sciences	5.0 - 7.5	7.5 - 10.0	50 - 55	125 - 130	1118	937	101	0
Tracy Daszkiewicz	Director of Public Health and Strategic Partnerships	2.5 - 5.0	0.0	15 - 20	0	288	224	30	0
Leanne Watkins	Chief Operating Officer	2.5 - 5.0	2.5 - 5.0	55 - 60	145 - 150	1212	1061	61	0
Rani Dash	Director of Corporate Governance	0.0 - 2.5	0.0	30 - 35	75 - 80	585	517	18	0
Paul Solloway	Director of Digital	5.0 - 7.5	15.0 - 17.5	45 - 50	120 - 125	1029	809	151	0

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

Pensions tax annual allowance – Scheme Pays arrangements 2019/20

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

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

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

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

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

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

Remuneration Relationship (Audited position)

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

		2024-25	2024-25	2024-25		2023-24	2023-24	2023-24
		£000	£000	£000		£000	£000	£000
Total pay and benefits		**Chief Executive**	**Employee**	**Ratio**		Chief Executive	Employee	Ratio
	25th percentile pay ratio	**240 - 245**	**29**	**8.2**		225 - 230	29	8.0
	Median pay	**240 - 245**	**37**	**6.5**		225 - 230	36	6.3
	75th percentile pay ratio	**240 - 245**	**49**	**5.0**		225 - 230	47	4.9
Salary component of total pay and benefits								
	25th percentile pay ratio	**240 - 245**	**29**			225 - 230	29	
	Median pay	**240 - 245**	**37**			225 - 230	36	
	75th percentile pay ratio	**240 - 245**	**49**			225 - 230	47	
Total pay and benefits		**Highest Paid Director**	**Employee**	**Ratio**		Highest Paid Director	Employee	Ratio
	25th percentile pay ratio	**240 - 245**	**29**	**8.2**		225 - 230	29	8.0
	Median pay	**240 - 245**	**37**	**6.5**		225 - 230	36	6.3
	75th percentile pay ratio	**240 - 245**	**49**	**5.0**		225 - 230	47	4.9
Salary component of total pay and benefits								
	25th percentile pay ratio	**240 - 245**	**29**			225 - 230	29	
	Median pay	**240 - 245**	**37**			225 - 230	36	
	75th percentile pay ratio	**240 - 245**	**49**			225 - 230	47	

In 2024-25, 15 (2023-24, 10) employees received remuneration in excess of the highest-paid director.

Remuneration for all staff ranged from £17k to £459k (2023-24, £15k to £383k).

The all staff range includes directors (including the highest paid director) and excludes pension benefits of all employees.

Financial year summary

There has been an increase in the pay ratio which is attributable to the increase in the chief executive / highest paid director salary being more than the increase in the employee median salary.

The median pay ratio for the relevant financial year is consistent with the pay, reward and progression policies for the entity's employees taken as a whole.

9.6.2 Percentage Changes	2023-24 to 2024-25	2022-23 to 2023-24
% Change from previous financial year in respect of Chief Executive	%	%
Salary and allowances	**7**	5
Performance pay and bonuses	**0**	0
% Change from previous financial year in respect of highest paid director		
Salary and allowances	**7**	5
Performance pay and bonuses	**0**	0
Average % Change from previous financial year in respect of employees takes as a whole		
Salary and allowances	**5**	7
Performance pay and bonuses	**0**	0

STAFF REPORT

Staff Numbers (Audited position)

Average number of employees (WTE)	Permanent	Staff on Secondment	Agency	Specialist	Other	**2024/25 Total**	2023-24
Administrative, clerical and board members	2,713	7	2	0	0	**2,722**	2,761
Medical and dental	845	5	49	430	10	**1,339**	1,338
Nursing, midwifery registered	3,975	0	146	0	0	**4,121**	4,012
Professional, Scientific, and technical staff	428	0	5	0	0	**433**	452
Additional Clinical Services	2,886	0	17	0	0	**2,903**	2,841
Allied Health Professions	953	6	23	0	0	**982**	876
Healthcare Scientists	253	0	4	0	0	**257**	247
Estates and Ancilliary	1,037	0	17	0	0	**1,054**	1,093
Students	6	0	0	0	0	**6**	9
Total	13,096	18	263	430	10	**13,817**	13,629

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

Turnover has reduced from the previous year to the pre-pandemic rates of 8.64%.

In the last 12 months staff in post has increased by 2.62%. The increases have been within Estates and Ancillary (6.17%) because of a targeted recruitment campaign that has taken place over the last 12 months to fill vacancies and reduce agency usage. Registered Nursing numbers have increased by 4.81% through an International Recruitment Campaign which has significantly reduced vacancies.

In terms of administration staff, over the past two years numbers had increased, however, this year there has been a decrease in administration resources of 80.08WTE (2%).

Staff Composition

The table below provides the breakdown of staff numbers per discipline and professional group within the Health Board.

The gender breakdown for all staff groups as of 31 March 2025 is provided below:

	2024-2025			2023-2024			2022-2023		
	Directors	WTE		Directors	WTE		Directors	WTE	%
Female	7.85	10,682	79.66%	8	10,413	79.60%	5	10,127	80.06%
Male	3	2742	20.33%	4	2669	20.40%	6	2521.5	19.94%
Total	**10.85**	**13,424.42**		**12**	**13,082.00**		**11**	**12,648.50**	

The total number of staff per discipline will differ from the staff numbers shown in the gender breakdown table as the gender figures are based on a point in time, as of 31 March 2025, whereas the staff per discipline numbers represent the average over a 52-week period of staff in post.

Sickness Absence Data

The Health Board's sickness absence rate for 2024/2025 is 6.44%, an increase in sickness related absence from 6.10% in 2023/2024 which was a reduction in the previous year of 6.74% (2022/2023). Sickness absence remained above 6% from July 2024 to February 2025 reducing to 5.94%, in March 2025. December 2024 recorded the highest sickness absence at 7.30%.

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

Sickness Absence	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
Days Lost (Short Term <28 days)	61261	53097	60406	54759	68229	60411	79761	98573	85948	86029
Days Lost (Long Term >28 days)	144562	147711	153345	162684	194289	188778	203781	205131	207218	223369
Total Days Lost	205823	200808	213751	217443	262518	249189	283542	303704	293166	309398
Total Staff Years	564	550	586	596	719	683	777	832	803	848
Average Working Days Lost	14.7	14.2	15.2	15.2	15.2	16	17.2	18	17.5	18.08
Total staff employed in period (headcount)	14020	14155	10412	14334	14835	15528	15863	16245	16735	17111
Total staff employed with no absence (headcount)	4919	5803	4848	5016	5402	6055	5710	5035	5188	4431
Percentage staff with no sick	40%	41%	37%	35%	36%	39%	36%	31%	31%	30%

Staff Policies

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

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

Staff policies renewed or newly applied during the reporting period 01 April 2024 to 31 March 2025 include:

- All Wales Flexible Pensions Policy
- All Wales Job Evaluation Policy and Procedure
- All Wales Pregnancy Loss Support Policy
- All Wales Procedure for the Recovery of Overpayments Salary and Expenses
- All Wales Respect and Resolution Policy and Frequently Asked Questions
- Annual Leave Policy for Consultants and Senior Medical Staff
- Bilingual Skills Strategy (Welsh Language)
- Disbarring Service (DBS) Policy
- Equality, Diversity and Inclusion Policy
- Medical Appraisal Policy
- Medical Staff Private Practice Policy
- Study Leave Policy
- Shared Parental Leave Policy
- Certificate of Eligibility for Specialist Registration (CESR) Policy

- Welsh Language Primary Care Policy
- Welsh Language Protocols

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

Employee Relations Matters

Details of the number of disciplinary cases between 1 April 2024 to 31 March 2025 is provided below:

Disciplinary Cases	Dismissals	Appeals	Employment Tribunals	Upholding Professional Standards in Wales	Respect and Resolution	Capability
66	6	5	6	3	29	11

The Health Board has continued to apply the principles of its avoidable employee harm programme of work to disciplinary investigations. This programme considers the impact on the people involved and improved application of process which has seen a 70% reduction in disciplinary cases in 2024/25.

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

Payment to Past Directors (Audited position)

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

Expenditure on Consultancy

Supplier	Services provided	Amount
		£p
Ideas Alliance CIC	Professional fees: Consultancy services provided to support the implementation of Dementia Alliance Commissioning	12,000
Supportive Care UK	Consultant Support to the Specialist Palliative Care Service	41,975
Ernst & Young LLP	VAT Consultancy & Advisory Services	39,579
Dorset Software Services Ltd	Focus Tier Consultancy Services	285,308
CGI IT UK Ltd	G Cloud Work Stream Business Case Consultancy	49,021
Public Digital Ltd	Board Development Consultancy Contract	44,400
Pam Wenger	Governance Review, fieldwork, interviews, report for Gwent Regional Partnership Board	4,000
Oxford Brookes Enterprises Ltd	Strategic Capital Development Plan 5 days work.	5,100
Total Consultancy 2024/25		481,382

Expenditure on Temporary Staff

Expenditure By Staff Group	2024/25 £000
Administrative, Clerical and board members	93
Medical and dental	11,618
Nursing, midwifery registered	12,789
Professional, Scientific, and technical staff	532
Additional Clinical Services	882
Allied Health Professions	2,017
Healthcare Scientists	392
Estates and Ancillary	649
Total	**28,973**

Tax Assurance for Off-payroll Engagements

Table 1 : For all off-Payroll engagements as of 31 March 2025	
No. of exisiting Engagements as of 31 March 2025	**2**
Of which, the number that have existed:	
for less than one year at time of reporting	1
for between one and two years at time of reporting	0
for between two and three years at time of reporting	0
for between three and four years at time of reporting	0
for four or more years at time of reporting	1

Table 2 : For all new off-Payroll engagements between 1 April 2024 and 31 March 2025	
Number of new engagements between 1 April 2024 and 31 March 2025	**3**
Of which...	
No. assessed as caught by IR35	0
No. assessed as not caught by IR35	3
No. engaged directly (via contracted to department) and are on the departmental payroll	0
No. of engagements reassessed for consistency/assurance purposes during the year	0
No. of engagements that saw a change to IR35 status following the consistency review	0

Exit Packages and Severance Payments (Audited position)

9.5 Reporting of other compensation schemes - exit packages					
9.5.1 Exit Packages Costs and Numbers					
	2024-25	**2024-25**	**2024-25**	**2024-25**	2023-24
Exit packages cost band (including any special payment element)	**Number of compulsory redundancies**	**Number of other departures**	**Total number of exit packages**	**Number of departures where special payments have been made**	Total number of exit packages
	Whole numbers only	**Whole numbers only**	**Whole numbers only**	**Whole numbers only**	Whole numbers only
less than £10,000	0	1	1	0	0
£10,000 to £25,000	0	0	0	0	1
£25,000 to £50,000	0	0	0	0	0
£50,000 to £100,000	0	0	0	0	0
£100,000 to £150,000	0	0	0	0	0
£150,000 to £200,000	0	0	0	0	0
more than £200,000	0	0	0	0	0
Total	0	1	1	0	1

	2024-25	**2024-25**	**2024-25**	**2024-25**	2023-24
Exit packages cost band (including any special payment element)	**Cost of compulsory redundancies**	**Cost of other departures**	**Total cost of exit packages**	**Cost of special element included in exit packages**	Total cost of exit packages
	£	**£**	**£**	**£**	£
less than £10,000	0	7,500	7,500	0	0
£10,000 to £25,000	0	0	0	0	24,254
£25,000 to £50,000	0	0	0	0	0
£50,000 to £100,000	0	0	0	0	0
£100,000 to £150,000	0	0	0	0	0
£150,000 to £200,000	0	0	0	0	0
more than £200,000	0	0	0	0	0
Total	0	7,500	7,500	0	24,254

Total Exit Costs Paid in Year	**Total paid in year**	Total paid in year
	2024-25	2023-24
	£	£
Exit costs paid in year	7,500	24,254
Total	7,500	24,254

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

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

The Health Board has not approved any VERS in 2024-25.

Additional requirement as per FreM

£0.00 exit costs were paid in 2024-25, relating to 2023-24 (the year of departure).

Senedd Cymru / Welsh Parliamentary Accountability and Audit Report 2024/25

Regularity of Expenditure
Regularity of Expenditure Regularity is the requirement for all items of expenditure and receipts to be dealt with in accordance with the

legislation authorising them, any applicable delegated authority and the rules of Government Accounting.

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

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

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

Fees and charges

Where the Health Board undertakes activities that are not funded directly by the Welsh Government the Health Board receives income to cover its costs which will offset expenditure reported under programme areas. Miscellaneous Income can be seen in Note 4 (page XX) of the Annual Accounts 2024/25. When charging for this activity the Health Board has complied with the cost allocation and charging requirements set out in HM Treasury guidance.

The Health Board incurred costs amounting to £0.446m for the provision of the statutory audit by the Wales Audit Office.

Managing public money

This is the required Statement for Public Sector Information Holders as referenced in the Directors' Report. In line with other Welsh NHS bodies, the Health Board has adopted standing financial instructions which enforce the principles outlined in HM Treasury guidance 'Managing Public Money' which sets out the main principles for dealing with resources in the UK public sector. As a result, the Health Board should have complied with the cost allocation and charging requirements of this guidance. The Health Board has not been made aware of any instances where this has not been done.

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

The remote contingent liabilities cost consists of 3 medical negligence cases and 1 personal injury case in 2024-25 (3 medical negligence cases and 1 GP indemnity case in 2023-24). Should these cases progress the majority of the costs incurred, in excess of £25K per case attributable to the Health Board, will be recovered from the Welsh Risk Pool.

Nicola Prygodzicz
Chief Executive **Date: XX July 2025**

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

Opinion on financial statements

I certify that I have audited the financial statements of Aneurin Bevan University Local Health Board for the year ended 31 March 2025 under Section 61 of the Public Audit (Wales) Act 2004.

These comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Cash Flow Statement and Statement of Changes in Taxpayers' Equity and related notes, including a summary of material accounting policies.

The financial reporting framework that has been applied in their preparation is applicable law and UK adopted international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual.

In my opinion, in all material respects, the financial statements:
• give a true and fair view of the state of affairs of Aneurin Bevan University Local Health Board as at 31 March 2025 and of its net operating costs for the year then ended;
• have been properly prepared in accordance with UK adopted international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual; and
• have been properly prepared in accordance with the National Health Service (Wales) Act 2006 and directions made there under by Welsh Ministers.

Opinion on regularity

In my opinion, except for the matter(s) described in the Basis for Qualified Regularity Opinion section of my report, in all material respects, the expenditure and income in the financial statements have been applied to the purposes intended by the Senedd and the financial transactions recorded in the financial statements conform to the authorities which govern them.

Basis for Qualified Opinion on regularity

I have qualified my opinion on the regularity of the Aneurin Bevan University Local Health Board's financial statements because the Health Board has breached its resource limit by spending £93.793 million over the amount that it was authorised to spend in the three-year period 2022-23 to 2045-25. This spending constitutes irregular expenditure.
Further detail is set out in my Report on page xx.

Basis for opinions
I conducted my audit in accordance with applicable law and International Standards on Auditing in the UK (ISAs (UK)) and Practice Note 10 'Audit of financial statements and regularity of public sector bodies in the United Kingdom'. My responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of my certificate.

My staff and I are independent of the Board in accordance with the ethical requirements that are relevant to my audit of the financial statements in the UK including the Financial Reporting Council's Ethical Standard, and I have fulfilled my other ethical responsibilities in accordance with these requirements. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinions.

Conclusions relating to going concern
In auditing the financial statements, I have concluded that the use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work I have performed, I have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the body's ability to continue to adopt the going concern basis of accounting for a period of at least 12 months from when the financial statements are authorised for issue.
My responsibilities and the responsibilities of the directors with respect to going concern are described in the relevant sections of this certificate.
The going concern basis of accounting for Aneurin Bevan University Local Health Board is adopted in consideration of the requirements set out in HM Treasury's Government Financial Reporting Manual, which require entities to adopt the going concern basis of accounting in the preparation of the financial statements where it anticipated that the services which they provide will continue into the future.

Other information
The other information comprises the information included in the annual report other than the financial statements and my auditor's report thereon. The Chief Executive is responsible for the other information contained within the annual report. My opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in my report, I do not express any form of assurance conclusion thereon. My responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or knowledge obtained in the course of the audit, or otherwise appears to be materially misstated. If I identify such material inconsistencies or apparent material misstatements, I am required to determine whether this gives rise to a material

misstatement in the financial statements themselves. If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact.

I have nothing to report in this regard.

Opinion on other matters
In my opinion, the part of the remuneration report to be audited has been properly prepared in accordance with the National Health Service (Wales) Act 2006 and directions made there under by Welsh Ministers.

In my opinion, based on the work undertaken in the course of my audit:

- the parts of the Accountability Report subject to audit have been properly prepared in accordance with the National Health Service (Wales) Act 2006 and directions made there under by Welsh Minsters' directions; and;
- the information given in the Performance and Accountability Reports for the financial year for which the financial statements are prepared is consistent with the financial statements and is in accordance with Welsh Ministers' guidance.

Matters on which I report by exception

In the light of the knowledge and understanding of the Health Board and its environment obtained in the course of the audit, I have not identified material misstatements in the Performance Report and the other unaudited parts of the Accountability Report or Annual Governance Statement.

I have nothing to report in respect of the following matters, which I report to you, if, in my opinion:

- I have not received all the information and explanations I require for my audit;
- adequate accounting records have not been kept, or returns adequate for my audit have not been received from branches not visited by my team;
- the financial statements and the audited part of the Accountability Report are not in agreement with the accounting records and returns;
- information specified by HM Treasury or Welsh Ministers regarding remuneration and other transactions is not disclosed;
- certain disclosures of remuneration specified by HM Treasury's Government Financial Reporting Manual are not made or parts of the Remuneration Report to be audited are not in agreement with the accounting records and returns; or
- the Governance Statement does not reflect compliance with HM Treasury's guidance.

Responsibilities of Directors and the Chief Executive for the financial statements

As explained more fully in the Statements of Directors' and Chief Executive's Responsibilities, the Directors and the Chief Executive are responsible for:

- maintaining adequate accounting records
- the preparation of financial statements and annual report in accordance with the applicable financial reporting framework and for being satisfied that they give a true and fair view;
- ensuring that the annual report and financial statements as a whole are fair, balanced and understandable;
- ensuring the regularity of financial transactions;
- internal controls as the Directors and Chief Executive determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; and
- assessing the Health Board's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Directors and Chief Executive anticipate that the services provided by the Health Board will not continue to be provided in the future.

Auditor's responsibilities for the audit of the financial statements

My responsibility is to audit, certify and report on the financial statements in accordance with the National Health Service (Wales) Act 2006.

My objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue a certificate that includes my opinion.

Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. I design procedures in line with my responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud.

My procedures included the following:
• enquiring of management, the Health Board's head of internal audit and those charged with governance, including obtaining and reviewing supporting documentation relating to Aneurin Bevan University Local Health Board's policies and procedures concerned with:

– identifying, evaluating and complying with laws and regulations and whether they were aware of any instances of non-compliance;
– detecting and responding to the risks of fraud and whether they have knowledge of any actual, suspected or alleged fraud; and
– the internal controls established to mitigate risks related to fraud or non-compliance with laws and regulations.

• considering as an audit team how and where fraud might occur in the financial statements and any potential indicators of fraud. As part of this discussion, I identified potential for fraud in the following areas: revenue recognition, expenditure recognition, posting of unusual journals.

• obtaining an understanding of Aneurin Bevan University Local Health Board's framework of authority as well as other legal and regulatory frameworks that the Health Board operates in, focusing on those laws and regulations that had a direct effect on the financial statements or that had a fundamental effect on the operations of the Health Board.

• obtaining an understanding of related party relationships.

In addition to the above, my procedures to respond to identified risks included the following:

- reviewing the financial statement disclosures and testing to supporting documentation to assess compliance with relevant laws and regulations discussed above;
- enquiring of management, those charged with governance and legal advisors about actual and potential litigation and claims;
- reading minutes of meetings of those charged with governance and the Board; and
- in addressing the risk of fraud through management override of controls, testing the appropriateness of journal entries and other adjustments; assessing whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluating the business rationale of any significant transactions that are unusual or outside the normal course of business.

I also communicated relevant identified laws and regulations and potential fraud risks to all audit team members and remained alert to any indications of fraud or non-compliance with laws and regulations throughout the audit.

The extent to which my procedures are capable of detecting irregularities, including fraud, is affected by the inherent difficulty in detecting irregularities, the effectiveness of the Aneurin Bevan University Local Health Board controls, and the nature, timing and extent of the audit procedures performed.

A further description of the auditor's responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website www.frc.org.uk/auditorsresponsibilities. This description forms part of my auditor's report.

Other auditor's responsibilities

I am also required to obtain evidence sufficient to give reasonable assurance that the expenditure and income recorded in the financial statements have been applied to the purposes intended by the Senedd and the financial transactions recorded in the financial statements conform to the authorities which govern them.

I communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

Please see my Report on pages x to y.

Adrian Crompton
Auditor General for Wales
27 June 2025

1 Capital Quarter
Tyndall Street
Cardiff
CF10 4BZ

Report of the Auditor General to the Senedd

Introduction

Under the Public Audit Wales Act 2004, I am responsible for auditing, certifying and reporting on Aneurin Bevan University Local Health Board (the Health Board's) financial statements. I am reporting on these financial statements for the year ended 31 March 2025 to draw attention to two key matters for my audit. These are the failure against the first financial duty and consequential qualification of my 'regularity' opinion and the failure of the second financial duty. I have not qualified my 'true and fair' opinion in respect of any of these matters.

Financial duties

Health Boards are required to meet two statutory financial duties – known as the first and second financial duties.

For 2024-25, the Health Board failed to meet both the first and the second financial duty.

Failure of the first financial duty

The **first financial duty** gives additional flexibility to Health Boards by allowing them to balance their income with their expenditure over a three-year rolling period. The three-year period being measured under this duty this year is 2022-23 to 2024-25.

As shown in Note 2.1 to the Financial Statements, the Health Board did not manage its revenue expenditure within its resource allocation over this three-year period, exceeding its cumulative revenue resource limit of £5,320.432 million by £93.793 million.

Where a Health Board does not balance its books over a rolling three-year period, any expenditure over the resource allocation (ie spending limit) for those three years exceeds the Health Board's authority to spend and is therefore 'irregular'. In such circumstances, I am required to qualify my 'regularity opinion' irrespective of the value of the excess spend.

Failure of the second financial duty

The **second financial duty** requires Health Boards to prepare and have approved by the Welsh Ministers a rolling three-year integrated medium-term plan. This duty is an essential foundation to the delivery of sustainable quality health services. A Health Board will be deemed to have met this duty for 2024-25 if it submitted a 2024-2027 plan approved by its Board to the Welsh Ministers, who were required to review and consider approval of the plan.

As shown in Note 2.3 to the Financial Statements, the Health Board did not meet its second financial duty to have an approved three-year integrated medium-term plan in place for the period 2024-2027.

Adrian Crompton
Auditor General for Wales
27 June 2025

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	24 June 2025
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Aneurin Bevan University Health Board Final Accounts for 2024/25
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Robert Holcombe, Director of Finance, Procurement and Value Based Healthcare
SWYDDOG ADRODD: **REPORTING OFFICER:**	Robert Jones, Assistant Director of Finance (Financial Systems and Services)

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

Ar Gyfer Penderfyniad/For Decision

To give assurance to the Committee along with the Head of Internal Audit Opinion and the Audit Wales audit of annual accounts report, to enable the Committee to recommend that the Board approve the ABUHB 2024/25 accounts.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The accounts for 2024/25 are attached to this paper.

There have been no changes from the draft accounts that affect the performance of any of the Health Boards' duties reported to the Committee on the 20th of May.

Audit Wales have confirmed they intend to give an unqualified opinion on the Aneurin Bevan University Health Board 2024/25 Financial Statements. They will qualify the regularity opinion as the Health Board has not achieved its statutory target to break even over a three-year period.

The final position as at 31 March 2025 shows a year end deficit of £7.185m and combined with the outcomes for 2022/23 and 2023/24, a three-year deficit of £93.793m.

A number of classification type adjustments have been made during the audit. These are included in Appendix 1 attached.



The Committee are asked to note that the accounts have been satisfactorily completed, and along with the audit of annual accounts report from Audit Wales and the Head of Internal Audit Opinion, recommend approval of the Accounts by the Board at the meeting on 25th June.

At the time of writing this report there are still some minor audit queries outstanding, with Audit Wales also conducting a final review of the audit and Final Accounts. A further update on the outstanding queries will be presented at the meeting.

Cefndir / Background

See above.

Asesiad / Assessment

This report provides the Committee with details of amendments actioned from the draft accounts to the final accounts on completion of the Audit, with confirmation that no adjustments have been made between Draft and Final Accounts which impact the 2024/25 reported position of the Health Board.

Argymhelliad / Recommendation

The Audit, Risk & Assurance Committee is asked to endorse the Aneurin Bevan University Health Board accounts for 2024/25 for approval by the Board on 25th June 2025.

Appendix 1 – Adjustments Actioned

Appendix 2 – Annual Accounts 2024/25 & Financial Returns

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	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:	**Appendix**
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• **Workforce**	Not Applicable
• **Service Activity & Performance**	Yes, outlined within the paper
• **Financial**	Yes, outlined within the paper
	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/	Integration - Considering how the public body's well-being objectives may impact upon each of the well-being goals, on their objectives, or on the objectives of other public bodies Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs



2024/25 ANNUAL ACCOUNTS – Appendix 1

Adjustments Actioned from Draft to Final 2023/24 Annual Accounts

Note No.	Issue	Impact On Fin. Target
	Adjustments Actioned – impact on financial target.	£0k
	None Identified	
	Adjustments Actioned – No impact on financial target	
1.24.1	**Narrative** The Health Board's estimated liability for 2024/25 was incorrectly stated as £379m; the correct figure is £0.379m.	None
1.25	**Narrative** Wording for policy in the Draft Accounts states: "...has been discounted using the PES (2021) Post Employment Benefits Liabilities Real Rate in Excess of CPI of 2.45%". This has been amended in the Final Accounts to read: "...has been discounted using the PES (2024) Post Employment Benefits Liabilities Real Rate in Excess of CPI of 2.4%".	None
3.3	**Narrative** Narrative note relating to Research & Development income and Expenditure omitted from draft accounts. Narrative now included.	None
4	**Classification** Training and Education income received from HEIW totalling £16.104m has been reclassified from Special Health Authorities income in the Draft Accounts to Education, Training and Research income in line an updated requirement within the Manual for Accounts for 2024/25.	None
9.1	**Classification** The amount for Staff on Inward Secondment of £1,020k was incorrectly entered as Other Employee Benefits in the Draft Accounts. This has been reclassified as Salaries & Wages.	None
20, 28 & Stmt of Cash Flows	**Classification** Other Losses arising in the year totalling £915k were showing twice in the Arising Provisions column, as Other Losses & Special Payments and Other Provisions. The entry in Other was removed, leaving only the entry within Other Losses & Special Payments. Following this adjustment there is a subsequent reduction of £915k to Non-Cash Movements on Note 28 and Provisions Utilised on the Statement of Cash Flows.	None
20	**Narrative** Narrative figures reclaimable from the Welsh Risk Pool were misstated in the Draft Accounts. The amount for 2025/26 should	None

	be £91,146k (not £91k), and the amount for 2026/27 should be £101,877k (not £102k)	
30	**Presentational** Expenditure and Income transactions with related parties have been re-cast from Draft to Final Accounts. Initially, Creditor and Debtor amounts were netted off instead of shown separately, leading to reconciliation issues with the LMS submission. Final Account figures in Note 30 now align with LMS Matrices.	None
30	**Completeness** An omitted declaration for Philip Robson has now been included in the Final Accounts. He continues to serve as a Trustee of Hospice of the Valleys in 2024/25, during which reportable transactions were identified: Expenditure: £548k Creditor: £33k	None
32	**Completeness** Memorandum Figures for the GWICES Pooled Budget were not received in advance of Draft Account submission. These have now been received from Torfaen CBC and populated in Note 32 of the Final Accounts. Minor amendment to Health Boards contribution figure from Draft to Final Accounts, from £1,292k to £1,289k to agree to Memorandum Statement. No change required to financial target due to trivial nature of value and transaction.	None
32	**Completeness** Memorandum Figures for the CHC Pooled Budget which were not received in advance of Draft Account submission have now been received from Torfaen CBC and populated in Note 32 of the Final Accounts.	None
	Adjustments to Financial Returns	
LFR 103	**Classification** Pharmaceutical Income totalling £84k was omitted from the financial return. No impact on bottom line, as this amount was included in Note 4, but not analysed as part of LFR.	None
LMS	**Classification** Creditor and Expenditure amounts for Caerphilly CBC, Monmouthshire CC and Torfaen CBC on the LMS did not agree and match the amounts reported in Note 30 - Related Parties on submission of Draft Accounts. This has now been amended and reconciled figures submitted.	None
	REMUNERATION REPORT & PENSIONS BENEFITS	
	None identified	

ANEURIN BEVAN UNIVERSITY LOCAL HEALTH BOARD

FOREWORD

These accounts have been prepared by the Local Health Board under schedule 9 section 178 Para 3(1) of the National Health Service (Wales) Act 2006 (c.42) in the form in which the Welsh Ministers have, with the approval of the Treasury, directed.

Statutory background

Performance Management and Financial Results

Welsh Health Circular WHC/2016/054 replaces WHC/2015/014 'Statutory and Administrative Financial Duties of NHS Trusts and Local Health Boards' and further clarifies the statutory financial duties of NHS Wales bodies and is effective for 2024-25. The annual financial duty has been revoked and the statutory breakeven duty has reverted to a three year duty, with the first assessment of this duty in 2016-17.

Local Health Boards in Wales must comply fully with the Treasury's Financial Reporting Manual to the extent that it is applicable to them. As a result, the primary statement of in-year income and expenditure is the Statement of Comprehensive Net Expenditure, which shows the net operating cost incurred by the Local Health Board which is funded by the Welsh Government. This funding is allocated on receipt directly to the General Fund in the Statement of Financial Position.

Under the National Health Services Finance (Wales) Act 2014, the annual requirement to achieve balance against Resource Limits has been replaced with a duty to ensure, in a rolling 3 year period, that its aggregate expenditure does not exceed its aggregate approved limits.

The Act came into effect from 1st April 2014 and under the Act the first assessment of the 3 year rolling financial duty took place at the end of 2016-17.

Statement of Comprehensive Net Expenditure for the year ended 31 March 2025

	Note	2024-25 £000	2023-24 £000
Expenditure on Primary Healthcare Services	3.1	**351,914**	325,276
Expenditure on healthcare from other providers	3.2	**527,203**	508,398
Expenditure on Hospital and Community Health Services	3.3	**1,177,190**	1,105,268
		2,056,307	1,938,942
Less: Miscellaneous Income	4	**(136,606)**	(121,956)
LHB net operating costs before interest and other gains and losses		**1,919,701**	1,816,986
Investment Revenue	5	**(16)**	(17)
Other (Gains) / Losses	6	**(41)**	331
Finance costs	7	**777**	1,168
Net operating costs for the financial year		**1,920,421**	**1,818,468**

Details of the Health Board's performance against its revenue and capital allocations over the last three financial periods are provided in Note 2 on page 27.

The notes on pages 8 to 76 form part of these accounts.

Other Comprehensive Net Expenditure

	2024-25 £000	2023-24 £000
Net (gain) / loss on revaluation of property, plant and equipment	(15,174)	(19,417)
Net (gain)/loss on revaluation of right of use assets	0	0
Net (gain) / loss on revaluation of intangibles	(42)	(114)
(Gain) / loss on other reserves	0	0
Net (gain)/ loss on revaluation of PPE & Intangible assets held for sale	0	0
Net (gain)/loss on revaluation of financial assets held for sale	0	0
Impairment and reversals	0	0
Transfers between reserves	0	0
Transfers to / (from) other bodies within the Resource Accounting Boundary	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0
Other comprehensive net expenditure for the year	(15,216)	(19,531)
Total comprehensive net expenditure for the year	**1,905,205**	1,798,937

The notes on pages 8 to 76 form part of these accounts.

Statement of Financial Position as at 31 March 2025

	Notes	31 March 2025 £000	31 March 2024 £000
Non-current assets			
Property, plant and equipment	11	**927,547**	892,817
Right of Use Assets	11.3	**18,121**	17,370
Intangible assets	12	**4,999**	4,685
Trade and other receivables	15	**105,883**	144,066
Other financial assets	16	**607**	667
Total non-current assets		**1,057,157**	1,059,605
Current assets			
Inventories	14	**10,433**	9,844
Trade and other receivables	15	**167,160**	136,573
Other financial assets	16	**60**	59
Cash and cash equivalents	17	**4,823**	4,145
		182,476	150,621
Non-current assets classified as "Held for Sale"	11	**0**	0
Total current assets		**182,476**	150,621
Total assets		**1,239,633**	1,210,226
Current liabilities			
Trade and other payables	18	**(204,826)**	(202,162)
Other financial liabilities	19	**0**	0
Provisions	20	**(98,570)**	(71,827)
Total current liabilities		**(303,396)**	(273,989)
Net current assets/ (liabilities)		**(120,920)**	(123,368)
Non-current liabilities			
Trade and other payables	18	**(16,314)**	(15,888)
Other financial liabilities	19	**0**	0
Provisions	20	**(109,154)**	(149,647)
Total non-current liabilities		**(125,468)**	(165,535)
Total assets employed		**810,769**	770,702
Financed by :			
Taxpayers' equity			
General Fund		**610,494**	581,378
Revaluation reserve		**200,275**	189,324
Total taxpayers' equity		**810,769**	770,702

The financial statements on pages 2 to 7 were approved by the Board on xx xx 2025 and signed on its behalf by:

Chief Executive and Accountable Officer ..... Date: 25 June 2025

The notes on pages 8 to 76 form part of these accounts.

Statement of Changes in Taxpayers' Equity
For the year ended 31 March 2025

	General Fund £000	Revaluation Reserve £000	Total Reserves £000
Changes in taxpayers' equity for 2024-25			
Balance as at 31 March 2024	581,378	189,324	**770,702**
NHS Wales Transfer	0	0	**0**
RoU Asset Transitioning Adjustment	422	0	**422**
Impact of IFRS 16 on PPP/PFI Liability	0	0	**0**
Balance at 1 April 2024	581,800	189,324	**771,124**
Net operating cost for the year	(1,920,421)		**(1,920,421)**
Net gain/(loss) on revaluation of property, plant and equipment	0	15,174	**15,174**
Net gain/(loss) on revaluation of right of use assets	0	0	**0**
Net gain/(loss) on revaluation of intangible assets	0	42	**42**
Net gain/(loss) on revaluation of financial assets	0	0	**0**
Net gain/(loss) on revaluation of assets held for sale	0	0	**0**
Impairments and reversals	0	0	**0**
Other Reserve Movement	0	0	**0**
Transfers between reserves	4,265	(4,265)	**0**
Release of reserves to SoCNE	0	0	**0**
Transfers to/from LHBs	0	0	**0**
Total recognised income and expense for 2024-25	(1,916,156)	10,951	**(1,905,205)**
Net Welsh Government funding	1,893,053		**1,893,053**
Notional Welsh Government Funding	51,797		**51,797**
Balance at 31 March 2025	610,494	200,275	**810,769**

Notional Welsh Government funding line includes 9.4% staff employer pension and Pensions Annual Allowance Charge Compensation Scheme (PAACCS) costs paid centrally by Welsh Government.
The Department of Health and Social Care (DHSC) 2023-24 consultation on the NHS Pension Scheme confirmed that the transitional approach that has operated since 2019-20 for employer contributions will continue in 2024-25. From 1 April 2024 an employer rate of 23.7% (23.78% inclusive of the administration charge) will apply. However, the NHS Business Services Authority will continue to only collect 14.38% from NHS Wales employers under their normal monthly payment process to the NHS Pension Scheme. This has resulted in an increase in the central payments made by Welsh Government from 6.3% to 9.4%.

Notional Welsh Government funding split:

Notional 9.4% staff employer pension £51,784K
Pensions Annual Allowance Charge Compensation Scheme (PAACCS) £13K

The notes on pages 8 to 76 form part of these accounts.

Statement of Changes in Taxpayers' Equity
For the year ended 31 March 2024

	General Fund £000	Revaluation Reserve £000	Total Reserves £000
Changes in taxpayers' equity for 2023-24			
Balance at 31 March 2023	552,847	179,062	**731,909**
NHS Wales Transfer	0	0	**0**
RoU Asset Transitioning Adjustment	0	0	**0**
Balance at 1 April 2023	551,304	179,062	**730,366**
Net operating cost for the year	(1,818,468)		**(1,818,468)**
Net gain/(loss) on revaluation of property, plant and equipment	0	19,417	**19,417**
Net gain/(loss) on revaluation of right of use assets	0	0	**0**
Net gain/(loss) on revaluation of intangible assets	0	114	**114**
Net gain/(loss) on revaluation of financial assets	0	0	**0**
Net gain/(loss) on revaluation of assets held for sale	0	0	**0**
Impairments and reversals	0	0	**0**
Other reserve movement	0	0	**0**
Transfers between reserves	9,269	(9,269)	**0**
Release of reserves to SoCNE	0	0	**0**
Transfers to/from LHBs	0	0	**0**
Total recognised income and expense for 2023-24	(1,809,199)	10,262	**(1,798,937)**
Net Welsh Government funding	1,807,206		**1,807,206**
Notional Welsh Government Funding	32,067		**32,067**
Balance at 31 March 2024	581,378	189,324	**770,702**

Notional Welsh Government funding line includes the 6.3% staff employer pension and Pensions Annual Allowance Charge Compensation Scheme (PAACCS) costs paid centrally by Welsh Government.

Notional Welsh Government funding split;
Notional 6.3% staff employer pension £32,065,000
Pensions Annual Allowance Charge Compensation Scheme (PAACCS) £2,000

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The notes on pages 8 to 76 form part of these accounts.

Statement of Cash Flows for year ended 31 March 2025

	Notes	2024-25 £000	2023-24 £000
Cash Flows from operating activities			
Net operating cost for the financial year		**(1,920,421)**	(1,818,468)
Movements in Working Capital	27	**8,153**	(69,062)
Other cash flow adjustments	28	**110,857**	175,424
Provisions utilised	20	**(22,996)**	(30,160)
Net cash outflow from operating activities		**(1,824,407)**	(1,742,266)
Cash Flows from investing activities			
Purchase of property, plant and equipment		**(61,328)**	(58,252)
Proceeds from disposal of property, plant and equipment		**116**	215
Purchase of intangible assets		**(2,271)**	(1,778)
Proceeds from disposal of intangible assets		**0**	0
Payment for other financial assets		**0**	0
Proceeds from disposal of other financial assets		**0**	0
Payment for other assets		**0**	0
Proceeds from disposal of other assets		**0**	0
Net cash inflow/(outflow) from investing activities		**(63,483)**	(59,815)
Net cash inflow/(outflow) before financing		**(1,887,890)**	(1,802,081)
Cash Flows from financing activities			
Welsh Government funding (including capital)		**1,893,053**	1,807,206
Capital receipts surrendered		**0**	0
Capital grants received		**0**	0
Capital element of payments in respect of finance leases and on-SoFP PFI Schemes		**0**	0
Capital element of payments in respect of on-SoFP PFI		**(639)**	(1,585)
Capital element of payments in respect of Right of Use Assets		**(3,846)**	(4,099)
Cash transferred (to)/ from other NHS bodies		**0**	0
Net financing		**1,888,568**	1,801,522
Net increase/(decrease) in cash and cash equivalents		**678**	(559)
Cash and cash equivalents (and bank overdrafts) at 1 April 2024		**4,145**	4,704
Cash and cash equivalents (and bank overdrafts) at 31 March 2025		**4,823**	4,145

The notes on pages 8 to 76 form part of these accounts.

Notes to the Accounts

1. Accounting policies

The Minister for Health and Social Services has directed that the financial statements of Local Health Boards (LHBs) in Wales shall meet the accounting requirements of the NHS Wales Manual for Accounts. Consequently, the following financial statements have been prepared in accordance with the 2024-25 Manual for Accounts. The accounting policies contained in that manual follow the 2024-25 Financial Reporting Manual (FReM) in accordance with international accounting standards in conformity with the requirements of the Companies Act 2006, to the extent that they are meaningful and appropriate to the NHS in Wales.

Where the LHB Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the LHB for the purpose of giving a true and fair view has been selected. The particular policies adopted by the LHB are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1. Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets and inventories.

1.2. Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.3. Income and funding

The main source of funding for the LHBs are allocations (Welsh Government funding) from the Welsh Government within an approved cash limit, which is credited to the General Fund of the LHB. Welsh Government funding is recognised in the financial period in which the cash is received.

Non-discretionary funding outside the Revenue Resource Limit is allocated to match actual expenditure incurred for the provision of specific pharmaceutical, or ophthalmic services identified by the Welsh Government. Non-discretionary expenditure is disclosed in the accounts and deducted from operating costs charged against the Revenue Resource Limit.

Funding for the acquisition of fixed assets received from the Welsh Government is credited to the General Fund.

Miscellaneous income is income which relates directly to the operating activities of the LHB and is not funded directly by the Welsh Government. This includes payment for services uniquely provided by the LHB for the Welsh Government such as funding provided to agencies and non-activity costs incurred by the LHB in its provider role. Income received from LHBs transacting with other LHBs is always treated as miscellaneous income.

From 2018-19, IFRS 15 Revenue from Contracts with Customers has been applied, as interpreted and adapted for the public sector, in the FREM. It replaces the previous standards IAS 11 Construction Contracts and IAS 18 Revenue and related IFRIC and SIC interpretations. The potential amendments identified as a result of the adoption of IFRS 15 are significantly below materiality levels.

Income is accounted for applying the accruals convention. Income is recognised in the period in which services are provided. Where income had been received from third parties for a specific activity to be delivered in the following financial year, that income will be deferred. Only non-NHS income may be deferred.

Only non-NHS income may be deferred.

1.4. Employee benefits

1.4.1. Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.4.2. Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

The Department of Health and Social Care (DHSC) 2023-24 consultation on the NHS Pension Scheme confirmed that the transitional approach that has operated since 2019-20 for employer contributions will continue in 2024-25. From 1 April 2024 an employer rate of 23.7% (23.78% inclusive of the administration charge) will apply. However, the NHS Business Services Authority will continue to only collect 14.38% from NHS Wales employers under their normal monthly payment process to the NHS Pension Scheme. This has a resulted in an increase in the central payments made by Welsh Government directly to the Pension Scheme administrator, the NHS Business Services Authority (BSA the NHS Pensions Agency) from 6.3% to 9.4%.

However, NHS Wales' organisations are required to account for their staff employer contributions of 23.78% in full and on a gross basis, in their annual accounts. Payments made on their behalf by Welsh Government are accounted for on a notional basis. For detailed information see the Other Note within these accounts.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the NHS Wales organisation commits itself to the retirement, regardless of the method of payment.

Where employees are members of the Local Government Superannuation Scheme, which is a defined benefit pension scheme this is disclosed. The scheme assets and liabilities attributable to those employees can be identified and are recognised in the NHS Wales organisation’s accounts. The assets are measured at fair value and the liabilities at the present value of the future obligations. The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The expected gain during the year from scheme assets is recognised within finance income. The interest cost during the year arising from the unwinding of the discount on the scheme liabilities is recognised within finance costs.

1.4.3. NEST Pension Scheme

An alternative pensions scheme for employees not eligible to join the NHS Pensions scheme has to be offered. The NEST (National Employment Savings Trust) Pension scheme is a defined contribution scheme and therefore the cost to the NHS body of participating in the scheme is equal to the contributions payable to the scheme for the accounting period.

1.5. Other expenses

Other operating expenses for goods or services are recognised when, and to the extent that, they have been received. They are measured at the fair value of the consideration payable.

1.6. Property, plant and equipment

1.6.1. Recognition

Property, plant and equipment is capitalised if:

● it is held for use in delivering services or for administrative purposes;

● it is probable that future economic benefits will flow to, or service potential will be supplied to, the NHS Wales organisation;

● it is expected to be used for more than one financial year;

● the cost of the item can be measured reliably; and

● the item has cost of at least £5,000; or

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

● Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.6.2. Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Land and buildings used for services or for administrative purposes are stated in the Statement of Financial Position (SoFP) at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

● Land and non-specialised buildings – market value for existing use

● Specialised buildings – depreciated replacement cost

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. NHS Wales' organisations have applied these new valuation requirements from 1st April 2009.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

In 2022-23 a formal revaluation exercise was applied to land and properties. The carrying value of existing assets at that date will be written off over their remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure.

References in IAS 36 to the recognition of an impairment loss of a revalued asset being treated as a revaluation decrease to the extent that the impairment does not exceed the amount in the revaluation surplus for the same asset, are adapted such that only those impairment losses that do not result from a clear consumption of economic benefit or reduction of service potential (including as a result of loss or damage resulting from normal business operations) should be taken to the revaluation reserve. Impairment losses that arise from a clear consumption of economic benefit should be taken to the Statement of Comprehensive Net Expenditure (SoCNE).

From 2015-16, IFRS 13 Fair Value Measurement must be complied with in full. However, IAS 16 and IAS 38 have been adapted for the public sector context which limits the circumstances under which a valuation is prepared under IFRS 13. Assets which are held for their service potential and are in use should be measured at their current value in existing use. For specialised assets current value in existing use should be interpreted as the present value of the assets remaining service potential, which can be assumed to be at least equal to the cost of replacing that service potential. Where there is no single class of asset that falls within IFRS 13, disclosures should be for material items only.

In accordance with the adaptation of IAS 16 in table 6.2 of the FReM, for non-specialised assets in operational use, current value in existing use is interpreted as market value for existing use which is defined in the RICS Red Book as Existing Use Value (EUV).

Assets which were most recently held for their service potential but are surplus should be valued at current value in existing use, if there are restrictions on the NHS organisation or the asset which would prevent access to the market at the reporting date. If the NHS organisation could access the market then the surplus asset should be used at fair value using IFRS 13. In determining whether such an asset which is not in use is surplus, an assessment should be made on whether there is a clear plan to bring the asset back into use as an operational asset. Where there is a clear plan, the asset is not surplus and the current value in existing use should be maintained. Otherwise the asset should be assessed as being surplus and valued under IFRS13.

Assets which are not held for their service potential should be valued in accordance with IFRS 5 or IAS 40 depending on whether the asset is actively held for sale. Where an asset is not being used to deliver services and there is no plan to bring it back into use, with no restrictions on sale, and it does not meet the IAS 40 and IFRS 5 criteria, these assets are surplus and are valued at fair value using IFRS 13.

1.6.3. Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any carrying value of the item replaced is written-out and charged to the SoCNE. As highlighted in previous years the NHS in Wales does not have systems in place to ensure that all items being "replaced" can be identified and hence the cost involved to be quantified. The NHS in Wales has thus established a national protocol to ensure it complies with the standard as far as it is able to which is outlined in the capital accounting chapter of the Manual For Accounts. This dictates that to ensure that asset carrying values are not materially overstated, for All Wales Capital Schemes that are completed in a financial year, NHS Wales organisations are required to obtain a revaluation during that year (prior to them being brought into use) and also similar revaluations are needed for all Discretionary Building Schemes completed which have a spend greater than £0.5m. The write downs identified are then charged to operating expenses.

1.7. Intangible assets

1.7.1. Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the NHS Wales organisation; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

● the technical feasibility of completing the intangible asset so that it will be available for use.

● the intention to complete the intangible asset and use it.

● the ability to use the intangible asset.

● how the intangible asset will generate probable future economic benefits.

● the availability of adequate technical, financial and other resources to complete the intangible asset and use it.

● the ability to measure reliably the expenditure attributable to the intangible asset during its development.

1.7.2 Measurement

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.8. Depreciation, amortisation and impairments

Freehold land, assets under construction and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the NHS Wales Organisation expects to obtain economic benefits or service potential from the asset. This is specific to the NHS Wales organisation and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and estimated useful lives.

At each reporting period end, the NHS Wales organisation checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

Impairment losses that do not result from a loss of economic value or service potential are taken to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to the SoCNE. Impairment losses that arise from a clear consumption of economic benefit are taken to the SoCNE. The balance on any revaluation reserve (up to the level of the impairment) to which the impairment would have been charged under IAS 36 are transferred to retained earnings. Right of use (ROU) asset impairments are reflected in ROU liability.

1.9. Research and Development

Research and development expenditure is charged to operating costs in the year in which it is incurred, except insofar as it relates to a clearly defined project, which can be separated from patient care activity and benefits there from can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the SoCNE on a systematic basis over the period expected to benefit from the project.

1.10 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale,

within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the SoCNE. On disposal, the balance for the asset on the revaluation reserve, is transferred to the General Fund.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead it is retained as an operational asset and its economic life adjusted. The asset is derecognised when it is scrapped or demolished.

1.11 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration.

IFRS 16 leases is effective across public sector from 1st April 2022. The transition to IFRS 16 has been completed in accordance with paragraph C5 (b) of the Standard, applying IFRS 16 requirements retrospectively recognising the cumulative effects at the date of initial application.

In the transition to IFRS 16 a number of elections and practical expedients offered in the standard have been employed. These are as follows: The entity has applied the practical expedient offered in the standard per paragraph C3 to apply IFRS 16 to contracts or arrangements previously identified as containing a lease under the previous leasing standards IAS 17 leases and IFRIC 4 determining whether an arrangement contains a lease and not to those that were identified as not containing a lease under previous leasing standards.

On initial application the LHB has measured the right of use assets for leases previously classified as operating leases per IFRS 16 C8 (b)(ii), at an amount equal to the lease liability adjusted for accrued or prepaid lease payments.

No adjustments have been made for operating leases in which the underlying asset is of low value per paragraph C9 (a) of the standard.

The transitional provisions have not been applied to operating leases whose terms end within 12 months of the date of initial application per paragraph C10 (c) of IFRS 16.

Hindsight is used to determine the lease term when contracts or arrangements contain options to extend or terminate the lease in accordance with C10 (e) of IFRS 16.

Due to transitional provisions employed the requirements for identifying a lease within paragraphs 9 to 11 of IFRS 16 are not employed for leases in existence at the initial date of application. Leases entered into on or after the 1st April 2022 will be assessed under the requirements of IFRS 16.

There are further expedients or election that have been employed by the LHB in applying IFRS 16.

These include:

- the measurement requirements under IFRS 16 are not applied to leases with a term of 12 months or less under paragraph 5 (a) of IFRS 16
- the measurement requirements under IFRS 16 are not applied to leases where the underlying asset is of a low value which are identified as those assets of a value of less than £5,000, excluding any irrecoverable VAT, under paragraph 5 (b) of IFRS 16

The LHB will not apply IFRS 16 to any new leases of intangible assets, applying the treatment described in section 1.7 instead.

List any other expedients employed by the entity (such as low value 5(b) or 15 on componentisation HM Treasury have adapted the public sector approach to IFRS 16 which impacts on the identification and measurement of leasing arrangements that will be accounted for under IFRS 16.

The LHB is required to apply IFRS 16 to lease like arrangements entered into with other public sector entities that are in substance akin to an enforceable contract, that in their formal legal form may not be enforceable. Prior to accounting for such arrangements under IFRS 16 the LHB has assessed that in all other respects these arrangements meet the definition of a lease under the standard.

The LHB is required to apply IFRS 16 to lease like arrangements entered into in which consideration exchanged is nil or nominal, therefore significantly below market value. These arrangements are described as peppercorn leases. Such arrangements are again required to meet the definition of a lease in every other respect prior to inclusion in the scope of IFRS 16. The accounting for peppercorn arrangements aligns to that identified for donated assets. Peppercorn leases are different in substance to arrangements in which consideration is below market value but not significantly below market value.

The nature of the accounting policy change for the lessee is more significant than for the lessor under IFRS 16. IFRS 16 introduces a singular lessee approach to measurement and classification in which lessees recognise a right of use asset.

For the lessor leases remain classified as finance leases when substantially all the risks and rewards incidental to ownership of an underlying asset are transferred to the lessee. When this transfer does not occur, leases are classified as operating leases.

1.11.1 Aneurin Bevan UHB as lessee

At the commencement date for the leasing arrangement a lessee shall recognise a right of use asset and corresponding lease liability. The LHB employs a revaluation model for the subsequent measurement of its right of use assets unless cost is considered to be an appropriate proxy for current value in existing use or fair value in line with the accounting policy for owned assets. Where consideration exchanged is identified as below market value, cost is not considered to be an appropriate proxy to value the right of use asset.

Irrecoverable VAT is expensed in the period to which it relates and therefore not included in the measurement of the lease liability and consequently the value of the right of use asset.

The incremental borrowing rate of [ ] been applied to the lease liabilities recognised at the date of initial application of IFRS 16.

Where changes in future lease payments result from a change in an index or rate or rent review, the lease liabilities are remeasured using an unchanged discount rate.

Where there is a change in a lease term or an option to purchase the underlying asset the LHB applies a revised rate to the remaining lease liability.

Where existing leases are modified the LHB must determine whether the arrangement constitutes a separate lease and apply the standard accordingly.

Lease payments are recognised as an expense on a straight-line or another systematic basis over the lease term, where the lease term is in substance 12 months or less, or is elected as a lease containing low value underlying asset by the LHB.

1.11.2 Aneurin Bevan UHB as lessor

A lessor shall classify each of its leases as an operating or finance lease. A lease is classified as finance lease when the lease substantially transfers all the risks and rewards incidental to ownership of an underlying asset. Where substantially all the risks and rewards are not transferred, a lease is classified as an operating lease.

Amounts due from lessees under finance leases are recorded as receivables at the amount of the LHB's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the LHB's net investment outstanding in respect of the leases.

Income from operating leases is recognised on a straight-line or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Where the LHB is an intermediate lessor, being a lessor and a lessee regarding the same underlying asset, classification of the sublease is required to be made by the intermediate lessor considering the term of the arrangement and the nature of the right of use asset arising from the head lease.

On transition the LHB has reassessed the classification of all of its continuing subleasing arrangements to include peppercorn leases.

1.12. Inventories

Whilst it is accounting convention for inventories to be valued at the lower of cost and net realisable value using the weighted average or "first-in first-out" cost formula, it should be recognised that the NHS is a special case in that inventories are not generally held for the intention of resale and indeed there is no market readily available where such items could be sold. Inventories are valued at cost and this is considered to be a reasonable approximation to fair value due to the high turnover of stocks. Work-in-progress comprises goods in intermediate stages of production. Partially completed contracts for patient services are not accounted for as work-in-progress.

1.13. Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in three months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value. In the Statement of Cash flows (SoCF), cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the cash management.

1.14. Provisions

Provisions are recognised when the LHB has a present legal or constructive obligation as a result of a past event, it is probable that the LHB will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using the discount rate supplied by HM Treasury.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the LHB has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the LHB has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.14.1. Clinical negligence and personal injury costs

The Welsh Risk Pool Services (WRPS) operates a risk pooling scheme which is co-funded by the Welsh Government with the option to access a risk sharing agreement funded by the participative NHS Wales bodies. The risk sharing option was implemented in both 2023-24 and 2024-25. The WRPS is hosted by Velindre University NHS Trust.

1.14.2. Future Liability Scheme (FLS) - General Medical Practice Indemnity (GMPI)

The FLS is a state backed scheme to provide clinical negligence General Medical Practice Indemnity (GMPI) for providers of GMP services in Wales.

In March 2019, the Minister issued a Direction to Velindre University NHS Trust to enable Legal and Risk Services to operate the Scheme. The GMPI is underpinned by new secondary legislation, The NHS (Clinical Negligence Scheme) (Wales) Regulations 2019 which came into force on 1st April 2019.

GMP Service Providers are not direct members of the GMPI FLS, their qualifying liabilities are the subject of an arrangement between them and their relevant LHB, which is a member of the scheme. The qualifying reimbursements to the LHB are not subject to the £25,000 excess.

1.15. Financial Instruments

From 2018-19 IFRS 9 Financial Instruments has applied, as interpreted and adapted for the public sector, in the FReM. The principal impact of IFRS 9 adoption by NHS Wales' organisations, was to change the calculation basis for bad debt provisions, changing from an incurred loss basis to a lifetime expected credit loss (ECL) basis.

All entities applying the FReM recognised the difference between previous carrying amount and the carrying amount at the beginning of the annual reporting period that included the date of initial application in the opening general fund within Taxpayer's equity.

1.16. Financial assets

Financial assets are recognised on the SoFP when the LHB becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

The accounting policy choice allowed under IFRS 9 for long term trade receivables, contract assets which do contain a significant financing component (in accordance with IFRS 15), and lease receivables within the scope of IAS 17 has been withdrawn and entities should always recognise a loss allowance at an amount equal to lifetime Expected Credit Losses. All entities applying the FReM should utilise IFRS 9's simplified approach to impairment for relevant assets.

IFRS 9 requirements required a revised approach for the calculation of the bad debt provision, applying the principles of expected credit loss, using the practical expedients within IFRS 9 to construct a provision matrix.

1.16.1. Financial assets are initially recognised at fair value

Financial assets are classified into the following categories: financial assets 'at fair value through SoCNE'; 'held to maturity investments'; 'available for sale' financial assets, and 'loans and receivables'. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

1.16.2. Financial assets at fair value through SoCNE

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through SoCNE. They are held at fair value, with any resultant gain or loss recognised in the SoCNE. The net gain or loss incorporates any interest earned on the financial asset.

1.16.3 Held to maturity investments

Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

1.16.4. Available for sale financial assets

Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to the SoCNE on de-recognition.

1.16.5. Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the net carrying amount of the financial asset.

At the SOFP date, the LHB assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the SoCNE and the carrying amount of the asset is reduced directly, or through a provision of impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through the SoCNE to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.17. Financial liabilities

Financial liabilities are recognised on the SOFP when the LHB becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.17.1. Financial liabilities are initially recognised at fair value

Financial liabilities are classified as either financial liabilities at fair value through the SoCNE or other financial liabilities.

1.17.2. Financial liabilities at fair value through the SoCNE

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the SoCNE. The net gain or loss incorporates any interest earned on the financial asset.

1.17.3. Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.18. Value Added Tax (VAT)

Most of the activities of the NHS Wales organisation are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.19. Foreign currencies

Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. Resulting exchange gains and losses are taken to the SoCNE. At the SoFP date, monetary items denominated in foreign currencies are retranslated at the rates prevailing at the reporting date.

1.20. Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS Wales organisation has no beneficial interest in them. Details of third party assets are given in the Notes to the accounts.

1.21. Losses and Special Payments

Losses and special payments are items that the Welsh Government would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and special payments are charged to the relevant functional headings in the SoCNE on an accruals basis, including losses which would have been made good through insurance cover had the LHB not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, the note on losses and special payments is compiled directly from the losses register which is prepared on a cash basis.

The LHB accounts for all losses and special payments gross (including assistance from the WRP).

The LHB accrues or provides for the best estimate of future pay-outs for certain liabilities and discloses all other potential payments as contingent liabilities, unless the probability of the liabilities becoming payable is remote.

All claims for losses and special payments are provided for where the probability of settlement of an individual claim is over 50%. Where reliable estimates can be made, incidents of clinical negligence against which a claim has not, as yet, been received are provided in the same way. Expected reimbursements from the WRP are included in debtors. For those claims where the probability of settlement is between 5- 50%, the liability is disclosed as a contingent liability.

1.22. Pooled budgets

The NHS Wales organisation has/has not entered into pooled budgets with Local Authorities. Under the arrangements funds are pooled in accordance with section 33 of the NHS (Wales) Act 2006 for specific activities defined in the Pooled budget Note.

The pool budget is hosted by one NHS Wales's organisation. Payments for services provided are accounted for as miscellaneous income. The NHS Wales organisation accounts for its share of the assets, liabilities, income and expenditure from the activities of the pooled budget, in accordance with the pooled budget arrangement.

Monmouthshire County Council - Monnow Vale Health and Social Care Unit
Funds are pooled for the provision of health and social care inpatient, outpatient, clinic and day care facilities to individuals who have medical, social, community or rehabilitation needs. The pool is hosted by Aneurin Bevan University Local Health Board. The financial operation of the pool is governed by a pooled budget agreement between the Local Health Board and Monmouthshire County Council. The income from Monmouthshire County Council is recorded as Local Authority Income in these accounts.

Expenditure for services provided under the arrangement is recorded under the appropriate expense headings in these accounts.

The property in which the unit is housed has been provided by a Private Finance Partner; the contract with the PFI partner is for 30 years and is categorised as an on balance sheet PFI scheme with the HB recognising 72% of the property - see Note 32 of these accounts for further details.

The five Local Authorities in Gwent - Gwent Wide Integrated Community Equipment Service
Funds are pooled for the provision of an efficient and effective GWICES (Gwent Wide Integrated Community Equipment Service) to service users who are resident in the partner localities. The pool is hosted by Torfaen County Borough Council. The Health Board makes a financial contribution to the scheme but does not account for the schemes expenditure or assets/liabilities generated by this expenditure.

The financial operation of the pool is governed by a pooled budget agreement between the bodies listed above and the Health Board. Payments for services provided by the host body, Torfaen County Borough Council, are accounted for as expenditure within these accounts.

Monmouthshire County Council - Mardy Park Rehabilitation Centre
Funds are pooled for the provision of care to individuals who have rehabilitation needs. The LHB has entered into a pooled budget with Monmouthshire County Council. The pool is hosted by Monmouthshire County Council.

The five Local Authorities in Gwent - Gwent Frailty Programme
Funds are pooled for the purpose of establishing a consistent service across Gwent. The pool is hosted by Caerphilly County Borough Council, as lead commissioner. The financial operation of the pool is governed by a pooled budget agreement between the bodies listed above and the Health Board. Payments for services provided by the host body, Caerphilly County Borough Council, are accounted for as expenditure within these accounts. Additional information is provided in Note 32.

The five Local Authorities in Gwent and ABUHB – A pooled Fund for Care Home Accommodation functions for Older People
Statutory Directions issued under section 169 of the Social Services and Wellbeing (Wales) Act 2014 required Partnership Bodies to enter into partnership arrangements and for the establishment and maintenance of pooled funds from April 2018, for the exercise of their Care Home Accommodation Functions.

The overarching strategic aim of this Agreement is: -

• To ensure coordinated arrangements for ensuring an integrated approach across the Partnership to the commissioning and arranging for Care Home Accommodation for Older People.

• To ensure provision of high quality, cost effective Care Home Accommodation which meets local health and social care needs, through the establishment of a pooled fund

• To develop a managed market approach to the supply of quality provision to meets the needs of Older People Care Home Accommodation.

Funds are pooled for the provision and commissioning of specified services for older people (>65 years of age) in a care home setting in Gwent. The pool has been hosted by Torfaen County Borough Council since August 2018.

The Health Board makes a financial contribution to the scheme equivalent to actual expenditure incurred in commissioning related placements in homes during the year, but in addition does incur minimal costs associated with a share of the services provided by the host organisation and these are accounted for as expenditure within these accounts.

1.23. Critical Accounting Judgements and key sources of estimation uncertainty

In the application of the accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources.

The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates. The estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or the period of the revision and future periods if the revision affects both current and future periods.

1.24. Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the SoFP date, that have a significant risk of causing material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Significant estimations are made in relation to on-going clinical negligence and personal injury claims. Assumptions as to the likely outcome, the potential liabilities and the timings of these litigation claims are provided by independent legal advisors. Any material changes in liabilities associated with these claims would be recoverable through the Welsh Risk Pool.

Significant estimations are also made for continuing care costs resulting from claims post 1st April 2003. An assessment of likely outcomes, potential liabilities and timings of these claims are made on a case by case basis. Material changes associated with these claims would be adjusted in the period in which they are revised.

Estimates are also made for contracted primary care services. These estimates are based on the latest payment levels. Changes associated with these liabilities are adjusted in the following reporting period.

1.24.1. Provisions

The LHB provides for legal or constructive obligations for clinical negligence, personal injury and defence costs that are of uncertain timing or amount at the balance sheet date on the basis of the best estimate of the expenditure required to settle the obligation.

Claims are funded via the Welsh Risk Pool Services (WRPS) which receives an annual allocation from Welsh Government to cover the cost of reimbursement requests submitted to the bi-monthly WRPS Committee. Following settlement to individual claimants by the NHS Wales organisation, the full cost is recognised in year and matched to income (less a £25K excess) via a WRPS debtor, until reimbursement has been received from the WRPS Committee.

1.24.2. Probable & Certain Cases – Accounting Treatment

A provision for these cases is calculated in accordance with IAS 37. Cases are assessed and divided into four categories according to their probability of settlement;

Remote	Probability of Settlement	0 – 5%
	Accounting Treatment	Remote Contingent Liability.
Possible	Probability of Settlement	6% - 49%
	Accounting Treatment	Defence Fee - Provision*
Probable	Probability of Settlement	50% - 94%
	Accounting Treatment	Full Provision
Certain	Probability of Settlement	95% - 100%
	Accounting Treatment	Full Provision

** Personal injury cases - Defence fee costs are provided for at 100%.*

The provision for probable and certain cases is based on case estimates of individual reported claims received by Legal & Risk Services within NHS Wales Shared Services Partnership.

The solicitor will estimate the case value including defence fees, using professional judgement and from obtaining counsel advice. Valuations are then discounted for the future loss elements using individual life expectancies and the Government Actuary's Department actuarial tables (Ogden tables) and Personal Injury Discount Rate of 0.5%.

Future liabilities for certain & probable cases with a probability of 95%-100% and 50%- 94% respectively are held as a provision on the balance sheet. Cases typically take a number of years to settle, particularly for high value cases where a period of development is necessary to establish the full extent of the injury caused.

The Health Board has provided for some £199m (£213m 2023/24) within note 20 in respect of potential clinical negligence and personal injury claims and associated defence fees. These provisions have been arrived at on the advice of NHS Wales Shared Services Partnership - Legal & Risk Services. Given the nature of such claims this figure could be subject to significant change in future periods. However, the potential financial effect of such uncertainty is mitigated by the fact that the LHB's ultimate liability in respect of individual cases is capped at £0.025m, with amounts above this excess level being reimbursed by the Welsh Risk Pool.

The Health Board has estimated a liability of £0.379m (£0.393m 2023/24) in respect of retrospective claims for Continuing Health Care funding. The estimated provision is based upon an assessment of the likelihood of claims meeting criteria for continuing health care and the actual costs incurred by individuals in care homes. The provision is based on information made available to the Health Board at the time of these accounts and could be subject to significant change as outcomes are determined.

Aneurin Bevan University Local Health Board has reviewed its portfolio of outstanding claims for continuing healthcare and made an assessment of likely financial liability based on an estimated success factor, eligibility factor and expected weekly average costs of claims. The assumptions have been derived by reviewing a sample of claims.

Primary care expenditure includes estimates for areas which are paid in arrears and not finalised at the time of producing the accounts. These estimates relate to GMS Quality Assurance and Improvement Framework, GMS Enhanced Services, and pharmacy estimates, which are based on an assessment of likely final performance.

1.25 Discount Rates

Where discount is applied, a disclosure detailing the impact of the discounting on liabilities to be included for the relevant notes. The disclosure should include where possible undiscounted values to demonstrate the impact. An explanation of the source of the discount rate or how the discount rate has been determined to be included.

Within the Provisions Note (note 20) the amount relating to Early Retirements and Permanent Injury benefits has been discounted using the PES (2024) Post Employment Benefits Liabilities Real Rate in Excess of CPI of 2.4%.

1.26 Private Finance Initiative (PFI) transactions

HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The LHB therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

a) Payment for the fair value of services received;

b) Payment for the PFI asset, including finance costs; and

c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

1.26.1. Services received

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

1.26.2. PFI asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the LHB's approach for each relevant class of asset in accordance with the principles of IAS 16.

1.26.3. PFI liability

A PFI liability is recognised at the same time as the PFI assets are recognised.

Prior year treatment

It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the SoCNE.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the SoCNE.

1.26.4 Impact of IFRS 16 on on-balance sheet PFI/PPP Schemes as from 1st April 2023.

On-balance sheet PPP arrangements should be based on IFRS 16 accounting principles from 2023-24.

When measuring the liability for on-balance sheet PPP contracts containing capital payments linked to a price index IFRS 16 requires that a lessee shall remeasure the lease liability where there is a change in future lease payments resulting from a change in an index or a rate used to determine those payments. The lessee shall remeasure the lease liability to reflect those revised lease payments only when there is a change in the cash flows.

Initial remeasurement - the future PPP liability will need to be remeasured at 1st April 2023 to include the actual indexation-linked changes to payments for the capital/infrastructure element which have taken effect in the cash flows since the PPP agreement commenced. This should use a cumulative catch-up approach, where the cumulative effect is recognised as an adjustment to the opening balance of retained earnings.

Subsequent measurement - The PPP liability will continue to require remeasurements whenever cash payments change in response to indexation movements as set out in the individual PPP contract. The double entry for the subsequent liability remeasurement should be Debit Finance Cost, Credit PPP liability.

The liability does not include estimated future indexation linked increases.

1.26.5. Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the LHB's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

1.26.6. Assets contributed by the LHB to the operator for use in the scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the LHB's SoFP.

1.26.7. Other assets contributed by the LHB to the operator

Assets contributed (e.g. cash payments, surplus property) by the LHB to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the LHB, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured at the present value of the minimum lease payments, discounted using the implicit interest rate. It is subsequently measured as a finance lease liability in accordance with IAS 17.

On initial recognition of the asset, the difference between the fair value of the asset and the initial liability is recognised as deferred income, representing the future service potential to be received by the NHS Wales organisation through the asset being made available to third party users.

Other PFI arrangements off Statement of Financial Position

The LHB has one PFI Scheme that was previously classified as off-statement of financial position. The scheme related to the provision of replacement heating and lighting systems within Nevill Hall hospital. The scheme commenced in 2000 for a period of 25 years. Since the introduction of IFRS 16 in 2022/23, the off-statement of Financial Position PFI has been recognised as a Right of use Asset.

Joint PFI contract

The LHB has entered into an agreement to share a facility, provided by a Private Finance Partner, with Monmouthshire County Council to match the agreement with the Private Finance Partner. The arrangement is treated as a PFI arrangement and the total obligation is included as a liability of the LHB. The contribution towards the unitary charge committed by Monmouthshire County Council is treated as a financial asset. The future contribution was measured initially at the same amount as the fair value of the share of the PFI asset and is subsequently measured as a finance lease.

1.27. Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the LHB, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the LHB. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

Remote contingent liabilities are those that are disclosed under Parliamentary reporting requirements and not under IAS 37 and, where practical, an estimate of their financial effect is required.

1.28. Absorption accounting

Transfers of function are accounted for as either by merger or by absorption accounting dependent upon the treatment prescribed in the FReM. Absorption accounting requires that entities account for their transactions in the period in which they took place with no restatement of performance required.

Where transfer of function is between LHBs the gain or loss resulting from the assets and liabilities transferring is recognised in the SoCNE and is disclosed separately from the operating costs.

1.29. Accounting standards that have been issued but not yet been adopted

The following accounting standards have been issued and or amended by the IASB and IFRIC but have not been adopted because they are not yet required to be adopted by the FReM

IFRS14 Regulatory Deferral Accounts - Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable.

IFRS 17 Insurance Contracts, Application required for accounting periods beginning on or after 1 January 2023, Standard is UK endorsed and adopted by the FReM. The date of initial application is the beginning of the annual reporting period in which IFRS 17 is first applied. In central government the date of initial application is 1 April 2025.

IFRS 18 Presentation and Disclosure in Financial Statements - Application required for accounting periods beginning on or after 1 January 2027. Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted.

IFRS 19 Subsidiaries without Public Accountability: Disclosures - Application required for accounting periods beginning on or after 1 January 2027. Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted.

1.30. Accounting standards issued that have been adopted early

During 2024-25 there have been no accounting standards that have been adopted early. All early adoption of accounting standards will be led by HM Treasury.

1.31. Charities

Following Treasury's agreement to apply IAS 27 to NHS Charities from 1 April 2013, the LHB has established that as it is the corporate trustee of the Aneurin University LHB NHS Charitable Fund, it is considered for accounting standards compliance to have control of the Aneurin Bevan University LHB NHS Charitable Fund as a subsidiary.

The determination of control is an accounting standard test of control and there has been no change to the operation of the Aneurin Bevan University LHB NHS Charitable Fund or its independence in its management of charitable funds.

Whilst there is a requirement to consolidate the results of the Aneurin Bevan University LHB NHS Charitable Fund within the statutory accounts of the LHB. The LHB has with the agreement of the Welsh Government adopted the IAS 27 (10) exemption to consolidate.

Welsh Government as the ultimate parent of the Local Health Boards will disclose the Charitable Accounts of Local Health Boards in the Welsh Government Consolidated Accounts.

Details of the transactions with the charity are included in the related parties' notes.

2. Financial Duties Performance

The National Health Service Finance (Wales) Act 2014 came into effect from 1st April 2014. The Act amended the financial duties of Local Health Boards under section 175 of the National Health Service (Wales) Act 2006. From 1st April 2014 section 175 of the National Health Service (Wales) Act places two financial duties on Local Health Boards:

- A duty under section 175 (1) to secure that its expenditure does not exceed the aggregate of the funding allotted to it over a period of 3 financial years;
- A duty under section 175 (2A) to prepare a plan in accordance with planning directions issued by the Welsh Ministers, to secure compliance with the duty under section 175 (1) while improving the health of the people for whom it is responsible, and the provision of health care to such people, and for that plan to be submitted to and approved by the Welsh Ministers.

The first assessment of performance against the 3 year statutory duty under section 175 (1) was at the end of 2016-17, being the first 3 year period of assessment.

Welsh Health Circular WHC/2016/054 "Statutory and Financial Duties of Local Health Boards and NHS Trusts" clarifies the statutory financial duties of NHS Wales bodies effective from 2016-17.

2.1 Revenue Resource Performance

	Annual financial performance			
	2022-23	2023-24	2024-25	Total
	£000	£000	£000	£000
Net operating costs for the year	1,676,282	1,818,468	1,920,421	**5,415,171**
Less general ophthalmic services expenditure and other non-cash limited expenditure	148	599	(1,693)	**(946)**
Less unfunded revenue consequences of bringing PFI schemes onto SoFP	0	29	(29)	**0**
Less any non funded revenue consequences of IFRS 16	0	0	0	**0**
Total operating expenses	1,676,430	1,819,096	1,918,699	**5,414,225**
Revenue Resource Allocation	1,639,588	1,769,330	1,911,514	**5,320,432**
Under /(over) spend against Allocation	**(36,842)**	**(49,766)**	**(7,185)**	**(93,793)**

Aneurin Bevan University LHB has not met its financial duty to break-even against its Revenue Resource Limit over the 3 years 2022-23 to 2024-25.

The Health Board received £7.36m cash-only support from Welsh Government during 2024-25 with the accumulated cash-only support for 2022-23 to 2024-25 as at 31 March 2025 being £80.3m. This support has been provided by Welsh Government to assist the Health Board with making payments staff and suppliers; there is no requirement for this funding to be repaid.

2.2 Capital Resource Performance

	2022-23	2023-24	2024-25	Total
	£000	£000	£000	£000
Gross capital expenditure	41,028	62,681	72,066	**175,775**
Add: Losses on disposal of donated assets	2	1	0	**3**
Less NBV on disposal of property, plant and equipment, right of use and intangible assets	(61)	(5,845)	(1,534)	**(7,440)**
Adjustment for transfers (to)/from NHS Trusts	0	0	(45)	**(45)**
Less capital grants received	(62)	0	0	**(62)**
Less donations received	(227)	(136)	(78)	**(441)**
Less IFRS16 Peppercorn income	0	0	0	**0**
Less **initial recognition** of RoU Asset Dilapidations	0	0	0	**0**
Charge against Capital Resource Allocation	40,680	56,701	70,409	**167,790**
Capital Resource Allocation	40,723	56,742	70,475	**167,940**
(Over) / Underspend against Capital Resource Allocation	**43**	**41**	**66**	**150**

Aneurin Bevan University LHB has met its financial duty to break-even against its Capital Resource Limit over the 3 years 2022-23 to 2024-25.

2.3 Duty to prepare a 3 year integrated plan

The NHS Wales Planning Framework for the period 2024-2027 issued to LHBs placed a requirement upon them to prepare and submit Integrated Medium Term Plans to the Welsh Government.

The LHB was unable to submit a balanced Integrated Medium Term Plan for the period 2024-2027 in accordance with NHS Wales Planning Framework. The Health Board submitted an Annual Plan for 2024-25 with a clear intention to reach a balanced in year position in 2026-27.

The Minister for Health and Social Services extant approval

Status

Date

Aneurin Bevan University LHB has not therefore met its statutory duty to have an approved financial plan.

2.4 Creditor payment

The LHB is required to pay 95% of the number of non-NHS bills within 30 days of receipt of goods or a valid invoice (whichever is the later). The LHB has achieved the following results:

	2024-25	2023-24
Total number of non-NHS bills paid	**301,118**	327,881
Total number of non-NHS bills paid within target	**294,215**	319,291
Percentage of non-NHS bills paid within target	97.7%	97.4%

The LHB has met the target.

3. Analysis of gross operating costs

3.1 Expenditure on Primary Healthcare Services

	Cash limited £000	Non-cash limited £000	2024-25 Total £000	2023-24 Total £000
General Medical Services	132,671		132,671	122,671
Pharmaceutical Services	37,351	(8,127)	29,224	25,756
General Dental Services	44,444		44,444	39,870
General Ophthalmic Services	5,255	9,820	15,075	10,659
Other Primary Health Care expenditure	4,729		4,729	4,373
Prescribed drugs and appliances	125,771		125,771	121,947
Total	**350,221**	**1,693**	**351,914**	325,276

Return of excess funds from primary care contractors are included in the figures above

Included within other notes to the accounts			
Additional Primary Care Expenditure	Positive	0	0
Additional Primary Care Income	Negative	-5843	0
Overall total		346,071	325,276

The General Medical Services expenditure includes £11,699k (2023/24 £18,793k) in relation to staff salaries, the General Dental Services expenditure includes £2,155k (2023/24 £4,070k) in relation to staff salaries, the Prescribed Drugs & Appliances expenditure includes £352k (2023/24 £348k) in relation to staff salaries, and the General Ophthalmic Services includes £88k (2023/24 £37k) in relation to staff salaries.

3.2 Expenditure on healthcare from other providers

	2024-25 £000	2023-24 £000
Goods and services from other NHS Wales Health Boards	**64,362**	69,753
Goods and services from other NHS Wales Trusts	**54,658**	47,460
Goods and services from Welsh Special Health Authorities	**0**	0
Goods and services from other non Welsh NHS bodies	**14,400**	12,041
Goods and services from NWJCC /WHSSC and EASC	**218,320**	208,640
Local Authorities	**41,544**	41,143
Voluntary organisations	**10,849**	9,408
NHS Funded Nursing Care	**11,817**	11,260
Continuing Care	**99,904**	99,136
Private providers	**10,942**	9,110
Specific projects funded by the Welsh Government	**0**	0
Other	**407**	447
Total	**527,203**	508,398

Local Authorities expenditure relates to the following bodies:	2024-25 £'000	2023-24 £'000
Blaenau Gwenty County Borough Council	3644	3,462
Caerphilly County Borough Council	17632	17,706
Monmouthshire County Council	4947	4,759
Newport City Council	8548	8,289
Torfaen County Borough Council	6876	6,874
Gloucestershire County Council	-103	52
Swansea Council	0	1
	41544	41,143

3.3 Expenditure on Hospital and Community Health Services

	2024-25	2023-24
	£000	£000
Directors' costs	2,741	2,218
Operational Staff costs	843,137	786,497
Single lead employer Staff Trainee Cost	43,004	32,482
Collaborative Bank Staff Cost	0	0
Supplies and services - clinical	143,559	130,717
Supplies and services - general	20,917	20,384
Consultancy Services	481	410
Establishment	6,438	7,251
Transport	1,542	1,441
Premises	46,305	43,954
External Contractors	0	0
Depreciation	42,231	43,001
Depreciation Right of Use assets (RoU)	3,896	4,474
Amortisation	1,964	2,349
Fixed asset impairments and reversals (Property, plant & equipment)	1,817	9,732
Fixed asset impairments and reversals (RoU Assets)	0	0
Fixed asset impairments and reversals (Intangible assets)	0	438
Impairments & reversals of financial assets	0	0
Impairments & reversals of non-current assets held for sale	0	0
Audit fees	443	455
Other auditors' remuneration	0	0
Losses, special payments and irrecoverable debts	3,065	3,217
Research and Development	0	0
Expense related to short-term leases	367	713
Expense related to low-value asset leases (excluding short-term leases)	973	936
Other operating expenses	14,310	14,599
Total	**1,177,190**	1,105,268

The Health Board Spent £2.8m (£2.9m 2023-24) on Research and Development. The majority of this spend relates to staff £2.2m (£2.3m 2023-24) which along with the non-staff spend is reflected under the various headings within note 3.3. During 2024-25 Research and Development income received was £2.6m (£2.7m 2023-24).

3.4 Losses, special payments and irrecoverable debts: charges to operating expenses

	2024-25	2023-24
Increase/(decrease) in provision for future payments:	**£000**	£000
Clinical negligence;		
Secondary care	**2,814**	72,303
Primary care	**49**	817
Redress Secondary Care	**180**	221
Redress Primary Care	**0**	0
Personal injury	**547**	734
All other losses and special payments	**1,062**	821
Defence legal fees and other administrative costs	**1,414**	1,308
Gross increase/(decrease) in provision for future payments	**6,066**	**76,204**
Contribution to Welsh Risk Pool	0	0
Premium for other insurance arrangements	0	0
Irrecoverable debts	73	198
Less: income received/due from Welsh Risk Pool	(3,074)	(72,845)
Total	**3,065**	3,557

	2024-25	2023-24
	£	£
Permanent injury included within personal injury £:	(472,029)	(613,210)

4. Miscellaneous Income

	2024-25 £000	2023-24 £000
Local Health Boards	24,380	22,054
NWJCC/ WHSSC and EASC	14,774	13,948
NHS Wales trusts	17,702	11,418
Welsh Special Health Authorities	1,404	15,800
Foundation Trusts	97	38
Other NHS England bodies	2,975	1,472
Other NHS Bodies	21	56
Local authorities	21,289	20,351
Welsh Government	3,729	4,788
Welsh Government Hosted bodies	0	0
Non NHS:		
Prescription charge income	3	0
Dental fee income	6,130	5,160
Private patient income	0	0
Overseas patients (non-reciprocal)	365	157
Injury Costs Recovery (ICR) Scheme	1,323	1,140
Other income from activities	2,528	1,083
Patient transport services	0	0
Education, training and research	19,086	2,034
Charitable and other contributions to expenditure	1,394	1,259
Receipt of NWSSP Covid centrally purchased assets	0	0
Receipt of Covid centrally purchased assets from other organisations	0	0
Receipt of donated assets	78	136
Receipt of Government granted assets	0	0
Right of Use Grant (Peppercorn Lease)	0	0
Non-patient care income generation schemes	155	131
NHS Wales Shared Services Partnership (NWSSP)	0	0
Deferred income released to revenue	0	0
Right of Use Asset Sub-leasing rental income	0	0
Contingent rental income from finance leases	0	0
Rental income from operating leases	467	343
Other income:		
Provision of laundry, pathology, payroll services	82	131
Accommodation and catering charges	3,349	3,519
Mortuary fees	422	364
Staff payments for use of cars	673	625
Business Unit	0	0
Scheme Pays Reimbursement Notional	81	463
Other	14,099	15,486
Total	**136,606**	121,956

Other income Includes;		
Salary Sacrifice Schemes & Fleet Vehicles	7,772	5,954
VAT recoveries re Business Activities and Contracted Out Services	986	2,249
Integrated Care Fund	0	3,678
Other	5,341	3,605
Total	**14,099**	15,486

Injury Cost Recovery (ICR) Scheme income

	2024-25 %	2023-24 %
To reflect expected rates of collection ICR income is subject to a provision for impairment of:	24.45	23.07

In accordance with the Manual for Accounts, an adjustment has been made to the 2024/25 Accounts to reflect HEIW income against Training & Education instead of against Special Health Authorities. The 2023/24 comparative figures have not been amended.

5. Investment Revenue

	2024-25	2023-24
	£000	£000
Rental revenue :		
PFI Finance lease income		
planned	0	0
contingent	0	0
Other finance lease revenue	0	0
Interest revenue :		
Bank accounts	0	0
Other loans and receivables	0	0
Impaired financial assets	0	0
Other financial assets	16	17
Total	16	17

6. Other gains and losses

	2024-25	2023-24
	£000	£000
Gain/(loss) on disposal of property, plant and equipment	41	(345)
Gain/(loss) on disposal other than by sale of right of use assets assets	0	14
Gain/(loss) on disposal of intangible assets	0	0
Gain/(loss) on disposal of assets held for sale	0	0
Gain/(loss) on disposal of financial assets	0	0
Change on foreign exchange	0	0
Change in fair value of financial assets at fair value through SoCNE	0	0
Change in fair value of financial liabilities at fair value through SoCNE	0	0
Recycling of gain/(loss) from equity on disposal of financial assets held for sale	0	0
Total	41	(331)

7. Finance costs

	2024-25	2023-24
	£000	£000
Interest on loans and overdrafts	0	0
Interest on obligations under finance leases	0	0
Interest on obligations under Right of Use Leases	353	274
Interest on obligations under PFI contracts;		
main finance cost	132	231
contingent finance cost	0	0
Impact of IFRS 16 on PPP/PFI contracts	147	521
Interest on late payment of commercial debt	0	0
Other interest expense	0	0
Total interest expense	632	1,026
Provisions unwinding of discount	145	142
Other finance costs	0	0
Total	777	1,168

8. Future charges to Statement of Comprehensive Net Expenditure (SoCNE)

LHB as lessee

As at 31st March 2025 the Health Board had 0 leases agreements in place for the leases of premises; 348 arrangements in respect of equipment and 237 in respect of vehicles, with 3 property, 164 equipment and 71 vehicle leases having expired in year.

The periods in which the remaining agreements will expire are shown below:

	2024-25 Low Value & Short Term	2024-25 Other	2024-25 Total	2023-24 Total
Payments recognised as an expense				
	£000	**£000**	**£000**	£000
Minimum lease payments	1,363	0	**1,363**	1,670
Contingent rents	0	0	**0**	0
Sub-lease payments	0	0	**0**	0
Total	**1,363**	**0**	**1,363**	1,670

Total future minimum lease payments				
Payable	**£000**	**£000**	**£000**	£000
Not later than one year	820	0	**820**	1,079
Between one and five years	803	0	**803**	862
After 5 years	0	0	**0**	0
Total	**1,623**	**0**	**1,623**	1,941

LHB as lessor

	2024-25	2023-24
Rental revenue	**£000**	£000
Rent	467	343
Contingent rents	0	0
Total revenue rental	**467**	343

Total future minimum lease payments		
Receivable	**£000**	£000
Not later than one year	290	289
Between one and five years	1,085	1,033
After 5 years	789	1,031
Total	**2,164**	2,353

9. Employee benefits and staff numbers

9.1 Employee costs

	Permanent Staff	Staff on Inward Secondment	Agency Staff	Specialist Trainee (SLE)	Collaborative Bank Staff	Other	Total	2023-24
	£000	£000	£000	£000	£000	£000	£000	£000
Salaries and wages	638,388	1,020	26,782	33,750	0	2,190	702,130	673,024
Social security costs	66,643	0	0	4,066	0		70,709	66,891
Employer contributions to NHS Pension Scheme	125,738	0	0	5,187	0		130,925	105,209
Other pension costs	229	0	0		0		229	298
Other employment benefits	0	0	0		0		0	0
Termination benefits	0	0	0		0		0	0
Total	830,998	1,020	26,782	43,003	0	2,190	903,993	845,422

Charged to capital	802	977
Charged to revenue	903,191	844,445
	903,993	845,422
Net movement in accrued employee benefits (untaken staff leave)	(38)	(167)

The staff under the 'Other' heading relate to Agency Medical Staff who are paid via a direct engagement scheme which commenced in January 2020.

9.2 Average number of employees

	Permanent Staff	Staff on Inward Secondment	Agency Staff	Specialist Trainee (SLE)	Collaborative Bank Staff	Other	Total	2023-24
	Number	Number	Number	Number	Number	Number	Number	Number
Administrative, clerical and board members	2,713	7	2	0	0	0	2,722	2,761
Medical and dental	845	5	49	430	0	10	1,339	1,338
Nursing, midwifery registered	3,975	0	146	0	0	0	4,121	4,012
Professional, Scientific, and technical staff	428	0	5	0	0	0	433	452
Additional Clinical Services	2,886	0	17	0	0	0	2,903	2,841
Allied Health Professions	953	6	23	0	0	0	982	876
Healthcare Scientists	253	0	4	0	0	0	257	247
Estates and Ancilliary	1,037	0	17	0	0	0	1,054	1,093
Students	6	0	0	0	0	0	6	9
Total	13,096	18	263	430	0	10	13,817	13,629

9.3. Retirements due to ill-health

	2024-25	2023-24
Number	16	15
Estimated additional pension costs £	1,456,012	1,462,604

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

9.4 Employee benefits

The Health Board does not have an employee benefit scheme.

9.5 Reporting of other compensation schemes - exit packages

9.5.1 Exit Packages Costs and Numbers

Exit packages cost band (including any special payment element)	2024-25 Number of compulsory redundancies	2024-25 Number of other departures	2024-25 Total number of exit packages	2024-25 Number of departures where special payments have been made	2023-24 Total number of exit packages
	Whole numbers only	Whole numbers only	Whole numbers only	Whole numbers only	Whole numbers only
less than £10,000	0	1	1	0	0
£10,000 to £25,000	0	0	0	0	1
£25,000 to £50,000	0	0	0	0	0
£50,000 to £100,000	0	0	0	0	0
£100,000 to £150,000	0	0	0	0	0
£150,000 to £200,000	0	0	0	0	0
more than £200,000	0	0	0	0	0
Total	0	1	1	0	1

Exit packages cost band (including any special payment element)	2024-25 Cost of compulsory redundancies	2024-25 Cost of other departures	2024-25 Total cost of exit packages	2024-25 Cost of special element included in exit packages	2023-24 Total cost of exit packages
	£	£	£	£	£
less than £10,000	0	7,500	7,500	0	0
£10,000 to £25,000	0	0	0	0	24,254
£25,000 to £50,000	0	0	0	0	0
£50,000 to £100,000	0	0	0	0	0
£100,000 to £150,000	0	0	0	0	0
£150,000 to £200,000	0	0	0	0	0
more than £200,000	0	0	0	0	0
Total	0	7,500	7,500	0	24,254

Total Exit Costs Paid in Year	Total paid in year 2024-25	Total paid in year 2023-24
	£	£
Exit costs paid in year	7,500	24,254
Total	7,500	24,254

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

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

The Health Board has not approved any VERS in 2024-25.

Additional requirement as per FReM
£0.00 exit costs were paid in 2024-25, relating to 2023-24 (the year of departure).

9.5 Reporting of other compensation schemes - exit packages continued

9.5.2 Analysis of other departures

Type of other departures	2024-25 Agreements Number	2024-25 Total value of agreements £
Voluntary redundancies including early retirement contractual costs	0	0
Contractual payments in lieu of notice*	1	1440
Exit payments following Employment Tribunals or court orders	1	5839
Non-contractual payments requiring Welsh Government Approval**	0	0
Other please specify	1	221
Other please specify	0	0
Total	**3**	**7500**

This disclosure provides detail for the number and value of exit packages agreed in the year.

Other Payments:
£221 - in relation to undertaken annual leave.

9.6 Fair Pay disclosures

9.6.1 Remuneration Relationship

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

Total pay and benefits	2024-25 £000 Chief Executive	2024-25 £000 Employee	2024-25 £000 Ratio	2023-24 £000 Chief Executive	2023-24 £000 Employee	2023-24 £000 Ratio
25th percentile pay ratio	240 - 245	29	8.2	225 - 230	29	8.0
Median pay	240 - 245	37	6.5	225 - 230	36	6.3
75th percentile pay ratio	240 - 245	49	5.0	225 - 230	47	4.9
Salary component of total pay and benefits						
25th percentile pay ratio	240 - 245	29		225 - 230	29	
Median pay	240 - 245	37		225 - 230	36	
75th percentile pay ratio	240 - 245	49		225 - 230	47	

Total pay and benefits	Highest Paid Director	Employee	Ratio	Highest Paid Director	Employee	Ratio
25th percentile pay ratio	240 - 245	29	8.2	225 - 230	29	8.0
Median pay	240 - 245	37	6.5	225 - 230	36	6.3
75th percentile pay ratio	240 - 245	49	5.0	225 - 230	47	4.9
Salary component of total pay and benefits						
25th percentile pay ratio	240 - 245	29		225 - 230	29	
Median pay	240 - 245	37		225 - 230	36	
75th percentile pay ratio	240 - 245	49		225 - 230	47	

In 2024-25, 15 (2023-24, 10) employees received remuneration in excess of the highest-paid director.

Remuneration for all staff ranged from £17k to £459k (2023-24, £15k to £383k).

The all staff range includes directors (including the highest paid director) and excludes pension benefits of all employees.

Financial Year Summary

There has been an increase in the pay ratio which is attributable to the increase in the chief exectuive / highest paid director salary being more than the increase in the employee median salary.

The median pay ratio for the relevant financial year is consistent with the pay, reward and progression policies for the entity's employees taken as a whole.

9.6.2 Percentage Changes	2023-24 to 2024-25	2022-23 to 2023-24
% Change from previous financial year in respect of Chief Executive	**%**	**%**
Salary and allowances	**7**	5
Performance pay and bonuses	**0**	0
% Change from previous financial year in respect of highest paid director		
Salary and allowances	**7**	5
Performance pay and bonuses	**0**	0
Average % Change from previous financial year in respect of employees takes as a whole		
Salary and allowances	**5**	7
Performance pay and bonuses	**0**	0

9.7 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”.
An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2025, is based on valuation data as at 31 March 2023, updated to 31 March 2025 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

c) National Employment Savings Trust (NEST)

NEST is a workplace pension scheme, which was set up by legislation and is treated as a trust-based scheme. The Trustee responsible for running the scheme is NEST Corporation. It's a non-departmental public body (NDPB) that operates at arm's length from government and is accountable to Parliament through the Department for Work and Pensions (DWP).

NEST Corporation has agreed a loan with the Department for Work and Pensions (DWP). This has paid for the scheme to be set up and will cover expected shortfalls in scheme costs during the earlier years while membership is growing.

NEST Corporation aims for the scheme to become self-financing while providing consistently low charges to members.

Using qualifying earnings to calculate contributions, currently the legal minimum level of contributions is 8% of a jobholder's qualifying earnings, for employers whose legal duties have started. The employer must pay at least 3% of this.

The earnings band used to calculate minimum contributions under existing legislation is called qualifying earnings. Qualifying earnings are currently those between £6,240 and £50,270 for the 2024-25 tax year (2023-24 £6,240 and £50,270).

Restrictions on the annual contribution limits were removed on 1st April 2017.

10. Public Sector Payment Policy - Measure of Compliance

10.1 Prompt payment code - measure of compliance

The Welsh Government requires that Health Boards pay all their trade creditors in accordance with the CBI prompt payment code and Government Accounting rules. The Welsh Government has set as part of the Health Board financial targets a requirement to pay 95% of the number of non-NHS creditors within 30 days of delivery.

	2024-25	**2024-25**	2023-24	2023-24
NHS	**Number**	**£000**	Number	£000
Total bills paid	5,193	433,942	4,932	402,257
Total bills paid within target	4,770	425,567	4,364	381,217
Percentage of bills paid within target	**91.9%**	**98.1%**	88.5%	94.8%
Non-NHS				
Total bills paid	301,118	700,384	327,881	709,739
Total bills paid within target	294,215	676,799	319,291	688,084
Percentage of bills paid within target	**97.7%**	**96.6%**	97.4%	96.9%
Total				
Total bills paid	**306,311**	**1,134,326**	332,813	1,111,996
Total bills paid within target	**298,985**	**1,102,366**	323,655	1,069,301
Percentage of bills paid within target	**97.6%**	**97.2%**	97.2%	96.2%

10.2 The Late Payment of Commercial Debts (Interest) Act 1998

	2024-25	2023-24
	£	£
Amounts included within finance costs (note 7) from claims made under this legislation	**0**	0
Compensation paid to cover debt recovery costs under this legislation	**114,172**	542
Total	**114,172**	**542**

11.1 Property, plant and equipment

2024-25

	Land £000	Buildings, excluding dwellings £000	Dwellings £000	Assets under construction & payments on account £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2024	75,111	750,899	2,390	40,777	117,063	281	39,458	3,953	1,029,932
Indexation	666	5,342	15	0	0	0	0	0	6,023
Additions									
- purchased	0	3,509	149	46,201	7,691	0	5,427	624	63,601
- donated	0	17	0	0	42	0	19	0	78
- government granted	0	0	0	0	0	0	0	0	0
Transfer from/into other NHS bodies	0	0	0	0	0	0	(45)	0	(45)
Reclassifications	0	37,289	0	(37,289)	(60)	0	16	44	0
Revaluations	3,288	6,243	0	0	0	0	0	0	9,531
Reversal of impairments	133	14,644	28	0	0	0	0	0	14,805
Impairments	0	(17,994)	0	0	0	0	0	0	(17,994)
Reclassified as held for sale	0	0	0	0	0	0	0	0	0
Disposals	0	(2,482)	0	0	(6,346)	99	(6,220)	(33)	(14,982)
At 31 March 2025	79,198	797,467	2,582	49,689	118,390	380	38,655	4,588	1,090,949
Depreciation at 1 April 2024	0	43,143	395	0	67,276	269	24,508	1,524	137,115
Indexation	0	374	6	0	0	0	0	0	380
Transfer from/into other NHS bodies	0	0	0	0	0	0	(11)	0	(11)
Reclassifications	0	0	0	0	(16)	0	16	0	0
Revaluations	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	403	1	0	0	0	0	0	404
Impairments	0	(1,776)	0	0	0	0	0	0	(1,776)
Reclassified as held for sale	0	0	0	0	0	0	0	0	0
Disposals	0	(2,482)	0	0	(6,306)	99	(6,219)	(33)	(14,941)
Provided during the year	0	23,479	86	0	12,454	6	5,793	413	42,231
At 31 March 2025	0	63,141	488	0	73,408	374	24,087	1,904	163,402
Net book value at 1 April 2024	75,111	707,756	1,995	40,777	49,787	12	14,950	2,429	892,817
Net book value at 31 March 2025	79,198	734,326	2,094	49,689	44,982	6	14,568	2,684	927,547
Net book value at 31 March 2025 comprises :									
Purchased	76,108	732,430	2,094	49,689	44,378	6	14,503	2,652	921,860
Donated	3,090	1,697	0	0	463	0	65	32	5,347
Government Granted	0	199	0	0	141	0	0	0	340
At 31 March 2025	79,198	734,326	2,094	49,689	44,982	6	14,568	2,684	927,547
Asset financing :									
Owned	79,198	730,440	2,094	49,689	44,982	6	14,568	2,684	923,661
On-SoFP MIMS Funded PPP contracts	0	0	0	0	0	0	0	0	0
On-SoFP PFI contracts	0	3,886	0	0	0	0	0	0	3,886
PFI residual interests	0	0	0	0	0	0	0	0	0
At 31 March 2025	79,198	734,326	2,094	49,689	44,982	6	14,568	2,684	927,547

The net book value of land, buildings and dwellings at 31 March 2025 comprises :

	£000
Freehold	811,217
Long Leasehold	4,390
Short Leasehold	11
	815,618

Valuers 'material uncertainty', in valuation. The disclosure relates to the materiality in the valuation report not that of the underlying account. 0

The land and buildings were revalued by the Valuation Office Agency with an effective date of 1st April 2022. The valuation has been prepared in accordance with the terms of the latest version of the Royal Institute of Chartered Surveyors' Valuation Standards. LHB s are required to apply the revaluation model set out in IAS 16 and value its capital assets to fair value. Fair value is defined by IAS 16 as the amount for which an asset could be exchanged between knowledgeable, willing parties in an arms length transaction. This has been undertaken on the assumption that the property is sold as part of the continuing enterprise in occupation.

11.1 Property, plant and equipment

2023-24	Land £000	Buildings, excluding dwellings £000	Dwellings £000	Assets under construction & payments on account £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost at 31 March bf	77,508	696,196	2,237	36,936	118,190	546	43,310	4,162	979,085
NHS Wales Transfers	0	0	0	0	0	0	0	0	0
Prepayments	0	0	0	0	0	0	0	0	0
Transfer of Finance Leases to ROU Asset Note	0	0	0	0	0	0	0	0	0
Cost or valuation at 1 April 2023	77,508	696,196	2,237	36,936	118,190	546	43,310	4,162	979,085
Indexation	(2,000)	21,643	33	0	0	0	0	0	19,676
Additions									
- purchased	0	2,574	19	46,443	5,806	0	2,471	243	57,556
- donated	0	0	0	0	136	0	0	0	136
- government granted	0	0	0	0	0	0	0	0	0
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	0
Reclassifications	0	42,054	0	(42,602)	124	0	250	(410)	(584)
Revaluations	0	(22)	0	0	0	0	0	0	(22)
Reversal of impairments	0	19,893	101	0	0	0	0	0	19,994
Impairments	(397)	(31,439)	0	0	0	0	0	0	(31,836)
Reclassified as held for sale	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	(7,193)	(265)	(6,573)	(42)	(14,073)
At 31 March 2024	**75,111**	**750,899**	**2,390**	**40,777**	**117,063**	**281**	**39,458**	**3,953**	**1,029,932**
Depreciation at 31 March bf	0	22,122	294	0	60,999	502	24,324	1,303	**109,544**
NHS Wales Transfers	0	0	0	0	0	0	0	0	**0**
Transfer of Finance Leases to ROU Asset Note	0	0	0	0	0	0	0	0	**0**
Depreciation at 1 April 2023	0	22,122	294	0	60,999	502	24,324	1,303	109,544
Indexation	0	879	15	0	0	0	0	0	894
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	(2)	0	79	(112)	(35)
Revaluations	0	(657)	0	0	0	0	0	0	(657)
Reversal of impairments	0	439	3	0	0	0	0	0	442
Impairments	0	(2,552)	0	0	0	0	0	0	(2,552)
Reclassified as held for sale	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	(6,642)	(265)	(6,573)	(42)	(13,522)
Provided during the year	0	22,912	83	0	12,921	32	6,678	375	43,001
At 31 March 2024	**0**	**43,143**	**395**	**0**	**67,276**	**269**	**24,508**	**1,524**	**137,115**
Net book value at 1 April 2023	**77,508**	**674,074**	**1,943**	**36,936**	**57,191**	**44**	**18,986**	**2,859**	**869,541**
Net book value at 31 March 2024	**75,111**	**707,756**	**1,995**	**40,777**	**49,787**	**12**	**14,950**	**2,429**	**892,817**
Net book value at 31 March 2024 comprises :									
Purchased	**72,053**	**705,809**	**1,995**	**40,777**	**49,031**	**12**	**14,879**	**2,393**	**886,949**
Donated	**3,058**	**1,745**	**0**	**0**	**560**	**0**	**71**	**36**	**5,470**
Government Granted	**0**	**202**	**0**	**0**	**196**	**0**	**0**	**0**	**398**
At 31 March 2024	**75,111**	**707,756**	**1,995**	**40,777**	**49,787**	**12**	**14,950**	**2,429**	**892,817**
Asset financing :									
Owned	**75,111**	**703,130**	**1,995**	**40,777**	**49,759**	**12**	**14,950**	**2,429**	**888,163**
On-SoFP PFI contracts	**0**	**4,626**	**0**	**0**	**28**	**0**	**0**	**0**	**4,654**
PFI residual interests	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
At 31 March 2024	**75,111**	**707,756**	**1,995**	**40,777**	**49,787**	**12**	**14,950**	**2,429**	**892,817**

The net book value of land, buildings and dwellings at 31 March 2024 comprises :

	£000
Freehold	780,060
Long Leasehold	4,783
Short Leasehold	19
	784,862

Valuers 'material uncertainty', in valuation. The disclosure relates to the materiality in the valuation report not that of the underlying account. 0

The land and buildings were revalued by the Valuation Office Agency with an effective date of 1st April 2022. The valuation has been prepared in accordance with the terms of the latest version of the Royal Institute of Chartered Surveyors' Valuation Standards. LHB s are required to apply the revaluation model set out in IAS 16 and value its capital assets to fair value. Fair value is defined by IAS 16 as the amount for which an asset could be exchanged between knowledgeable, willing parties in an arms length transaction. This has been undertaken on the assumption that the property is sold as part of the continuing enterprise in occupation.

11. Property, plant and equipment (continued)

Disclosures:

Disclosures:
i) Donated Assets
Assets totalling £78k were purchased via Charitable Funds donations during the year.

ii) Valuations
The LHBs land and Buildings were revalued by the Valuation Office Agency with an effective date of 1st April 2022. The valuation has been prepared in accordance with the terms of the latest version of the Royal Institute of Chartered Surveyors' Valuation Standards.

The LHB is required to apply the revaluation model set out in IAS 16 and value its capital assets to fair value. Fair value is defined by IAS 16 as the amount for which an asset could be exchanged between knowledgeable, willing parties in an arms length transaction. This has been undertaken on the assumption that the property is sold as part of the continuing enterprise in operation.

In 2024-25, indexation has been applied to land and buildings based on indices received from the Valuation Office Agency and as agreed in the Technical Update Note 03 issued by Welsh Government on 20th September 2024. No indexation has been applied to equipment.

In addition, in 2024-25 there have been separate revaluations for eight assets under construction coming into use. These include 19 Hills Health and Well-being Centre, the Sanctuary Hub and roof upgrade at St Cadoc's Hospital, the discharge lounge at Grange University Hospital, Ty Gwent offices, and various infrastructure works and ward upgrades at the Royal Gwent Hospital.

iii) Asset Lives
Depreciated as follows:
- Land is not depreciated.
- Buildings as determined by the Valuation Office Agency.
- Equipment 5-15 years.

iv) Compensation
There has been no compensation received from third parties for assets impaired, lost or given up, that is included in the income statement.

v) Write Downs
There have not been any write downs.

vi) The LHB does not hold any property where the value is materially different from its open market value.

vii) Assets Held for Sale or sold in the period.
There are no assets held for sale or sold in the period.

viii) IFRS 13 Fair value measurement
There are no assets requiring Fair Value measurement under IFRS 13.

11. Property, plant and equipment

11.2 Non-current assets held for sale

	Land	Buildings, including dwelling	Other property, plant and equipment	Intangible assets	Other assets	Total
	£000	£000	£000	£000	£000	£000
Balance brought forward 1 April 2024	0	0	0	0	0	**0**
Plus assets classified as held for sale in the year	0	0	0	0	0	**0**
Revaluation	0	0	0	0	0	**0**
Less assets sold in the year	0	0	0	0	0	**0**
Add reversal of impairment of assets held for sale	0	0	0	0	0	**0**
Less impairment of assets held for sale	0	0	0	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	**0**
Balance carried forward 31 March 2025	0	0	0	0	0	**0**
Balance brought forward 1 April 2023	0	0	0	0	0	**0**
Plus assets classified as held for sale in the year	0	0	0	0	0	**0**
Revaluation	0	0	0	0	0	**0**
Less assets sold in the year	0	0	0	0	0	**0**
Add reversal of impairment of assets held for sale	0	0	0	0	0	**0**
Less impairment of assets held for sale	0	0	0	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	**0**
Balance carried forward 31 March 2024	0	0	0	0	0	**0**

11.3 Right of Use Assets

The organisation's right of use asset leases are disclosed across the relevant headings below. Most are individually insignificant, however, six are significant in their own right:
- Blaenavon Primary Care Resource Centre (LHB lease) held under Land & Buildings NBV at 31 March 2025 £1,213k
- Brynmawr Primary Care Resource Centre (LHB lease) held under Land & Buildings NBV at 31 March 2025 £2,117k
- Rhymney Integrated H&SC Resource Centre (LHB lease) held under Land & Buildings NBV at 31 March 2025 £2,078k
- Ty Gwent held under Land & Buildings NBV at 31 March 2025 £1,092k
- Biochemistry Managed Service Contract held under Plant & Machinery NBV at 31 March 2025 £2,172k
- NHH Energy scheme (previously classified as an off balance sheet PFI scheme) held under Plant & Machinery NBV at 31 March 2025 £1,411k

2024-25	Land £000	Land & buildings £000	Buildings £000	Dwellings £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2024	**813**	**12,180**	**0**	**0**	**9,058**	**860**	**2,045**	**0**	**24,956**
Additions	0	4,151	0	0	1,818	184	0	0	**6,153**
Transfer from/into other NHS bodies	0	(57)	0	0	0	0	0	0	**(57)**
Disposals other than by sale	(155)	(808)	0	0	(1,847)	(100)	(223)	0	**(3,133)**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Revaluations	0	0	0	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	0	0	0	**0**
De-recognition	0	0	0	0	0	0	0	0	**0**
At 31 March 2025	**658**	**15,466**	**0**	**0**	**9,029**	**944**	**1,822**	**0**	**27,919**
Depreciation at 1 April 2024	**196**	**2,968**	**0**	**0**	**3,138**	**339**	**945**	**0**	**7,586**
Recognition	0	0	0	0	0	0	0	0	**0**
Transfers from/into other NHS bodies	0	(12)	0	0	0	0	0	0	**(12)**
Disposals other than by sale	(155)	(513)	0	0	(681)	(100)	(223)	0	**(1,672)**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Revaluations	0	0	0	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	0	0	0	**0**
De-recognition	0	0	0	0	0	0	0	0	**0**
Provided during the year	91	1,442	0	0	1,724	293	346	0	**3,896**
At 31 March 2025	**132**	**3,885**	**0**	**0**	**4,181**	**532**	**1,068**	**0**	**9,798**
Net book value at 1 April 2024	**617**	**9,212**	**0**	**0**	**5,920**	**521**	**1,100**	**0**	**17,370**
Net book value at 31 March 2025	**526**	**11,581**	**0**	**0**	**4,848**	**412**	**754**	**0**	**18,121**

RoU Asset Total Value Split by Lessor Lessor	Land £000	Land & buildings £000	Buildings £000	Dwellings £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
NHS Wales Peppercorn Leases	0	0	0	0	0	0	0	0	**0**
NHS Wales Market Value Leases	0	0	0	0	0	0	0	0	**0**
Other Public Sector Peppercorn Leases	516	277	0	0	0	0	0	0	**793**
Other Public Sector Market Value Leases	10	1,046	0	0	0	0	0	0	**1,056**
Private Sector Peppercorn Leases	0	0	0	0	0	0	0	0	**0**
Private Sector Market Value Leases	0	10,258	0	0	4,848	412	754	0	**16,272**
Total	**526**	**11,581**	**0**	**0**	**4,848**	**412**	**754**	**0**	**18,121**

11.3 Right of Use Assets

The organisation's right of use asset leases are disclosed across the relevant headings below. Most are individually insignificant, however, five are significant in their own right:
- Blaenavon Primary Care Resource Centre (LHB lease) held under Land & Buildings NBV at 31 March 2024 £1,341k
- Rhymney Integrated H&SC Resource Centre (LHB lease) held under Land & Buildings NBV at 31 March 2024 £2,317k
- Ty Gwent held under Land & Buildings NBV at 31 March 2024 £1,213k
- Biochemistry Managed Service Contract held under Plant & Machinery NBV at 31 March 2024 £2,441k
- NHH Energy scheme (previously classified as an off balance sheet PFI scheme) held under Plant & Machinery NBV at 31 March 2024 £2,180k

2023-24	Land £000	Land & buildings £000	Buildings £000	Dwellings £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 31 March 2023	813	16,854	0	0	8,473	559	1,660	0	**28,359**
Lease prepayments in relation to RoU Assets	0	0	0	0	0	0	0	0	**0**
Transfer of Finance Leases from PPE Note	0	0	0	0	0	0	0	0	**0**
Operating Leases Transitioning	0	0	0	0	0	0	0	0	**0**
Cost or valuation at 1 April 2023	**813**	**16,854**	**0**	**0**	**8,473**	**559**	**1,660**	**0**	**28,359**
Additions	0	1,768	0	0	585	533	385	0	**3,271**
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	**0**
Disposals other than by sale	0	-6,442	0	0	0	-232	0	0	**-6,674**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Revaluations	0	0	0	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	0	0	0	**0**
De-recognition	0	0	0	0	0	0	0	0	**0**
At 31 March 2024	**813**	**12,180**	**0**	**0**	**9,058**	**860**	**2,045**	**0**	**24,956**
Depreciation at 31 March 2023	98	2,118	0	0	1,519	269	488	0	**4,492**
Transfer of Finance Leases from PPE Note	0	0	0	0	0	0	0	0	**0**
Operating Leases Transitioning	0	0	0	0	0	0	0	0	**0**
Depreciation at 1 April 2023	**98**	**2,118**	**0**	**0**	**1,519**	**269**	**488**	**0**	**4,492**
Recognition	0	0	0	0	0	0	0	0	**0**
Transfers from/into other NHS bodies	0	0	0	0	0	0	0	0	**0**
Disposals other than by sale	0	-1,169	0	0	0	-211	0	0	**-1,380**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Revaluations	0	0	0	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	0	0	0	**0**
De-recognition	0	0	0	0	0	0	0	0	**0**
Provided during the year	98	2,019	0	0	1,619	281	457	0	**4,474**
At 31 March 2024	**196**	**2,968**	**0**	**0**	**3,138**	**339**	**945**	**0**	**7,586**
Net book value at 1 April 2023	**715**	**14,736**	**0**	**0**	**6,954**	**290**	**1,172**	**0**	**23,867**
Net book value at 31 March 2024	**617**	**9,212**	**0**	**0**	**5,920**	**521**	**1,100**	**0**	**17,370**

RoU Asset Total Value Split by Lessor Lessor	Land £000	Land & buildings £000	Buildings £000	Dwellings £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
NHS Wales Peppercorn Leases	0	0	0	0	0	0	0	0	**0**
NHS Wales Market Value Leases	0	0	0	0	0	0	0	0	**0**
Other Public Sector Peppercorn Leases	606	296	0	0	0	0	0	0	**902**
Other Public Sector Market Value Leases	11	1,153	0	0	0	0	0	0	**1,164**
Private Sector Peppercorn Leases	0	0	0	0	0	0	0	0	**0**
Private Sector Market Value Leases	0	7,763	0	0	5,920	521	1,100	0	**15,304**
Total	**617**	**9,212**	**0**	**0**	**5,920**	**521**	**1,100**	**0**	**17,370**

11.3 Right of Use Assets continued

Quantitative disclosures

Maturity analysis Contractual undiscounted cash flows relating to lease liabilities	2024-25 Land £000	2024-25 Buildings £000	2024-25 Other £000	2024-25 Total £000	2023-24 Total £000
Less than 1 year	0	1,853	2,238	4,091	3,710
2-5 years	1	5,078	2,554	7,633	7,550
> 5 years	11	6,147	1,133	7,291	6,157
Less finance charges allocated to future periods	-2	-1,645	-231	-1,878	-1,080
Total	**10**	**11,433**	**5,694**	**17,137**	**16,337**

Lease Liabilities (net of irrecoverable VAT)	2024-25	2023-24
Current	3,708	3,445
Non-Current	13,429	12,892
Total	**17,137**	**16,337**

Amounts Recognised in Statement of Comprehensive Net Expenditure	2024-25	2023-24
Depreciation	3,896	4,474
Impairment	0	0
Variable lease payments not included in lease liabilities - Interest expense	353	274
Sub-leasing income	(2)	(2)
Expense related to short-term leases	367	713
Expense related to low-value asset leases (excluding short-term leases)	973	936

Amounts Recognised in Statement of Cashflows (net of irrecoverable VAT)		
Interest expense	(353)	(274)
Repayments of principal on leases	(3,846)	(4,099)
Total	**(4,199)**	**(4,373)**

12. Intangible non-current assets

2024-25

	Software (purchased)	Software (internally generated)	Licences and trademarks	Patents	Development expenditure- internally generated	Assets under Construction	Total
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2024	3,531	0	2,924	0	0	1,063	7,518
Revaluation	0	0	27	0	0	0	27
Reclassifications	21	0	158	0	0	(179)	0
Reversal of impairments	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0
Additions- purchased	15	0	2,064	0	0	157	2,236
Additions- internally generated	0	0	0	0	0	0	0
Additions- donated	0	0	0	0	0	0	0
Additions- government granted	0	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0	0
Transfer from/into other NHS bodies	0	0	0	0	0	0	0
Disposals	(449)	0	(87)	0	0	0	(536)
Gross cost at 31 March 2025	3,118	0	5,086	0	0	1,041	9,245
Amortisation at 1 April 2024	1,800	0	1,033	0	0	0	2,833
Revaluation	0	0	(15)	0	0	0	(15)
Reclassifications	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0
Impairment	0	0	0	0	0	0	0
Provided during the year	701	0	1,263	0	0	0	1,964
Reclassified as held for sale	0	0	0	0	0	0	0
Transfer from/into other NHS bodies	0	0	0	0	0	0	0
Disposals	(449)	0	(87)	0	0	0	(536)
Amortisation at 31 March 2025	2,052	0	2,194	0	0	0	4,246
Net book value at 1 April 2024	1,731	0	1,891	0	0	1,063	4,685
Net book value at 31 March 2025	1,066	0	2,892	0	0	1,041	4,999
NBV at 31 March 2025							
Purchased	1,066	0	2,892	0	0	1,041	4,999
Donated	0	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0	0
Internally generated	0	0	0	0	0	0	0
Total at 31 March 2025	1,066	0	2,892	0	0	1,041	4,999

12. Intangible non-current assets
2023-24

	Software (purchased)	Software (internally generated)	Licences and trademarks	Patents	Development expenditure- internally generated	Assets under Construction	Total
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2023	**3,547**	**0**	**7,772**	**0**	**0**	**0**	**11,319**
Revaluation	0	0	0	0	0	0	**0**
Reclassifications	35	0	0	0	0	548	**583**
Reversal of impairments	0	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	(438)	**(438)**
Additions- purchased	50	0	716	0	0	953	**1,719**
Additions- internally generated	0	0	0	0	0	0	**0**
Additions- donated	0	0	0	0	0	0	**0**
Additions- government granted	0	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	0	**0**
Transfer from/into other NHS bodies	0	0	0	0	0	0	**0**
Disposals	(101)	0	(5,564)	0	0	0	**(5,665)**
Gross cost at 31 March 2024	**3,531**	**0**	**2,924**	**0**	**0**	**1,063**	**7,518**
Amortisation at 31 March bf	**1,129**	**0**	**5,099**	**0**	**0**	**0**	**6,228**
NHS Wales Transfers	0	0	0	0	0	0	**0**
Transfer of Finance Leases to ROU Asset Note	0	0	0	0	0	0	**0**
Amortisation at 1 April 2023	**1,129**	**0**	**5,099**	**0**	**0**	**0**	**6,228**
Revaluation	0	0	(114)	0	0	0	**(114)**
Reclassifications	35	0	0	0	0	0	**35**
Reversal of impairments	0	0	0	0	0	0	**0**
Impairment	0	0	0	0	0	0	**0**
Provided during the year	737	0	1,612	0	0	0	**2,349**
Reclassified as held for sale	0	0	0	0	0	0	**0**
Transfer from/into other NHS bodies	0	0	0	0	0	0	**0**
Disposals	(101)	0	(5,564)	0	0	0	**(5,665)**
Amortisation at 31 March 2024	**1,800**	**0**	**1,033**	**0**	**0**	**0**	**2,833**
Net book value at 1 April 2023	**2,418**	**0**	**2,673**	**0**	**0**	**0**	**5,091**
Net book value at 31 March 2024	**1,731**	**0**	**1,891**	**0**	**0**	**1,063**	**4,685**
NBV at 31 March 2024							
Purchased	1,731	0	1,891	0	0	1,063	**4,685**
Donated	0	0	0	0	0	0	**0**
Government Granted	0	0	0	0	0	0	**0**
Internally generated	0	0	0	0	0	0	**0**
Total at 31 March 2024	**1,731**	**0**	**1,891**	**0**	**0**	**1,063**	**4,685**

Additional Disclosures re Intangible Assets

Disclosures:
i) Donated Assets

Aneurin Bevan University LHB has not received any donated intangible assets during the year.

ii) Recognition

Intangible assets acquired separately are initially recognised at fair value. The amount recognised for internally-generated intangible assets is the sum of the expenditure incurred to date when the criteria for recognising internally generated assets has been met (see accounting policy 1.7 for criteria).

iii) Asset Lives

The useful economic life of Intangible non-current assets are assigned on an individual asset basis. Software is generally assigned a 5 year UEL and the UEL of internally generated software is based on the professional judgement of LHB professionals and Finance staff.

iv) Additions during the period
Intangible assets acquired during the period amounted to £2.236m; this was primarily on software licence renewals and new purchases.

v) Disposals during the period
Fully amortised software and licences with a GBV of £0.536m were disposed of as no longer in use, during the year.

vi) Transfers into other NHS Bodies

Aneurin Bevan LHB has not received any intangible assets transferred from another NHS body**.**

13 . Impairments

	2024-25 Property, plant & equipment £000	2024-25 Right of Use Assets £000	2024-25 Intangible assets £000	2024-25 Held for sale assets £000	2024-25 Financial Assets £000	2024-25 Total Asset Impairment £000
Impairments arising from :						
Loss or damage from normal operations	236	0	0	0	0	236
Abandonment in the course of construction	0	0	0	0	0	0
Over specification of assets (Gold Plating)	0	0	0	0	0	0
Loss as a result of a catastrophe	0	0	0	0	0	0
Unforeseen obsolescence	0	0	0	0	0	0
Changes in market price	0	0	0	0	0	0
Others (specify)	15,982	0	0	0	0	15,982
Reversal of Impairments	(14,401)	0	0	0	0	(14,401)
Total of all impairments	1,817	0	0	0	0	1,817
Analysis of impairments charged to reserves in year :						
Impairments charged to the Statement of Comprehensive Net Expenditure	1,817	0	0	0	0	1,817
Impairments as a result of revaluation/indexation charged to Revaluation Reserve	0	0	0	0	0	0
Impairments as a result of a loss of economic value or service potential Charged to Revaluation Reserve	0	0	0	0	0	0
Right of Use (RoU) asset impairments reflected in RoU Liability	0	0	0	0	0	0
Total	1,817	0	0	0	0	1,817

	2023-24 Property, plant & equipment £000	2023-24 Right of Use Assets £000	2023-24 Intangible assets £000	2023-24 Held for sale assets £000	2023-24 Financial Assets £000	2023-24 Total Asset Impairment £000
Impairments arising from :						
Loss or damage from normal operations	0	0	0	0	0	0
Abandonment in the course of construction	0	0	438	0	0	438
Over specification of assets (Gold Plating)	0	0	0	0	0	0
Loss as a result of a catastrophe	0	0	0	0	0	0
Unforeseen obsolescence	0	0	0	0	0	0
Changes in market price	0	0	0	0	0	0
Others (specify)	31,284	0	0	0	0	31,284
Reversal of Impairments	(19,552)	0	0	0	0	(19,552)
Total of all impairments	11,732	0	438	0	0	12,170
Analysis of impairments charged to reserves in year :						
Impairments charged to the Statement of Comprehensive Net Expenditure	9,732	0	438	0	0	10,170
Impairments as a result of revaluation/indexation charged to Revaluation Reserve	2,000	0	0	0	0	2,000
Impairments as a result of a loss of economic value or service potential Charged to Revaluation Reserve	0	0	0	0	0	0
Right of Use (RoU) asset impairments reflected in RoU Liability	0	0	0	0	0	0
Total	11,732	0	438	0	0	12,170

2024-25	Impairment amount £000	Reason for impairment £000	Nature of Asset £000	Valuation basis £000	Charge to SoCNE £000	Charge to reserve £000
19 Hills HWBC (Newport East)	12,142	Assets Valued on Coming Into Use	Operational	Fair Value	12,142	0
Glan Usk Roof, St Cadocs Hospital	878	Assets Valued on Coming Into Use	Operational	Fair Value	878	0
CAMHS, St Cadocs Hospital	871	Assets Valued on Coming Into Use	Operational	Fair Value	871	0
GUH Discharge Lounge	797	Assets Valued on Coming Into Use	Operational	Fair Value	797	0
B Block Infrastructure, RGH	466	Assets Valued on Coming Into Use	Operational	Fair Value	466	0
Ty Gwent	443	Assets Valued on Coming Into Use	Operational	Fair Value	443	0
Cordell Centre, RGH	243	Assets Valued on Coming Into Use	Operational	Fair Value	243	0
D7W Ward Refurb, RGH	142	Assets Valued on Coming Into Use	Operational	Fair Value	142	0
19 Hills HWBC (Newport East)	236	Loss or damage from normal operations	Operational	Fair Value	236	0
Total Impairment	16,218				16,218	0
Reversal of Impairments						
Grange University Hospital	(6,456)	VAT Recovery adjustment - no reduction to asset value	Operational	Fair Value	(6,456)	0
Indexation - Land	(133)	Indexation - reversal of impairment in previous years	Operational	Indexation	(133)	0
Grange University Hospital	(5,053)		Operational	Indexation	(5,053)	0
Royal Gwent	(1,149)		Operational	Indexation	(1,149)	0
Ysbyty Aneurin Bevan	(724)		Operational	Indexation	(724)	0
Neville Hall	(526)		Operational	Indexation	(526)	0
Bevan Health Centre	(147)		Operational	Indexation	(147)	0
Ysbyty Ystrad Fawr	(99)		Operational	Indexation	(99)	0
Llanfrechfa Grange	(63)		Operational	Indexation	(63)	0
St Cadocs	(47)		Operational	Indexation	(47)	0
Various Community Sites	(4)		Operational	Indexation	(4)	0
Total Reversal of Impairments	(14,401)				(14,401)	0
Net credit to SoCNE	1817				1817	0

The impairment losses disclosed above as "other" comprises:

14.1 Inventories

	31 March 2025	31 March 2024
	£000	£000
Drugs	3,753	3,095
Consumables	6,430	6,482
Energy	250	267
Work in progress	0	0
Other	0	0
Total	**10,433**	9,844
Of which held at realisable value	0	0

14.2 Inventories recognised in expenses

	31 March 2025	31 March 2024
	£000	£000
Inventories recognised as an expense in the period	0	0
Write-down of inventories (including losses)	0	0
Reversal of write-downs that reduced the expense	0	0
Total	**0**	**0**

15. Trade and other Receivables

Current	31 March 2025 £000	31 March 2024 £000
Welsh Government	2,406	2,246
NWJCC/ WHSSC and EASC	478	2,911
Welsh Health Boards	3,753	3,971
Welsh NHS Trusts	7,109	5,901
Welsh Special Health Authorities	1,037	1,044
Non - Welsh Trusts	0	24
Other NHS	1,426	267
2019-20 Scheme Pays - Welsh Government Reimbursement	686	604
Welsh Risk Pool Claim reimbursement		
NHS Wales Secondary Health Sector	125,057	93,727
NHS Wales Primary Sector FLS Reimbursement	883	920
NHS Wales Redress	422	502
Other	412	791
Local Authorities	5,617	5,468
Capital receivables - Tangible	0	0
Capital receivables - Intangible	0	0
Other receivables	10,929	12,766
Provision for irrecoverable debts	(2,015)	(1,942)
Pension Prepayments NHS Pensions	0	0
Pension Prepayments NEST	0	0
Other prepayments	8,960	7,373
Other accrued income	0	0
Sub total	**167,160**	136,573
Non-current		
Welsh Government	0	0
NWJCC/WHSSC and EASC	0	0
Welsh Health Boards	0	0
Welsh NHS Trusts	0	0
Welsh Special Health Authorities	0	0
Non - Welsh Trusts	0	0
Other NHS	0	0
2019-20 Scheme Pays - Welsh Government Reimbursement	0	0
Welsh Risk Pool Claim reimbursement;		
NHS Wales Secondary Health Sector	104,507	142,085
NHS Wales Primary Sector FLS Reimbursement	10	0
NHS Wales Redress	0	0
Other	0	744
Local Authorities	0	0
Capital receivables - Tangible	0	0
Capital receivables - Intangible	0	0
Other receivables	1,366	1,237
Provision for irrecoverable debts	0	0
Pension Prepayments NHS Pensions	0	0
Pension Prepayments NEST	0	0
Other prepayments	0	0
Other accrued income	0	0
Sub total	**105,883**	144,066
Total	**273,043**	280,639

The great majority of trade is with other NHS bodies. As NHS bodies are funded by Welsh Government, no credit scoring of them is considered necessary.

The value of trade receivables that are past their payment date but not impaired is £3.286m (£3.875m in 2023-24).

15. Trade and other Receivables (continued)

Receivables past their due date but not impaired

	31 March 2025 £000	31 March 2024 £000
By up to three months	1,420	1,922
By three to six months	142	383
By more than six months	1,724	1,570
	3,286	3,875

Expected Credit Losses (ECL) / Provision for impairment of receivables

Balance at 1 April	(1,942)	(1,763)
Transfer to other NHS Wales body	0	0
Amount written off during the year	0	20
Amount recovered during the year	0	0
(Increase) / decrease in receivables impaired	(58)	(176)
Bad debts recovered during year	(15)	(22)
Balance at 31 March	(2,015)	(1,942)

In determining whether a debt should be impaired, consideration is given to the age of the debt, historic collectability rates and the results of actions already taken including referral to the Health Board's credit agencies.

Receivables VAT

Trade receivables	1,295	2,091
Other	137	195
Total	1,432	2,286

16. Other Financial Assets

	Current		Non-current	
	31 March 2025	31 March 2024	**31 March 2025**	31 March 2024
	£000	£000	**£000**	£000
Financial assets				
Shares and equity type investments				
Held to maturity investments at amortised costs	**0**	0	**0**	0
At fair value through SOCNE	**0**	0	**0**	0
Available for sale at FV	**0**	0	**0**	0
Deposits	**0**	0	**0**	0
Loans	**36**	35	**417**	452
Derivatives	**0**	0	**0**	0
Other (Specify)				
Right of Use Asset Finance Sublease	**24**	24	**190**	215
Held to maturity investments at amortised costs	**0**	0	**0**	0
At fair value through SOCNE	**0**	0	**0**	0
Available for sale at FV	**0**	0	**0**	0
Total	**60**	**59**	**607**	**667**

RoU Sub-leasing income Recognised in Statement of Comprehensive Net Expenditure	**2024-25**	**2023-24**
RoU Sub-leasing income	-2	-2

17. Cash and cash equivalents

	2024-25	2023-24
	£000	£000
Balance at 1 April	**4,145**	4,704
Net change in cash and cash equivalent balances	**678**	(559)
Balance at 31 March	**4,823**	4,145
Made up of:		
Cash held at GBS	**4,801**	4,122
Commercial banks	**0**	0
Cash in hand	**22**	23
Cash and cash equivalents as in Statement of Financial Position	**4,823**	4,145
Bank overdraft - GBS	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in Statement of Cash Flows	**4,823**	4,145

In response to the IAS 7 requirement for additional disclosure, the changes in liabilities arising for financing activities are;

Lease Liabilities (ROUA) £0.800m
Lease Liabilities (short-term and low value leases) -£0.318m
PFI liabilities: -£0.609m

The movement relates to cash, no comparative information is required by IAS 7 in 2024-25.

18. Trade and other payables

Current	**31 March 2025**	31 March 2024
	£000	£000
Welsh Government	**12**	22
NWJCC/WHSSC and EASC	**3,785**	4,681
Welsh Health Boards	**5,590**	5,964
Welsh NHS Trusts	**3,954**	5,416
Welsh Special Health Authorities	**61**	39
Other NHS	**7,336**	7,477
Taxation and social security payable / refunds	**17,338**	16,072
Refunds of taxation by HMRC	**0**	0
VAT payable to HMRC	**0**	0
Other taxes payable to HMRC	**0**	0
NI contributions payable to HMRC	**0**	0
Non-NHS payables - Revenue	**59,008**	56,658
Local Authorities	**16,397**	19,638
Capital payables- Tangible	**8,766**	6,493
Capital payables- Intangible	**112**	147
Overdraft	**0**	0
Rentals due under operating leases	**0**	0
RoU Lease Liability	**3,708**	3,445
Obligations under finance leases, HP contracts		
Imputed finance lease element of on SoFP PFI contracts	**125**	638
Impact of IFRS 16 on SoFP PFI contracts	**122**	108
Pensions: staff	**11,571**	10,718
Non NHS Accruals	**77,652**	74,734
Deferred Income:		
Deferred Income brought forward	**0**	0
Deferred Income Additions	**0**	0
Transfer to / from current/non current deferred income	**0**	0
Released to SoCNE	**0**	0
Other creditors	**0**	0
PFI assets –deferred credits	**0**	0
Payments on account	**(10,711)**	(10,088)
Sub Total	**204,826**	202,162
Non-current		
Welsh Government	**0**	0
NWJCC/WHSSC and EASC	**0**	0
Welsh Health Boards	**0**	0
Welsh NHS Trusts	**0**	0
Welsh Special Health Authorities	**0**	0
Other NHS	**0**	0
Taxation and social security payable / refunds	**0**	0
Refunds of taxation by HMRC	**0**	0
VAT payable to HMRC	**0**	0
Other taxes payable to HMRC	**0**	0
NI contributions payable to HMRC	**0**	0
Non-NHS payables - Revenue	**0**	0
Local Authorities	**0**	0
Capital payables- Tangible	**0**	0
Capital payables- Intangible	**0**	0
Overdraft	**0**	0
Rentals due under operating leases	**0**	0
RoU Lease Liability	**13,429**	12,892
Obligations under finance leases, HP contracts		
Imputed finance lease element of on SoFP PFI contracts	**1,464**	1,590
Impact of IFRS 16 on SoFP PFI contracts	**1,421**	1,406
Pensions: staff	**0**	0
Non NHS Accruals	**0**	0
Deferred Income :		
Deferred Income brought forward	**0**	0
Deferred Income Additions	**0**	0
Transfer to / from current/non current deferred income	**0**	0
Released to SoCNE	**0**	0
Other creditors	**0**	0
PFI assets –deferred credits	**0**	0
Payments on account	**0**	0
Sub Total	**16,314**	15,888
Total	**221,140**	218,050

It is intended to pay all invoices within the 30 day period directed by the Welsh Government.

The LHB aims to pay all invoices within the 30 day period directed by the Welsh Government.

The Capital Payables - Tangibles figure includes balances that have been agreed with Welsh NHS Trusts, as part of the Agreement of Balances process, totalling £52K.

18. Trade and other payables (continued).

Amounts falling due more than one year are expected to be settled as follows:	**31 March 2025 £000**	31 March 2024 £000
Between one and two years	**2,601**	3,182
Between two and five years	**5,136**	4,810
In five years or more	**8,577**	7,896
Sub-total	**16,314**	15,888

19. Other financial liabilities

	Current		**Non-current**	
Financial liabilities	**31 March 2025 £000**	31 March 2024 £000	**31 March 2025 £000**	31 March 2024 £000
Financial Guarantees:				
At amortised cost	**0**	0	**0**	0
At fair value through SoCNE	**0**	0	**0**	0
Derivatives at fair value through SoCNE	**0**	0	**0**	0
Other:				
At amortised cost	**0**	0	**0**	0
At fair value through SoCNE	**0**	0	**0**	0
Total	**0**	0	**0**	0

20. Provisions

	At 1 April 2024	Structured settlement cases transferred to Risk Pool	Transfer of provisions to creditors	Transfer between current and non-current	Arising during the year	Utilised during the year	Reversed unused	Unwinding of discount	At 31 March 2025
Current	£000	£000	£000	£000	£000	£000	£000	£000	£000
Clinical negligence:-									
Secondary care	64,140	(3,887)	1,586	34,629	28,319	(18,490)	(15,647)	0	90,650
Primary care	791	0	0	0	91	(94)	(42)	0	746
Redress Secondary care	263	0	3	0	326	(287)	(146)	0	159
Redress Primary care	0	0	0	0	0	0	0	0	0
Personal injury	37	0	0	0	162	(136)	(14)	0	49
All other losses and special payments	0	0	0	0	1,062	(147)	0	0	915
Defence legal fees and other administration	1,954	0	0	(419)	1,244	(939)	(395)		1,445
Pensions relating to former directors	0			0	0	0	0	0	0
Pensions relating to other staff	397			107	418	(405)	(189)	72	400
2019-20 Scheme Pays - Reimbursement	7			0	26	0	0	0	33
Restructuring	0			0	0	0	0	0	0
RoU Asset Dilapidations CAME	0			0	0	0	0	0	0
Other Capital Provisions	1,727			0	524	(1,115)	(65)	0	1,071
Other	2,511		0	0	1,699	0	(1,108)		3,102
Total	71,827	(3,887)	1,589	34,317	33,871	(21,613)	(17,606)	72	98,570
Non Current									
Clinical negligence:-									
Secondary care	142,027	0	0	(34,629)	20,546	(706)	(26,517)	0	100,721
Primary care	0	0	0	0	0	0	0	0	0
Redress Secondary care	0	0	0	0	0	0	0	0	0
Redress Primary care	0	0	0	0	0	0	0	0	0
Personal injury	3,027	0	0	0	466	(330)	(67)	73	3,169
All other losses and special payments	0	0	0	0	0	0	0	0	0
Defence legal fees and other administration	1,017	0	0	419	732	(247)	(167)		1,754
Pensions relating to former directors	0			0	0	0	0	0	0
Pensions relating to other staff	2,586			(107)	0	0	0	0	2,479
2019-20 Scheme Pays - Reimbursement	597			0	55	0	0	0	652
Restructuring	0			0	0	0	0	0	0
RoU Asset Dilapidations CAME	0			0	0	0	0	0	0
Other Capital Provisions	0			0	0	0	0	0	0
Other	393		0	0	249	(100)	(163)		379
Total	149,647	0	0	(34,317)	22,048	(1,383)	(26,914)	73	109,154
TOTAL									
Clinical negligence:-									
Secondary care	206,167	(3,887)	1,586	0	48,865	(19,196)	(42,164)	0	191,371
Primary care	791	0	0	0	91	(94)	(42)	0	746
Redress Secondary care	263	0	3	0	326	(287)	(146)	0	159
Redress Primary care	0	0	0	0	0	0	0	0	0
Personal injury	3,064	0	0	0	628	(466)	(81)	73	3,218
All other losses and special payments	0	0	0	0	1,062	(147)	0	0	915
Defence legal fees and other administration	2,971	0	0	0	1,976	(1,186)	(562)		3,199
Pensions relating to former directors	0			0	0	0	0	0	0
Pensions relating to other staff	2,983			0	418	(405)	(189)	72	2,879
2019-20 Scheme Pays - Reimbursement	604			0	81	0	0	0	685
Restructuring	0			0	0	0	0	0	0
RoU Asset Dilapidations CAME	0			0	0	0	0	0	0
Other Capital Provisions	1,727			0	524	(1,115)	(65)	0	1,071
Other	2,904		0	0	1,948	(100)	(1,271)		3,481
Total	221,474	(3,887)	1,589	0	55,919	(22,996)	(44,520)	145	207,724

Expected timing of cash flows:

	In year to 31 March 2026	Between 1 April 2026 31 March 2030	Thereafter	Total
				£000
Clinical negligence:-				
Secondary care	90,650	100,721	0	191,371
Primary care	746	0	0	746
Redress Secondary care	159	0	0	159
Redress Primary care	0	0	0	0
Personal injury	49	3,169	0	3,218
All other losses and special payments	915	0	0	915
Defence legal fees and other administration	1,445	1,754	0	3,199
Pensions relating to former directors	0	0	0	0
Pensions relating to other staff	400	2,479	0	2,879
2019-20 Scheme Pays - Reimbursement	33	652	0	685
Restructuring	0	0	0	0
RoU Asset Dilapidations CAME	0	0	0	0
Other Capital Provisions	1,071	0	0	1,071
Other	3,102	379	0	3,481
Total	98,570	109,154	0	207,724

The expected timing of cash flows are based on best available information; but they could change on the basis of individual case changes. The claims outstanding with the Welsh Risk Pool are based on best estimates of settlement of claims provided by the Health Board's legal advisors. The Health Board estimates that in 2025/26 it will receive £91,146k and in 2026/27 and beyond £101,877k from the Welsh Risk Pool in respect of clinical negligence and personal injury payments.

Other provisions include: Continuing Healthcare Independent Review Panel (IRP) & Ombudsman claims £379K. The estimation method used to calculate the provision for 2024/25 is consistent with the methodology used in 2023/24. In the continuing absence of detailed assessment information the Health Board has used a mixture of actual assessments and the application of an expected success factor and average weekly costs to determine whether an individual claimant provision would be established.
Other provisions include an amount for Ancillary Staff Banked Annual Leave Payments, potential VAT payment to HMRC and Capital provision.
The total Health Board provision also includes an amount of £164K which relates to 22 Redress cases where offers have been made to the families but not yet accepted or breach and causation have been proven.

20. Provisions (continued)

	At 1 April 2023	Structured settlement cases transferred to Risk Pool	Transfer of provisions to creditors	Transfer between current and non-current	Arising during the year	Utilised during the year	Reversed unused	Unwinding of discount	At 31 March 2024
Current	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Clinical negligence:-									
Secondary care	80,878	(10,810)	4,456	652	33,576	(25,049)	(19,563)	0	**64,140**
Primary care	79	0	0	0	820	(105)	(3)	0	**791**
Redress Secondary care	331	0	(1)	0	363	(288)	(142)	0	**263**
Redress Primary care	0	0	0	0	0	0	0	0	**0**
Personal injury	479	0	0	0	436	(631)	(247)	0	**37**
All other losses and special payments	0	0	0	0	821	(821)	0	0	**0**
Defence legal fees and other administration	2,306	0	0	181	1,402	(1,314)	(621)		**1,954**
Pensions relating to former directors	0			0	0	0	0	0	**0**
Pensions relating to other staff	385			41	401	(401)	(103)	74	**397**
2019-20 Scheme Pays - Reimbursement	6			0	1	0	0	0	**7**
Restructuring	0			0	0	0	0	0	**0**
RoU Asset Dilapidations CAME	0			0	0	0	0	0	**0**
Other Capital Provisions	449			0	1,278	0	0	0	**1,727**
Other	2,367		0	0	1,429	(3)	(1,282)		**2,511**
Total	**87,280**	**(10,810)**	**4,455**	**874**	**40,527**	**(28,612)**	**(21,961)**	**74**	**71,827**
Non Current									
Clinical negligence:-									
Secondary care	74,527	0	0	(652)	76,834	(948)	(7,734)	0	**142,027**
Primary care	0	0	0	0	0	0	0	0	**0**
Redress Secondary care	0	0	0	0	0	0	0	0	**0**
Redress Primary care	0	0	0	0	0	0	0	0	**0**
Personal injury	2,770	0	0	0	545	(356)	0	68	**3,027**
All other losses and special payments	0	0	0	0	0	0	0	0	**0**
Defence legal fees and other administration	775	0	0	(181)	587	(104)	(60)		**1,017**
Pensions relating to former directors	0			0	0	0	0	0	**0**
Pensions relating to other staff	2,627			(41)	0	0	0	0	**2,586**
2019-20 Scheme Pays - Reimbursement	136			0	461	0	0	0	**597**
Restructuring	0			0	0	0	0	0	**0**
RoU Asset Dilapidations CAME	0			0	0	0	0	0	**0**
Other Capital Provisions	0			0	0	0	0	0	**0**
Other	351		0	0	272	(140)	(90)		**393**
Total	**81,186**	**0**	**0**	**(874)**	**78,699**	**(1,548)**	**(7,884)**	**68**	**149,647**
TOTAL									
Clinical negligence:-									
Secondary care	155,405	(10,810)	4,456	0	110,410	(25,997)	(27,297)	0	**206,167**
Primary care	79	0	0	0	820	(105)	(3)	0	**791**
Redress Secondary care	331	0	(1)	0	363	(288)	(142)	0	**263**
Redress Primary care	0	0	0	0	0	0	0	0	**0**
Personal injury	3,249	0	0	0	981	(987)	(247)	68	**3,064**
All other losses and special payments	0	0	0	0	821	(821)	0	0	**0**
Defence legal fees and other administration	3,081	0	0	0	1,989	(1,418)	(681)		**2,971**
Pensions relating to former directors	0			0	0	0	0	0	**0**
Pensions relating to other staff	3,012			0	401	(401)	(103)	74	**2,983**
2019-20 Scheme Pays - Reimbursement	142			0	462	0	0	0	**604**
Restructuring	0			0	0	0	0	0	**0**
RoU Asset Dilapidations CAME	0			0	0	0	0	0	**0**
Other Capital Provisions	449			0	1,278	0	0	0	**1,727**
Other	2,718		0	0	1,701	(143)	(1,372)		**2,904**
Total	**168,466**	**(10,810)**	**4,455**	**0**	**119,226**	**(30,160)**	**(29,845)**	**142**	**221,474**

The expected timing of cash flows are based on best available information; but they could change on the basis of individual case changes. The claims outstanding with the Welsh Risk Pool are based on best estimates of settlement of claims provided by the Health Board's legal advisors. The Health Board estimates that in 2024/25 it will receive £65,272K and in 2025/26 and beyond £142,829K from the Welsh Risk Pool in respect of clinical negligence and personal injury payments.

Other provisions include: Continuing Healthcare Independent Review Panel (IRP) & Ombudsman claims £393K. The estimation method used to calculate the provision for 2023/24 is consistent with the methodology used in 2022/23. In the continuing absence of detailed assessment information the Health Board has used a mixture of actual assessments and the application of an expected success factor and average weekly costs to determine whether an individual claimant provision would be established.
Other provisions include an amount for Ancillary Staff Banked Annual Leave Payments, potential VAT payment to HMRC and Capital provision.
The total Health Board provision also includes an amount of £270K which relates to 33 Redress cases where offers have been made to the families but not yet accepted or breach and causation have been proven.

Provision (Continued)

Pensions tax annual allowance – Scheme Pays arrangements 2019/20

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

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

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

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

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

The Health Board have included a Scheme Pay provsion of £685,920 (as notified by Welsh Government) within these accounts.

21. Contingencies

21.1 Contingent liabilities

Provisions have not been made in these accounts for the following amounts :	**2024-25 £'000**	2023-24 £'000
Legal claims for alleged medical or employer negligence:-		
Secondary care	**305,930**	271,446
Primary care	**1,470**	547
Redress Secondary care	**63**	3
Redress Primary care	**0**	0
Doubtful debts	**0**	0
Equal Pay costs	**0**	0
Defence costs	**4,364**	4,244
Continuing Health Care costs	**1,388**	1,483
Other	**0**	0
Total value of disputed claims	**313,215**	277,723
Amounts (recovered) in the event of claims being successful	**(307,921)**	(272,258)
Net contingent liability	**5,294**	5,465

Other litigation claims could arise in the future due to known incidents. The expenditure which may arise from such claims cannot be determined and no provision has been made for them. The value of legal claims has increased by £36m from the value of legal claims in 2023-24, while the number of claims has increased from 236 in 2023-24 to 252 in 2024-25.

Liability for Permanent Injury Benefit under the NHS Injury Benefit Scheme lies with the employer. Individual claims to the NHS Pensions Agency could arise due to known incidents.

Continuing Healthcare Cost uncertainties

The Health Board continues to review claims for reimbursement of retrospective care payments (IRPs). As a consequence, there has been a movement in the level of provision and uncertainty including in these Accounts.

Note 20 sets out the £0.379m provision made for probable continuing care costs relating to 69 outstanding phase 9 and 10 claims received by 31st March 2025. This compares with the 2023/24 provision of £0.393m and 69 outstanding phase 3 to 8 claims.

Note 21.1 also sets out the £1.388m contingent liability for possible additional continuing care costs relating to those claims if they are all settled and in full, comparing favourably with the £1.483m reported for 2023/24.

There are still 4 new (Phase 10) claims, which have been received whereby the assessment process remains incomplete, as we are still awaiting full details to support the claims. The assessment process is highly complex and involves a multi-disciplinary teams and for those reasons can take many months. At this stage, the HB does not have enough information to make a judgement on the likely success or otherwise of these claims, however, they may result in additional costs to the HB, which cannot be quantified at this time.

21.2 Remote Contingent liabilities

	2024-25 £000	2023-24 £000
Guarantees	0	0
Indemnities	428	24,064
Letters of Comfort	0	0
Total	**428**	**24,064**

The remote contingent liabilities cost consists of 3 medical negligence cases and 1 personal injury case in 2024-25 (3 medical negligence cases and 1 GP indemnity case in 2023-24). Should these cases progress the majority of the costs incurred, in excess of £25K per case attributable to the Health Board, will be recovered from the Welsh Risk Pool.

21.3 Contingent assets

	2024-25 £000	2023-24 £000
	0	0
Total	**0**	0

22. Capital commitments

Contracted capital commitments at 31 March

The disclosure of future capital commitments not already disclosed as liabilities in the accounts.

	2024-25 £000	2023-24 £000
Property, plant and equipment	12,365	25,569
Right of Use Assets	0	0
Intangible assets	14	173
Total	**12,379**	25,742

23. Losses and special payments

Losses and special payments are charged to the Statement of Comprehensive Net Expenditure in accordance with IFRS but are recorded in the losses and special payments register when payment is made. Therefore, the payments in this note for settlement and claimant costs are prepared on a cash basis.

Gross loss to the Exchequer

23.1 Number of cases and associated amounts paid out during the financial year

	Amounts paid out during period to 31 March 2025	
	Number of cases	£
Clinical negligence:-		
Secondary Care	119	19,196,632
Primary Care	5	93,520
Redress Secondary Care	25	287,319
Redress Primary Care	0	0
Personal injury	41	465,650
All other losses and special payments	41	161,702
Total	231	20,204,823

23.2 Analysis of number of cases and associated amounts paid out during the financial year

	Case Type	In year cases in excess of £300,000		Cumulative amount
L&R Case reference number		Number of cases	£	£
Cases in excess of £300,000:				
	Medical Negligence	MN/107/2757	540,898	583,798
	Medical Negligence	MN/107/3440	1,515,750	1,515,750
	Medical Negligence	MN/107/2166	706,227	706,227
	Medical Negligence	MN/107/3712	880,000	880,000
	Medical Negligence	MN/107/0942	1,993,559	1,993,559
	Medical Negligence	MN/107/2837	765,000	795,000
	Medical Negligence	MN/107/0404	438,431	438,431
	Medical Negligence	MN/107/1102	450,000	450,000
	Medical Negligence	MN/107/2767	2,525,000	2,525,000
	Medical Negligence	MN/107/3793	557,499	557,499
	Medical Negligence	MN/107/4090	367,500	367,500
	Medical Negligence	MN/107/3718	1,509,500	1,799,106

	Number of cases	£	£
Sub-total	**12**	**12,249,364**	**12,611,870**
All other cases paid in year	219	7,955,459	27,391,517
Total cases paid in year	**231**	**20,204,823**	**40,003,387**

23.3 Analysis of number of cases and associated amounts where no payments were made in financial year

	Number of cases	£
Cumulative amount up to £300k	36	2,513,693
Cumulative amount greater than £300k	3	2,135,000
Total	**39**	**4,648,693**

24. Right of Use lease obligations

24.1 Obligations (as lessee)

Amounts payable under right of use asset leases:

2024-25

	LAND	BUILDINGS	OTHER	TOTAL
	31 March 2025	31 March 2025	31 March 2025	31 March 2025
Minimum lease payments	£000	£000	£000	£000
Within one year	0	1,853	2,238	**4,091**
Between one and five years	1	5,078	2,554	**7,633**
After five years	11	6,147	1,133	**7,291**
Less finance charges allocated to future periods	(2)	(1,645)	(231)	**(1,878)**
Minimum lease payments	**10**	**11,433**	**5,694**	**17,137**
Included in:				
Current borrowings	0	1,567	2,141	**3,708**
Non-current borrowings	10	9,866	3,553	**13,429**
	10	**11,433**	**5,694**	**17,137**
Present value of minimum lease payments				
Within one year	0	1,567	2,141	**3,708**
Between one and five years	1	4,241	2,436	**6,678**
After five years	9	5,625	1,117	**6,751**
Present value of minimum lease payments	**10**	**11,433**	**5,694**	**17,137**
Included in:				
Current borrowings	0	1,567	2,141	**3,708**
Non-current borrowings	10	9,866	3,553	**13,429**
	10	**11,433**	**5,694**	**17,137**

2023-24	LAND	BUILDINGS	OTHER	TOTAL
	31 March 2024	31 March 2024	31 March 2024	31 March 2024
Minimum lease payments	£000	£000	£000	£000
Within one year	0	1,531	2,179	3,710
Between one and five years	2	3,641	3,907	7,550
After five years	11	4,668	1,478	6,157
Less finance charges allocated to future periods	(2)	(762)	(316)	(1,080)
Minimum lease payments	**11**	**9,078**	**7,248**	**16,337**
Included in:				
Current borrowings	0	1,402	2,043	**3,445**
Non-current borrowings	11	7,676	5,205	**12,892**
	11	**9,078**	**7,248**	**16,337**
Present value of minimum lease payments				
Within one year	0	1,402	2,043	3,445
Between one and five years	1	3,250	3,755	7,006
After five years	10	4,426	1,450	5,886
Present value of minimum lease payments	**11**	**9,078**	**7,248**	**16,337**
Included in:				
Current borrowings	0	1,402	2,043	**3,445**
Non-current borrowings	11	7,676	5,205	**12,892**
	11	**9,078**	**7,248**	**16,337**

24.2 Right of Use Assets receivables (as lessor)

The Health Board has one Right of Use Assets lease receivable, as a lessor, at the balance sheet date.

Amounts receivable under right of use assets :

	31 March 2025	31 March 2024
Gross Investment in leases	**£000**	£000
Within one year	**26**	26
Between one and five years	**106**	106
After five years	**92**	118
Less finance charges allocated to future periods	**(9)**	(11)
Minimum lease payments	**215**	**239**
Included in:		
Current financial assets	**25**	24
Non-current financial assets	**190**	215
	215	239
Present value of minimum lease payments		
Within one year	**25**	24
Between one and five years	**100**	99
After five years	**90**	116
Less finance charges allocated to future periods	**0**	0
Present value of minimum lease payments	**215**	239
Included in:		
Current financial assets	**25**	24
Non-current financial assets	**190**	215
	215	239

25. Private Finance Initiative contracts

25.1 PFI schemes off-Statement of Financial Position

The LHB has one PFI Scheme that was previously classified as off-statement of financial position. The scheme related to the provision of replacement heating and lighting systems within Neville Hall hospital. The scheme commenced in 2000 for a period of 25 years. Since the introduction of IFRS 16 in 2022/23, the off-statement of Financial Position PFI has been recognised as a Right of use Asset.

Commitments under off-SoFP PFI contracts	**Off-SoFP PFI contracts**	Off-SoFP PFI contracts
	31 March 2025	31 March 2024
	£000	£000
Total payments due within one year	**0**	0
Total payments due between 1 and 5 years	**0**	0
Total payments due thereafter	**0**	0
Total future payments in relation to PFI contracts	**0**	0
Total estimated capital value of off-SoFP PFI contracts	**0**	0

25.2 PFI schemes on-Statement of Financial Position

Capital value of scheme included in Fixed Assets Note 11	**£000**
	0
Contract start date:	**Feb-00**
Contract end date:	**Mar-25**

Chepstow Community Hospital - a new community hospital including the provision of ancillary support services. This scheme commenced in 1998 with unitary charge payments being made for a period of 25 years from February 2000. There is no obligation remaining for this scheme as the contract ended during 2024/25.

	£000
Capital value of scheme included in Fixed Assets Note 11	**3,886**
Contract start date:	**Mar-04**
Contract end date:	**Mar-36**

Monnow Vale Health and Social Care Facility - a new health and social care facility. This scheme commenced in 2006 with unitary charge payments being made for a period of 30 years from 2006. The obligation for the scheme is £3,132k. In 2024/25, the liability for the scheme was increased by £147k due to the IFRS16 requirement to reflect the impact of RPI increases within the scheme obligation.

	£000
Capital value of scheme included in Fixed Assets Note 11	**0**
Contract start date:	**Sep-99**
Contract end date:	**Jun-24**

Nevill Hall Hospital Day Surgery - a purpose built day unit including the provision of medical equipment for the unit. The PFI partner has responsibility for maintaining the building and replacing the equipment used with the unit. The scheme commenced in 1998 with unitary charge payments being made for a period of 25 years from 1999. There is no obligation remaining for this scheme as the contract ended during 2024/25.

Total obligations for on-Statement of Financial Position PFI contracts due:

2024-25	**On SoFP PFI Capital element**	**On SoFP PFI IFRS 16 impact Finance Charge**	**On SoFP PFI Imputed interest**	**On SoFP PFI Service charges**
	31 March 2025	**31 March 2025**	**31 March 2025**	**31 March 2025**
	£000	**£000**	**£000**	**£000**
Total payments due within one year	**125**	**122**	**86**	**735**
Total payments due between 1 and 5 years	**538**	**521**	**274**	**2,938**
Total payments due thereafter	**926**	**900**	**174**	**4,407**
Total future payments in relation to PFI contracts	**1,589**	**1,543**	**534**	**8,080**

2023-24	On SoFP PFI Capital element	On SoFP PFI IFRS 16 impact Finance Charge	On SoFP PFI Imputed interest	On SoFP PFI Service charges
	31 March 2024	31 March 2024	31 March 2024	31 March 2024
	£000	£000	£000	£000
Total payments due within one year	638	108	80	2,888
Total payments due between 1 and 5 years	523	462	338	2,856
Total payments due thereafter	1,067	944	222	5,080
Total future payments in relation to PFI contracts	2,228	1,514	640	10,824

	31/03/2025
	£000
Total present value of obligations for on-SoFP PFI contracts	**11,746**

25.3 Charges to expenditure	2024-25	2023-24
	£000	£000
Service charges for On Statement of Financial Position PFI contracts (excl interest costs)	2,764	2,394
Total expense for Off Statement of Financial Position PFI contracts	0	0
The total charged in the year to expenditure in respect of PFI contracts	2,764	2,394

The LHB is committed to the following annual charges

PFI scheme expiry date:	£000	£000
Not later than one year	0	1,953
Later than one year, not later than five years	0	0
Later than five years	735	726
Total	735	2,679

The estimated annual payments in future years will vary from those which the Health Board is committed to make during the next year by the impact of movement in the Retail Prices Index.

25.4 Number of PFI contracts

	Number of on SoFP PFI contracts	Number of off SoFP PFI contracts
Number of PFI contracts	1	0
Number of PFI contracts which individually have a total commitment > £500m	0	0

PFI Contract	On / Off-statement of financial position
Number of PFI contracts which individually have a total commitment > £500m	0

PFI Contract

The LHB has one on-going PFI contract as at 31.03.25. As described in note 25.2, two of the LHB's PFI contracts have concluded during 2024/25.

25.5 The Health Board did not have any Public Private Partnerships during the year

26. Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking it's activities. The Health Board is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which these standards mainly apply. The Health Board has limited powers to invest and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Health Board in undertaking its activities.

Currency risk

The Health Board is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the United Kingdom and Sterling based. The Health Board does not have any overseas operations. The Health Board therefore has low exposure to currency rate fluctuations.

Interest rate risk

Health Boards are not permitted to borrow and the Health Board therefore has low exposure to interest rate fluctuations.

Credit risk

As the majority of the Health Board's funding derives from funds voted by the Welsh Government the Health Board has low exposure to credit risk.

Liquidity risk

The Health Board is required to operate within cash limits set by the Welsh Government for the financial year and draws down funds from the Welsh Government as the requirement arises. The Health Board is not, therefore, exposed to significant liquidity risks.

27. Movements in working capital

	2024-25 £000	2023-24 £000
(Increase)/decrease in inventories	**(589)**	(268)
(Increase)/decrease in trade and other receivables - non-current	**38,243**	(66,541)
(Increase)/decrease in trade and other receivables - current	**(30,588)**	15,588
Increase/(decrease) in trade and other payables - non-current	**426**	(4,804)
Increase/(decrease) in trade and other payables - current	**2,664**	(19,962)
Total	**10,156**	(75,987)
Adjustment for accrual movements in fixed assets - creditors	**(1,599)**	1,791
Adjustment for accrual movements in fixed assets - debtors	**(34)**	(34)
Adjustment for accrual movements in right of use assets - creditors	**(800)**	6,135
Adjustment for accrual movements in right of use assets - debtors	**(25)**	(24)
Other adjustments	**455**	(943)
	8,153	**(69,062)**

28. Other cash flow adjustments

	2024-25 £000	2023-24 £000
Depreciation	**46,127**	47,475
Amortisation	**1,964**	2,349
(Gains)/Loss on Disposal	**(41)**	331
Impairments and reversals	**1,817**	10,170
Release of PFI deferred credits	**0**	0
NWSSP Covid assets issued debited to expenditure but non-cash	**0**	0
Covid assets received credited to revenue but non-cash	**0**	0
Donated assets received credited to revenue but non-cash	**(78)**	(136)
Government Grant assets received credited to revenue but non-cash	**0**	0
Right of Use Grant (Peppercorn Lease) credited to revenue but non cash	**0**	0
Non-cash movements in right of use assets	**25**	0
Non-cash movements in provisions	**9,246**	83,168
Other movements	**51,797**	32,067
Total	**110,857**	**175,424**

Other movements are Notional funding received for the

- LHB notional 9.4% Staff Employer Pension Contributions and
- 2019/20 Pensions Annual Allowance Charge Compensation Scheme

funded directly to the NHSBA Pensions Division by Welsh Government.

29. Events after the Reporting Period

These financial statements were authorised for issue by the Chief Executive and Accountable Officer on 30th June 2025 ; post the date the financial statements were certified by the Auditor General for Wales.

30. Related Party Transactions

The Welsh Government is regarded as a related party of the Health Board. During the year the Health Board had a significant number of material revenue and capital transactions with either the Welsh Government or with other entities for which the Welsh Government is regarded as the parent body, namely:

	2024-25		As at 31st March 2025	
	Expenditure to related party	Income from related party	Amounts owed to related party	Amounts due from related party
	£000	£000	£000	£000
Welsh Government	3	5,777	12	2,406
Betsi Cadwaladr University Health Board	202	293	54	71
Cardiff & Vale University Health Board	43,976	3,497	3,506	1,238
Cwm Taf University Health Board	19,263	3,653	1,572	943
Hywel Dda University Health Board	438	377	17	33
Powys Teaching Health Board	204	15,387	30	1,221
Swansea Bay University Health Board	2,467	1,271	411	247
Public Health Wales NHS Trust	761	6,806	61	1,233
Velindre NHS Trust	113,640	11,913	3,538	5,802
Welsh Ambulance Services NHS Trust	701	257	407	74
NHS Wales Joint Commissioning Committee (WHSSC)	218,364	14,774	3,785	483
Digital Health and Care Wales (DHCW)	8,099	1,018	17	92
Health Education and Improvement Wales (HEIW)	44	16,535	44	945

In addition the LHB has had significant number of material transactions with other Government Departments and other central and local Government bodies. The most significant of these transactions are with the following:-

Government Body	2024-25		As at 31st March 2025	
	Expenditure to related party	Income from related party	Amounts owed to related party	Amounts due from related party
	£000	£000	£000	£000
Blaenau Gwent County Borough Council	4,362	987	2,153	98
Caerphilly County Borough Council	20,116	14,048	4,712	4,387
Monmouthshire County Council	7,361	1,692	1,734	624
Newport City Council	7,995	2,486	4,188	356
Torfaen County Borough Council	9,500	1,393	3,368	106

The LHB has also had significant material transactions with the following:

	2024-25		As at 31st March 2025	
	Expenditure to related party	Income from related party	Amounts owed to related party	Amounts due from related party
	£000	£000	£000	£000
Aneurin Bevan Local Health Board Charitable Fund	17	1,394	3	263

A number of the LHB's Board members have interests in related parties as follows:

			2024-25		As at 31st March 2025	
Member	Related Organisation	Relationship with Related Party	Expenditure to related party	Income from related party	Amounts owed to related party	Amounts due from related party
			£000	£000	£000	£000
Dafydd Vaughan	Public Digital Ltd	Chief Technology Officer	44	0	0	0
Penny Jones	Monmouthshire County Council	Councillor	7,361	1,692	1,734	624
Peter Carr	Digital Health & Care Wales	Chair of National LIMS 2.0 Programme Board	8,099	1,018	17	92
Richard Clark	Torfaen Voluntary Alliance	Company Secretary and Trustee	234	0	0	0
	Torfaen County Borough Council	Elected Member, Deputy Leader and Executive Member for Children, Families and Education	9,500	1,393	3,368	106
Philip Robson	Hospice of the Valleys	Trustee	548	0	33	0

31. Third Party assets

The LHB held £33,690.04 cash at bank and in hand at 31 March 2025 (31st March 2024, £32,719.58) which relates to monies held by the LHB on behalf of patients. Cash held in patient Investment Accounts amounted to £0 at 31st March 2025 (31st March 2024, £0). This has been excluded from the Cash and Cash equivalents figure reported in the accounts.

In addition the LHB had located on its premises a significant quantity of consignment stock. This stock remains the property of the supplier until it is used. The value of consignment stock at 31 March 2025 amounted to £3.5m (£3.5m as at 31st March 2024).

32. Pooled budgets

The Health Board has five pooled budgets. The specific accounting treatment of each pooled budget is covered within Accounting Policies note 1.22.

Monnow Vale Health and Social Care Unit

The Health Board has entered into a pooled budget with Monmouthshire County Council. Under the arrangement funds are pooled under section 33 of the NHS (Wales) Act 2006 to provide health and social care inpatient, outpatient, clinic and day care facilities to individuals who have medical, social, community or rehabilitation needs and a memorandum note to the accounts provides details of the joint income and expenditure. The asset value of property, plant & equipment is **£5,397K** which is split 72% Aneurin Bevan Health Board and 28% Monmouthshire County Council. The costs incurred under the pooled budget is declared in the memorandum trading account.

	Cash	Contribution	Grants	2024/25	2023/24
Pooled Budget contributions				**£000**	**£000**
Aneurin Bevan University Health Board	-	2,965	-	2,965	2,863
Monmouthshire County Council	439	943	-	1,382	1,309
Total Pooled Budget contributions for the year	**439**	**3,909**	**-**	**4,347**	**4,172**
Expenditure					
Aneurin Bevan Health Board	-	3,271	-	3,271	3,220
Monmouthshire County Council	617	885	-	1,501	1,447
Total Expenditure for the year	**617**	**4,156**	**0**	**4,772**	**4,667**
Net Surplus/(Deficit) on the Pooled Budget for the Year	**(178)**	**(247)**	**0**	**(425)**	**(495)**

Gwent Wide Integrated Community Equipment Service

The Health Board has entered into a pooled budget with the 5 Local Authorities in the Gwent area, namely Blaenau Gwent, Caerphilly, Monmouth, Newport and Torfaen County Borough Councils, for the provision of an effective integrated GWICES (Gwent Wide Integrated Community Equipment Service) to service users who are resident in the partners' localities. Under the arrangement funds are pooled under section 33 of the NHS (Wales) Act 2006 for the joint equipment store in the Gwent area. The Health Board accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement. The LHB's contribution is **£1,289K** for 2024/25 (£971K in 2023/24).

	2024/25	2023/24
Pooled Budget contributions	**£000**	**£000**
Blaenau Gwent County Borough Council	379	298
Caerphilly County Borough Council	635	520
Monmouthshire County Borough Council	518	406
Newport City Council	537	377
Torfaen County Borough Council	989	1,475
Aneurin Bevan University Health Board	1264	938
CRT	161	124
Contribution to Lead Commisioner - LAs	98	165
Contribution to Lead Commisioner - UHB	25	33
Reserve	180	120
Total Pooled Budget contributions for the year	**4,787**	**4,457**
Expenditure		
Staff Costs	149	197
Non Staff Expenditure	4638	4,260
Total Expenditure for the year	**4787**	**4,457**
Net Surplus/(Deficit) on the Pooled Budget for the Year	**0**	**0**

Mardy Park Rehabilitation Centre

The Health Board has entered into a pooled budget arrangement with Monmouthshire County Council. Under the arrangement funds are pooled under Section 33 of the NHS (Wales) Act 2006 to provide care to individuals who have rehabilitation needs. The pool is hosted by Monmouthshire County Council and the LHBs contribution is **£278K** for 2024/25 (£277K in 2023/24).

	2024/25	2023/24
Pooled Budget contributions	**£000**	**£000**
Monmouthshire County Borough Council	368	367
Aneurin Bevan University Health Board	278	277
Total Pooled Budget contributions for the year	**646**	**644**
Expenditure		
Staff Costs	421	419
Premises	92	147
Transport	6	-
Supplies & Services	32	35
Other Expenditure	45	31
Total Expenditure for the year	**596**	**632**
Net Surplus/(Deficit) on the Pooled Budget for the Year	**50**	**12**

32. Pooled budgets (continued)

Gwent Frailty Programme

The Health Board has entered into a pooled budget with 5 Local Authorities in the Gwent area, namely Blaenau Gwent , Caerphilly, Monmouthshire, Newport and Torfaen County councils, for the provision of a Gwent wide integrated health and social care Frailty service, for service users who are resident in the partners' localities. Under the arrangement funds are pooled under section 33 of the NHS (Wales) Act 2006 for the purpose of establishing a consistent service for the Gwent area. The Health Board accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement. The LHB's contribution is **£10,320K** for 2024/25 (£9,892K in 2023/24).

	2024/25	2023/24
Pooled Budget contributions	**£000**	**£000**
Blaenau Gwent County Borough Council	689	649
Caerphilly County Borough Council	2,349	2,249
Monmouthshire County Borough Council	1,628	1,626
Newport City Council	2,148	1,994
Torfaen County Borough Council	833	822
Aneurin Bevan University Health Board	10,320	9,892
Total Pooled Budget contributions for the year	**17,967**	**17,232**
Expenditure		
Reimbursements to Local Authorities from Pooled Fund:		
Blaenau Gwent County Borough Council	159	489
Caerphilly County Borough Council	1,940	1,803
Monmouthshire County Borough Council	1,442	1,353
Newport City Council	2,131	1,938
Torfaen County Borough Council	680	909
Reimbursements to ABUHB from Pooled Fund	11,006	9,921
Central Costs	777	753
Total Expenditure for the year	**18,135**	**17,166**
Net Surplus/(Deficit) on the Pooled Budget for the Year	**(168)**	**66**

Continuing Healthcare - Older People in Care Homes

The Health Board has entered into a pooled budget with the 5 Local Authorities in the Gwent area, namely Blaenau Gwent, Caerphilly, Monmouthshire, Newport and Torfaen County Councils, for the provision and commissioning of certain specialised services for older people (>65 years of age) in a care home setting in Gwent. Statutory Directions issued under section 169 of the Social Services and Wellbeing (Wales) Act 2014 required Partnership Bodies to enter into partnership arrangements and for the establishment and maintenance of pooled funds from April 2018, for the exercise of their Care Home Accommodation Functions.

The pool was established in August 2018 and is hosted by Torfaen County Borough Council. Under the arrangement, the Health Board makes a financial contribution equivalent to related expenditure in commissioning related placements in homes during the year. The LHB's contribution is **£43,955K** for 2024/25 (£41,298K in 2023/24).

	2024/25	2023/24
Pooled Budget contributions	**£000**	**£000**
Blaenau Gwent County Borough Council	11,303	9,769
Caerphilly County Borough Council	34,641	31,521
Monmouthshire County Borough Council	15,255	12,680
Newport City Council	29,117	28,529
Torfaen County Borough Council	15,983	14,154
Aneurin Bevan University Health Board	43,955	41,298
Total Pooled Budget contributions for the year	**150,254**	**137,951**
Expenditure		
Gwent Local Auhtority Residential Homes	20,193	18,828
Other Elderly Frail Residential Care	14,817	14,477
Other EMI Residential Care	29,968	26,580
Elderly Frail Funded Nursing Care	32,863	30,222
EMI Funded Nursing Care	21,264	18,457
Elderly frail Continuing Health Care	8,908	8,373
EMI Conituining Health Care	21,942	20,685
Step Up/ Step Down	237	267
Lead Commissioner Costs	62	62
Total Expenditure for the year	**150,254**	**137,951**
Net Surplus/(Deficit) on the Pooled Budget for the Year	**0**	**0**

33. Operating segments

IFRS 8 requires bodies to report information about each of its operating segments.

Whilst the organisation is structured into divisions, the performance management and the allocation of resources flow from the Board of Aneurin Bevan University Health Board.

There are no hosted services within the health board. Divisions do not manage capital programmes, have any autonomy in relation to balance sheets or produce discrete accounts.

For the purposes of IFRS 8 it is therefore deemed that there is no requirement to report any operating segments.

34. Other Information

34.1. 9.4% Staff Employer Pension Contributions - Notional Element

The value of notional transactions is based on estimated costs for the twelve month period 1st April 2024 to 31st March 2025. This has been calculated from actual Welsh Government expenditure for the 9.4% staff employer pension contributions between April 2024 and February 2025 alongside Health Board data for March 2025.

Transactions include notional expenditure in relation to the 9.4% paid to NHSBSA by Welsh Government and notional funding to cover that expenditure as follows:

	2024-25	2023-24
Statement of Comprehensive Net Expenditure for the year ended 31 March 2025	**£000**	**£000**
Expenditure on Primary Healthcare Services	**780**	662
Expenditure on healthcare from other providers	**0**	0
Expenditure on Hospital and Community Health Services	**51,004**	31,403
Statement of Changes in Taxpayers' Equity for the year ended 31 March 2025		
Net operating cost for the year	**51,784**	32,065
Notional Welsh Government Funding	**51,784**	32,065
Statement of Cash Flows for year ended 31 March 2025		
Net operating cost for the financial year	**51,784**	32,065
Other cash flow adjustments	**51,784**	32,065
2.1 Revenue Resource Performance		
Revenue Resource Allocation	**51,784**	32,065
3. Analysis of gross operating costs		
3.1 Expenditure on Primary Healthcare Services		
General Medical Services	**684**	662
Pharmaceutical Services	**0**	0
General Dental Services	**85**	0
Other Primary Health Care expenditure	**11**	0
3.2 Expenditure on healthcare from other providers		
	0	0
	0	0
3.3 Expenditure on Hospital and Community Health Services		
Directors' costs	**166**	103
Staff costs	**50,838**	31,300
9.1 Employee costs		
Permanent Staff		
Employer contributions to NHS Pension Scheme	**51,784**	32,065
Charged to capital	**0**	0
Charged to revenue	**51,784**	32,065
18. Trade and other payables		
Current		
Pensions: staff	**0**	0
28. Other cash flow adjustments		
Other movements	**51,784**	32,065

The Department of Health and Social Care (DHSC) 2023-24 consultation on the NHS Pension Scheme confirmed that the transitional approach that has operated since 2019-20 for employer contributions will continue in 2024-25. From 1 April 2024 an employer rate of 23.7% (23.78% inclusive of the administration charge) will apply. However, the NHS Business Services Authority will continue to only collect 14.38% from NHS Wales employers under their normal monthly payment process to the NHS Pension Scheme. This has a resulted in an increase in the central payments made by Welsh Government from 6.3% to 9.4%.

Other

34.2 IFRS 17 - Insurance Contract Disclosures

The outcome of the contract review for a range of income contract types applicable to the organisation, did not identify any insurance contracts that fall within the scope of IFRS 17.

STATEMENT OF FINANCIAL POSITION

(Signage as per provision note disclosure)	£000
Liability for incurred claims @ 1 April 2024	0
Liability for remaining payments @ 31 March 2025	0
	0
Arising during year	0
Utiised	0
Reversed unused	0
Movement in Discount Rates	0
	0

STATEMENT OF COMPREHENSIVE NET EXPENDITURE / STATEMENT OF COMPREHENSIVE INCOME *Delete as appropriate

(Signage as per income and expenditure note disclosure)	£000
Insurance Income	0
Insurance expenditure	0

THE NATIONAL HEALTH SERVICE IN WALES ACCOUNTS DIRECTION GIVEN BY WELSH MINISTERS IN ACCORDANCE WITH SCHEDULE 9 SECTION 178 PARA 3(1) OF THE NATIONAL HEALTH SERVICE (WALES) ACT 2006 (C.42) AND WITH THE APPROVAL OF TREASURY

LOCAL HEALTH BOARDS

1. Welsh Ministers direct that an account shall be prepared for the financial year ended 31 March 2011 and subsequent financial years in respect of the Local Health Boards (LHB)1, in the form specified in paragraphs [2] to [7] below.

BASIS OF PREPARATION

2. The account of the LHB shall comply with:

(a) the accounting guidance of the Government Financial Reporting Manual (FReM), which is in force for the financial year in which the accounts are being prepared, and has been applied by the Welsh Government and detailed in the NHS Wales LHB Manual for Accounts;

(b) any other specific guidance or disclosures required by the Welsh Government.

FORM AND CONTENT

3. The account of the LHB for the year ended 31 March 2011 and subsequent years shall comprise a statement of comprehensive net expenditure, a statement of financial position, a statement of cash flows and a statement of changes in taxpayers' equity as long as these statements are required by the FReM and applied by the Welsh Assembly Government, including such notes as are necessary to ensure a proper understanding of the accounts.

4. For the financial year ended 31 March 2011 and subsequent years, the account of the LHB shall give a true and fair view of the state of affairs as at the end of the financial year and the operating costs, changes in taxpayers' equity and cash flows during the year.

5. The account shall be signed and dated by the Chief Executive of the LHB.

MISCELLANEOUS

6. The direction shall be reproduced as an appendix to the published accounts.

7. The notes to the accounts shall, inter alia, include details of the accounting policies adopted.

Signed by the authority of Welsh Ministers

Signed : Chris Hurst Dated :

1. Please see regulation 3 of the 2009 No.1559 (W.154); NATIONAL HEALTH SERVICE, WALES; The Local Health Boards (Transfer of Staff, Property, Rights and Liabilities) (Wales) Order 2009.

Archwilio Cymru
Audit Wales

Audit of Accounts Report – Aneurin Bevan Health Board

Audit year: 2024-25

Date issued: June 2025

Document reference: 4926A2025



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

Introduction



Adrian Crompton

Auditor General for Wales

I am pleased to share my Audit of Accounts Report. The Report summarises the main findings from my audit of your 2024-25 annual report and accounts. My team have already discussed these findings with Finance officers.

My team have substantially completed the audit work as set out in my Audit Plan dated March 2025. There are a small number of queries remaining outstanding at the time of writing, as well as some final review processes to be completed by the Audit Manager and Engagement Lead. The audit team will provide an update to the Audit, Risk and Assurance Committee on any queries that remaining outstanding.

Since my Audit Plan, I have updated materiality to reflect the 2024-25 accounts. I have not identified any new audit risks. My response to previously identified risks is set out in **Appendix 1.**

I am required to provide an opinion on whether the accounts have been properly prepared, give a true and fair view, in all material aspects, and whether income and expenditure have been applied to the purposes intended. My proposed audit opinion and basis for it is outlined on page 19.

It is the responsibility of the those charged with governance, ie Board to address any matters raised in my report and provide me with a Letter of Representation.

I would like to extend my gratitude to the officers and staff of the Health Board for their cooperation throughout the audit process which has been invaluable in completing this audit effectively.

Your audit at a glance

We intend to issue an **unqualified true and fair opinion** and a **qualified regularity opinion** on the accounts.
We are also proposing to issue a **substantive report.**

See **Appendix 4**

There are no **other significant matters** to report

See **Audit findings**

There are no **uncorrected misstatements** in the accounts.

See **Audit findings**

The recommendations arising from our work will be set out in an Accounts Addendum which will be communicated with officers in due course.

We are planning to certify your accounts on 27 June 2025, which is ahead of the deadline of 30 June 2025.

Materiality

I use professional judgement to set a materiality threshold to identify and correct misstatements that could affect users' decisions, considering both financial errors and disclosure requirements according to the applicable accounting framework and laws. My team updates materiality throughout the audit and I include in this report matters that exceed my reporting threshold, as set out below:

Materiality	Reporting threshold (trivial)
Set at 1% of gross expenditure based upon 2024-25 draft financial statements.	Set at 5% of materiality.
Audited body £20.6 million	**Audited body £1 million**

There are some areas of the accounts that may be of more importance to the user of the accounts. We confirm lower materiality levels for these:

Remuneration report	Related party disclosures
£5,000 or nearest banding	£10,000 (relating to individuals)

Audit Findings

Misstatements

A misstatement arises where information in the accounts is not in accordance with accounting standards.

Uncorrected misstatements

There were no uncorrected misstatements identified in the accounts.

Corrected misstatements

During our audit, we identified misstatements that have been corrected by management, but which we consider should be drawn to your attention.

These are set out in **Appendix 2**.

Other significant issues

International Standard on Auditing 260 requires us to communicate with those charged with governance. We must tell you significant findings from the audit and other matters if they are significant to your oversight of the Health Board's financial reporting process.

There were no such issues identified during the audit.

Proposed audit opinion

Audit opinion

We intend to issue an unqualified true and fair opinion and a qualified regularity opinion following the failure of the Health Board to meet its financial duty to break even against its revenue resource limit over the three years 2022-23 to 2024-25.

We are also proposing to issue a substantive report which explains why our audit opinion in respect of the regularity of expenditure is qualified. This report will also refer to the fact that the Health Board did not meet its financial duty to have an approved three-year integrated medium-term plan for the period 2024-27. The regularity opinion is not qualified for this.

Our proposed audit report is set out in **Appendix 3**.

Letter of representation

A Letter of Representation is a formal letter in which you confirm to us the accuracy and completeness of information provided to us during the audit. Some of this information is required by auditing standards; other information may relate specifically to your audit.

The letter we are requesting you to sign is included in **Appendix 4**, the contents of which are in line with our standard request for representations.

Audit team and ethical compliance

The main members of my team who carried out the audit work, together with their contact details, are summarised in **Exhibit 1**.

Exhibit 1: my local audit team

Engagement Lead	Richard Harries richard.harries@audit.wales
Audit Manager	Julie Rees julie.rees@audit.wales
Audit Lead	Angharad Clemens angharad.clemens@audit.wales

Compliance with ethical standards

We confirm that:

- we have complied with the ethical standards we are required to follow in carrying out our work;
- we have remained independent of yourselves;
- our objectivity has not been comprised; and
- we have no relationships that could undermine our independence or objectivity.

Appendix 1 – Audit risks and outcomes

My Audit Plan set out the risks of material misstatement and irregularity for the audit of the Health Board's accounts. **Exhibit 2** lists these audit risks and sets out how they were addressed as part of the audit. No additional audit risks have been identified since that need to be brought to your attention.

Exhibit 2: audit risks reported previously, work done and outcome

Audit risk	Work done	Outcome
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].	• Tested the appropriateness of journal entries and other adjustments made in preparing the financial statements. • Reviewed accounting estimates for bias. • Evaluated the rationale for any significant transactions outside the normal course of business.	My audit work did not identify any instances of management override of controls.

Audit risk	Work done	Outcome
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].	• Substantively test income and expenditure and review it for completeness to ensure that it is appropriately recorded. • Test cut-off to provide assurance that items are recorded in the correct year.	My audit of income and expenditure, including cut-off sampling, did not identify any material misstatements.

Audit risk	Work done	Outcome
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. Where you fail this financial duty, I will place a substantive report on the financial statements highlighting the failure and qualify your regularity opinion. 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, I will place a substantive report on the financial statements highlighting this.	• 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. • Consider the impact of any relevant uncorrected misstatements over the three-year period to 31 March 2025.	My testing did not identify any material misstatement in the accounts as a whole. However, I do intend to issue a qualified regularity opinion following the failure of the Health Board to meet its first financial duty to break even over the three-year period 2022-23 to 2024-25. I am also proposing to issue a substantive report which explains why our audit opinion in respect of the regularity of expenditure is qualified. This report will also refer to the fact that the Health Board did not meet its second financial duty to have an approved three-year integrated medium-term plan for the period 2024-2027. The regularity opinion is not qualified for this.

Audit risk	Work done	Outcome
Remuneration report disclosures Remuneration paid to senior officers and board members continues to be an area of high interest and is material by nature. I 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.	• 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. • Ensure that disclosures are complete based on the team's knowledge and are prepared in accordance with requirements.	My testing did not identify any material errors in the remuneration report.

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.	• 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. • Test the reconciliation between the financial ledger and the asset register.	My testing did not identify any material errors in the valuation of property assets.

Audit risk	Work done	Outcome
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, the 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.	• Review management's process for identifying related party relationships and associated transactions and balances. • Undertake procedures to confirm the completeness of related party relationships. • Ensure disclosures are complete, accurate, consistent with evidence and are in accordance with requirements.	My testing did not identify any material errors in the related party note.

Audit risk	Work done	Outcome
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 increase the risk of material misstatement.	• 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. • Ensure that disclosures are in accordance with the FReM and the Welsh Government's Manual for Accounts.	My testing did not identify any material errors in the accounting for provisions and contingent liabilities.

Appendix 2 – Summary of corrections made

During our audit, we identified the following misstatements that have been corrected by management, but which we consider should be drawn to your attention.

Value of correction	Accounts area	Explanation
£16,104k	Note 4 Miscellaneous Income	Income reclassified from 'Welsh Special Health Authorities' to 'Education, training and research'. This was in response to a new requirement in the Manual for Accounts in 2024-25: that income and expenditure headings should be used to specify which activities they relate to. Organisational headings should only be used if there are no relevant categories available. Reclassification within Note 4 only.
£3.7k (net impact)	Note 30 Related Party Transactions - table	The related party transactions and balances with Welsh Government and the Health bodies were restated as they had been prepared incorrectly.
£581k	Note 30 Related Party Transactions	Our testing identified one Board member failed to declare a related party relationship on their

	– Board member interests	declaration of interest that covered the period of account. The relationship had been correctly disclosed in prior years. The related party relationship table was updated accordingly.
Various amounts and narrative	Various	We identified a number of trivial errors in accounting policies and notes to the accounts which the Health Board has chosen to amend.
Various narrative	Performance Report and Accountability Report	A small number of amendments to the Performance and Accountability Report were requested to ensure full compliance with relevant guidance. These amendments included an additional table required in the Staff Report analysing expenditure on temporary staff, as required by the Manual for Accounts.

Appendix 3 – Proposed audit report

The Certificate and report of the Auditor General for Wales to the Senedd

Opinion on financial statements

I certify that I have audited the financial statements of Aneurin Bevan University Local Health Board for the year ended 31 March 2025 under Section 61 of the Public Audit (Wales) Act 2004.

These comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Cash Flow Statement and Statement of Changes in Taxpayers' Equity and related notes, including a summary of material accounting policies.

The financial reporting framework that has been applied in their preparation is applicable law and UK adopted international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual.

In my opinion, in all material respects, the financial statements:

- give a true and fair view of the state of affairs of Aneurin Bevan University Local Health Board as at 31 March 2025 and of its net operating costs for the year then ended;
- have been properly prepared in accordance with UK adopted international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual; and
- have been properly prepared in accordance with the National Health Service (Wales) Act 2006 and directions made there under by Welsh Ministers.

Opinion on regularity

In my opinion, except for the matter(s) described in the Basis for Qualified Regularity Opinion section of my report, in all material respects, the expenditure and income in the financial statements have been applied to the purposes intended by the Senedd and the financial transactions recorded in the financial statements conform to the authorities which govern them.

Basis for Qualified Opinion on regularity

I have qualified my opinion on the regularity of the Aneurin Bevan University Local Health Board's financial statements because the Health Board has

breached its resource limit by spending £93.793 million over the amount that it was authorised to spend in the three-year period 2022-23 to 2045-25. This spending constitutes irregular expenditure.

Further detail is set out in my Report on page xx.

Basis for opinions

I conducted my audit in accordance with applicable law and International Standards on Auditing in the UK (ISAs (UK)) and Practice Note 10 'Audit of financial statements and regularity of public sector bodies in the United Kingdom'. My responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of my certificate.

My staff and I are independent of the Board in accordance with the ethical requirements that are relevant to my audit of the financial statements in the UK including the Financial Reporting Council's Ethical Standard, and I have fulfilled my other ethical responsibilities in accordance with these requirements. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinions.

Conclusions relating to going concern

In auditing the financial statements, I have concluded that the use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work I have performed, I have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the body's ability to continue to adopt the going concern basis of accounting for a period of at least 12 months from when the financial statements are authorised for issue.

My responsibilities and the responsibilities of the directors with respect to going concern are described in the relevant sections of this certificate.

The going concern basis of accounting for Aneurin Bevan University Local Health Board is adopted in consideration of the requirements set out in HM Treasury's Government Financial Reporting Manual, which require entities to adopt the going concern basis of accounting in the preparation of the financial statements where it anticipated that the services which they provide will continue into the future.

Other information

The other information comprises the information included in the annual report other than the financial statements and my auditor's report thereon. The Chief Executive is responsible for the other information contained within the annual report. My opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in my report, I

do not express any form of assurance conclusion thereon. My responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or knowledge obtained in the course of the audit, or otherwise appears to be materially misstated. If I identify such material inconsistencies or apparent material misstatements, I am required to determine whether this gives rise to a material misstatement in

the financial statements themselves. If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact.

I have nothing to report in this regard.

Opinion on other matters

In my opinion, the part of the remuneration report to be audited has been properly prepared in accordance with the National Health Service (Wales) Act 2006 and directions made there under by Welsh Ministers.

In my opinion, based on the work undertaken in the course of my audit:

- the parts of the Accountability Report subject to audit have been properly prepared in accordance with the National Health Service (Wales) Act 2006 and directions made there under by Welsh Minsters' directions; and;
- the information given in the Performance and Accountability Reports for the financial year for which the financial statements are prepared is consistent with the financial statements and is in accordance with Welsh Ministers' guidance.

Matters on which I report by exception

In the light of the knowledge and understanding of the Health Board and its environment obtained in the course of the audit, I have not identified material misstatements in the Performance Report and the other unaudited parts of the Accountability Report or Annual Governance Statement.

I have nothing to report in respect of the following matters, which I report to you, if, in my opinion:

- I have not received all the information and explanations I require for my audit;

- adequate accounting records have not been kept, or returns adequate for my audit have not been received from branches not visited by my team;
- the financial statements and the audited part of the Accountability Report are not in agreement with the accounting records and returns;
- information specified by HM Treasury or Welsh Ministers regarding remuneration and other transactions is not disclosed;
- certain disclosures of remuneration specified by HM Treasury's Government Financial Reporting Manual are not made or parts of the Remuneration Report to be audited are not in agreement with the accounting records and returns; or
- the Governance Statement does not reflect compliance with HM Treasury's guidance.

Responsibilities of Directors and the Chief Executive for the financial statements

As explained more fully in the Statements of Directors' and Chief Executive's Responsibilities, the Directors and the Chief Executive are responsible for:

- maintaining adequate accounting records
- the preparation of financial statements and annual report in accordance with the applicable financial reporting framework and for being satisfied that they give a true and fair view;
- ensuring that the annual report and financial statements as a whole are fair, balanced and understandable;
- ensuring the regularity of financial transactions;
- internal controls as the Directors and Chief Executive determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; and
- assessing the Health Board's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Directors and Chief Executive anticipate that the services provided by the Health Board will not continue to be provided in the future.

Auditor's responsibilities for the audit of the financial statements

My responsibility is to audit, certify and report on the financial statements in accordance with the National Health Service (Wales) Act 2006.

My objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue a certificate that includes my opinion.

Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. I design procedures in line with my responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud.

My procedures included the following:

- enquiring of management, the Health Board's head of internal audit and those charged with governance, including obtaining and reviewing supporting documentation relating to Aneurin Bevan University Local Health Board's policies and procedures concerned with:
  - identifying, evaluating and complying with laws and regulations and whether they were aware of any instances of non-compliance;
  - detecting and responding to the risks of fraud and whether they have knowledge of any actual, suspected or alleged fraud; and
  - the internal controls established to mitigate risks related to fraud or non-compliance with laws and regulations.
- considering as an audit team how and where fraud might occur in the financial statements and any potential indicators of fraud. As part of this discussion, I identified potential for fraud in the following areas: revenue recognition, expenditure recognition, posting of unusual journals.
- obtaining an understanding of Aneurin Bevan University Local Health Board's framework of authority as well as other legal and regulatory frameworks that the Health Board operates in, focusing on those laws and regulations that had a direct effect on the financial statements or that had a fundamental effect on the operations of the Health Board.
- obtaining an understanding of related party relationships.

In addition to the above, my procedures to respond to identified risks included the following:

- reviewing the financial statement disclosures and testing to supporting documentation to assess compliance with relevant laws and regulations discussed above;
- enquiring of management, those charged with governance and legal advisors about actual and potential litigation and claims;
- reading minutes of meetings of those charged with governance and the Board; and
- in addressing the risk of fraud through management override of controls, testing the appropriateness of journal entries and other adjustments; assessing whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluating the business rationale of any significant transactions that are unusual or outside the normal course of business.

I also communicated relevant identified laws and regulations and potential fraud risks to all audit team members and remained alert to any indications of fraud or non-compliance with laws and regulations throughout the audit.

The extent to which my procedures are capable of detecting irregularities, including fraud, is affected by the inherent difficulty in detecting irregularities, the effectiveness of the Aneurin Bevan University Local Health Board controls, and the nature, timing and extent of the audit procedures performed.

A further description of the auditor's responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website www.frc.org.uk/auditorsresponsibilities. This description forms part of my auditor's report.

Other auditor's responsibilities

I am also required to obtain evidence sufficient to give reasonable assurance that the expenditure and income recorded in the financial statements have been applied to the purposes intended by the Senedd and the financial transactions recorded in the financial statements conform to the authorities which govern them.

I communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

Report

Please see my Report on pages x to y.

Adrian Crompton
Auditor General for Wales
27 June 2025

1 Capital Quarter
Tyndall Street
Cardiff
CF10 4BZ

Report of the Auditor General to the Senedd

Introduction

Under the Public Audit Wales Act 2004, I am responsible for auditing, certifying and reporting on Aneurin Bevan University Local Health Board (the Health Board's) financial statements. I am reporting on these financial statements for the year ended 31 March 2025 to draw attention to two key matters for my audit. These are the failure against the first financial duty and consequential qualification of my 'regularity' opinion and the failure of the second financial duty. I have not qualified my 'true and fair' opinion in respect of any of these matters.

Financial duties

Health Boards are required to meet two statutory financial duties – known as the first and second financial duties.

For 2024-25, the Health Board failed to meet both the first and the second financial duty.

Failure of the first financial duty

The **first financial duty** gives additional flexibility to Health Boards by allowing them to balance their income with their expenditure over a three-year rolling period. The three-year period being measured under this duty this year is 2022-23 to 2024-25.

As shown in Note 2.1 to the Financial Statements, the Health Board did not manage its revenue expenditure within its resource allocation over this three-year period, exceeding its cumulative revenue resource limit of £5,320.432 million by £93.793 million.

Where a Health Board does not balance its books over a rolling three-year period, any expenditure over the resource allocation (ie spending limit) for those three years exceeds the Health Board's authority to spend and is therefore 'irregular'. In such circumstances, I am required to qualify my 'regularity opinion' irrespective of the value of the excess spend.

Failure of the second financial duty

The **second financial duty** requires Health Boards to prepare and have approved by the Welsh Ministers a rolling three-year integrated medium-

term plan. This duty is an essential foundation to the delivery of sustainable quality health services. A Health Board will be deemed to have met this duty for 2024-25 if it submitted a 2024-2027 plan approved by its Board to the Welsh Ministers, who were required to review and consider approval of the plan.

As shown in Note 2.3 to the Financial Statements, the Health Board did not meet its second financial duty to have an approved three-year integrated medium-term plan in place for the period 2024-2027.

Adrian Crompton

Auditor General for Wales

27 June 2025

Appendix 4 – Letter of representation

Audited body's letterhead

Auditor General for Wales
Wales Audit Office
1 Capital Quarter
Cardiff
CF10 4BZ

25 June 2025

Representations regarding the 2024-25 financial statements

This letter is provided in connection with your audit of the financial statements (including that part of the Remuneration Report that is subject to audit) of Aneurin Bevan University Local Health Board for the year ended 31 March 2025 for the purpose of expressing an opinion on their truth and fairness, their proper preparation and the regularity of income and expenditure.

We confirm that to the best of our knowledge and belief, having made enquiries as we consider sufficient, we can make the following representations to you.

Management representations

Responsibilities

As Chief Executive and Accountable Officer I have fulfilled my responsibility for:

- preparing the financial statements in accordance with legislative requirements and the Treasury's Financial Reporting Manual. In preparing the financial statements, I am required to:

  - observe the accounts directions issued by Welsh Ministers, including the relevant accounting and disclosure requirements and apply appropriate accounting policies on a consistent basis;
  - make judgements and estimates on a reasonable basis;
  - state whether applicable accounting standards have been followed and disclosed and explain any material departures from them; and
  - prepare them on a going concern basis on the presumption that the services of Aneurin Bevan University Local Health Board will continue in operation;
- ensuring the regularity of any expenditure and other transactions incurred;
- the design, implementation and maintenance of internal control to prevent and detect error.

Information provided

We have provided you with:

- full access to:
  - all information of which we are aware that is relevant to the preparation of the financial statements such as books of account and supporting documentation, minutes of meetings and other matters;
  - additional information that you have requested from us for the purpose of the audit; and
  - unrestricted access to staff from whom you determined it necessary to obtain audit evidence;
- the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud;
- our knowledge of fraud or suspected fraud that we are aware of and that affects Aneurin Bevan University Local Health Board and involves:
  - management;

  - employees who have significant roles in internal control; or
  - others where the fraud could have a material effect on the financial statements;
- our knowledge of any allegations of fraud, or suspected fraud, affecting the financial statements communicated by employees, former employees, regulators or others;
- our knowledge of all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing the financial statements;
- the identity of all related parties and all the related party relationships and transactions of which we are aware; and
- our knowledge of all possible and actual instances of irregular transactions.

Financial statement representations

All transactions, assets and liabilities have been recorded in the accounting records and are reflected in the financial statements.

The methods, the data and the significant assumptions used in making accounting estimates, and their related disclosures are appropriate to achieve recognition, measurement or disclosure that is reasonable in the context of the applicable financial reporting framework.

Related party relationships and transactions have been appropriately accounted for and disclosed.

All events occurring subsequent to the reporting date which require adjustment or disclosure have been adjusted for or disclosed.

All known actual or possible litigation and claims whose effects should be considered when preparing the financial statements have been disclosed to the auditor and accounted for and disclosed in accordance with the applicable financial reporting framework.

The financial statements are free of material misstatements, including omissions.

Representations by Aneurin Bevan University Local Health Board

We acknowledge that the representations made by management, above, have been discussed with us.

We acknowledge our responsibility for the preparation of true and fair financial statements in accordance with the applicable financial reporting framework. The financial statements were approved by Aneurin Bevan University Local Health Board on 25 June 2025.

We confirm that we have taken all the steps that we ought to have taken in order to make ourselves aware of any relevant audit information and to establish that it has been communicated to you. We confirm that, as far as we are aware, there is no relevant audit information of which you are unaware.

Signed by:	Signed by:
Chief Executive	Chair of the Health Board
Date:	Date:

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.



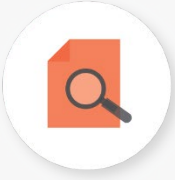
Our People

- 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

Supporting you

Audit Wales has a range of resources to support the scrutiny of Welsh public bodies, and to support them in continuing to improve the services they provide to the people of Wales.

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Information on our upcoming work and forward work programme for performance audit.



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Details of our Good Practice work and events including the sharing of emerging practice and insights from our audit work.



Our newsletter which provides you with regular updates on our public service audit work, good practice, and events.

Archwilio Cymru
Audit Wales

Audit Wales

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E-mail: info@audit.wales

Website: www.audit.wales

We welcome correspondence and telephone calls in Welsh and English.

Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	24 June 2025
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Counter Fraud Functional Standard Return 2024/25
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Robert Holcombe, Director of Finance, Procurement and Value Based Healthcare
SWYDDOG ADRODD: **REPORTING OFFICER:**	Gareth Lavington Head of Counter Fraud

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

Er Gwybodaeth/For Information

To inform the Audit, Risk and Assurance Committee that the Counter Fraud Functional Standard Return (CFFSR) has now been completed, reviewed and submitted to the NHS Counter Fraud Authority (NHSCFA) in compliance with the Government Functional Standards GovS 013.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

A CFFSR has been completed by the Head of Counter Fraud. The report has been completed on an online platform. The report has been reviewed and agreed by the Director of Finance, and Procurement and the Chair of the Audit, Risk and Assurance Committee (ARAC).

Subsequently the CFFSR has been submitted to NHSCFA for review, prior to the allotted deadline of 31/05/2025.

Cefndir / Background

Since April 2021 all NHS funded services have been required to provide assurance to the NHSCFA that the requirements of the *Government Functional Standard GovS 013: Counter Fraud*, are being complied with.

The report requires the reporting officer to carry out a self-assessment into each of the 12 components of requirement set by the NHSCFA. They are:

1. Accountable Individual
2. Counter Fraud Bribery and Corruption Strategy
3. Fraud Bribery and Corruption Risk Assessment
4. Policy and Response Plan
5. Annual Action Plan
6. Outcome-Based Metrics
7. Reporting routes for staff, contractors and members of the public
8. Report identified loss
9. Access to trained investigators
10. Undertake detection activity
11. Access to and completion of training
12. Policies and registers for gifts and hospitality and conflicts of interest (COI)

The options for assessment are:

Red – non compliant
Amber – partially compliant
Green – fully compliant

The report also covers key areas of the work that are mirrored in the Aneurin Bevan University Health Board (ABUHB) Counter Fraud Annual report that is presented to ARAC on an annual basis. This includes but is not limited to, sanctions applied, financial losses, recoveries and preventions, days of resource allotted to reactive and proactive workstreams.

All NHS Organisations are subject to periodic engagement visits from the NHSCFA Quality Assurance team that aim to test the declarations made within the CFFSR.

Asesiad / Assessment

The report for ABUHB this year, declares that all components of the requirement have achieved a **Green** rating.

ABUHB Counter Fraud team are not subject to an engagement visit this year.

A PDF version of the report is provided as an attachment to this cover paper for review.

Argymhelliad / Recommendation

This report is intended to inform the Committee that the work of the Counter Fraud team for 2024/25 remained relevant and compliant to the standards set by the Cabinet Office for public sector organisations.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	SRR 001G – Supports financial sustainability
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Not Applicable Not Applicable
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item. FInance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	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**	Yes, outlined within the paper
• **Financial**	Not Applicable
Asesiad Effaith Cydraddoldeb **Equality Impact Assessment** (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Not Applicable Choose an item.

Counter Fraud Functional Standard Return (2024/2025)

ANEURIN BEVAN UNIVERSITY LHB

Your Overall Self-Assessment Rating is: GREEN

Submitted By: lcfs13841 - Gareth Lavington

Organisational information

Name of the organisation	ANEURIN BEVAN UNIVERSITY LHB
Annual budget of the organisation	Over £ 1 billion
Staff headcount at the organisation including contracted employees	Over 15,000
Organisation code	7A6
Organisation/provider type	Health Board
For which provider organisations are you the commissioner?||Co-ordinating Commissioner for this provider	WALES Co-ordinating Commissioner for this provider
NHS England region	Wales

Personnel information

Name of the member of the executive board or equivalent body responsible for overseeing and providing strategic management	Robert Holcombe
Name of the Local Counter Fraud Specialist	Gareth Lavington
Email of the Local Counter Fraud Specialist	Gareth.Lavington3@wales.nhs.uk
Name of the counter fraud supplier organisation (including in-house)	In House (Wales)
Counter fraud supplier type	Wales
Name of the Chair of the Audit Committee / equivalent body	Iwan Jones
Email of the Chair of Audit Committee / equivalent body	Iwan.Jones6@wales.nhs.uk
Name of the Counter Fraud Champion	Robert Jones
Email of the Counter Fraud Champion	Robert.J.Jones2@wales.nhs.uk

Costs and days information

Proactive days used (Maximum 3 digits)	195
Reactive days used (Maximum 3 digits)	300
Total days used for counter fraud work	495
Cost of counter fraud staffing per financial year - Proactive	70191.00
Cost of counter fraud staffing per financial year - Reactive	105286.00
Total costs for counter fraud work	175477.00

Reactive information

Number of allegations received and recorded as an investigation during the most recent financial year	57
Number of allegations received during the most recent financial year and recorded as an investigation on the case management system	61
Rationale for any discrepancy between case management system investigations received and expected	Assumption is that 4 Cases transferred to CFS Wales team and therefore no longer showing on ABUHB CLUE
Number of investigations recorded and closed during the most recent financial year	64
Number of investigations closed during the most recent financial year as recorded on the case management system	66
Rationale for any discrepancy between case management system investigations closed and expected	Cases transferred to CFS Wales team and therefore no longer showing on ABUHB CLUE so unable to report upon them. Local Audit of CLUE produces figure of 64 cases closed during this period
Number of investigations open as at 31/03/2025	19
Number of investigations open as at 31/03/2025 as recorded on the case management system	23
Rationale for any discrepancy between case management system investigations open as of 31/03/2025 and expected	Assumption is that the discrepancy relates to Cases transferred to CFS Wales
Amount of fraud losses identified and recorded during the most recent financial year	135278.23

Amount of fraud losses recovered and recorded during the most recent financial year	135278.23
Amount of fraud losses prevented from reactive work and recorded during the most recent financial year	0.00
Number of criminal sanctions applied and recorded during the year	1
Number of civil sanctions applied and recorded during the year	17
Number of disciplinary sanctions applied and recorded during the year	7

Proactive information

Number of proactive exercises conducted and recorded during the most recent financial year	10
Amount of fraud losses identified and recorded from proactive exercises during the most recent financial year	0.00
Amount of fraud losses prevented and recorded from proactive exercises during the most recent financial year	31476.00
Amount of fraud losses recovered and recorded from proactive exercises during the most recent financial year	0.00

Engagement information

Have you had an engagement visit which provided recommendations by NHSCFA to improve counter fraud work in the last two financial years	No
Have you actioned the recommendations	No
Please provide a statement outlining your progress against your recommendations	N/A

1: Accountable individual

NHS Requirement 1A:

A member of the executive board or equivalent body is accountable for provision of strategic management of all counter fraud, bribery and corruption work within the organisation. The accountable board member is responsible for the provision of assurance to the executive board in relation to the quality and effectiveness of all counter fraud bribery and corruption work undertaken. The accountable board member is responsible for ensuring that nominations to the NHSCFA for the accountable board member, audit committee chair and counter fraud champion are accurate and that any changes are notified to the NHSCFA at the earliest opportunity and in accordance with the nominations process. N.B. ‘Equivalent body’ may include, but is not limited to, the board of directors, the board of trustees or the governing body. Oversight of counter fraud, bribery and corruption work should not be delegated to an individual below this level of seniority in the organisation

Your Rating is: **GREEN**

Comments:

Within ABUHB the Director of Finance oversees all the counter fraud work undertaken by the ABUHB LCFS team and the investigations carried out on behalf of the HB by NHS CFSW. This work is communicated to him via quarterly reports that are submitted to him and the Welsh Government via NHS CFSW. There are regular meetings between the DOF and the Head of Counter Fraud. The work undertaken by the HB LCFS is presented quarterly via a report to the Audit, Risk and Assurance Committee (ARAC) which in turn scrutinises the work undertaken. This committee is made up of lay non-executive members and executives. The Chair of the ARAC has remained the same in this financial year. The ARAC and the DOF agree and sign off the annual work plan. The Assistant Director of Corporate Finance remains as the fraud champion and is the line manager of the Head of Counter Fraud. DoF, ACC, Fraud Champion, and all LCFS' are nominated with the NHSCFA.

NHS Requirement 1B:

The organisation’s non-executive directors, counter fraud champion or lay members and board/governing body level senior management are accountable for gaining assurance that sufficient control and management mechanisms in relation to counter fraud, bribery and corruption are present within the organisation. The counter fraud champion understands the threat posed and promotes awareness of fraud, bribery and corruption within the organisation. Board level evaluation of the effectiveness of counter fraud, bribery and corruption work undertaken is documented. Where recommendations have

been made by NHSCFA following an engagement, it is the responsibility of the accountable board member to provide assurance to the board surrounding the progress of their implementation. The organisation reports annually on how it has met the standards set by NHSCFA in relation to counter fraud, bribery and corruption work, and details corrective action where standards have not been met.

Your Rating is: **GREEN**

Comments:

The ARAC oversees that senior managers know their responsibilities in relation to Counter Fraud. It is a standing agenda item on every ARAC meeting. Actions raised by ARAC are recorded and followed up. The Head of Counter Fraud meets quarterly a provides a quarterly report of the work undertaken by the Counter Fraud Team. The Head of Counter Fraud meets in private with the ARAC Chair and other ARAC lay members every 6 months as a standing agenda, but can approach the Chair independently at anytime to raise concerns if not dealt with appropriately by the HB. The end of year report aims to provide assurance to the ARAC that the counter fraud provision for the past year has been effective and has met the current standards set by NHS CFA. If this isn't the case it aims to highlight areas of need. This report is signed off by both the DOF and the ARAC.

2: Counter fraud bribery and corruption strategy

NHS Requirement 2:

The organisation aligns counter fraud, bribery and corruption work to the NHSCFA counter fraud, bribery and corruption strategy. This is documented in the organisational counter fraud, bribery and corruption policy, and is submitted upon request. The counter fraud work plan and resource allocation are aligned to the objectives of the strategy and locally identified risks. (The organisation may have its own counter fraud, bribery and corruption strategy, however, this must be aligned to and referenced to the NHSCFA counter fraud, bribery and corruption strategy)

Your Rating is: **GREEN**

Comments:

The ABUHB annual report provides evidence that the work completed during the year was carried out in alignment with the strategy put forward by NHS CFA. ABUHB has a Counter Fraud, Bribery and Corruption Policy and Procedure which is in date and current. The policy is available to all staff via our Intranet and has been promoted and signposted staff complete fraud awareness work. The LCFS team this year has ensured to align any counter fraud, bribery, and corruption work to any recent changes in NHSCFA requirements. The annual CF plan in place directly aligns to the NHS CFA standards requirements to ensure that CFA strategy is mirrored within it. Further work will be carried out in the year ahead to ascertain if possible to make the relevant documents more visible.

3: Fraud bribery and corruption risk assessment

NHS Requirement 3:

The organisation has carried out comprehensive local risk assessments to identify fraud, bribery and corruption risks, and has counter fraud, bribery and corruption provision that is proportionate to the level of risk identified. Risk analysis is undertaken in line with Government Counter Fraud Profession (GCFP) fraud risk assessment methodology and is recorded and managed in line with the organisation's risk management policy and included on the appropriate risk registers, and the risk assessment is submitted upon request. Measures to mitigate identified risks are included in an organisational work plan, progress is monitored at a senior level within the organisation and results are fed back to the audit committee (or equivalent body). For NHS organisations the fraud risk assessments should also consider the fraud risks within any associated sub company of the NHS organisation.

Your Rating is: **GREEN**

Comments:

The Head of Counter Fraud has attended all policy review meetings that have taken place and provided fraud proofing input in order to strengthen and reduce the risk of fraud due to poor policy or governance controls. Risk assessment work has been prioritised in the latter part of the year and a number of locally emerging risks along with inherent risks have been subject to formal risk assessment, review and recommendation for remedy has been made in a number of areas. These are subject to ongoing review. All risk work carried out has been compliant with Cabinet Office Methodology and the local Risk Management Policy. A Fraud Risk Profile has been introduced that is maintained by the Head of Counter Fraud. Local proactive exercises have been commenced as a result of fraud risk assessments in the areas of Agile Working, Primary Care Prescribing, Hospital Prescription storage and use, and Employee Leave. This work will continue into the new financial year and will be reported via ARAC.

4: Policy and response plan

NHS Requirement 4:

The organisation has a counter fraud, bribery and corruption policy and response plan (the policy and plan) that follows NHSCFA's strategic guidance and has been approved by the executive body or senior management team. The plan is reviewed, evaluated and updated as required, and levels of staff awareness are measured.

Your Rating is: **GREEN**

Comments:

ABUHB has a Counter Fraud Policy in place, which is up to date and is in line with the requirements of NHSCFA. This policy has been reviewed and renewed during Q3 of this year. Further to this a new joint working protocol with WOD and IA and a new communication strategy have been added. The Counter Fraud, Bribery and Corruption Policy's next review is in 2027. The policy is publicised on the HB Intranet site within the Policies section and on the CF pages. The Standards of Behaviour Framework Policy also refers to fraud, bribery, and corruption within the HB. Staff CF awareness is monitored and reported to ARAC. CF E-Learning continues to be mandated. Feedback is always requested following presentations given in follow up communication with participants. Targeted presentations have been designed and implemented. Delivery has been provided thus far to GP Primary Care partners and Senior Nursing and Divisional Management groups across ABUHB. This effort continues into 2025-26

5: Annual action plan

NHS Requirement 5:

The organisation maintains an annual work plan that is informed by national and local fraud, bribery and corruption risk assessment identifying activities to improve capability and resilience. This includes (but is not limited to) defined objectives, milestones for the delivery of each activity and measurable areas for improvement in line with strategic aims and objectives. The plan is agreed, and progress monitored by the audit committee (or equivalent body).

Your Rating is: **GREEN**

Comments:

The Counter Fraud, Bribery, and Corruption workplan for 2025/26 has been reviewed and agreed by DoF and has been subject to scrutiny and approval at ARAC. It has been designed and implemented in compliance with the Gov Standards SO13. The plan is a fluid plan that is subject to change in order to meet any emerging needs of the organisation. This is reported to the ARAC on a regular basis. In this past year more days were used in investigation and reactive work than was planned. This has been addressed in Q3 and Q4 in order that a more balanced provision is now being provided. All work carried out has been reported in the Annual Report that s subject to scrutiny and review by DOF and ARAC. There has been one national exercise this year regarding Contracts Management. Partial participation has taken place only in order not to duplicate the ongoing work of the Internal Audit Team in this area.

6: Outcome-based metrics

NHS Requirement 6:

The organisation identifies and reports on annual outcome-based metrics with objectives to evidence improvement in performance. This should be informed by national and local risk assessment, national benchmarking and other comparable data. Proactive and reactive outcomes and progress are recorded on the approved NHS fraud case management system. Metrics should include all reported incidents of fraud, bribery and corruption, the value of identified fraud losses, the value of fraud recoveries, the value of fraud prevented, criminal sanctions and disciplinary sanctions.

Your Rating is: **GREEN**

Comments:

Locally managed data systems have been introduced in Q3 of the year. They aim to provide accurate measurement of, and, greater insight into, work carried out by the department and the outcomes achieved. They supplement existing systems such as ESR, CLUE case management, NFI, and all Wales statistical reporting. Review and measurement has taken place in areas including, awareness and promotion, investigation and referral, risk, joint working, strategic planning, sanctioning, and financial loss and recovery. The system introduced has been successful in documenting results that inform direction and, where necessary, modifying work streams throughout the year. The collection and review of these figures identifies areas of work that are proving effective and areas that may require improvement. The data collection also aims to identify areas of emerging risk that require immediate focus and action.

7: Reporting routes for staff, contractors and members of the public

NHS Requirement 7:

The organisation has well established and documented reporting routes for staff, contractors and members of the public to report incidents of fraud, bribery and corruption. Reporting routes should include NHSCFA's Fraud and Corruption Reporting Line and online reporting tool. All incidents of fraud, bribery and corruption are recorded on the approved NHS fraud case management system. The incident reporting routes are publicised, reviewed, evaluated and updated as required, and levels of staff awareness are measured.

Your Rating is: **GREEN**

Comments:

ABUHB continues to receive fraud referrals via the NHS CFA Fraud and Corruption Reporting Line and the NHS CFA Online Reporting Tool. This information is initially reported to the NHS CFA CIT team and disseminated to ABUHB's CF team for actioning via the CLUE system. The CF team has its own webpage and a specific newly introduced digital form has been introduced for concerns to be reported. Other reporting avenues available are also detailed on the webpage. These reporting routes are formalised in the Counter Fraud Policy and in the Counter Fraud awareness programme for the HB which now includes E-Learning which is mandatory. Its effectiveness is evaluated via the referral data, which is reported to NHS CFSW, the ARAC meetings and DOF. Staff awareness is measured via E-Learning and presentation data. The All-Wales Raising Concerns (whistleblowing) Policy is in place that allows staff to feel supported and protected when reporting fraud.

8: Report identified loss

NHS Requirement 8:

The organisation uses the approved NHS fraud case management system to record all incidents of reported suspect fraud, bribery and corruption, to inform national intelligence and NHS counter fraud functional standard return submission by the NHSCFA. The case management system is used to record all fraud, bribery and corruption investigative activity, including all outcomes, recoveries and system weaknesses identified during the course of investigations and/or proactive prevention and detection exercises

Your Rating is: **GREEN**

Comments:

The Counter Fraud team has reported all incidents of suspected fraud and financial crime using the CLUE case management system. This reporting tool is used to record all investigations, sanctions, financial recoveries and losses and preventions and also has a mechanism to record system weakness and Local Proactive Exercise work. This system is supervised by NHS CFA and all information has been used to inform progress reporting to Audit Committee. All identified loss to fraud is reported within the Annual report and in the Functional Return submitted to the NHS CFA. In Wales the Head of NHS CFSW oversees NHS Wales CF quarterly statistics. This is subsequently reported to Welsh Government via the Counter Fraud Steering Group.

9: Access to trained investigators

NHS Requirement 9:

The organisation employs or contracts in an accredited, person (or persons) nominated to the NHSCFA to undertake the full range of counter fraud, bribery and corruption work, including proactive work to prevent and deter fraud, bribery and corruption and reactive work to hold those who commit fraud, bribery or corruption to account. The organisation will ensure that any changes to nominations are notified to the NHSCFA at the earliest opportunity and in accordance with the nominations process. The accredited nominated person (or persons) must demonstrate continuous professional competencies and capabilities on an annual basis by examples of practical application of skills and associated training to include (but is not limited to), obtaining witness statements, conducting interviews under caution and maintaining up to date knowledge of legal and procedural requirements.

Your Rating is: **GREEN**

Comments:

At the time of reporting the team is fully staffed. The team is made up of the Head of Counter Fraud who acts as the Senior Investigating Officer; and three Local Counter Fraud Specialists. All are experienced criminal investigators. All staff hold Accredited Counter Fraud Specialist (ACFS) status. All LCFS have completed a number of Investigations and IUCs in this past year which have been reviewed for compliance and quality. All the mandatory staff training provided by NHS CFA has been attended by all staff members this year. All nominations are up to date with no other movement of staff. The DOF, and the ARAC Chair have remained the same. A new Fraud Champion has been appointed and is currently going through the nomination process.

10: Undertake detection activity

NHS Requirement 10:

The organisation undertakes proactive work to detect fraud using relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption and takes the appropriate action, including local exercises and participation or response to national exercises. Results of this work are evaluated and where appropriate feed into improvements to prevent and deter fraud, bribery and corruption. Relevant information and intelligence may include (but is not limited to) internal and external audit reports, information on outliers, recommendations in investigation reports and NHSCFA led loss measurement exercises. The findings are acted upon promptly.

Your Rating is: **GREEN**

Comments:

Where anomalies have been identified through counter fraud work e.g. investigations, the CF team strives to carry out proactive activity to assess whether there are any weaknesses present and remedial action required. Local Proactive Exercises have been undertaken this year with a view to detecting offences or identify process and/or system weakness. A PPV programme is undertaken by the organisation and the Head of CF attends quarterly meetings. Direct reports are submitted to counter fraud, and where appropriate, an investigation/local proactive action will commence into outlier information. Data mining exercise - NFI - carried out in relation to the 2024-25 exercise. All matches have now been opened and successfully closed or remain ‘under investigation’. The team have responded to all fraud prevention notices and Intelligence bulletins issued by the NHSCFA. LiN meetings attended re drug activity in the community that may impact ABUHB. All referrals have been thoroughly investigated.

11: Access to and completion of training

NHS Requirement 11:

The organisation has an ongoing programme of work to raise awareness of fraud, bribery and corruption and to create a counter fraud, bribery and corruption culture among all staff, across all sites, using all available media. This should cover the role of the NHSCFA, LCFS and the requirements and national implications of Government Counter Fraud Functional Standard providing a standardised approach to counter fraud work.Content may be delivered through presentations, newsletters, leaflets, posters, intranet pages, induction materials for new staff, emails and other media, making use of the NHSCFA's fraud awareness toolkit as appropriate. The effectiveness of the awareness programme is measured.

Your Rating is: **GREEN**

Comments:

All Wales fraud awareness training has remained available to all staff throughout the year via ESR. This module remains mandatory training. 82% of all staff have completed this at 31/03/25. CF input is provided to all new starters via Corporate Induction. Where fraud issues have been identified in a certain directorate a specific presentation has been given. Some remote presentations have been given and this has been to accommodate more staff that have made use of agile working. Counter Fraud staff completed International Fraud Awareness Week at various hospital sites within ABUHB. Counter Fraud team staff have attended all sessions of formal training provided by NHSCFA. Training has been undertaken by CF staff into areas of Risk Management and in use of Digital Systems. All CF staff have been surveyed in relation to training needs and areas of requirement are being investigated for action.

12: Policies and registers for gifts and hospitality and COI.

NHS Requirement 12:

The organisation has a managing conflicts of interest policy and registers that includes reference to gifts and hospitality with reference to fraud, bribery and corruption, and the requirements of the Bribery Act 2010. Staff awareness of the requirements of the policy are tested sufficiently regularly to demonstrate effectiveness of the process.

Your Rating is: **GREEN**

Comments:

ABUHB currently has policies in place that cover the requirement of staff and non-executive board members to report any conflicts of interest. This is carried out on a yearly basis and is linked to our PADR system, all are made aware that this is an ongoing requirement and should be completed as and when the conflict or suspect conflict arises. This information along with gifts and hospitality is then collated in a register and held by the Director of Governance and shared with Counter Fraud. The requirement to disclose COI and gifts and hospitality together with the bribery act is covered in the ABUHB Fraud awareness session that is provided to all staff and also within the mandated CF E-learning. These polices are accessible on the ABUHB staff website and are updated in line with their renewal dates.

ACC Declaration

I declare that the anti-fraud, bribery and corruption work carried out during the year to date has been self reviewed against the NHS CFA requirements for anti-fraud, bribery and corruption.As the Audit Committee Chair, and in line with the audit committee's responsibility for the strategic assurance and oversight of counter fraud work as described in chapter 11 of the NHS Audit Committee Handbook, I confirm that the information contained in this self review for ANEURIN BEVAN UNIVERSITY LHB reflects the work reported to and considered by the Audit Committee.

acc14340 - Iwan Jones

Tue May 13 09:23:33 BST 2025

Opportunity to comment

DOF Declaration

I declare that the anti-fraud, bribery and corruption work carried out during the year to date has been self reviewed against the NHS CFA requirements for anti-fraud, bribery and corruption.	dof14220 - Robert Holcombe Tue May 13 10:03:32 BST 2025

Opportunity to comment

Declaration

Overall Rating	Green
Please ensure that this functional standard return has been fully completed. If your Director of Finance and/ or audit committee chair have not authorised or reviewed the functional standard return you will not be able to submit it. Once you have submitted the functional standard return, no further changes are possible.	lcfs13841 - Gareth Lavington Mon May 19 09:48:08 BST 2025

Counter Fraud Services in NHS Wales

Operational Performance Report 2024/25

Quarter 4 – 1st January to 31st March 2025

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Introduction

This quarterly report format summarises the operational resources, referrals, and performance of the NHS Counter Fraud Service (CFS) Wales National Team and the network of Local Counter Fraud Specialists (LCFS) based at health bodies in NHS Wales during Quarter 4 of 2024/25 (1st January to 31st March 2025). The NHS Counter Fraud Authority (NHSCFA) continue to report to Welsh Government (WG) via a separate quarterly and annual report document.

1 Resources

1.1 NHS Counter Fraud Service (CFS) Wales

The NHS CFS Wales team is hosted by NHS Wales Shared Service Partnership (NWSSP), part of Velindre NHS Trust who employ the team members. The CFS Wales consists of 6.0 wte experienced investigators and 1.0 wte administrative support. Their primary role is the investigation and prosecution of serious, complex, or large-scale economic crimes. This includes offences that may involve more than one organisation, cross border investigations and all corruption and bribery cases in NHS Wales. They also provide support and guidance to the LCFS network in Wales and conduct presentations to key stakeholders in NHS Wales.

The CFS Wales team provide a specialist independent investigation resource to NHS Wales. This provides an impartial investigation service if senior NHS executives or management are implicated, as suspects or witnesses, to provide the health bodies with the independent assurance required. The CFS Wales team's employers is listed as a regulatory body under POCA 2002, this enables the two Accredited Financial Investigators (AFIs) and three Financial Intelligence Officers (FIOs) on the CFS Wales team to conduct financial investigations, or for the AFIs to restrain and recover funds from convicted persons. The CFS Wales team also work closely with the LCFSs, often providing guidance on investigations or pro-active work, conducting financial intelligence checks, or jointly investigating suitable cases.

1.2 Local Counter Fraud Specialists (LCFS)

WG Directions require each health body to work closely with CFS Wales and nominate a qualified LCFS who is accredited by the Counter Fraud Professional Accreditation Board. LCFSs are the primary point of contact for all economic crime concerns within their health body, they have a key proactive role in raising fraud awareness, identifying risks, and preventing fraud within their health bodies, while also investigating offences reported at a local level in collaboration with CFS Wales.

The LCFS work is aligned to the delivery of the current Fraud, Bribery and Corruption Standards for NHS bodies (Wales), which are reviewed and updated annually by the NHS Counter Fraud Authority (NHSCFA) under their SLA with WG. The NHSCFA standards are now aligned with the new Cabinet Office Standards on Counter Fraud Work and NHS Wales has adopted the new Cabinet Office Functional Standards since 2022.

The table below summarises the counter fraud resources in NHS Wales during Q4 of 2024/25. This is consolidated from data provided to CFS Wales by the Lead LCFS at each health body. The health boards with the most LCFS resources are SB UHB at 3.2 wte and 0.6 admin support, and ABUHB with 3.4 wte. WAST has two full time LCFS' for a relatively small number of employees (4,379 staff). The ratio of LCFS wte to NHS staff is included in the table. This shows that CVUHB (0.13) and BCUHB (0.14) have the lowest ratio of LCFS resources while SB (0.22), AB (0.22) and CTM (0.20) have the highest ratios of the larger health bodies. In the smaller support type health bodies, the best resourced are HEIW (0.65), PTHB (0.46) and WAST (0.46). The total LCFS provision plus admin support staff in NHS Wales has increased from 14.3 wte in April 2014 to 22.17 wte with 1.5 wte admin support roles as of 31st March 2025, which is a significant increase. The table at Appendix 1 provides details of the LCFS provision in 2014/15 for comparison purposes.

NHS WALES COUNTER FRAUD RESOURCE 2024/25									
Health Body	**LCFS Annual WTE**	**Admin Support Annual WTE**	**Annual Planned LCFS Days**	**Q4 LCFS Days**	**YTD LCFS Days**	**Salary Costs Q4**	**Annual Staffing budget**	**Staff Headcount (at 30.09.24) *** **	**LCFS wte per 1,000 NHS staff**
Aneurin Bevan UHB (ABUHB)	3.40	0	630	139.50	544	£27,099	£207,264	15,504	0.22
Betsi Cadwaladr UHB (BCUHB)	2.91	0.5	590	149.50	498	£50,814	£175,444	21,285	0.14
Cardiff & Vale UHB (CVUHB) *	2.18	0	480	126	457	£36,008	£144,032	17,350	0.13
Cwm Taf Morgannwg UHB CTMUHB) **	2.60	0.2	606	152	584	£37,818	£151,272	13,125	0.20
Digital Health & Care Wales (DCHW) *	0.39	0	85	22	79	£6,377	£25,506	1,261	0.31
Health Education & Improvement Wales (HEIW) *	0.39	0	85	18	79	£6,377	£25,506	604	0.65
Hywel Dda UHB (HDUHB)	2.00	0	420	110	430	£23,529	£94,116	12,119	0.17
NHS Wales Shared Services Partnership (NWSSP)	1.00	0	210	53	211	£13,401	£50,088	6,188	0.16
Powys THB (PTHB) **	1.20	0.2	308	77	308	£19,896	£79,582	2,634	0.46
Public Health Wales (PHW) *	0.45	0	100	26	90	£7,502	£30,007	2,558	0.18
Swansea Bay UHB (SBUHB) **	3.20	0.6	704	176	704	£44,371	£177,484	14,531	0.22
Velindre NHS Trust (VUNHST) *	0.45	0	100	27	90	£7,502	£30,007	1,836	0.25
Welsh Ambulance Service Trust (WAST)	2.00	0	420	105	315	£29,500	£118,000	4,379	0.46
TOTAL	**22.17**	**1.5**	**4,738**	**1,181**	**4,389**	**£310,194**	**£1,308,308**		
NHS Counter Fraud Service Wales (CFS Wales)	6	1	1,314	274	274	£111,097	£444,389	**113,374**	**Average is 0.25**
ALL WALES TOTAL	**28.17**	**2.5**	**6,052**	**1,455**	**4,663**	**£421,291**	**£1,752,697**		

* C&V UHB LCFS Team provide an LCFS service to Velindre UNHST, HEIW, DHCW and PHW.
** Swansea Bay UHB LCFS Team provide LCFS services to CTMUHB and PTHB via an annual SLA. CTM YTD LCFS Days includes an adjustment from figures missing in Q3.
*** Staff Headcount data obtained from Welsh Government Stats Wales website. This is the latest headcount at the time of reporting. The next update is due in May 2025.

1.3 NHS Counter Fraud Authority (NHSCFA)

The WG purchase specialist support services from the NHSCFA for NHS Wales under the terms of an annual SLA. A meeting to review the NHSCFA SLA with WG took place on 19th March 2025 and a workplan and budget was agreed for 2025/26. The NHSCFA provide separate quarterly and annual reports to WG and CFS Wales to account for the specialist services provided to NHS CFS Wales and LCFSs in Wales.

The specialist support services purchased from NHSCFA include the Digital Fraud Unit, Dental Advisor, Fraud Training, Risk Measurement and Quality Assurance Services which are reviewed and monitored via the quarterly reports and six-monthly meetings between NHSCFA, WG and CFS Wales. A NHSCFA senior management representative also attends the NHS Wales Counter Fraud Steering Group (CFSG) Quarterly Meetings.

NHS counter fraud colleagues from England, Northern Ireland, Scotland, and Wales hold a Four Nations Meeting to review counter fraud strategies, workplans and emerging NHS fraud trends and risks. It was agreed that future meetings would be held annually, with the next meeting scheduled for November 2025 in Edinburgh.

2 Proactive Work: Media Reports and Risk Reviews conducted by LCFS during Q4 of 2024/25

The following table summarises some of the pro-active work completed at each health body during Q4 of 2024/25. LCFSs are required to promote successful investigations via media reports on the staff intranet, social media websites and staff newsletters as a deterrent to fraud.

During Q4, the most media reports were generated by BCUHB (18), ABUHB (12) and SBUHB (8). The LCFSs undertook 56 risk reviews in total within their organisations. This work includes fraud proofing policies and Local Pro-active Exercises (LPEs). CTMUHB completed the most risk reviews (13) followed by ABUHB (10) and WAST (8). The quarterly total fluctuates as it is dependent on the reports on ongoing court cases and the CFA, CFS Wales and LCFSs promoting the cases via the media and in newsletters. During 2024/25, there were a total of 289 media reports generated (304 in 2023/24) and 292 risk reviews completed (264 in 2023/24).

Proactive Work / Media Reports & Risk Reviews	Proactive Work Q4		Proactive Work YTD	
	Media Reports*	Risk Reviews	Media Reports	Risk Reviews
Aneurin Bevan UHB	12	10	24	22
Betsi Cadwaladr UHB	18	2	90	20
Cardiff & Vale UHB	4	1	15	12
Cwm Taf Morgannwg UHB	4	13	17	44
DHCW	4	1	10	8
HEIW	4	1	10	8
Hywel Dda UHB	2	5	14	51
NWSSP	1	5	14	18
Powys THB	4	5	22	44
Public Health Wales	4	1	10	8
Swansea Bay UHB	8	3	29	3
Velindre UNHST	4	1	10	8
WAST	3	8	24	46
TOTAL	**72**	**56**	**289**	**292**

2.1 Counter Fraud Presentations and Number of Contacts made to LCFSs requiring advice on fraud related queries during Q4 of 2024/25

The following table summarises the total fraud query contacts made to each health body during Q4 of 2024/25, via telephone calls, MS Teams or email. During Q4, the health body that received the most contacts was Hywel Dda (45), followed by CTMUHB (33) and ABUHB (29). While Powys THB (1), HEIW (4) and DHCW (4) have reported the lowest number of fraud related contacts. The LCFSs received a total of 224 enquiries in Q4 and 1,318 enquiries in 2024/25 (641 in 2023/24).

The table below also summarises the presentations delivered to NHS staff during Q4. ABUHB LCFSs provide online counter fraud video presentations for staff to access during their induction process, while other health boards use virtual presentations formats to raise staff awareness of fraud risks. During Q4 a total of **1,618** staff received 50 fraud awareness presentations in NHS Wales. The highest number of presentations was at SBUHB (9) which were delivered to 161 staff. There were also a considerable number of staff who received presentations at ABUHB (612), HDUHB (218) and HEIW (179). During 2024/25, a total of 236 presentations were made to 7,115 NHS staff. (278 presentations to 6,210 staff in 2023/24)

Contacts / Presentations	Contacts Q4	Presentations Q4			Contacts YTD	Presentations YTD	
		No Conducted	No Staff			No Conducted	No Staff
Aneurin Bevan UHB*	29	4	612		72	19	1326
Betsi Cadwaladr UHB	24	4	78		132	15	255
Cardiff & Vale UHB	25	0	0		144	3	74
Cwm Taf Morgannwg UHB***	33	3	20		119	13	91
DHCW	4	1	24		17	6	148
HEIW**	4	6	179		15	27	1,818
Hywel Dda UHB	45	6	218		525	33	983
NWSSP	15	6	127		101	22	335
Powys THB	1	3	38		17	22	316
Public Health Wales	5	1	70		19	3	175
Swansea Bay UHB	6	9	161		29	46	1,019
Velindre UNHST	5	3	23		19	10	100
WAST	28	4	68		109	17	475
TOTAL	**224**	**50**	**1,618**		**1,318**	**236**	**7,115**

** Includes number of staff who accessed and completed the ABUHB on-line counter fraud induction course.*
*** HEIW staff figures include student nurses who are not directly employed by HEIW but receive bursaries via HEIW.*
**** CTMUHB, presentations YTD figure was overcounted in Q3, corrected at 13 for Q4*
The LCFS induction and presentation data for recent years is available at Appendix 2 for comparison purposes.

3 Counter Fraud Awareness E-Learning Staff Completion Figures 1st January to 31st March 2025

The data below is compiled and provided by health bodies to NWSSP Digital Learning and lists the number of staff at each health body that completed the NHS Wales Counter Fraud E-Learning Module in Q4. The high completion rates at BCUHB (1,368) and Hywel Dda (814) reflect that they have mandated the fraud E-Learning training for staff. The low completion rates at Powys, Velindre, HEIW and C&VUHB are noted, as they have not mandated the training. The high cumulative data for BCU staff (33,296) and HDUHB (16,233) reflects that many of their staff have competed the old and new versions of the training in the relevant period, and some may have also completed the NHS Wales and NHS England versions of the training via ESR.

The NHS Wales Fraud E-Learning module was updated and was re-launched in mid-April 2023. The Welsh language version has been finalised by CFS Wales and NWSSP staff and will be made available in Q1 of 2025/26. During 2024/25, a total of 23,393 staff completed the E-Learning training (17,343 in 2023/24).

Health Body	Staff Completion Q4	Staff Completion YTD	Cumulative March 2015 to 31st March 2025	No of Employees * (As at 30/09/2024)
Aneurin Bevan UHB	975	6,620	15,448	15,504
Betsi Cadwaladr UHB	1,368	9,727	33,296	21,285
Cardiff & Vale UHB	2	23	1,189	17,350
Cwm Taf Morgannwg UHB	10	39	466	13,125
DHCW	22	340	1,311	1,261
HEIW	0	7	26	604
Hywel Dda UHB	814	4,289	16,233	12,119
NWSSP	84	1,073	1,598	6,188
Powys THB	0	2	93	2,634
Public Health Wales	7	46	567	2,558
Swansea Bay UHB	29	214	2,262	14,531
Velindre UNHST	3	4	898	1,836
WAST	247	1,009	7,665	4,379
TOTAL	**3,561**	**23,393**	**81,052**	**113,374**

* *Source: Welsh Govt – Headcount/Staff directly employed as at 30/09/24, data to be updated in May 2025.*

4 NHS CFS Wales Statistics / Operational Outcomes – 1st January to 31st March 2025

The table below summarises the CFS Wales operational data and sanctions secured in Q4. The CFS Wales team were investigating 25 cases at the start of the quarter and were dealing with **28** active cases at the end of Q4 with **6** new referrals received and **3** cases closed during the reporting period.

The **11** active financial investigations currently conducted by CFS Wales listed at Para 4.1 are in addition to the **28** active CFS Wales investigations in the table below. The sanitised list of active CFS Wales investigations is at Appendix 3 for review.

NHS CFS Wales Team (CFS Wales) – Q4 2024/25													
NHS Organisation	No of open cases as at 31/12/2024	No of referrals received	No of cases closed	No of open cases at 31/03/2025	Loss £	Recoveries £	Prevented £	IUCs	Sanctions				
									Criminal			Disciplinary	Civil
									Court Case	Police Caution	Police Community Resolution		
Aneurin Bevan UHB	2	2	1	3	£0	£0	£0	0	0	0	0	0	0
Betsi Cadwaladr UHB	3	1	0	4	£0	£0	£0	0	0	0	0	0	0
Cardiff & Vale UHB*	3	1	0	4	£0	£0	£0	0	0	0	0	0	0
Cwm Taf Morgannwg UHB	6	1	1	6	£0	£120	£0	2	1	0	0	0	0
DHCW	0	0	0	0	£0	£0	£0	0	0	0	0	0	0
Hywel Dda UHB	3	1	0	4	£0	£0	£0	0	0	0	0	0	0
HEIW	0	0	0	0	£0	£0	£0	0	0	0	0	0	0
NWSSP	1	0	1	0	£0	£0	£0	0	0	0	0	0	0
Powys THB	1	0	0	1	£0	£60	£0	0	0	0	0	0	0
Public Health Wales	0	0	0	0	£0	£0	£0	0	0	0	0	0	0
Swansea Bay UHB	6	0	0	6	£0	£12,149	£0	1	0	0	0	0	0
Velindre UNHST	0	0	0	0	£0	£0	£0	0	0	0	0	0	0
WAST	0	0	0	0	£0	£0	£0	0	0	0	0	0	0
TOTAL	**25**	**6**	**3**	**28**	**£0**	**£12,329**	**£0**	**3**	**1**	**0**	**0**	**0**	**0**

Recoveries may include agreed monthly repayments as the civil sanction was previously recorded at the commencement of the repayment plan. *Prevented data was introduced during Q1 2021/22 and follows guidance from NHSCFA on equations for calculating the fraud / non-fraud prevented in the future due to an investigation. The Loss is recorded when the amount has been investigated and quantified.*

NHS CFS Wales Team (CFS Wales) – Cumulative 2024/25														
NHS Organisation	No of open cases as at 01/04/2024	No of referrals received	No of cases closed	No of open cases at 31/03/2025	Loss £	Recoveries £	Prevented £	IUCs	Sanctions				
									Criminal			Disciplinary	Civil
									Court Case	Police Caution	Police Community Resolution		
Aneurin Bevan UHB	2	3	2	3	£7,272	£7,272	£0	0	3	0	0	0	1
Betsi Cadwaladr UHB	4	3	3	4	£0	£0	£0	0	0	0	0	0	0
Cardiff & Vale UHB	7	2	5	4	£87,640	£88,660	£0	1	0	0	0	0	3
Cwm Taf Morgannwg UHB	5	8	7	6	£115,073	£115,193	£0	4	2	0	0	0	1
DHCW	0	0	0	0	£0	£0	£0	0	0	0	0	0	0
Hywel Dda UHB	2	2	0	4	£0	£0	£0	1	0	0	0	0	0
HEIW	0	0	0	0	£0	£0	£0	0	0	0	0	0	0
NWSSP	2	3	5	0	£30,152	£30,152	£3,631	1	0	0	0	0	0
Powys THB	1	0	0	1	£0	£1,120	£0	0	0	0	0	0	0
Public Health Wales	0	0	0	0	£0	£0	£0	0	0	0	0	0	0
Swansea Bay UHB	6	3	3	6	£25,000	£37,149	£0	2	3	0	0	0	0
Velindre UNHST	0	0	0	0	£0	£0	£0	0	0	0	0	0	0
WAST	0	1	1	0	£0	£0	£0	0	0	0	0	0	0
TOTAL	**29**	**25**	**26**	**28**	**£265,137**	**£279,546**	**£3,631**	**9**	**8**	**0**	**0**	**0**	**5**

Recoveries may include agreed monthly repayments as the civil sanction was previously recorded at the commencement of the repayment plan. *Prevented data was introduced during Q1 2021/22 and follows guidance from NHSCFA on equations for calculating the fraud / non-fraud prevented in the future due to an investigation. The Loss is recorded when the amount has been investigated and quantified.*

During 2024/25, CFS Wales received a total of 25 referrals which led to 8 criminal sanctions and 5 disciplinary outcomes, with a total of £279,546 recovered. This compares to 22 referrals with 5 criminal sanctions and 5 disciplinary sanctions with £127,402 recovered in 2023/24.

4.1 NHS CFS Wales Financial Investigations – 1st January to 31st March 2025

Velindre University NHS Trust is a regulatory body under the Proceeds of Crime Act (POCA) 2002. This enables Accredited Financial Investigators (AFI) on the CFS Wales team to conduct financial investigations and restrain and recover funds from convicted persons. CFS Wales currently has two Accredited Financial Investigators (AFI) and three Financial Intelligence Officers (FIO).

The table below indicates the number of active CFSW Wales financial investigations at the end of Q4. These are in addition to the **28** CFS Wales active investigations. These are specialist financial investigations conducted by CFS Wales AFIs to support ongoing CFS Wales and LCFS investigations. In total, 26 FIO enquiries were undertaken by the FIO and AFIs in Q4. FIO enquires can include intelligence checks with financial institutions, Suspicious Activity Reports (SARS) or credit reference checks. During 2024/25, CFS Wales conducted a total of 62 FIO checks, completed 17 investigation orders and 2 POCA confiscation actions.

NHS CFS Wales Financial Investigations - Active Investigations and FIO checks Q4									Cumulative (01.04.24 to 31.03.25)			
Organisation	FIO Checks QTR 4	FI Investigations as at 31/12/24	Referrals	Closures	FI Investigations as at 31/03/25	Q4 Investigation Orders	Q4 POCA Confiscation Hearings	Recoveries Q4	FIO Checks YTD	Investigation Orders YTD	POCA Confiscation Hearings YTD	Recoveries YTD *
Aneurin Bevan UHB	3	1	0	1	0	0	0	£0	4	0	0	£0
Betsi Cadwaladr UHB	1	1	0	0	1	0	0	£0	4	5	0	£0
Cardiff & Vale UHB	2	1	0	0	1	0	0	120	5	1	0	£140
Cwm Taf Morgannwg UHB	5	7	0	4	3	0	0	£0	12	3	0	£145
DHCW	0	0	0	0	0	0	0	£0	0	0	0	£0
Hywel Dda UHB	3	3	0	1	2	0	0	£0	5	0	0	£0
HEIW	0	0	0	0	0	0	0	£0	0	0	0	£0
NWSSP	0	1	0	1	0	0	0	£0	2	0	0	£0
Powys THB	0	1	0	1	0	0	0	£60	1	0	0	£240
Public Health Wales	0	0	0	0	0	0	0	£0	0	0	0	£0
Swansea Bay UHB	12	4	1	1	4	4	1	£12,149	24	5	2	£12,149
Velindre UNHST	0	0	0	0	0	0	0	£0	1	0	0	£0
Welsh Ambulance NHST	0	2	0	2	0	0	0	£0	4	3	0	£0
TOTAL	**26**	**21**	**1**	**11**	**11**	**4**	**0**	**£12,329**	**62**	**17**	**2**	**£12,674**

5 LCFS Statistics / Operational Outcomes – 1st January to 31st March 2025

The table below summarises the NHS Wales LCFS operational data and sanctions secured in Q4 of 2024/25. The LCFSs were investigating a total of 147 cases at the start of the quarter, 85 new referrals were reported with 94 cases closed and 3 cases transferred to CFS Wales during the reporting period, leaving a total of 135 cases under LCFS investigation on 31st March 2025.

The LCFS investigations secured 7 civil sanctions and 11 disciplinary outcomes in Q4, with recoveries of £89,773 for NHS Wales. HDUHB recovered £34,884 while WAST recovered £31,996. During Q4, the LCFS' conducted 18 Interviews Under Caution (IUCs). The LCFS data for fraud prevented has been included for Q4; CVUHB prevented £24,372 and WAST prevented £22,345.

BCUHB & WAST have the highest number of active investigations with 28 and 22 open cases respectively at the end of Q4, while SBUHB (20) and ABUHB (19) have the next highest number of open investigations. ABUHB (15) had the highest number of new referrals during Q4 followed by HDUHB (14) and SBUHB (12). BCUHB closed the highest number of cases in Q4 with 18, followed by HDUHB (15) and ABUHB (13).

During 2024/25, the cumulative table at page 14 confirms that ABUHB had the highest number of referrals (58), closely followed by HDUHB (55), SBUHB (43) and WAST (43). SBUHB LCFSs secured 3 criminal convictions while ABUHB recovered the highest amount (£165,881) followed by WAST (£150,885).

SBUHB conducted the highest number of interviews under caution in 2024/25 (20 IUCs), followed by ABUHB (9 IUCs) and HDUHB (7 IUCs).

There is a sanitised list of active LCFS investigations at NHS Wales health bodies at **Appendix 4.**

A sanitised list of the CFS Wales and LCFS investigations closed during Q4 is included at **Appendix 5.**

Local Counter Fraud Specialists in NHS Wales – Q4 2024/25														
NHS Organisation	No of open cases at 31/12/24	No of referrals received	No of cases closed	Cases transferred to CFS Wales	No of open cases at 31/03/25	Loss £	Recoveries £	Prevented £	IUCs	Sanctions				
										Criminal			Disciplinary	Civil
										Court Case	Police Caution	Police Community Resolution		
Aneurin Bevan UHB	19	15	13	2	19	£609	£609	£0	2	0	0	1	4	2
Betsi Cadwaladr UHB	36	10	18	0	28	£12,000	£0	£0	1	0	0	0	2	0
Cardiff & Vale UHB	11	7	5	0	13	£15,787	£15,787	£24,372	0	1	0	0	1	1
Cwm Taf Morgannwg UHB	11	10	7	0	14	£0	£0	£0	1	0	0	0	0	0
DHCW	1	0	0	0	1	£0	£0	£0	0	0	0	0	0	0
Hywel Dda UHB	12	14	15	0	11	£34,884	£34,884	£0	2	0	2	0	0	2
HEIW	0	0	0	0	0	£0	£0	£0	0	0	0	0	0	0
NWSSP	6	2	7	0	1	£0	£0	£0	0	0	0	0	0	0
Powys THB	5	4	3	0	6	£0	£0	£0	1	0	0	0	0	0
Public Health Wales	2	0	2	0	0	£0	£0	£0	0	0	0	0	0	0
Swansea Bay UHB	20	12	11	1	20	£9,292	£6,297	£1,554	11	0	0	0	0	2
Velindre University UNHST	0	1	1	0	0	£200	£200	£0	0	0	0	0	1	0
WAST	24	10	12	0	22	£31,996	£31,996	£22,345	0	0	0	0	3	0
TOTAL	**147**	**85**	**94**	**3**	**135**	**£104,768**	**£89,773**	**£48,271**	**18**	**1**	**2**	**1**	**11**	**7**

Recoveries may include agreed monthly repayments as the civil sanction was previously recorded at the commencement of the repayment plan. *Prevented data was introduced during Q1 2021/22 and follows guidance from NHSCFA on equations for calculating the fraud / non-fraud prevented in the future due to an investigation. The Loss is recorded when the amount has been investigated and quantified. Therefore, the loss figure may be less than recoveries reported, as these figures may not be reported in same financial period.*

Local Counter Fraud Specialists in NHS Wales – Cumulative 2024/25															
NHS Organisation	No of open cases as at 01/04/24	No of referrals received	No of cases closed	Cases transferred to CFS Wales	No of open cases at 31/03/2025	Loss £	Recoveries £	Prevented £	IUCs	Sanctions				
										Criminal			Disciplinary *	Civil*
										Court Case	Police Caution	Police Community Resolution		
Aneurin Bevan UHB	28	58	65	2	19	£165,881	£165,881	£31,476	9	0	0	1	7	17
Betsi Cadwaladr UHB	23	40	35	0	28	£12,000	£0	£0	1	0	0	0	3	0
Cardiff & Vale UHB	15	42	43	1	13	£57,174	£56,844	£97,338	2	1	0	0	6	5
Cwm Taf Morgannwg UHB	14	29	27	2	14	£22,780	£17,794	£0	3	0	0	0	2	1
DHCW	1	2	2	0	1	£0	£0	£0	0	0	0	0	10	0
Hywel Dda UHB	12	55	55	1	11	£56,107	£56,107	£0	7	1	3	0	2	7
HEIW	0	0	0	0	0	£0	£0	£0	0	0	0	0	0	0
NWSSP	7	6	11	1	1	£11,475	£11,475	£0	0	0	0	0	0	0
Powys THB	12	10	16	0	6	£120	£120	£0	3	0	0	0	0	1
Public Health Wales	1	1	2	0	0	£0	£0	£0	0	0	0	0	0	0
Swansea Bay UHB	22	43	41	4	20	£52,654	£36,110	£2,947	20	3	0	0	1	4
Velindre UNHST	1	2	3	0	0	£5,775	£5,775	£0	0	0	0	0	1	0
WAST**	30	43	50	1	22	£153,998	£150,885	£30,145	6	0	0	0	5	9
TOTAL	**166**	**331**	**350**	**12**	**135**	**£537,964**	**£500,991**	**£161,906**	**51**	**5**	**3**	**1**	**37**	**44**

Recoveries may include agreed monthly repayments as the civil sanction was previously recorded at the commencement of the repayment plan. *Prevented data was introduced during Q1 2021/22 and follows guidance from NHSCFA on equations for calculating the fraud / non-fraud prevented in the future due to an investigation. The Loss is recorded when the amount has been investigated and quantified. Therefore, the loss figure may be less than recoveries reported, as these figures may not be reported in same financial period.*

***The total Disciplinary and Civil figures for WAST were incorrectly reported in Q3. These have now been corrected.*

6 Working in Partnership

CFS Wales and Lead LCFSs have previously reviewed the Audit Wales reports on counter fraud resources in the public sector in Wales. The reports were tabled at Audit Committees with a response plan agreed for each health body. CFS Wales has recently contributed to the LCFS response to the new CFA LPE on procurement fraud and a co-ordinated response plan for NHS Wales is under review via joint work with CFS Wales and the LCFSs at NWSSP and HDUHB.

CFS Wales has ensured that all risk alerts and updates were swiftly circulated to key stakeholders and routinely share counter fraud articles or documents with LCFS colleagues. CFS Wales staff, LCFSs and NHS CFA staff work closely together and often jointly attend meetings with key stakeholders, e.g., CFSG or PPV meetings and jointly progress suitable reactive investigations or proactive projects. During Q4, CFS Wales staff attended virtual meetings with WG, NWSSP, NHSCFA, PPV, Lead LCFSs, CFSG Sub-Groups, Audit Wales and CPS. The Counter Fraud Task & Finish Group Chaired by the ABUHB DOF met in Q4 and will report on their progress on the key action points from the LCFS Strategic Review Process to the Counter Fraud Steering Group (CFSG) on 14th May 2025. The newly formed Counter Fraud Liaison Group (CFLG) which consists of CFS Wales Heads and Lead LCFSs met on two occasions in Q4. The CFLG is currently Chaired by the WAST Lead LCFS. The group meet every six weeks to share good practice, intelligence on crime trends and identify emerging risks to NHS Wales. The next full LCFS Training Forum is scheduled to be held on 15th May 2025.

CFS Wales staff piloted Clue, the new case management system (CMS) which replaced FIRST the old NHSCFA CMS which had been in use for fifteen years. All counter fraud staff in NHS Wales are now using Clue, which is a marked improvement on the old FIRST CMS system.

The following table indicates the operational outcomes combined for CFS Wales and LCFSs for the 5-year period 1st April 2020 to 31st March 2025.

A total of 1,362 referrals have been investigated in the five-year period which have led to 59 criminal sanctions (including PCRs*), 253 civil recoveries and 194 disciplinary outcomes which have secured a total of £4,198,141 in financial recoveries for NHS Wales. The combined number of 356 referrals received in 2024/25 is a reduction when compared to 2023/24 (411 referrals) while the amount recovered in 2024/25 (£780,538) is an increase on the amount recovered in 2023/24 (£672,250). During 2024/25, 17 criminal sanctions, 49 civil recoveries and 37 disciplinary outcomes were secured.

The slight increase in criminal sanctions and secured recoveries in 2024/25 is noted. The criminal sanctions continue to be impacted by the backlog in the criminal justice system, especially when compared to the number of successful civil and disciplinary outcomes secured under the parallel sanctions policy.

	NHS CFS Wales and LCFS Sanctions April 2020 to March 2025					
	Referrals	Recoveries	Sanctions			
			Criminal	PC and PCR *	Civil	Disciplinary
2020/2021	125	£1,174,171	9	1	30	22
2021/2022	199	£592,993	5	1	44	54
2022/2023	271	£978,189	11	2	66	41
2023/2024	411	£672,250	12	1	64	40
2024/2025	356	£780,538	13	4	49	37
TOTAL	**1,362**	**£4,198,141**	**50**	**9**	**253**	**194**

* Police Community Resolution (PCR) was introduced in 2020/21 and included as a criminal sanction like a Police Caution (PC).

NHS Wales Counter Fraud Resources 2014/15

NHS Wales Local Counter Fraud Provision 2014/15				
Health Body	Resource Allocation (LCFS days)	LCFS WTE	Admin Support WTE	Budgeted Salary Cost
Abertawe Bro Morgannwg	559	2.6	0.10	£110,096
Aneurin Bevan	602	2.8	1.00	£122,902
Betsi Cadwaladr	645	3	0.50	£156,822
Cardiff & Vale	387	1.8	0.25	£83,512
Cwm Taf	215	1.0	0.50	£61,977
Hywel Dda	201	0.9	0.00	£57,900
Powys	92	0.4	0.00	£23,704
Public Health Wales	107.5	0.5	0.00	£25,000
Velindre / NWSSP	150.5	0.7	0.25	£47,600
Welsh Ambulance	125	0.6	0.00	£25,968
TOTAL	**3084**	**14.3**	**2.60**	**£715,481**
NHS CFS Wales Regional Team	1032	4.8	1	£234,996
ALL WALES TOTAL	**4116**	**19.1**	**3.6**	**£950,477**

NHS Wales LCFS Fraud Awareness Presentations and Induction Sessions, 2021/22, 2022/23 & 2023/24

2021/22	Inductions		Presentations		Total Staff 2021/22	Staff Headcount (at 31/12/21)
	No Conducted	No Staff	No Conducted	No Staff		
Aneurin Bevan UHB	On-Line	839*	11	275	1,114	14,471
Betsi Cadwaladr UHB	0	0	5	85	85	19,610
Cardiff & Vale UHB	0	0	9	125	125	16,021
Cwm Taf Morgannwg	0	0	10	45	45	12,726
DHCW	0	0	2	30	30	926
HEIW	5	36	2	44	80	423
Hywel Dda UHB	0	0	25	576	576	11,188
NWSSP	0	0	13	261	261	2,516
Powys THN	12	133	19	45	178	2,297
Public Health Wales	2	30	13	49	79	4,688
Swansea Bay UHB	0	0	65	1,004	1,004	13,368
Velindre NHST	0	0	4	28	28	1,420
Welsh Ambulance NHST	7	201	14	233	434	4,180
TOTALS	**26**	**1,239**	**192**	**2,800**	**4,039**	**103,834**

* *Number of staff who accessed/completed the on-line CF induction*

2022/23	Inductions		Presentations		Total Staff 2022/23	Staff Headcount (at 31/12/2022)
	No Conducted	No Staff	No Conducted	No Staff		
Aneurin Bevan UHB	On-line	451	2	32	1701	14,664
Betsi Cadwaladr UHB	0	0	3	60	401	20,251
Cardiff & Vale UHB	0	0	7	20	310	16,465
Cwm Taf Morgannwg	0	0	9	122	204	12,858
DHCW	5	92	6	9	227	1,065
HEIW	0	0	6	10	350	466
Hywel Dda UHB	0	0	8	205	885	11,543
NWSSP	0	0	3	80	527	5,538
Powys THN	3	41	4	288	513	2,577
Public Health Wales	0	0	7	20	40	2,237
Swansea Bay UHB	0	0	14	46	591	13,613
Velindre NHST	0	0	6	0	38	1,637
Welsh Ambulance NHST	3	30	1	2	437	4,081
TOTALS	**11**	**614**	**76**	**894**	**6224**	106,995

2023/24	Contacts made to LCFSs*	Presentations		Staff Headcount (at 31/03/2024)
		No Conducted	No Staff	
Aneurin Bevan UHB	35	15	1270	15,410
Betsi Cadwaladr UHB	64	14	230	21,283
Cardiff & Vale UHB	92	36	457	17,247
Cwm Taf Morgannwg	17	16	143	12,991
DHCW	2	22	333	1,244
HEIW	7	29	1,307	542
Hywel Dda UHB	278	32	781	12,179
NWSSP	56	18	432	5,766
Powys THB	5	5	235	2,582
Public Health Wales	11	17	280	2,425
Swansea Bay UHB	20	47	527	14,322
Velindre NHST	2	20	99	1,781
Welsh Ambulance NHST	52	7	116	4,333
TOTALS	**641**	**278**	**6,210**	**112,105**

**From Q2 of 2023/24, all LCFSs agreed to include how many contacts were made in each quarter that required a response via specialist fraud advice.*

Summary of CFS Wales Cases Open at 31st March 2025

No.	Case No	Health Body	Case Start Date	Subject	Potential Offences
1	INV/25/00725	Cwm Taf Morgannwg UHB	12/03/2025	GP Practice	Inflation of claims
2	INV/25/00978	Hywel Dda UHB	28/03/2025	NHS Employee	Overpayment of Salary/Abuse of Position
3	INV/25/00565	Cardiff and Vale UHB	25/02/2025	NHS Employee	Computer Misuse & Fraud by Misrepresentation
4	INV/25/00482	Aneurin Bevan UHB	19/02/2025	GP Pensions	Fraud by False Representation
5	INV/25/00220	Betsi Cadwaladr UHB	16/01/2025	Dentist	Fraud by Misrepresentation
6	INV/24/03178	Swansea Bay UHB	11/12/2024	HCSW	Fraud by False Representation
7	INV/24/03217	Cwm Taf Morgannwg UHB	16/12/2024	Care Home Recruitment	Abuse of Position
8	INV/24/02922	Cwm Taf Morgannwg UHB	15/11/2024	Estate staff	Bribery & Corruption
9	INV/24/02786	Betsi Cadwaladr UHB	01/11/2024	Nandita PARMAR	Failing to disclose
10	INV/24/02405	Hywel Dda UHB	27/09/2024	NHS Pharmacy Contractor	Fraud by False Representation
11	INV/24/02035	Swansea Bay UHB	12/08/2024	NHS employee	Theft / Money Laundering
12	INV/24/02025	Cwm Taf Morgannwg UHB	12/08/2024	Consultant	Theft / Money Laundering
13	INV/24/01812	Cwm Taf Morgannwg UHB	16/07/2024	NHS Employee	Money Laundering
14	INV/24/01509	Cardiff and Vale UHB	14/06/2024	Pharmacist	Fraud
15	INV/24/01395	Swansea Bay UHB	30/05/2024	NHS Dental Contractor	Fraud by False Representation
16	INV/24/01065	Cwm Taf Morgannwg UHB	25/04/2024	NHS Employee	Theft/Money Laundering
17	INV/24/00295	Betsi Cadwaladr UHB	06/02/2024	NHS Manager	Fraud by Abuse of Position
18	INV/23/02303	Swansea Bay UHB	16/10/2023	Fraudulently obtained CBT result	Fraud
19	INV/23/01970	Powys Teaching LHB	27/09/2023	Health care support worker	Theft / Money Laundering
20	INV/23/01736	Cardiff and Vale UHB	17/08/2023	Health Care Support Worker (Ex employee)	Theft / Money Laundering
21	INV/23/01610	Aneurin Bevan UHB	02/08/2023	Nurse-failing to declare receipt of 2 salaries while on secondment	Theft & Money Laundering
22	INV/23/00355	Swansea Bay UHB	15/02/2023	Practice Manager	Fraud by abuse of position / money laundering / theft
23	INV/22/01725	Hywel Dda UHB	21/11/2022	GP Practice Manager	Fraud by Abuse of Position /Theft/ Money Laundering
24	INV/22/01542	Betsi Cadwaladr UHB	02/12/2022	Senior Managers / Contractors	Misconduct in Public Office/Fraud by Abuse of Position

25	INV/22/00474	Swansea Bay UHB	01/04/2022	GP Practice Manager	Fraud by False Representation/Money Laundering
26	INV/21/00414	Hywel Dda UHB	13/01/2022	Senior Nurse/Manager	Fraud by Failing to Disclose
27	INV/21/00252	Cardiff and Vale UHB	28/09/2021	Overpayment of Salary	Theft/Money Laundering
28	WARO/18//00164	Aneurin Bevan UHB	15/11/2018	Dentist	Fraud by False Representation

Summary of LCFS Cases Open at 31st March 2025

No.	Case No	Health Body	Date Opened	Subject	Offence	Case Summary
1	INV/25/00904	Aneurin Bevan UHB	25/03/2025	Care Home Provider	Illegal working	To be closed Q1 - Home Office issue/intel shared, company not contracted to ABUHB
2	INV/25/00849	Aneurin Bevan UHB	19/03/2025	Nurse	Not working contracted hours/claiming for shifts not worked	Investigation ongoing
3	INV/25/00848	Aneurin Bevan UHB	19/03/2025	Patient	Prescription Fraud	Investigation ongoing
4	INV/25/00847	Aneurin Bevan UHB	19/03/2025	Nurse	Timesheet Fraud and shift allocation	Investigation ongoing
5	INV/25/00819	Aneurin Bevan UHB	19/03/2025	Nurse	Timesheet fraud	Investigation ongoing
6	INV/25/00508	Aneurin Bevan UHB	19/02/2025	Facilities Staff	Working while sick/secondary employment	Investigation ongoing
7	INV/25/00329	Aneurin Bevan UHB	05/02/2025	Facilities Staff	Working while sick/secondary employment	Investigation ongoing
8	INV/24/03222	Aneurin Bevan UHB	16/12/2024	NHS Staff	Not completing contracted hours	Investigation ongoing
9	INV/24/03033	Aneurin Bevan UHB	27/11/2024	Nurse	Theft/misuse of HP10HPs	Joint investigation with Gwent Police
10	INV/24/02857	Aneurin Bevan UHB	11/11/2024	Patient	Selling GP prescribed weight loss medication	Investigation ongoing
11	INV/24/02846	Aneurin Bevan UHB	08/11/2024	NHS Staff	Employee Fraud (other)	Investigation ongoing
12	INV/24/01290	Aneurin Bevan UHB	21/05/2024	Admin	Covid Mass-Vaccination salary overpayment	Investigation ongoing
13	INV/24/01205	Aneurin Bevan UHB	13/05/2024	Nurse	Salary Overpayment	Investigation ongoing
14	INV/24/01199	Aneurin Bevan UHB	13/05/2024	NHS Staff	Salary Overpayment	Investigation ongoing
15	INV/24/00944	Aneurin Bevan UHB	16/04/2024	Facilities Staff	Breach of leave policy	Investigation ongoing
16	INV/24/00857	Aneurin Bevan UHB	05/04/2024	NHS Staff	Unauthorised access to Omnicell	Investigation ongoing
17	INV/23/02427	Aneurin Bevan UHB	27/10/2023	HCSW	Salary Overpayment	Investigation ongoing
18	INV/23/01521	Aneurin Bevan UHB	28/07/2023	NHS Staff	Timesheet Fraud	Investigation ongoing
19	INV/23/01520	Aneurin Bevan UHB	28/07/2023	NHS Staff (Nurse)	Salary Sacrifice/non-payment (lease vehicle)	Investigation ongoing

No.	Case No	Health Body	Date Opened	Subject	Offence	Case Summary
1	WARO/18/00010	Betsi Cadwaladr UHB	15/01/2018	Consultant / Surgeon (NHS)	Working elsewhere whilst sick	Subject had received a warning from the GMC, worked under supervision. Enquiries show he had been working as a Locum elsewhere whilst sick and when contracted to BCU. Since resigned from BCU. IUC carried out, suspect admitted working whilst sick and offered to pay monies back. Repayment offer of £4k made which was rejected as sick is £6k+ alone. Continual contact with Solicitor. Response finally received and negotiations ongoing, but subject is suffering with illness. Complaint made to legal firm re lack of response. Invoice for £6k now sent direct to subject by recorded delivery.
2	INV/22/01489	Betsi Cadwaladr UHB	17/10/2022	Nurse (NHS)	Working while sick	Allegation that whilst on paid sick leave at BCU, Subject undertook Agency work. Subject failed to engage and didn't attend sickness reviews. Subject resigned from BCUHB; thus, disciplinary process not progressed. LCFS enquiries revealed that Subject submitted resignation prior to working elsewhere but failed to work notice period. Letters from W&OD and supervisor appear to have been sent to incorrect address. Civil recovery to be arranged for unworked notice period. W&OD now arranged for notice period to be recorded as unauthorised absence and recharge invoice calculated before sending to Subject. Consideration for closure.
3	INV/22/01490	Betsi Cadwaladr UHB	17/10/2022	GP Practice Manager	Diversion of GP Practice funds	Inquiries with GP Practice found irregularities in salary and bonus payments to Subject, their Practice Manager. Further issues found with Petty Cash and reimbursement of unknown expenditure to Subject, who was dismissed for Gross Misconduct. Various meetings and visits to GP Practice. Extensive review of financial records, NHS Finance, suppliers and witness statements received, led to a recent IUC of the Subject. File preparation for CPS started.
4	INV/23/02290	Betsi Cadwaladr UHB	13/10/2023	Substance Misuse Practitioner	Employee Fraud - Travel / Subsistence, misuse of NHS vehicle	Manager reported staff member who attended at workplace in weekends to use NHS vehicle without authorisation. Concerns with use of vehicle privately for family whilst not insured (only business use) and use of company fuel card. LCFS instructed that a parallel internal disciplinary investigation should commence. Witness statement of Manager received. Meeting

						held with manager revealed Disciplinary Panel concluded in April with outcome Final Written Warning on file for 24 months. Civil recovery not actioned; manager provide backing information for calculation. Invoice is sent to Subject. Consideration for closure
5	INV/23/02932	Betsi Cadwaladr UHB	20/12/2023	Nurse (NHS)	Employee Fraud - Other / Identity, declaration and potential counterfeit documents	W&OD referral, Nurse recruited from overseas is in possession of two birth certificates with different DOB. She admitted the later DOB is correct. She had applied and was recruited on the birth certificate with the earlier DOB in line with ID papers she had shown. Concerns that the person attending for Nurse duties is not the actual person recruited. Evidential paperwork received. Nurse dismissed from her BCUHB role, upheld on appeal. VISA sponsorship cancelled and Subject reported to UKVI. Nurse is also reported to the NMC.
6	INV/24/00244	Betsi Cadwaladr UHB	31/01/2024	GP Managed Practice staff	Employee Fraud - Other / Leave Entitlement Fraud	Allegation that GPs of a managed practice have been allowed to take annual leave over their entitlement the last two years. Staff other than GPs record their leave on ESR, leave for GPs is still recorded on paper records.. Meeting to be arranged with PCC / Cluster Lead for Managed Practices to discuss the system weakness and if evidence of deliberate overtaking of leave by the Subject is present.
7	INV/24/00360	Betsi Cadwaladr UHB	14/02/2024	Community Pharmacist	Pharmaceutical / Dispensing Fraud - reissued medicines	Anonymous allegation that the owner of Community Pharmacies is returning uncollected patient medication on the shelf and is endorsing NHS Prescriptions to branded, to receive higher reimbursement for dispensed drugs. LCFS requested NWSSP-PCS to undertake an audit review over a 4-month period to identify any endorsed and submitted NHS Prescriptions for higher payment. Report on the targeted review of prescriptions found no evidence of fraud. Consideration for closure
8	INV/24/00539	Betsi Cadwaladr UHB	05/03/2024	Nurse (NHS)	Employee Fraud - Other / Non declaration of financial gift	Anonymous allegation that a staff member had received donations from family at a BCUHB hospital and from staff for a X-mas party which she had not declared. Contact made with Finance and Charitable Funds. Name of the staff member handing over cash and cheques to Charitable Funds is not recorded on registers. Meeting held with Matron found that allegation

						may be incorrect, X-mas parties are paid for by staff and not using donations. No historic or current conduct concerns with Subject.
9	INV/24/01084	Betsi Cadwaladr UHB	29/04/2024	Patient (GMS)	NHS Patients - Misuse of prescriptions / NHS services	Allegation received that a female patient is using two names to access NHS medication, care and treatment. Enquiries started with GP Practice and turned out that female changed her name by deed poll leading her to be issued a second NHS Ref No and Hospital No in her new name. Records show that patient is often moving GP Practices and registration. Patient suffers from MH issues, might depend on Diazepam and is pregnant. LCFS requested the vast patient records to be scrutinised and corrected. Discussion to be held with Senior Management on how to proceed, and decision if Subject's actions relate to her MH or are considered criminal.
10	INV/24/01410	Betsi Cadwaladr UHB	03/06/2024	General Practitioner	GP Practice - Diversion of global sum	Primary Care Contracting reported an allegation received from a former GP Practice staff member that annual pay uplifts had not been paid by her former employer, a single-handed GP Practice, contrary to WG arrangements in place. This had been going on for several years. PCC forwarded information letters and e-mails sent to all GMS contractors to ensure to pay staff at uplifted salary pay through their increased Global Sum payments and statement provided. Two staff members from the GP Practice identified. Contact to be made to meet and confirm allegation with their statements.
11	INV/24/01570	Betsi Cadwaladr UHB	20/06/2024	NHS Social Worker	Working while sick	Anonymous allegation that a Social Worker is working and receiving cash in hand whilst recorded on paid sick leave at the Health Board. Subject is also claiming benefits from DWP it is further alleged. Enquiries started, but cash in hand payments might be difficult to prove. Subject is not a Social Worker, but a Ward Clerk. ESR checks show that the Subject was on unpaid unauthorised leave between 30/5 and 11/8 in 2024, therefore no financial gain. Consideration for closure
12	INV/24/01619	Betsi Cadwaladr UHB	25/06/2024	GP Practice staff	Employee Fraud - Other / Theft of medication drugs	Anonymous allegation that a staff member of a GP Practice is stealing NHS medication drugs from her employer and selling on to others from outside her home. GP Practice where Subject

						works is not named. Home address of Subject provided. Enquiries made and LCFS has informed CDLO at North Wales Police. Reply from NWP is awaited as well as enquiries with GP practice regarding any medication errors, pharmacy stock discrepancies or previous issues regarding staff member.
13	INV/24/01662	Betsi Cadwaladr UHB	01/07/2024	Consultant / Surgeon (NHS)	Employee Fraud - Other / Switching Private to NHS patients and DVLA Medical Tests	Concerns raised that Subject a Consultant is allowing his Private Patients preferential urgent NHS access without correct paperwork which may constitute as jumping the queue leading to potential financial loss to the NHS when not charged private. Subject is also accused of putting himself forward for DVLA requests for private medical assessments. Meetings held with Senior Management found actions of Subject might be unintentional. System weaknesses identified which led to SOPs created.
14	INV/24/02079	Betsi Cadwaladr UHB	19/08/2024	Health Care Assistant	Timesheet / overtime fraud	Allegation that an HCA has falsely claimed a bereavement event in order to take special leave. Subject is identified and enquiries seem to point to one day special leave for a bereavement and subject now having left the NHS which requires confirmation.
15	INV/24/02123	Betsi Cadwaladr UHB	28/08/2024	Doctor GP	General Practitioner - Self Prescribing	Allegation that a GP was self-prescribing and to friends/relatives. The prescriptions were issued, printed and cancelled. Subject was dismissed and no longer works for the GP Practice. Enquiries found that Subject works as a Locum GP at a BCUHB Managed Practice. Executive Medical Director is informed. GMS is aware and are in contact with LCFS. Audit conducted by BCUHB is shared with LCFS. GP Practice forwarded records on patients and actions from Subject on their patient system for LCFS to review and distinguish if prescriptions issued were presented, with requesting evidence of scanned images of these scripts.
16	INV/24/02148	Betsi Cadwaladr UHB	28/08/2024	NHS Staff (IM&T)	Employee Fraud - Nepotism/recruitment concerns employing spouses	Anonymous allegation that Managers have appointed their wives to work with them in the same department. It is alleged that they have acted unethically in order to create posts for their wives. Several staff mentioned. DoI forms are checked. Enquiries ongoing to check recruitment process with W&OD. It was found that TRAC

						records and interview notes are kept for a short term and may no longer be available.
17	INV/24/02614	Betsi Cadwaladr UHB	16/10/2024	NHS Staff (SBRI)	Employee Fraud - Recruitment and breach of procurement concerns	Anonymous accusation that a Department Head has abused their position by recruiting a friend to work on projects and offered incentives to private businesses. Individual identified and matter discussed with Associate Director for W&OD. Full details of the accusation shared and enquiries to find if there is any substance to the allegation is ongoing.
18	INV/24/02925	Betsi Cadwaladr UHB	18/11/2024	Pharmacy Technician	Employee Fraud - Working whilst sick	Anonymous allegation that a Pharmacy Technician is working for her own business whilst on paid sick leave. Subject is identified and has returned to work at BCUHB. Additional intelligence shared with LCFS. Enquiries are ongoing.
19	INV/24/03141	Betsi Cadwaladr UHB	06/12/2024	NHS Staff (Medical Secretary)	Employee Fraud - Working whilst sick	Anonymous allegation that a Medical Secretary who is on paid sick leave at BCUHB is working for her own business. Enquiries started, Subject identified, Companies House and Facebook found the business. No DoI was made. Absence recording shows that Subject is back in work. Meeting to be arranged with Line Management and W&OD.
20	INV/25/00150	Betsi Cadwaladr UHB	21/01/2025	Consultant / Surgeon (NHS)	Employee Fraud - Other / Secondary Employment	Anonymous allegation that two Doctors, are not meeting their contractual NHS obligations by recording multiple YouTube videos each day in NHS uniform.. Initial checks conducted on YouTube and account is active, but no videos of concern noted. Although DoI this shows as zero declaration. Meeting to be arranged with Clinical Director.
21	INV/25/00302	Betsi Cadwaladr UHB	04/02/2025	Health Care Assistant	Employee Fraud - Other / Falsifying sick notes	HCA believed to have submitted an altered/false sickness note to cover period of absence before moving to another role in BCUHB where he attempted to submit a similar note to cover absence. Subject has since resigned from BCUHB. Enquiries ongoing, copies of sick notes recovered, witnesses identified and arrangements for statement recording, then IUC to be conducted.
22	INV/25/00399	Betsi Cadwaladr UHB	12/02/2025	Radiographer	Employee Fraud - Working whilst sick	Anonymous allegation that Subject is running a business during long term sickness. Subject has resigned from BCUHB. Companies House checks revealed Subject as Director for the company. ESR checks identified the staff

						member and her recorded sickness. Checks to be conducted on nature of sickness, amount of paid sick leave and any DoI.
23	INV/25/00431	Betsi Cadwaladr UHB	13/02/2025	Supplier	NHS Supplier Fraud - Post Contract-Duplicate Invoices	A duplicate purchase invoice was received from a supplier. Appears goods on the original invoice were never received. Enquiries revealed that the supplier had gone into liquidation. Bank account used raised suspicion. BCUHB LCFS to conduct initial enquiries and liaise with CFS Wales FIO to transfer case if appropriate.
24	INV/25/00545	Betsi Cadwaladr UHB	25/02/2025	NHS Staff (W&OD)	Employee Fraud - Breach of procurement concerns	Anonymous allegation that a Senior Manager at BCUHB has outsourced activities to a supplier and may be breaching procurement rules in place. Previous association with the supplier may constitute corruption. Enquiries show no direct line between employee and supplier, past and present. No evidence to support the allegation as named company have a long history of work with BCUHB and this was in place well before subject started at BCUHB. Consideration for closure
25	INV/25/00629	Betsi Cadwaladr UHB	03/03/2025	Consultant / Surgeon (NHS)	Employee Fraud - Other / Potential Bribery	Anonymous allegation that Subject is carrying out Locum work during NHS contracted time. The allegation also speaks of potential bribes from another doctor who is Subject's line manager and a person who cannot be identified. Initial enquiries have started and are ongoing.
26	INV/25/00648	Betsi Cadwaladr UHB	05/03/2025	Patient (GMS)	NHS Patient Fraud - Misuse of prescriptions	Anonymous allegation that a named individual is selling Heroin and prescription medication such as Pregabalin. Enquiries identified the NHS patient and registered address. GP Practice instructed to conduct a patient medication review. Subject selling on drugs is shared and forwarded to CDLO at North Wales Police. Case considered for closure
27	INV/25/00667	Betsi Cadwaladr UHB	06/03/2025	Health Care Support Worker	Employee Fraud - Study Leave during college closure	Anonymous allegation that a HCSW is claiming study leave including when the college he is attending is closed i.e. half-term. Meeting held with Manager who confirms Subject is studying, funded by BCUHB and time off provided, at a local college. Matron to forward learning agreement in place. Contact to be made with the Course Facilitator for term times. Case may be considered for closure
28	INV/25/00766	Betsi Cadwaladr UHB	20/03/2025	Nurse (NHS)	Employee Fraud - Working whilst sick	Anonymous report that a named Nurse and Subject, employed by BCUHB, went abroad on holiday for surgery during paid sickness, posting

						the results on social media. Checks reveal four nurses with the same name working at BCUHB. Enquiries ongoing to try identifying the individual and decide if Fraud has taken place as at present appears to be a W&OD matter.
No.	**Case No**	**Health Body**	**Date Opened**	**Subject**	**Offence**	**Case Summary**
1	INV/23/00825	Cardiff and Vale UHB	02/05/2023	Employee	Theft	Referred to CCI
2	INV/23/01634	Cardiff and Vale UHB	03/08/2023	Employee	Theft	Pending civil legal action
3	INV/23/02002	Cardiff and Vale UHB	15/09/2023	Employee	Theft	Pending CPS advice
4	INV/24/00462	Cardiff and Vale UHB	21/02/2024	Employee	Fraud	Pending CPS advice
5	INV/24/01972	Cardiff and Vale UHB	02/08/2024	Employee	Fraud	Awaiting disciplinary outcome
6	INV/24/02795	Cardiff and Vale UHB	04/11/2024	Employee	Fraud	Under investigation
7	INV/24/03059	Cardiff and Vale UHB	29/11/2024	Employee	Theft	Under investigation
8	INV/24/03132	Cardiff and Vale UHB	06/12/2024	Employee	Fraud	Under investigation
9	INV/25/00121	Cardiff and Vale UHB	15/01/2025	Employee	Cyber	Under investigation
10	INV/25/00253	Cardiff and Vale UHB	29/01/2025	Employee	Fraud	Under investigation
11	INV/25/00286	Cardiff and Vale UHB	03/02/2025	Employee	Fraud	Awaiting disciplinary outcome
12	INV/25/00720	Cardiff and Vale UHB	11/03/2025	Employee	Theft	Under investigation
13	INV/24/03145	Cardiff and Vale UHB	09/12/2024	Employee	Theft	Under investigation
No.	**Case No**	**Health Body**	**Date Opened**	**Subject**	**Offence**	**Case Summary**
1	WARO/20/00032	Cwm Taf Morgannwg UHB	04/03/2020	Theft	Theft	Awaiting POCA and NMC outcome
2	INV/24/00221	Cwm Taf Morgannwg UHB	29/01/2024	Timesheet/Overtime	False representation	Case review
3	INV/24/00223	Cwm Taf Morgannwg UHB	29/01/2024	Timesheet/Overtime	False representation	Case review
4	INV/24/02428	Cwm Taf Morgannwg UHB	30/09/2024	Salary Overpayment	Theft	VIUC suspended in order for subject to obtain legal advice
5	INV/24/03044	Cwm Taf Morgannwg UHB	28/11/2024	Not working contracted hours	False representation	Enquiries ongoing with Healthroster Team
6	INV/24/03275	Cwm Taf Morgannwg UHB	19/12/2024	Community Pharmacy inflating claims for out-of-pocket expenses	False representation	PPV data being analysed
7	INV/25/00905	Cwm Taf Morgannwg UHB	25/03/2025	Working Whilst Sick	False representation	Enquiries concluded, no fraud established.
8	INV/25/00864	Cwm Taf Morgannwg UHB	20/03/2025	Working Whilst Sick	False representation	Enquiries concluded, no fraud established.

9	INV/25/00682	Cwm Taf Morgannwg UHB	06/03/2025	Working Whilst Sick	False representation	Established via NFI, information shared with managers for consideration for disciplinary.
10	INV/25/00632	Cwm Taf Morgannwg UHB	04/03/2025	Theft	Theft	Enquiries ongoing to assess property missing and processes in place for managing removal/disposal.
11	INV/25/00630	Cwm Taf Morgannwg UHB	03/03/2025	Timesheet/Overtime	False representation	Enquiries concluded, no fraud established.
12	INV/25/00458	Cwm Taf Morgannwg UHB	17/02/2025	Overseas Patient	False representation	Trace of patient and any treatments received underway.
13	INV/25/00448	Cwm Taf Morgannwg UHB	14/02/2025	Contractor - false claims	False representation	Enquiries concluded, no fraud established.
14	INV/22/01136	Cwm Taf Morgannwg UHB	18/08/2022	Agency	False representation	Advice received from CPS, actions requested underway.
No.	**Case No**	**Health Body**	**Date Opened**	**Subject**	**Offence**	**Case Summary**
1.	INV/24/02625	Digital Health Care Wales	16/10/2024	NHS Staff	Fraud by false representation	Enquiries ongoing
No.	**Case No**	**Health Body**	**Date Opened**	**Subject**	**Offence**	**Case Summary**
1	INV/25/00910	Hywel Dda UHB	25/03/2025	Contractor	Fraud by false representation	Allegation received, witnesses identified and enquiries ongoing.
2	INV/25/00552	Hywel Dda UHB	25/02/2025	Employee	Theft	Allegation received, witnesses identified and enquiries ongoing.
3	INV/25/00465	Hywel Dda UHB	17/02/2025	Contractor	Fraud by false representation	Allegation received, witnesses identified and enquiries ongoing.
4	INV/25/00464	Hywel Dda UHB	17/02/2025	Service user	Fraud by false representation	Allegation received, witnesses identified and enquiries ongoing.
5	INV/25/00089	Hywel Dda UHB	13/01/2025	Employee	Fraud by false representation	Allegation received, witnesses identified and enquiries ongoing.
6	INV/25/00088	Hywel Dda UHB	13/01/2025	Contractor	Fraud by false representation	Allegation received, witnesses identified and enquiries ongoing.
7	INV/24/03198	Hywel Dda UHB	12/12/2024	Employee	Fraud by false representation	Allegation received, witnesses identified and enquiries ongoing.
8	INV/24/03055	Hywel Dda UHB	10/04/2025	Service user	Supply of controlled drugs	Allegation received, witnesses identified and enquiries ongoing.
9	INV/24/02714	Hywel Dda UHB	28/10/2024	Employee	Theft	Allegation received, witnesses identified and enquiries ongoing.
10	INV/24/01954	Hywel Dda UHB	01/08/2024	Contractor	Fraud by false representation	Allegation received, witnesses identified and enquiries ongoing.
11	INV/24/01605	Hywel Dda UHB	25/06/2024	Employee	Fraud by abuse of position	Allegation received, witnesses identified and enquiries ongoing.
No.	**Case No**	**Health Body**	**Date Opened**	**Subject**	**Offence**	**Case Summary**
1	INV/25/00418	NWSSP	12/02/2025	NHS Employee	Fraud by False Rep (Overlapping Shifts)	Identified from NFI working for 2 NHS Wales orgs. Analysis of Shifts and Overtime identified overlapping hrs. Evidence obtained; further

						analysis required to decide on most appropriate action.
No.	**Case No**	**Health Body**	**Date Opened**	**Subject**	**Offence**	**Case Summary**
1	INV/24/00525	Powys THB	04/03/2024	Ex NHS Employee	Working whilst on the sick	allegations that subject was seen working at a location within PTHB. All PTHB systems checked, and relevant data collected. Witness Statement account sought. Company has provided data which has been cross-referenced with PTHB sick data. Statements obtained - chasing signatures. There is sufficient evidence of working whilst on the sick and to carry out an IUC. TBA.
2	INV/24/03253	Powys THB	17/12/2024	NHS Employee	Working Elsewhere - Dual Employment	NHS England have reported to PTHB LCFS that a substantive Powys employee is working fulltime in administration roles for both PTHB and NHS England. Engagement with Management in Powys has provided on concerns around performance and attendance. NHS England have NFA'd their case as no evidence of timekeeping kept. NHSE HR are dealing with subject for performance issues only. Statements in hand from NHSE and PTHB documenting employment and contract documents. IUC to be carried out once statements are signed.
3	INV/25/00156	Powys THB	21/01/2025	Non-NHS Staff /Service user	Prescription Fraud	Anonymous letter to Health Board, stating that subject has been using his mother's address in Powys to receive free prescription services when he lives in England. WDS Checks made with Practice – Subject has been registered at a GP on and off in PTHB and is currently registered in Powys. Subject has now been deregistered and asked to register at GP close to his English address. Prescription Services checks underway.
4	INV/25/00243	Powys THB	29/01/2025	NHS Employee	Diversion of Ring-fenced funding	Anonymous letter received and forwarded by CFS Wales - Concerns cite that ring-fenced funding to Drugs & Alcohol Services is being siphoned off to Prevent Suicide Team. Also cited was that the Prevent Suicide Team are over staffed, and this is due to interfamilial relationships. Finance have provided funding and staffing data from both services. Reviewed by ME - no evidence to support the concerns found. meeting to be arranged with Finance to

						discuss, affirm the review of the funding data with Finance. Meeting requested by LCFS.
5	INV/25/00591	Powys THB	27/02/2025	Non-NHS Staff /Service user	Possession of controlled drugs	Controlled drugs (painkillers) purchased from online pharmacies found in possession of a Powys hospital inpatient. All safeguarding put in place; drugs confiscated prior to discharge. Inpatient stated they buy from different sites and could not state which. Welsh Regional Police Operation underway for dealing with buying controlled drugs from online/dark web sites. LCFS referral submitted to Police. Will be added to Cases Closed on Q1 returns.
6	INV/25/00902	Powys THB	24/03/2025	Contractor	Diversion of Practice Funds / Abuse of Position	Concerns were raised after GP Practice Manager retired. Replacement has reported financial anomalies to a Partner at the Practice and that subject has returned to the Practice and locked access to a number of financial documents, which other GP Partners were not aware of. Reporting Source also stated that there have been other financial issues in the past. Statements taken. CFS WALES has been met with and aware and asked for statements and PPV reporting data to be obtained by PTHB LCFS. PPV Manager - has been contacted by LCFS LS, meeting arranged for 08/04/2025, which is being rescheduled at AL's request.
No.	**Case No**	**Health Body**	**Date Opened**	**Subject**	**Offence**	**Case Summary**
1	INV/23/00407	Swansea Bay University Health Board	27/02/2023	Agency Nurse	False Representation	Investigation ongoing
2	INV/23/01395	Swansea Bay University Health Board	17/07/2023	Psychologist	Working whilst sick	File to forwarded to CPS
3	INV/23/01458	Swansea Bay University Health Board	24/07/2023	Psychologist	Timesheet Fraud	Investigation ongoing
4	INV/23/01900	Swansea Bay University Health Board	06/09/2023	HCSW	False Representation	Investigation ongoing
5	INV/23/02302	Swansea Bay University Health Board	16/10/2023	HCSW	False Timesheets	Following disciplinary hearing, subject dismissed on 14/06/2024. File being prepared for CPS
6	INV/24/00199	Swansea Bay University Health Board	26/01/2024	Phlebotomist	Falsifying Timesheets	Investigation ongoing

7	INV/24/01390	Swansea Bay University Health Board	30/05/2024	Nurse	Prescription	Investigation ongoing
8	INV/24/01432	Swansea Bay University Health Board	05/06/2024	Nurse	Timesheet Fraud	Investigation ongoing
9	INV/24/01848	Swansea Bay University Health Board	19/07/2024	Manager	Corruption	Investigation ongoing
10	INV/24/02582	Swansea Bay University Health Board	14/10/2024	Nurse	Theft of NHS products	Investigation ongoing
11	INV/24/02723	Swansea Bay University Health Board	28/10/2024	Nurse	False Qualifications	File being prepared for CPS
12	INV/24/02865	Swansea Bay University Health Board	12/11/2024	Nurse	Salary Overpayment	Investigation ongoing
13	INV/24/02894	Swansea Bay University Health Board	13/11/2024	Domestic	Salary Overpayment	Investigation ongoing
14	INV/24/03284	Swansea Bay University Health Board	20/12/2024	HB Employee	False Representation	Investigation ongoing
15	INV/24/03289	Swansea Bay University Health Board	20/12/2024	Portering Manager	Abuse of Position	Investigation ongoing
16	INV/25/00314	Swansea Bay University Health Board	05/02/2025	Doctor	Dual working at the same time	Investigation ongoing
17	INV/25/00472	Swansea Bay University Health Board	18/02/2025	Patient	False identify to obtain NHS services	Investigation ongoing
18	INV/25/00498	Swansea Bay University Health Board	19/02/2025	Nurse	Timesheet / Overtime Fraud	Investigation ongoing
19	INV/25/00647	Swansea Bay University Health Board	05/03/2025	General Practitioner	Prescription	Investigation ongoing
20	INV/25/00658	Swansea Bay University Health Board	05/03/2025	General Practitioner	Prescription	Investigation ongoing
No.	**Case No**	**Health Body**	**Date Opened**	**Subject**	**Offence**	**Case Summary**
1	INV/23/00284	Welsh Ambulance	03/02/2023	UCS	False rep - timesheet fraud	awaiting closure - disciplinary outcome pending

2	INV/24/00351	Welsh Ambulance	13/02/2024	EMT	Fraud Act - false rep / failure to disclose	omission of information on application around previous dismissals
3	INV/24/00464	Welsh Ambulance	23/02/2024	APP	Fraud Act - secondary role not working hours	contact with third party and timesheet analysis
4	INV/24/00620	Welsh Ambulance	12.03/2024	APP	Fraud Act - Timesheet fraud	alleged to have not completed the shifts claimed - ongoing
5	INV/24/01087	Welsh Ambulance	29/04/2024	Student paramedic	Theft Act - Overpayment retained	13k - initial enquiries ongoing
6	INV/24/01280	Welsh Ambulance	20/05/2024	Paramedic	Fraud act - working elsewhere whilst sick	initial enquiries to confirm private work - ongoing
7	INV/24/01536	Welsh Ambulance	17/06/2024	EMS allocation	Fraud Act - holidays whilst sick	initial evidence and witness engagement
8	INV/24/01843	Welsh Ambulance	18/07/2024	EMS operations	Fraud Act - sickness fraud	evidence of being on holiday and false claims made to work
9	INV/24/01884	Welsh Ambulance	08/08/2024	Locality Senior	Fraud act - overtime fraud and vehicle misuse	initial enquiries
10	INV/24/02536	Welsh Ambulance	09/10/2024	Ambulance Care Assistant	Fraud Act - false representation around sickness	evidence gathered; private companies evidence requests required
11	INV/24/02860	Welsh Ambulance	12/11/2024	Ambulance Care Assistant	Fraud Act - sickness fraud	review initial and evidence gathering
12	INV/24/03271	Welsh Ambulance	19/12/2024	WAST Employee / private medical	Theft Act - medical supplies for private company	evidence capture ongoing
13	INV/24/03276	Welsh Ambulance	19/12/2024	CFR	Fraud Act - false representation around application	evidence capture ongoing
14	INV/24/03288	Welsh Ambulance	20/12/2024	Paramedic	Fraud Act -working whilst sick	evidence capture ongoing
15	INV/25/00012	Welsh Ambulance	03/01/2025	eBay private seller	Theft Act - sale of WAST equipment	evidence capture eBay contact
16	INV/25/00023	Welsh Ambulance	06/01/2025	Paramedic	Fraud Act - working when sick	initial contact for evidence
17	INV/25/00097	Welsh Ambulance	13/01/2025	111 call taker	Fraud Act - false sickness documents	engagement with GP
18	INV/25/00182	Welsh Ambulance	22/01/2025	111 call taker	Fraud Act - false sickness documents	initial engagement review
19	INV/25/00282	Welsh Ambulance	03/02/2025	Paramedic	Theft Act - equipment for private use	review of intelligence
20	INV/25/00442	Welsh Ambulance	14/02/2025	Private company	Fraud Act - articles used in fraud	use of WAST branded wear - ongoing review
21	INV/25/00546	Welsh Ambulance	25/02/2025	Ops Manager	Fraud Act / Theft Act - misuse, theft of stock	initial engagement review - ongoing
22	INV/25/00965	Welsh Ambulance	28/03/2025	Senior Operations	Fraud Act - timesheet / duplicitous working	initial review and evidence gathering

Summary of NHS CFS Wales Cases Closed 1st January to 31st March 2025

No.	Case No	Health Body	Date Opened / Date Closed	Subject	Offence	Case Summary / Outcome
1	INV/25/00336	Aneurin Bevan UHB	05/02/25 / 11/02/25	GP	Theft / Money Laundering	A referral was made to CFS Wales by ABUHB LCFS in relation to a GP who had taken a 12-month career break but had still been receiving his full salary. This is an urgent case because the person is due to fly back to India in the next few days. Financial queries conducted and this showed that some of the money was still in the account. Due to the urgency of this case, it was decided that CFS Wales would make contact with the person and explain that they have had money that they were not entitled to and that it needs to be paid back. The ex employee agreed that the money needs to be paid back and he paid the full amount back of £ 51, 995.85 the same day.
2	INV/24/03280	Cwm Taf Morgannwg UHB	20/12/24 / 11/02/25	Nurse	Fraud by False representation	Allegation that the subject a Nurse at Hospital in CTMUHB has obtained false English qualifications from India to support his NMC registration. Enquiries with NMC to check registration history has commenced with no further communication received and follow-up emails have not been answered. Initial enquiries are continuing and CTMUHB have been informed of the allegation.
3	INV/24/02482	NHS Wales Shared Services Partnership (NWSSP)	03/10/24 / 17/01/25	GP Trainee	Theft / Money Laundering -	This is a new referral in relation to a GP Trainee who is on training rotation. They were off sick for a long period of time and reduced their working hours. This has resulted in an overpayment. Enquiries are ongoing. After investigation this allegation, evidence became known that there was a number of issues with this case around sickness and the fact that it was not recorded properly, / if at all in the GP rotation period. There were also issues in relation to the reduction in hours and the completion of the paperwork to action those hours. Given all the weaknesses in the case, a decision was made not to take this case forward as a criminal investigation however, HR should complete an investigation and also request that the employee repays the money as soon as possible.

Summary of LCFS Cases Closed 1st January to 31st March 2025

No	Case Ref	Health Body	Case Start Date	Closure Date	Subject	Offences	Summary outcome
1	INV/25/00483	Aneurin Bevan UHB	18/02/2025	03/03/2025	Pharmacy/Contractor	False claims	Claims checked, no fraud, closed NFA
2	INV/25/00345	Aneurin Bevan UHB	06/02/2025	10/03/2025	Patient	Prescription charge evasion (subject resides in England)	No fraud - suspected misinformation or malicious, closed NFA
3	INV/25/00241	Aneurin Bevan UHB	29/01/2025	30/01/2025	Patient	Patient selling GP prescribed medication	Anonymous report - unable to locate subject, insufficient information
4	INV/25/00231	Aneurin Bevan UHB	28/01/2025	30/01/2025	External/Third Party Provider	Illegal Care Home Workers	Company not contracted to ABUHB, Fraud NFA, intel shared with external agencies
5	INV/25/00191	Aneurin Bevan UHB	23/01/2025	17/02/2025	Out of Hours Call Handler/Driver	Dual employment issues/working while sick	No fraud, secondary employment declared, to be dealt with as management issue
6	INV/25/00116	Aneurin Bevan UHB	15/01/2025	17/01/2025	Nurse	Inflated overtime claims/timesheet fraud	Anonymous report - no evidence of fraud, closed NFA
7	INV/24/03221	Aneurin Bevan UHB	16/12/2024	19/03/2025	Nurse	Working While Sick	Unable to substantiate allegation, secondary employment not disclosed, subsequently left ABUHB employment
8	INV/24/03062	Aneurin Bevan UHB	16/12/2024	17/01/2025	Midwife (Independent Prescriber)	Illegitimate prescribing of weight loss medication via WP10	No fraud identified, closed NFA
9	INV/24/01935	Aneurin Bevan UHB	29/11/2024	10/01/2025	NHS Staff	Working in secondary employment during NHS contracted time	Fraud not proven, dealt with as management issue - verbal warning via HR disciplinary
10	INV/24/01886	Aneurin Bevan UHB	31/07/2024	22/01/2025	Hospital Doctor	Theft/misuse of HP10HPs	Mitigating circumstances, subject left ABUHB employment. Referred to GMC
11	INV/24/00945	Aneurin Bevan UHB	24/07/2024	27/01/2025	Facilities Staff	Working while sick	Fraud not proven - dealt with as management issue, HR disciplinary / written warning
12	INV/22/01414	Aneurin Bevan UHB	16/04/2024	20/01/2025	HCSW	Salary Overpayment	Civil recovery (£10,046 Q2), HR Disciplinary, Final Written Warning

13	INV/22/01184	Aneurin Bevan UHB	04/10/2022	20/01/2025	Nurse	Timesheet fraud/bank shifts	HR Disciplinary - NFA. Financial Recovery £934.13 via workback/unpaid shift work
14	INV/25/00482	Aneurin Bevan UHB					Case Transferred to CFS Wales
15	INV/25/00336	Aneurin Bevan UHB					Case Transferred to CFS Wales
No.	**Case Ref**	**Health Body**	**Start Date**	**Closure Date**	**Subject**	**Offences**	**Summary outcome**
1	INV/24/01938	Betsi Cadwaladr UHB	02/08/2024	14/01/2025	Nurse (NHS)	Employee Fraud - Other / False Sickness	No evidence of any fraud. It is confirmed that employee is on genuine sick absence and has informed line management and followed correct procedures. Anonymous report appears to be malicious. Member of the general public and source of allegation identified and is reported to Police. NHS Fraud case closed
2	INV/24/01939	Betsi Cadwaladr UHB	02/08/2024	30/01/2025	Patient (GMS)	NHS Patients - Misuse of prescriptions	Anonymous allegation that a female who lives in Southsea, Wrexham is selling illegal drugs and also her prescription drugs, which she gets from her GP to children as young as 12 and 13. Intelligence shared with North Wales Police for them to carry out necessary inquiries. No further action required. Case closed
3	INV/25/00396	Betsi Cadwaladr UHB	12/02/2025	12/02/2025	Health Care Assistant	Employee Fraud - Other / Falsifying sick notes	Double recording of the same case, see also INV/25/00302 which is on-going. This case INV/25/00396 was created and closed the same day.
4	INV/23/00740	Betsi Cadwaladr UHB	19/04/2023	07/03/2025	SpR Maxilo Facial	Overpayment	Formal referral from Finance regarding a double salary payment made to an SpR Maxilo Facial at BCUHB and after receiving confirmation from NWSSP-Payroll. Doctor is also recorded on SLE by NWSSP. Initial fact-finding enquiries found an earlier salary overpayment outstanding relating to Subject's Maternity Leave. Civil debt action by BCUHB prevents any potential POCA action by CFS Wales. Double salary payment debt written off on authority of W&OD. Case closed and outcome reported to AC

5	INV/23/01423	Betsi Cadwaladr UHB	20/07/2023	07/03/2025	Consultant / Surgeon (NHS)	Timesheet / overtime fraud	Allegation is not dissimilar from previous ones against the same Consultant Radiology. Latest job plan for Subject received, on reduced sessions, but works WLI. No DoI submitted after 2018/19. Subject seems involved in Care Home Group. Consultant job plan reviewed. Meeting held with the Executive Medical Director. Matter has not progressed due to Executive Medical Director and Deputy Medical Director absence. Further challenge is that private Care Home Group will not release records. Considerable amount of time passed with no evidence obtained to corroborate the matter. Job plan allows for some private work. No fraud identified. Case closed
6	INV/23/01531	Betsi Cadwaladr UHB	31/07/2023	07/03/2025	Consultant / Surgeon (NHS)	Employee Fraud - Other / Private Practice	Executive Medical Director reported a Consultant T&O for working privately during NHS time. Enquiries started and online checks confirm Consultant recorded working at Spire. DoI identified although no recent one after 2020/21. Latest job plan and PP screenshot received. Proof of working privately requested, but never received. Meeting held with the Executive Medical Director. Matter has not progressed due to Executive Medical Director and Deputy Medical Director absence. Further challenge is that Spire will not release records. Considerable amount of time has passed with no evidence obtained to corroborate the matter. Job plan allows for some private work. Case closed
7	INV/23/01589	Betsi Cadwaladr UHB	01/08/2023	07/03/2025	Consultant / Surgeon (NHS)	Employee Fraud - Other / Private Practice	Anonymous allegation from CIU re a Consultant Radiology working privately during NHS time. Consultant opted out of on-call due to health concerns, but frequently works extra shifts and weekends outside NHS time. Similar allegation received previously. Historic DoI showed private work declared, but

							no DoI after 2020/21. Latest job plan for Subject received. Doctor might not work private any longer. Subject is recorded a director for own business. Meeting held with the Executive Medical Director. Matter has not progressed due to Executive Medical Director and Deputy Medical Director absence. Further challenge is that private healthcare company will not release records. Considerable amount of time passed with no evidence obtained to corroborate the matter. Job plan allows for some private work. Case closed
8	INV/23/01665	Betsi Cadwaladr UHB	09/08/2023	07/03/2025	Nurse (NHS)	Employee Fraud - Other / NFI match with C&VUHB, overlap	NFI match identified a member of BCUHB substantive staff also undertaking Bank work at C&VUHB (UHW). Shifts compared between both NHS organisations raised concerns with potential overlap in working times considering lengthy travel down south. Meeting held with Head of Nursing Central, no concern with Subject. C&VUHB LCFS confirms that Subject is on the bank at C&VUHB and has no concerns. No shifts recorded at the same time. Matter closed on NFI by C&VUHB LCFS. Case has been reviewed, outcome reported to AC and agreed to be closed
9	INV/24/00085	Betsi Cadwaladr UHB	12/01/2024	07/03/2025	Consultant / Surgeon (NHS)	Employee Fraud - Other / Theft and working elsewhere	Allegation that a Consultant Surgeon and assistant are taking surgical items from a BCUHB hospital to use abroad in Africa to carry out private work. It's further alleged that they also do not take leave when carrying out this work. Meeting held with Deputy Executive Medical Director and accusations discussed. No evidence of theft or fraud received, there is also a working arrangement in place between BCUHB and healthcare work in Africa. Procedural gaps in annual leave recording highlighted. Case closed

10	INV/24/00403	Betsi Cadwaladr UHB	19/02/2024	07/03/2025	Health Care Assistant	Overpayment	Part-time HCA in Cancer left BCUHB in January 2023 and was overpaid salary for a year before this was identified by line management. Employee had held several positions over years and is still employed working on a zero-hour Bank contract. Draft statement received from line management states that the Subject had been spoken to and was put on Suspend No Pay. Invoice for £12k raised, no payment received and is with CCI. No prospect of POCA due to civil recovery process. Still employed by BCUHB and significant amount of time passed with no action undermines case. Case has been reviewed, outcome reported to AC and agreed to be closed
11	INV/24/01409	Betsi Cadwaladr UHB	03/06/2024	07/03/2025	Unknown	Potential payment scam (victim staff member)	Junior doctor paid for internal ATLS course by telephone using credit card. Fee of £685 taken from her account, but never received by BCUHB. LCFS advised to report as Fraud / Scam to Credit Card company who refunded the payment to the victim. Nat West contacted by victim several times asking for details of bank account where the original fee is paid into, but no forthcoming. No monetary loss to NHS and no further lines of enquiry. Case closed
12	INV/24/01672	Betsi Cadwaladr UHB	01/07/2024	07/03/2025	Consultant / Surgeon (NHS)	Employee Fraud - Other / Private Practice	Allegation that a consultant has been carrying out DOLS and Mental Health Act Assessments privately instead of running the Substance Misuse Clinics at Drug and Alcohol Service which he is contracted to run and passes on the running of these clinics to his trainees whilst he undertakes the private work. Similar allegation had been received in the past. Meeting held with Medical Director MH&LD, no performance or other issues identified and no evidence of undertaking private work during BCUHB time. Case has been reviewed,

							outcome reported to AC and agreed to be closed
13	INV/24/02835	Betsi Cadwaladr UHB	08/11/2024	07/03/2025	Nurse (NHS)	Employee Fraud - False qualification	Anonymous accusation that a Specialist Nurse at WMH does not hold the correct qualification or experience for her post. It was further alleged that the Subject might have been given the post by a family member. Meeting held with W&OD, Director of Nursing and Professional Qualifications for potential NMC referral. Allegation is known, incorrect and might be vexatious. Nurse holds correct qualifications and is capable, no issue. Case has been reviewed, outcome reported to AC and agreed to be closed
14	INV/24/03084	Betsi Cadwaladr UHB	03/12/2024	07/03/2025	NHS Staff (Catering)	Employee Fraud - Theft of NHS goods (money and patients' food)	Anonymous accusation that a member of Catering staff had stolen money from the till and taking food intended for patients home over two decades ago. Enquiries identified the Subject still employed at BCUHB. Contact made with Finance for procedure on banking arrangements. Financial procedures received and contact made with Finance colleague found that there is no longer a cash till at NWAS. Also, financial records not kept for over 6 years. No evidence to corroborate allegation. Case has been reviewed, outcome reported to AC and agreed to be closed
15	INV/24/03140	Betsi Cadwaladr UHB	06/12/2024	07/03/2025	Health Care Assistant	Employee Fraud - False qualification	Anonymous allegation that a Student Nurse is bragging on social media about her Nursing qualification. Subject has failed course on several occasions. Enquiries started; Subject identified but has only ever undertaken HCA duties on the Bank for BCUHB. Last payslip found from June 2023. Case has been reviewed, outcome reported to AC and agreed to be closed
16	INV/24/03219	Betsi Cadwaladr UHB	16/12/2024	07/03/2025	Consultant / Surgeon (NHS)	Employee Fraud - Working privately in NHS time	Anonymous allegation that a Consultant Cardiologist is using NHS premises and equipment to see patients privately. Although his job plan allows private

							practice for limited hours, Subject is over ceding this regularly. Subject is seeing patients privately during NHS contracted time. Checks show that this is a repeat allegation relating to an employment tribunal. Discussion took place with Associate Director of People Services (West). Matter was previously investigated by W&OD and no evidence found to corroborate allegation. Case has been reviewed, outcome reported to AC and agreed to be closed
17	INV/24/02127	Betsi Cadwaladr UHB	28/08/2024	26/03/2025	Patient (GMS)	NHS Patients - False address likely for charge evasion and/or other forms of fraud	Anonymous allegation that a male patient is using his parents address in North Wales to claim free prescriptions when he is currently residing in the Staffordshire area. Prescribing practice identified and registration addresses. Contact made with GP Practice, details given, and they are removing Subject from their patient list if no up-to-date proof of residency provided. Details re possible benefit fraud passed over to relevant agencies. Case closed
18	INV/24/03312	Betsi Cadwaladr UHB	31/12/2024	26/03/2025	NHS Staff (Smoking Cessation)	Employee Fraud - Working whilst sick	Anonymous allegation that a Smoking Cessation Practitioner is off on paid sick and is using the time to finish her master's degree. It is alleged that the Subject is also running an Air BNB and is paid for Zumba classes. Enquiries carried out and no evidence available of paid Zumba classes or any other fraud. Case closed

No.	Case Ref	Health Body	Start Date	Closure Date	Subject	Offences	Summary outcome
1	INV/23/02421	Cardiff & Vale UHB	26/10/2023	20/01/2025	Employee	Theft	Subject found guilty at crown court, 18-month sentence, suspended for 21 months and ordered to complete 15 days rehabilitation. Payment plan commenced to repay funds.
2	INV/24/00336	Cardiff & Vale UHB	09/02/2024	14/02/2025	Employee	Theft	No offence identified
3	INV/25/00135	Cardiff & Vale UHB	17/01/2025	21/01/2025	Employee	Fraud	No offence identified
4	INV/25/00473	Cardiff & Vale UHB	18/02/2025	11/03/2025	Patient	Fraud	No offence identified
5	INV/25/00913	Cardiff & Vale UHB	25/03/2025	25/03/2025	Patient	Fraud	No further action

No.	Case Ref	Health Body	Start Date	Closure Date	Subject	Offences	Summary outcome
1	INV/25/00065	Cwm Taf Morgannwg UHB	09/01/2025	14/01/2025	Patient	False representation	Unable to corroborate allegation information
2	INV/25/00197	Cwm Taf Morgannwg UHB	23/01/2025	04/02/2025	Employee	False representation	No fraud identified
3	INV/23/02885	Cwm Taf Morgannwg UHB	18/12/2023	23/01/2025	Employee	False representation	No fraud identified
4	INV/24/03189	Cwm Taf Morgannwg UHB	12/12/2024	21/02/2025	Patient	False representation	No fraud identified
5	INV/24/02945	Cwm Taf Morgannwg UHB	24/01/2025	17/03/2025	Patient	False representation	Intelligence shared
6	INV/24/01324	Cwm Taf Morgannwg UHB	23/05/2025	24/03/2025	Employee	False representation	No fraud identified
7	INV/24/01334	Cwm Taf Morgannwg UHB	24/05/2025	24/03/2025	Employee	False representation	No fraud identified
No.	**Case Ref**	**Health Body**	**Start Date**	**Closure Date**	**Subject**	**Offences**	**Summary outcome**
1	INV/24/03003	Hywel Dda UHB	25/11/2024	31/03/2025	Contractor	Fraud by false representation	Matter finalised, no fraud proven against NHS, no further action. Controls implemented.
2	INV/24/02555	Hywel Dda UHB	10/10/2024	31/03/2025	Employee	Fraud by false representation	Matter finalised, no fraud proven against NHS, no further action.
3	INV/25/00690	Hywel Dda UHB	07/03/2025	07/03/2025	Service user	Fraud by false representation	Matter finalised, no fraud proven against NHS, no further action.
4	INV/25/00600	Hywel Dda UHB	27/02/2025	03/03/2025	Employee	Fraud by false representation	Matter finalised, no fraud proven against NHS, no further action.
5	INV/25/00507	Hywel Dda UHB	19/02/2025	03/03/2025	Employee	Theft	Matter finalised, no fraud proven against NHS, no further action.
6	INV/23/01687	Hywel Dda UHB	11/08/2023	03/03/2025	Employee	Fraud by false representation	Following an investigation and VIUC, CPS advice was obtained, resulting in a financial recovery and Police Caution followed by disciplinary.
7	INV/25/00169	Hywel Dda UHB	22/01/2025	11/02/2025	Employee	Fraud by false representation	Matter finalised, no fraud proven against NHS, no further action. LPE commenced.
8	INV/24/01321	Hywel Dda UHB	23/05/2024	05/02/2025	Contractor	Fraud by false representation	Matter finalised following review in partnership with PPV. Subject identified and interviewed. No fraud proven, but a financial recovery made.
9	INV/25/00195	Hywel Dda UHB	23/01/2025	27/01/2025	Employee	Fraud by false representation	Matter finalised, no fraud proven against NHS, no further action.
10	INV/25/00011	Hywel Dda UHB	03/01/2025	27/01/2025	Employee	Fraud by false representation	Matter finalised, no fraud proven against NHS, no further action.
11	INV/24/02740	Hywel Dda UHB	29/10/2024	27/01/2025	Employee	Fraud by false representation	Matter finalised, no fraud proven against NHS, no further action.

12	INV/24/02583	Hywel Dda UHB	14/10/2024	27/01/2025	Service user	Fraud by false representation	Matter finalised, no fraud proven against NHS, no further action.
13	INV/24/00203	Hywel Dda UHB	26/01/2024	27/01/2025	Employee	Theft	Following an investigation and VIUC, CPS advice was to be obtained, insufficient evidence to seek a charge, but a financial recovery made and a referral for disciplinary.
14	INV/25/00115	Hywel Dda UHB	14/01/2025	24/01/2025	Service user	Supply of controlled drugs	Matter finalised, no fraud proven against NHS, no further action.
15	INV/25/00173	Hywel Dda UHB	22/01/2025	23/01/2025	Employee	Theft	Matter finalised, overpayment proven, but referred for disciplinary and internal recovery. No sanction claimed on clue.
No.	**Case Ref**	**Health Body**	**Start Date**	**Closure Date**	**Subject**	**Offences**	**Summary outcome**
1	INV/23/01983	NWSSP	15/09/2023	11/02/2025	NHS Employee	Fraud by False Represenatation	NFA No Fraud Found
2	INV/24/00661	NWSSP	13/03/2024	30/01/2025	NHS Employee	Fraud by False Represenatation	NFA No Fraud Found
3	INV/24/00564	NWSSP	06/03/2024	07/02/2025	NHS Employee	Theft (of Sal O/P)	NFA No Fraud Found
4	INV/24/00834	NWSSP	02/04/2024	28/01/2025	NHS Employee	Theft (of Sal O/P)	NFA No Fraud Found
5	INV/24/03238	NWSSP	17/12/2024	24/01/2025	NHS Employee	Theft (of Sal O/P)	NFA No Fraud Found
6	INV/25/00625	NWSSP	03/03/2025	07/03/2025	NHS Employee	Fraud by Abuse of Position of Trust	NFA No Fraud Found
7	INV/25/00555	NWSSP	06/03/2024	07/02/2025	NHS Employee	Theft (of Sal O/P)	NFA No Fraud Found
No.	**Case Ref**	**Health Body**	**Start Date**	**Closure Date**	**Subject**	**Offences**	**Summary outcome**
1	INV/23/02907	Powys THB	03/01/2024	29/01/2025	NHS Employee	Working whilst on the sick	NHSCFA Anonymous Intel- allegedly working in a pub while on sick leave from Powys LHB, and that was doing so with CTM and C&V UHBs. Enquires made with named HBs. Subject is no trace within both health boards on ESR and Healthroster. DPA enquires made with Pubs who stated rota details would be kept with the Pub Manager at the relevant time. This would be subject's mother/Conflict of interest issues. All enquiries completed. Insufficient evidence to support the anonymous intelligence. LCFS Outcome - NFA
2	INV/24/01639	Powys THB	10/06/2024	26/02/2025	Ex NHS Employee	Forge Documents - Payslips	Dismissed from health board then stated they had not been paid. Provided two payslips that had been stuck

							together with cello tape. Payroll have confirmed they have been paid for said hours, have received overpayment and that the payslips are forged. Witness statements obtained in draft. IUC - 16/01/2025. MC denies fraud allegations Case reviewed. Insufficient evidence to meet CPS charging threshold. Finance have set up a repayment plan to recover the salary overpayment. LCFS Outcome NFA
3	INV/24/02788	Powys THB	30/10/2024	13/03/2025	NHS Employee	Working privately in NHS time	Reported to be using NHS shift time to set up and run private company. Company house checks completed, LB is a director of one business recently set up and also has an online shop on Esty. Open-Source checks made. Business has a Facebook/Meta account set up in 02/01/2025. All posts have been preset to post at a certain time. No evidence to support concerns that subject was using NHS working time to run either business. Workforce/ Line Manager to manage subject in relation to performance issues and secondary employment declarations. LCFS Outcome NFA
No.	**Case Ref**	**Health Body**	**Start Date**	**Closure Date**	**Subject**	**Offences**	**Summary outcome**
1	INV/24/00483	Public Health Wales	27/02/2024	12/03/2025	Employee	Theft	Overpayment repaid in full, no dishonesty/offence shown.
2	INV/24/02145	Public Health Wales	28/08/2024	21/01/2025	Employee	Fraud	No offence identified, SWR/LPE to be completed
No.	**Case Ref**	**Health Body**	**Start Date**	**Closure Date**	**Subject**	**Offences**	**Summary outcome**
1	INV/24/02080	Swansea Bay UHB	19/08/2024	23/01/2025	Medical Secretary	Private work in NHS time	Fraud Found. Not in the public interest to pursue criminally. Civil recovery £81.48.
2	INV/25/00119	Swansea Bay UHB	15/01/2025	04/02/2025	Ward Clerk	Inappropriate Overtime	No fraud found.
3	INV/24/02287	Swansea Bay UHB	12/09/2024	06/03/2025	HCSW	Salary Overpayment	No fraud found. Civil recovery £6,215.25 net.
4	INV/24/01997	Swansea Bay UHB	07/08/2024	12/03/2025	Not Known	False Application	No fraud found.
5	INV/24/03152	Swansea Bay UHB	09/12/2024	12/03/2025	Finance Office	Working whilst sick	No fraud found.

6	INV/25/00114	Swansea Bay UHB	14/01/2025	12/03/2025	Patient	Prescription Fraud	No fraud found.
7	INV/25/00117	Swansea Bay UHB	15/01/2025	13/03/2025	Manager	Allocation of Overtime to Family members	No fraud found.
8	INV/25/00145	Swansea Bay UHB	20/01/2025	13/03/2025	Pharmacy	Inappropriate Pharmacy Service Claims	No fraud found.
9	INV/25/00281	Swansea Bay UHB	31/01/2025	13/03/2025	Manager	Allocation of Overtime to Family members	No fraud found.
10	INV/25/00484	Swansea Bay UHB	18/02/2025	18/02/2025	Service User	False Representation	No fraud found.
11	INV/22/01950	Swansea Bay UHB	20/12/2022	07/03/2025	Contractor	Prescription Fraud	NFA, passed to GDC as a Regulatory matter
12	INV/24/02581	Swansea Bay UHB					Transferred to CFS Wales
No.	**Case Ref**	**Health Body**	**Start Date**	**Closure Date**	**Subject**	**Offences**	**Summary outcome**
1	INV/25/00372	VUNHST	07/02/2025	19/03/2025	Employee	Theft	Stolen funds repaid in full, subject dismissed from the organisation.
No.	**Case Ref**	**Health Body**	**Start Date**	**Closure Date**	**Subject**	**Offences**	**Summary outcome**
1	INV/24/02992	Welsh ambulance Service Trust	21/11/2024	08/01/2025	paramedic	Theft Act - retained overpayment	No fraud, contacts made, and money recovered
2	INV/23/02321	Welsh ambulance Service Trust	17/10/2023	08/01/2025	clinical advisor	Fraud Act - working whilst sick	Insufficient evidence, guidance around DOIs
3	INV/24/02688	Welsh ambulance Service Trust	23/10/2024	28/01/2025	Occ Health / well being	Theft Act - retained overpayment	No evidence of fraud, matter raised with payroll
4	INV/22/01128	Welsh ambulance Service Trust	18/08/2022	31/01/2025	EMT	Fraud Act - holiday and sickness fraud	resigned prior to engagement / not in PI to pursue
5	INV/24/02111	Welsh ambulance Service Trust	22/08/2024	11/02/2025	paramedic	Theft Act - retained overpayment	insufficient evidence of fraud - recovery of monies arranged **(£18,697)**
6	INV/24/02591	Welsh ambulance Service Trust	14/10/2024	11/02/2025	paramedic	Fraud Act - working when sick	**£3648** recovered in settlement / employee left service
7	INV/24/00549	Welsh ambulance Service Trust	05/03/2024	11/03/2025	NEPTS	Theft Act - salary overpayment retained	No fraud, supported recovery of **£7590**
8	INV/24/03258	Welsh ambulance Service Trust	18/12/2024	19/03/2025	ACA	Fraud Act - working when suspended	No evidence, guidance around DOIs issued
9	INV/25/00147	Welsh ambulance Service Trust	20/01/2025	19/03/2025	NEPTS	Fraud Act - working when sick	Insufficient evidence of fraud - advice around DOIs

10	INV/24/02110	Welsh ambulance Service Trust	22/08/2024	20/03/2025	call hander	Fraud Act - working when sick	no evidence of shifts worked elsewhere
11	INV/25/00269	Welsh ambulance Service Trust	30/01/2025	20/03/2025	ACA	Fraud Act - working when sick	no evidence of bank shifts elsewhere
12	INV/24/02585	Welsh ambulance Service Trust	14/10/2024	20/03/2025	paramedic	Theft Act - retained overpayment	fraud not proven - intervention from CF led to recovery **£9,651.32**

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	24 June 2025
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Post Payment Verification (PPV) End of Year Report 2024-2025
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Robert Holcombe Director of Finance and Procurement
SWYDDOG ADRODD: **REPORTING OFFICER:**	Amanda Legge Post Payment Verification (PPV) Manager

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

Er Sicrwydd/For Assurance

This paper highlights the narrative on how practices have been performing over the current PPV cycle.

PPV of claims from General Medical Services (GMS), General Ophthalmic Services (GOS) and General Pharmaceutical Services (GPS) are undertaken as a part of an annual plan by NHS Wales Shared Services Partnership (NWSSP). It compares the overall performance of the Health Board (HB) against the national PPV visits.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

Mid-year and end of financial year, the PPV Manager will prepare a report for Health Board audit committees to outline how Primary Care contractors have been performing and highlighting PPV progress. The paper is being produced for the Committee to review and seek assurance that the PPV cycle is being managed appropriately.

NWSSP-PCS are responsible for undertaking PPV duties on behalf of HBs across Wales. PPV of claims for GMS, GOS and GPS are undertaken as a part of an annual plan and run on a 3-year cycle agreed by HBs.

Cefndir / Background

The purpose of the PPV process is to provide assurance to Health Boards that the claims for payment made by primary care contractors are appropriate and that the

delivery of the service is as defined by NHS service specifications and relevant legislation.

The PPV team also manages the Waste Management Audit programme on behalf of the Health Boards offering advice and support to GP Practices and Community Pharmacies in respect of Waste Management.

Asesiad / Assessment

The following key points should be noted:

General Medical Services (GMS): in 2024-2025 we had 62 visits planned for Aneurin Bevan University Health Board consisting of 20 routine and 42 revisits. By the 31st of March 2024, we had 12 routine visits with 16 revisits in progress. The incompletion of routine/revisits was a national issue and is not specific to any individual Health Board. With revisits, we need to check 100% of the services that have been triggered, and they take a long time to finalise and unfortunately this year we are experiencing unexpected absence in the team in a disproportionate number.

In the first 3 months of the new financial year, we will be completing all outstanding visits that are overdue before we begin the new visit plan for 2025/2026.

We have also been requested by Welsh Government to undertake the additional verification of Covid and RSV vaccines and will begin these checks for the visits due in 2025/2026.

General Ophthalmic Services (GOS): The visit plans for GOS 2024-2025 progressed well than the last few years based on us having the ability to carry out remote access on more contractors who have transferred to electronic patient records. We do however have to carry out elements of physical visits too, as not all contractors are electronic.

This new financial year of 2024-2025 we completed 18 visits out of 20 visits planned for Aneurin Bevan University Health Board and have 2 more to complete and carry over into the new financial year of 2025/2026.

Moving forward into 2025/2026 we will also be verifying claims for an additional 2 services, which are the WGOS 4 (Glaucoma and Medical Retina) and Independent Prescribing Optometry Service 5 urgent claims (IPOS5).

General Pharmacy Services (GPS): In 2024/2025 PPV introduced a new service check following a successful pilot, which was the Collaborative Working Scheme. We now verify this service along with the Quality and Safety Scheme remotely. We have 42 visits in progress out of 42 visits planned and have no more to complete this financial year for Aneurin Bevan University Health Board.

Additional Services: We progressed will with our quarterly dispensing data checks and have introduced a robust service moving forward into the new financial year, which may result in future financial recoveries. The results will be added to our PPV reports once finalised. Clinical Waste Self Assessments for GMS are going well and as planned to ensure compliance with legislation. We are hoping to incorporate these into our GOS visits this new year financial to align to the WGOS reform and the managing of clinical waste.

Quarterly meetings are scheduled with all Health Boards and Counter Fraud teams to regularly review the progress report and to discuss themes, recommendations, and any risks.

We are also continue investigating other avenues for savings from the provision of Clinical Waste services.

There are bi-monthly National GMS, GOS Working Group and Clinical Waste meetings with Primary Care Managers and PPV, to discuss and agree any issues regarding the national application of the programme. These are beneficial to all parties who attend.

PPV training events continue to be delivered to our Health Boards and contractors, and we facilitate one-on-one training requirements when required, particularly for new practice staff within the Primary Care setting

Argymhelliad / Recommendation

It is recommended that the Audit & Risk Assurance Committee Members note the contents of this report. There are no options included in this report. The report is for Assurance and will detail specific risks if any, but will provide the narrative for what PPV, Primary Care, Finance and Counter Fraud consider the be the best approach to support practices in improving.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	SRR 001G supports financial sustainability
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	Choose an item. Choose an item.
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	Explained throughout 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. N/A

Audit Report - 1st April to 31st March 2025 = Aneurin Bevan University Health Board

To Note
Above planned numbers were sent to HB for 2024/2025 Visit Plan. Numbers may change due to ad hoc visits or closures/mergers
Health Board and Counter Fraud receive copies of each visit report to act upon PPV recommendations
PPV work collaboratively with Health Board managers and Local Counter Fraud to assist with any concerns that may arise
Training/support is provided to practices after visit and throughout the year, whenever requested

Summary of themes/findings/issues
Revisits are taking longer that expected due to 100% check of claims
Revisits are normally expected to have higher claim error rates

ABuHB 2023/2024 = 43 visits were completed with a total of recovery of £64,691.85	ALL WALES 2023/2024 = 205 visits were completed with a recovery of £216,810.03

GMS	Visit Type	HB Annual Visits Due	No. In progress	No. Recoveries	Value of recoveries	All Wales Visits Due	All Wales No. in progress	All Wales Value of Recoveries
	Routine	20	12	229	£6,253.00	152	106	£87,881.10
	Revisit	42	16	613	£12,967.55	241	88	£111,273.26
	TOTAL	**62**	**28**	**842**	£19,220.55	**393**	**194**	**£199,154.36**

PRACTICE	Routine or Revisit	Claim errors	% recovery	Value of recovery
Practice 1	Revisit	2	1.87%	£42.94
Practice 2	Routine	4	2.05%	£114.17
Practice 2	Revisit	51	2.04%	£2,239.85
Practice 3	Revisit	20	18.35%	£1,436.20
Practice 4	Routine	13	4.63%	£344.93
Practice 4	Revisit	0	0.00%	£0.00
Practice 5	Routine	18	9.00%	£415.25
Practice 5	Revisit	119	5.55%	£1,352.21
Practice 6	Revisit	38	1.94%	£1,213.02
Practice 7	Routine	5	3.18%	£50.15
Practice 7	Revisit	2	2.50%	£63.66
Practice 8	Routine	42	15.33%	£1,574.90
Practice 8	Revisit	4	10.00%	£350.52
Practice 9	Revisit	69	18.40%	£712.77
Practice 10	Revisit	102	4.95%	£1,023.06
Practice 11	Revisit	119	70.41%	£2,098.08
Practice 12	Routine	25	12.95%	£666.36
Practice 12	Revisit	7	77.78%	£445.55
Practice 13	Revisit	0	0.00%	£0.00
Practice 14	Routine	33	12.64%	£668.06
Practice 15	Routine	30	10.56%	£758.97
Practice 16	Routine	4	0.90%	£155.67
Practice 17	Routine	0	0.00%	£0.00
Practice 17	Revisit	20	1.77%	£349.22
Practice 18	Revisit	30	17.05%	£452.81
Practice 19	Routine	25	10.64%	£859.50
Practice 19	Revisit	30	15.38%	£1,187.66
Practice 20	Routine	30	7.56%	£645.04

GOS	Visit Type	Annual Visits Planned	No. In progress	No. Recoveries	Value of recoveries	All Wales visits due	All Wales No. in progress	All Wales Value of Recoveries
	Routine	20	18	53	£1,976.15	126	99	£16,247.97
	Revisit	0	0	0	0	5	1	£68.70
	TOTAL	**20**	**18**	**53**	**£1,976.15**	**131**	**100**	**£16,316.67**

Summary of themes/findings/issues

As contractors are transistioning to electronic records, remote access and physical visits are progressing well

PRACTICE	Routine or Revisit	Claim errors	% recovery	Value of recovery
Practice 1	Routine	1	0.97%	£59.30
Practice 2	Routine	5	4.85%	£124.68
Practice 3	Routine	0	0.00%	£0.00
Practice 4	Routine	0	0.00%	£0.00
Practice 5	Routine	0	0.00%	£0.00
Practice 6	Routine	5	4.85%	£200.46
Practice 7	Routine	2	1.94%	£54.46
Practice 8	Routine	0	0.00%	£0.00
Practice 9	Routine	3	2.91%	£129.78
Practice 10	Routine	2	1.94%	£148.40
Practice 11	Routine	5	4.85%	£142.16
Practice 12	Routine	4	3.88%	£71.80
Practice 13	Routine	6	5.83%	£173.88
Practice 14	Routine	12	11.65%	£477.40
Practice 15	Routine	4	3.88%	£182.85
Practice 16	Routine	1	0.97%	£63.88
Practice 17	Routine	1	0.97%	£35.00
Practice 18	Routine	2	1.94%	£112.10

Summary of themes/findings/issues

Nothing to report at this stage

GPS	Visit Type	Annual Visits Planned	No. In progress	No. Recoveries	Value of recoveries	All Wales visits due	All Wales No. in progress	No. Recoveries	All Wales Value of Recoveries
Q&S Scheme / Collaborative Working Scheme	Routine	42	42	0	£0.00	238	179	0	£0.00
	TOTAL	**42**							

GIG CYMRU NHS WALES | Partneriaeth Cydwasanaethau Shared Services Partnership

Primary Care Services
Post Payment Verification
April 2025

Situation

Between 2020-2023 Post Payment Verification (PPV) faced significant challenges associated with the COVID-19 pandemic and a new General Medical Services (GMS) Family Practitioner Payment System (FPPS).

The PPV service was initially reinstated towards the latter part of 2020 and through reinstatement at the end of 2020, to April 2022 we managed to complete a 3-year cycle of routine visits into a 2-year period. At this point, the revisits that were triggered in these periods were carried over in an attempt to complete them at the earliest opportunity.

As with all new systems there is a bedding in period, and with a new way for the contractors to submit evidence to support their claims posed more pressure for the PPV Team.

Moving forward into a new financial year, we have undertaken an analysis of the data to understand the position of our outstanding revisits remaining and to realign an achievable solution to provide the levels of assurance required.

Background



Comms 23 - PPV Schedule 2022_23.pdf



Comms 26 - FPPS_PPV.pdf



Comms 22 - Supporting Evidence_

In 22-23 there were 261 visits on our GMS visit plan.

In 23-24 there were 297 visits on our GMS visit plan.

In 24-25 we had 393 GMS visits to undertake = 152 routine, and 241 revisits. On nearing the end of this financial year, we have 106 Routine visits, and 88 revisits finalised or in progress.

In 22-23 and 23-24 we undertook our routine visits which were triggering a higher-than-average number of revisits than we have seen in previous years. On closer inspection, it was noted that the data submitted by practices through the payment system was limited, resulting in a smaller pool of information available for sample verification.

Our normal process in creating a sample for a routine visit is 10% or 22 of the claims out of all the submissions, whichever is the greater. E.g. 100 claims we would check 22 as this is more than 10 and 250 claims, we would check 25.

Assessment

We have recently reviewed the prompts for revisits along with looking at a plan moving into the next financial year. Due to a lower volume of claims submitted through the payment system, and the reduction of available evidence, we can give assurance that a large number of outlined visits would not have prompted a revisit in traditional circumstances.

There are approximately 40 routine visits to carry over into 25-26 which we will complete as a priority and then we will proceed with the new financial year's routine visits.

The revisits remaining that need to be undertaken, will be completed throughout the year and may include the routine visit as well. We refer to these as extended visits and has been an effective performance tool for us previously.

Alongside this, we are currently experiencing unexpected absence in the team, and we aim to adopt a practical approach going forward, focusing on what is realistically achievable while continuing to uphold a high standard of assurance.

Recommendation

Following the review of our practices, those that prompted revisits under unusual circumstances, specifically for claims verified at 19 and under in the financial years of 22-23 and 23-24, where the claim data and evidence provided by the practices affected the standard data samples available for PPV to be able to validate, we will recommend remove the need to revisit those practices, given the assurance we have in place.

We have also analysed the history of these practices to ensure there is no patterns to take into consideration in this provision of assurance, and we can confirm that we find nothing to raise concern with moving forward with the outlined plan.

Alongside this assurance, we have other trend data available to our team, and since October 2024, we have been verifying any duplicate claims in conjunction our visits, which is proving to be valuable in supporting assurance around practice claiming. We will continue to undertake this moving forward as additional assurance to our Health Boards, Committees and the service.

Partneriaeth Cydwasanaethau
Gwasanaethau Gofal Sylfaenol
Shared Services Partnership
Primary Care Services

Ceri Evans
Head of Transaction Services
nwssp-primarycareservices@wales.nhs.uk

For the attention of: Heads of Primary Care
Directors of Finance
GPC Wales

June 2022

Dear Colleague

Communication No 23: Post Payment Verification Schedule 2022/23

You will all be aware of the transition to the Family Practitioner Payment Service (FPPS) System as part of the decommissioning of the National Health Application Information Services (NHAIS) System including Open Exeter. The FPPS System was launched to enable the submission of enhanced services claims with the first payment being made on 31st January 2022 (Qtr 3/Month 9 activity).

One of the key differences between Open Exeter and FPPS is that evidence submitted, specifically NHS numbers, is not subject to validation as it is not linked to a patient demographic system. FPPS requires practices to:

i) enter the quantity of each enhanced service to be claimed, and
ii) upload supporting evidence

These requirements are documented in the published user guide, relayed via Comms letters and reiterated during a series of workshops.

On reviewing the evidence submitted via FPPS to-date there is considerable disparity across the majority of practices regarding the accuracy of evidence provided when compared to the claim submitted in FPPS. Examples of the issues identified to-date include:

- Number of claims in FPPS does not correlate with the supporting evidence, e.g.:
  - Qty 10 Minor Surgery claimed in FPPS, 8 NHS numbers provided in supporting evidence
  - Qty 108 Warfarin Level A – Monitoring claimed in FPPS, 109 NHS numbers provided in supporting evidence
- Supporting evidence provides a list of NHS numbers only, no service description, no date of activity
- No evidence provided

We acknowledge that the transition to the new system has been challenging for some practices however, it is important to ensure this information is both accurate and complete. To that end we have provided practices with the opportunity to review evidence submitted to-date and re-submit evidence where necessary and by 22nd June 2022.

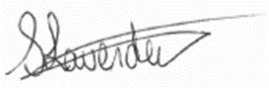
A consequence of the above is that the planned PPV schedule for 2022/23 will be delayed. It is proposed that the PPV programme will commence with the team contacting practices in August 2022 to schedule, with a view to remote access visits starting in September 2022.

Please be assured that system development within FPPS has been prioritised which will seek to reduce the potential to submit incorrect evidence for enhanced service claims. In the meantime, we will continue to work with practices to support them during this transitional period with a view to having a focussed approach to GMS PPV from August 2022 to ensure the planned schedule is completed in this financial year.

Should you require any further clarification regarding the above, please contact us.

Yours sincerely





Ceri Evans
Head of Transaction Services

Scott Lavender
Deputy Head of Engagement & Support Services

Communications record:

No:	Recipients:	Subject:	Released:
-	DoPC, HoPC, CPW, OW, GPCW	Changes to Contractor Payments	November 2020
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21	All GP Practices, cc HoPC Primary Care Mgrs	FPPS – Statements	May 2022
22	All GP Practices, cc HoPC Primary Care Mgrs	PPV – Urgent Action Required	June 2022

Andrew Evans
Director of Primary Care Services
nwssp-primarycareservices@wales.nhs.uk

For the attention of: Directors of Primary Care
Directors of Finance
Heads of Primary Care

20th December 2022

Dear Colleague

Communication No 26: FPPS – Post Payment Verification

Since the transition of family practitioner payments away from the National Health Application and Infrastructure Services to Business Services Organisation in Northern Ireland's Family Practitioner Payment System in December 2021, NWSSP's post payment verification service has been largely restricted. It was our intention, agreed with individual health boards, to re-instate the post payment verification service in the second half of 2022/23, and to undertake reviews of 222 practices in 2022/23, with resumption of full reviews from April 2023. Due to difficulties experienced with data collection and submission from practices to NWSSP Primary Care Services using the new system, Primary Care Services is unable to meet this target or deadline.

Background

NHS Digital has traditionally provided the Open Exeter system used for making payments to general practices in Wales, via its National Health Application and Infrastructure Service (NHAIS). On notification of NHS Digital's intention to decommission this system, NWSSP began the process of procuring an alternative system. In April 2020 the contract for provision of this service was awarded to the Business Services Organisation in Northern Ireland, to be delivered via their Family Practitioner Payment System (FPPS), and this became operational in December 2021

Following the implementation of the FPPS, the claims verification process was designed around practices submitting evidence in support of claims via the payment system; and the Payment Team then collating the supporting evidence submitted at the end of each payment cycle (either monthly or quarterly). This is then passed on to the Post Payment Verification Team to form a claim sample for each practice. This sample shows payments made against claims, based on individual NHS numbers, and forms the basis of the post payment verification process.

The claims process in NHS Northern Ireland differs from that in Wales in that there is no requirement for practices to submit evidence to support their claims at the point of claiming, and therefore this not an existing feature within the FPPS.

This was a recognised difference from the outset, and it was hoped that it could be solved through system design changes within the FPPS itself to replicate some of the previous Open Exeter/NHAIS functionality. This allowed for claims to be submitted and then matched directly against NHS numbers provided as evidence within the payment system, resulting in a "cleansed" sample being available to the Post Payment Verification Team.

Unfortunately, despite much work within both Wales and Northern Ireland teams, this has not proved possible. In short, this functionality was never designed to be built into the original system and has proved too problematic to resolve in the way originally anticipated.

As a consequence, the Post Payment Verification Team has been unable to receive collated practice samples and is therefore unable to meet the planned review of 222 practices as anticipated.

Assessment

There are clearly two key risks in the current situation:

1. Errors in claims go undetected and un-reconciled (Finance)
2. NWSSP is unable to meet its post payment verification commitment as agreed with health boards, and submitted to their respective Audit Committees (Reputation)

Next Steps

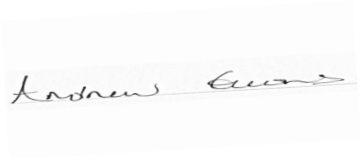
In order to mitigate the risks noted above, NWSSP Primary Care Services will:

a) Suspend all GMS Post Payment Verification reviews for the remainder of 2022/23. Restarting them fully again from April 2023 when the actions noted below are operational. Ophthalmic and Pharmacy reviews will continue as planned during this period.
b) Establish an in-house Reconciliation System that replicates, as far as practicable, the original Open Exeter cleansing process that links claims submitted by practices to NHS numbers. This will be operational from 3rd January 2023. Review all claims data from October 2021 to September 2022, through the Payment Team, using the in-house Reconciliation System to provide verification of all payments made during that period. This process will be subject to Internal Audit review to assure effectiveness. Claims from October 2022 onwards will not need to be reviewed retrospectively as they will have been processed through the Reconciliation System directly.

c) Work with health boards and practices to ensure clarity around the process for monthly and quarterly claims submission, as both are achievable via the system (54% of practices currently submit data monthly).
d) Establish communications with health boards and practices to explain the current situation and plans.

Please contact me using the details provided at the top of this letter if you would like to discuss this further.

Yours sincerely



Andrew Evans
Director of Primary Care Services

cc GPC Wales

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22	All GP Practices, cc HoPC Primary Care Mgrs	PPV – Urgent Action Required	June 2022
23	HoPC, DoFs, GPC Wales	PPV Schedule 2022/23	June 2022
24	All GP Practices, cc HoPC, Primary Care Mgrs	FPPS – ES Evidence Upload workshops	July 2022
25	All GP Practices, cc HoPC, Primary Care Mgrs	FPPS Update and Drop In Sessions	September 2022

Partneriaeth Cydwasanaethau
Gwasanaethau Gofal Sylfaenol
Shared Services Partnership
Primary Care Services

Ceri Evans
Head of Transaction Services
nwssp-primarycareservices@wales.nhs.uk

For the attention of: GP Practice Managers

June 2022

Dear Colleague

Communication No 22: FPPS Enhanced Services Supporting Evidence - URGENT ACTION REQUIRED

Practices will be aware of the requirement to submit supporting evidence for each claim entered in FPPS.

Primarily this is required to enable Post Payment Verification (PPV) processes to take place, but also will benefit GP practices to:

- Identify any underclaiming
- Identify incorrect service claims
- Reduce the potential for submission of duplicate claims
- Support processes to reconcile GMS statements
- Assist with the completion of the FP34
- Consolidate evidence minimising or avoiding pre-visit PPV requests for any missing evidence.

On reviewing the evidence submitted via FPPS to-date there is considerable disparity across the majority of practices regarding the accuracy of evidence provided when compared to the claim submitted in FPPS.

Examples of the issues identified to-date include:

- Number of claims in FPPS does not correlate with the supporting evidence, e.g.:
  - Qty 10 Minor Surgery claimed in FPPS, 8 NHS numbers provided in supporting evidence
  - Qty 108 Warfarin Level A – Monitoring claimed in FPPS, 109 NHS numbers provided in supporting evidence
- Supporting evidence provides a list of NHS numbers only, no service description, no date of activity
- No evidence provided

We do acknowledge that the transition to the new system has been challenging for some practices however, it is important to ensure this information is accurate for each claim submitted across all claim periods.

URGENT ACTION REQUIRED: To ensure evidence submitted in FPPS to-date is accurate, Practices are asked to review evidence for all claims submitted in FPPS and re-submit via FPPS where necessary by 22nd June 2022.

System modifications are being identified to improve how supporting evidence is captured in FPPS. In the meantime practices are reminded to ensure the evidence provided is complete, i.e., the correct number of NHS Numbers per enhanced service match the number of claims submitted in FPPS.

Practices scheduled a PPV visit in the coming months may be contacted separately to re-submit evidence where this has been found to be incorrect.

If you need any assistance or clarification, please contact nwssp-primarycareservices@wales.nhs.uk outlining what assistance you require and a member of the Payments or PPV team will contact you.

Thank you in advance.

Yours sincerely



Ceri Evans
Head of Transaction Services

cc Heads of Primary Care
Primary Care Managers

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	24 June 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 potential strategic risks that could threaten the delivery of the Board's strategic objectives and the Health Board's overarching purpose.

The identification of these risks is undertaken as a means of exploring credible worst-case scenarios, thereby supporting proactive risk management and providing assurance that such risks are being effectively identified, assessed, and managed.

Cefndir / Background

The Strategic Risk Report, last presented to the Committee in April, identified nine principal risks and 21 sub-risks. These risks continue to be actively managed to ensure appropriate mitigation and oversight.

This approach is fully aligned with the Board's Risk Management Framework, strengthening governance and enabling robust scrutiny and assurance of all potential threats to the successful delivery of the 2025–2028 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*

Risk Exposure and Appetite

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	**Consequence/Impact**				
	1. Negligible	**2. Minor**	**3. Moderate**	**4. Major**	**5. Catastrophic**
5. Almost Certain (>75%)					
4. Likely (41-75%)				**1** (Extreme) ***SRR 001G**	
3. Possible (11-40%)			**1 (**High) SRR 007 B	**13** (High) SRR 001 A - D, F, ***I,** ***SRR 002 B** ***SRR 004 B,** SRR 005 A SRR 006 A, B, C ***SRR 010**	**2** (Extreme) ***SRR 002A** SRR 011A
2. Unlikely (1-10%)				**4** (Moderate) SRR 001 E SRR 004 A SRR 007 A SRR 008 A	
1. Rare (<1%)					

**Risks outside of appetite*

Risk Appetite

The Committee should note that six sub-risks currently exceed the acceptable thresholds for their respective domains. However, each of these risks is under active management. Ongoing assessments are in place to monitor residual risk, ensuring that new threats and vulnerabilities are promptly identified and addressed.

The Table below sets out the suggested management of the risks.

Risk ID	Sub Risk Description	Current Score	Management of the Risk
SRR 001G	Due to the failure to deliver a sustainable financial position and longer-term financial plan.	**16**	**Treat** the residual risk, but also **Take Opportunities** to redesign and strengthen services for long-term sustainability.
SRR 001I	Due to a failure to implement the required performance improvements in some areas of the organisation in line with the Health Board's Performance Management Framework domains of Quality and Safety, Operational Delivery, and Finance.	**12**	**Treat** the residual risk, but also **Take the Opportunity** to redesign and strengthen services for long-term sustainability.
SRR 002A	Due to the presence of Reinforced Autoclaved Aeriated Concrete (RAAC) within structures	**15**	**Tolerate** the risk until it can be **Terminated.**
SRR 002B	Due to significant levels of backlog maintenance and structural impairment.	**12**	**TREAT** the risk through proactive estate investment and maintenance planning.
SRR 004B	Due to ineffective and insufficient arrangements across all service areas to respond to a Business Continuity or Critical Incident	**12**	**TREAT** the risk by developing, standardising, and testing effective Business Continuity and Critical Incident Response Plans.
SRR 010	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.	**12**	**Treat** the residual risk, but also **Take the Opportunity** to improve staff safety culture.

Management of Risks Outside Appetite

To strengthen the Health Board’s resilience and ensure alignment with its risk appetite, targeted work is required across three control categories, preventative, detective, and corrective for risks currently outside of appetite in the domains of financial sustainability, compliance, and safety.

In the year ahead, focused monitoring of risks will remain a priority. This ongoing surveillance, combined with strengthened control measures, will be essential in managing associated risks and ensuring alignment between resources, performance measures, and safety.

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 **six** 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.

Argymhelliad / Recommendation

The Audit, Risk and Assurance Committee is requested to:

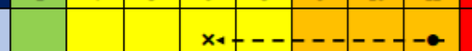
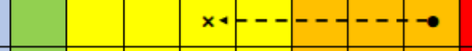
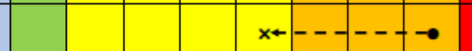
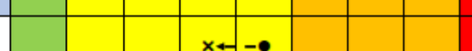
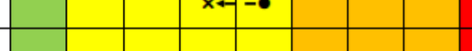
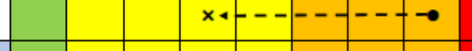
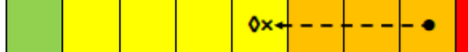
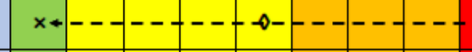
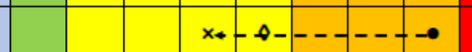
- **NOTE** the Strategic Risk Register and the Risk Assessments for the 21 sub-risks, acknowledging the comprehensive review and ongoing management of these risks;
- **CONSIDER** whether it has sufficient assurance that the strategic risks are being assessed, managed, and reviewed appropriately and effectively, 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.

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:

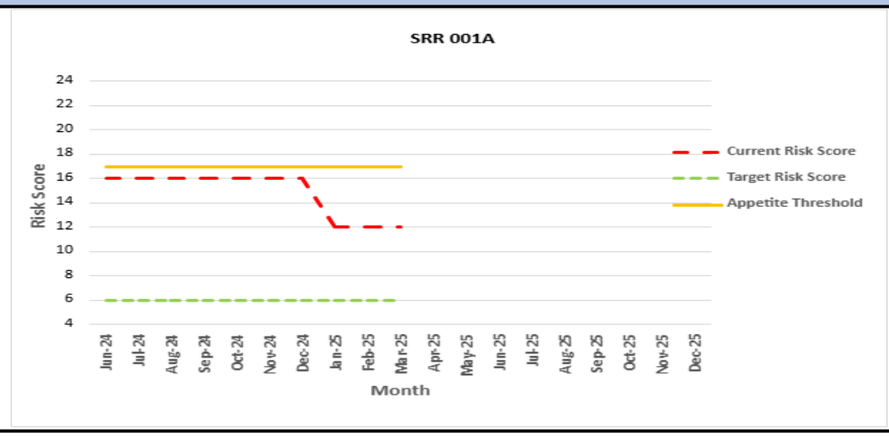
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	N/A
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	At each meeting, the relevant Committee will monitor the risk theme relevant 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
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					
SRR 001	**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**
Strategic Threat	**a. 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	• Adverse impacts on delivery of care to patients across acute and non-acute settings • Non-compliance with safe staffing principles and standards • Reliance on agency and bank staff • Litigation & Financial Penalties				**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.	
					Expected Date Target Score will be Achieved –	
Lead Director	Director of Workforce & Organisational Development	**Risk Exposure**	**Current Level**	**Target Level**		
Monitoring Committee	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 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)*
• 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. • 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 • 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.

- Working with partners to improve visibility and attraction
- DBS Policy in place with DBS risk assessment form

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 June 2024. 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; workshop dates available with spaces for 120 people (with monthly training sessions available). Sessions are nearly fully booked with 114/120 places booked**.**
- 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, provisionally scheduled for the end of January 2025.
- 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)
- Cadet Nursing programme in place – 16 candidates attended for the 2024 induction and work is ongoing to support all 16 to achieve accreditations.
- 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) is in its second year. Similar program for Directorate Managers (DMx) a 10-month leadership development program to support the capability of this key group commenced 23 April 2024. 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.
- Delivery of workforce planning training

- Looking to increase Assistant band 4 in Community/Mental Health and areas such as Cardiology Physiology
- Continue to extend scope of Advanced Clinical Practitioners to undertake new procedures, reporting etc reducing medical capacity.
- Increasing consultant therapy and nurse practitioners.
- RCN introduction of Registered Nursing Associate role to help build the capacity of the nursing workforce – 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 on line training modules level 1. 15 managers enrolled on level 2 training delivered locally March 25.

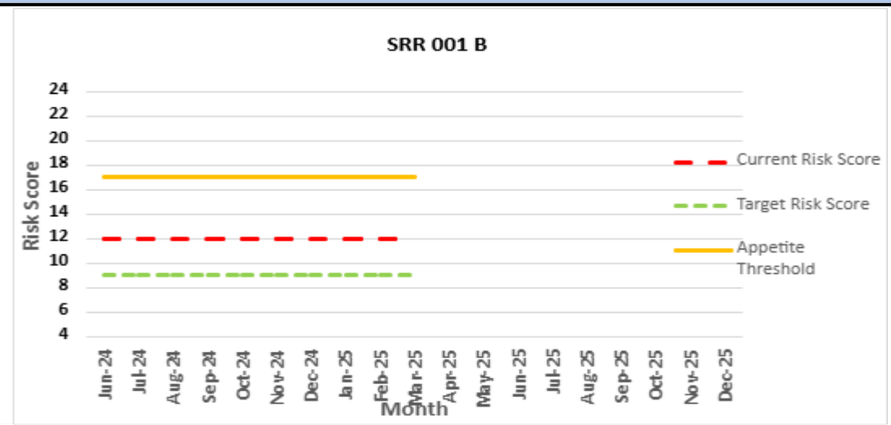
Vacancy Numbers and establishment control • Quarterly reporting of vacancy numbers for each staff to the WG as of 30th September 2024 were 585 WTE a reduction of 51 WTE since March 2024. • Development of ESR establishments commenced on a national basis w/c 03 September 2023. Local delivery action plan 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 • External reporting on Nursing Staffing Levels • National Acuity Audits (Nursing) • 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. • 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)*

Negative – Insufficient evidence that the controls in place are working effectively.	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**Positive Assurance**

RISK THEME	PEOPLE				
SRR 001	**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**
Strategic Threat	**b. Due to a deterioration in, and a failure to improve, the well-being of staff.**			**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	• High absence levels, with some sustained long periods • Adverse impacts on delivery of care to patients across acute and non-acute settings • Non-compliance with safe staffing principles and standards • Reputational damage to the health board as an employer • Work-related claims • Financial Implications			**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.	
				Expected Date Target Score will be Achieved –	
Lead Director	Director of Workforce & Organisational Development	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee	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 January 2024	**Risk rating**	**= 12** *(High)*	**= 9** *(High)*	
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)*
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.	**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. **Occupational Health.** • Reviewed Occupational Health provision and consider options to improve sustainability within the service, paper drafted. • 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. • Support equality and diversity of workforce. • Review of staff diversity networks. • Review of wellbeing survey through and equality lens to understand variations within diverse workforce demographic profile. • 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.

• 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 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 12 months to offer additional psychosocial wellbeing support to staff, including a waiting list initiative. Waiting times have now reduced on average by 30%. **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 (December 2023 – December 2024). • Band 5 EDI Officer appointed and commence 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.	

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)*

Negative – Insufficient evidence that the controls in place are working effectively.	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**Positive Assurance**

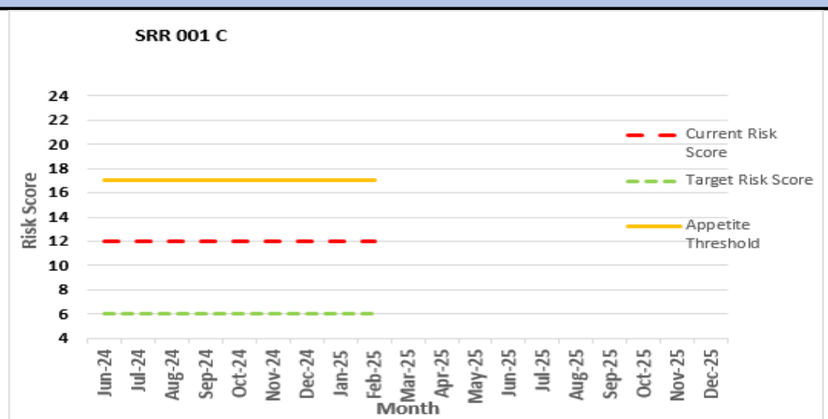
RISK THEME	PEOPLE				
SRR 001	**The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**			**Publication Status**	**Public**
Strategic Threat	**c.** Due to insufficient and ineffective leadership levels throughout the organisation				
Impact	• Adverse impacts on delivery of care to patients across acute and non-acute settings; • 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; • Adverse impacts on staff recruitment and retention				
Lead Director	Director of Workforce & Organisational Development	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee	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 January 2024	**Risk rating**	**= 12** *(High)*	**= 6** *(Moderate)*	
Next Review (Quarterly based on risk score)	01 April 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.

Expected Date Target Score will be Achieved –



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 • 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 manager development programme DMx to launch Q1 2024/25, 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 8 may 2024) • 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 in order to maximise Governmental Grants and utilisation of the apprentice levy. • Continued commitment to NHS graduate schemes.

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)*

Negative – Insufficient evidence that the controls in place are working effectively.	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**Positive Assurance**

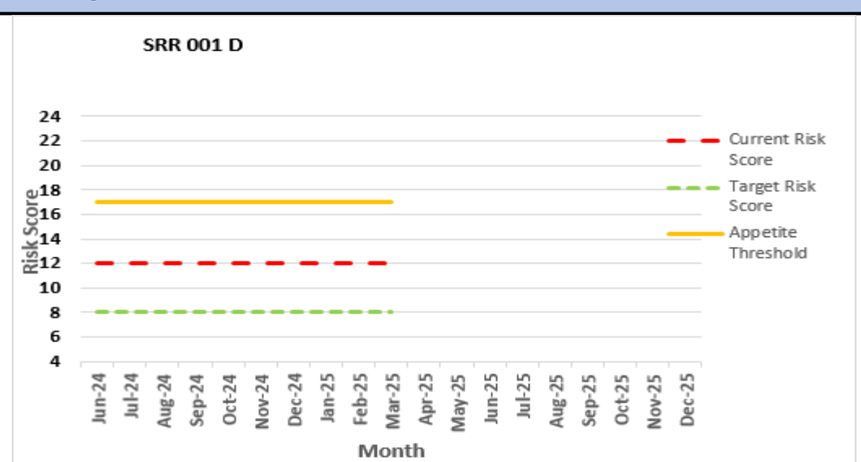
RISK THEME	PEOPLE				
SRR 001	**The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**			**Publication Status**	**Public**
Strategic Threat	**d.** Due to the threat of Industrial Action during ongoing disputes and negotiations at a national level				
Impact	• Adverse impacts on delivery of care to patients across acute and non-acute settings • Non-compliance with safe staffing principles and standards • Litigation & Financial Penalties • Reputational damage to the health board and loss of public confidence				
Lead Director	Director of Workforce & Organisational Development	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee	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 March 2025	**Risk rating**	**= 12** *(High)*	**= 8** *(Moderate)*	
Next Review (Quarterly based on risk score)	01 June 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.

Expected Date Target Score will be Achieved –



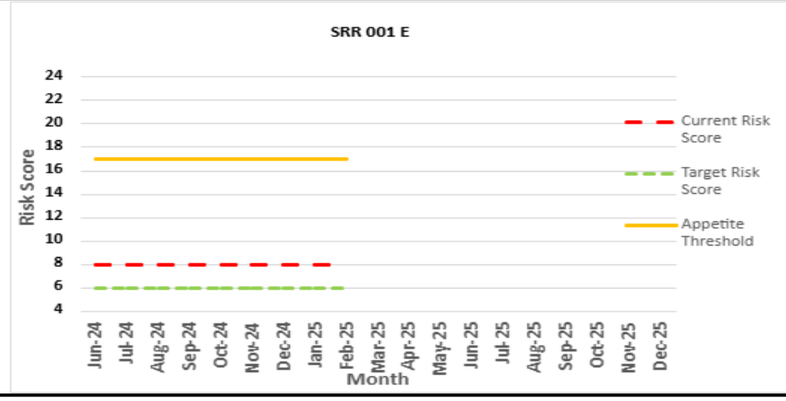
Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, 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)*

Negative – Insufficient evidence that the controls in place are working effectively.	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**Reasonable Assurance**

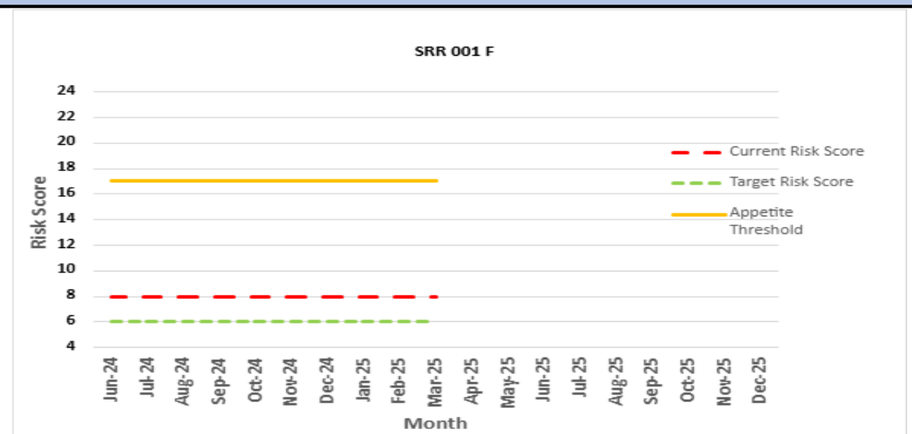
RISK THEME	SERVICE DELIVERY					
SRR 001	**The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**				**Publication Status**	**Public**
Strategic Threat	**E. Due to inadequate strategic plans which respond to population 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	• Increased demand • Increased patient acuity levels • Worsening of health inequalities • Worsening of health outcomes • 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.	
					Expected Date Target Score will be Achieved –	
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)*	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 • RPB reporting to Board and Population Health, Planning and Partnerships Committee • Regional Planning reporting to Population Health, Planning and Partnerships Committee • Clinical Futures Programme Reporting to Population Health, Planning and Partnerships Committee		• Outcome of the Internal Audit Partnership Arrangements scheduled for Q1 2024/25 Plan

Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
• Internal Audit Reviews 2023-24 • IMTP Planning (Q1) Outcome – Reasonable Assurance		

Assurance Rating (*Overall Assessment of controls and assurances)*			
Negative – Insufficient evidence that the controls in place are working effectively.	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**Reasonable Assurance**

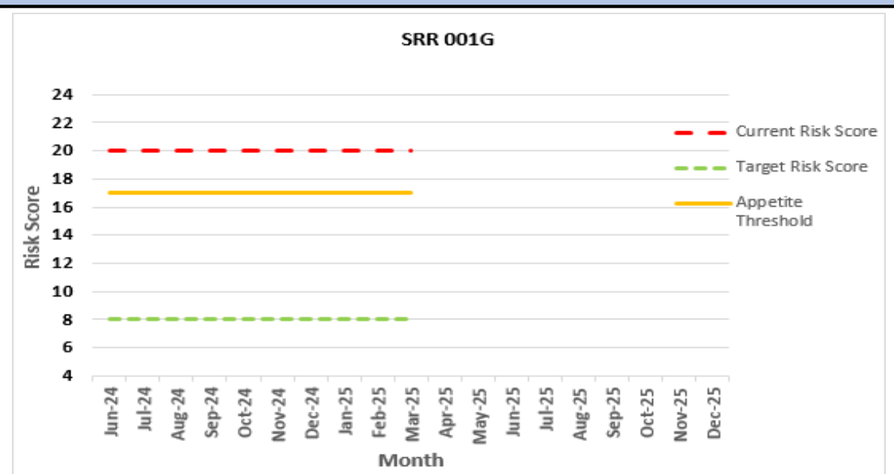
RISK THEME	SERVICE DELIVERY					
SRR 001	**The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**				**Publication Status**	**Public**
Strategic Threat	**F. Due to unsustainable service models**				**Risk Appetite 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	• Increased demand • Increased patient acuity levels • Worsening of health inequalities • Worsening of health outcomes • 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.	
					Expected Date Target Score will be Achieved –	
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)*	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)*
• 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 – to launch Summer 2024.

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. • Regional Planning reporting to Population Health, Planning and Partnerships Committee. • Clinical Futures Programme Reporting to Population Health, Planning and Partnerships Committee.		• Outcome of the Internal Audit Partnership Arrangements scheduled for Q1 2024/25 Plan
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)		

Assurance Rating (*Overall Assessment of controls and assurances)*			
Negative – Insufficient evidence that the controls in place are working effectively.	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**Reasonable Assurance**

RISK THEME	FINANCIAL SUSTAINABILITY					
SRR 001	**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**
Strategic Threat	**G. Due to the failure to deliver a sustainable financial position and longer-term financial plan.**				**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	• 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				**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.	
					Expected Date Target Score will be Achieved –	
Lead Director	Director of Finance and Procurement	**Risk Exposure**	**Current Level**	**Target Level**		
Monitoring Committee	Finance & Performance Committee	**Likelihood**	**5** *(Almost certain)* x	*2 (Unlikely)* x		
Initial Date of Assessment	01 June 2023	**Impact**	*4 (Major)*	**4** *(Major)*		
Last Reviewed	01 March 2025	**Risk rating**	**= 20** *(Extreme)*	**= 8** *(Moderate)*		
Next Review (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)*
• IMTP 2023/24-25/26 • IMTP Delivery Framework • Accountability Framework • Performance Framework • 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 • Cost intervention procedures • 23/24 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. • 3-year route map to sustainable recovery developed and approved by Board July 24.	• Revised V&SB approach for 2024/25 to help drive financial recovery, separating thematic and divisional scrutiny. • 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. • 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.		• 2024/25 IMTP plans focussed on 'living within' budget levels. • 2024/25 savings plan to be delivered. • Detailed delivery plans will be a constant development over next 2 years.
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)	**Internal Audit Reviews 2023 – 24** • Savings Programmes – Reported to ARAC - Reasonable Assurance • Financial Controls – Reported to ARAC July 2024 – Substantial Assurance • Asset Management Q3 – Reported to ARAC April 2024 - Reasonable Assurance **External Audit Reports 2023 -24** • Efficiency Review 23/24 Q3/Q4 – Not yet reported. • Structured Assessment - Received at ARAC November 2023. • Audit of Financial Statements Q4 2023/24 – True & Fair view given, minor recommendations, qualified on deficit and 3-year IMTP not agreed. • Financial assessment and review reports to Welsh Government – monthly • Enhanced monitoring T.I. meetings with Welsh Government – monthly	•

Assurance Rating (*Overall Assessment of controls and assurances)*

Negative – Insufficient evidence that the controls in place are working effectively.	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**Reasonable Assurance**

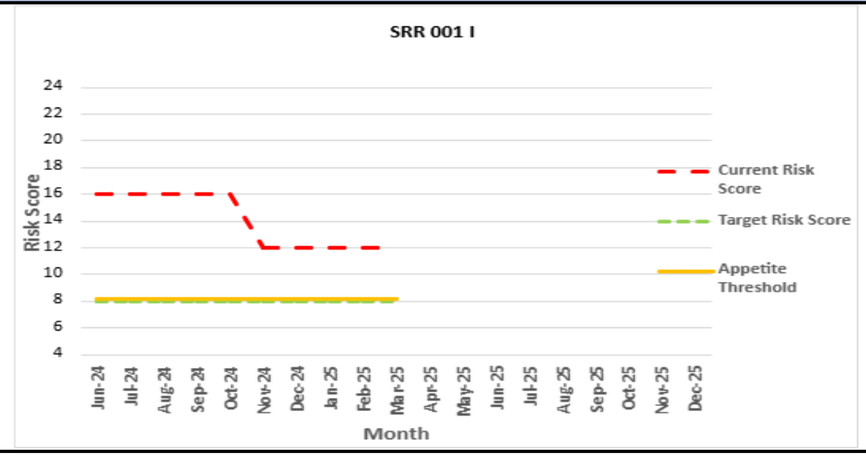
RISK THEME	COMPLIANCE AND SAFETY			
SRR 001	**The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**		**Publication Status**	**Public**
Strategic Threat	**i.** Due to a failure to implement the required performance improvements in some areas of the organisation in line with the Health Board's Performance Management Framework domains of Quality and Safety, Operational Delivery, and Finance.			
Impact	• Unintended patient harm • Negative patient/public experience • Loss of patient/public trust and confidence • Reduced staff morale leading to potential absence from work • Scrutiny from external organisations (AW/HIW/WG) • Punitive Action • Adverse publicity • Financial implications			
Lead Director	Director of Strategy, Planning & Partnerships	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Finance & Performance Committee	**Likelihood**	***3 (****Possible)* x	2 *(Unlikely)* x
Initial Date of Assessment	19 April 2024	**Impact**	4 *(Major)*	**4** *(Major)*
Last Reviewed	01 March 2025	**Risk rating**	**= 12** *(High)*	**= 8** *(Moderate)*
Next Review (Quarterly based on risk score)	01 June 2025			

Risk Appetite Level - MINIMAL
Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurrence of the risk after application of controls.

Risk Appetite Threshold – SCORE 8 AND BELOW
Risks relating to all aspects of patient safety but also including safeguarding, staff & public security in addition to risks relating to compliance and/or legal implications.

SUMMARY
The current risk level is **OUTSIDE** of target and the appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.

Expected Date Target Score will be Achieved –



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	• 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

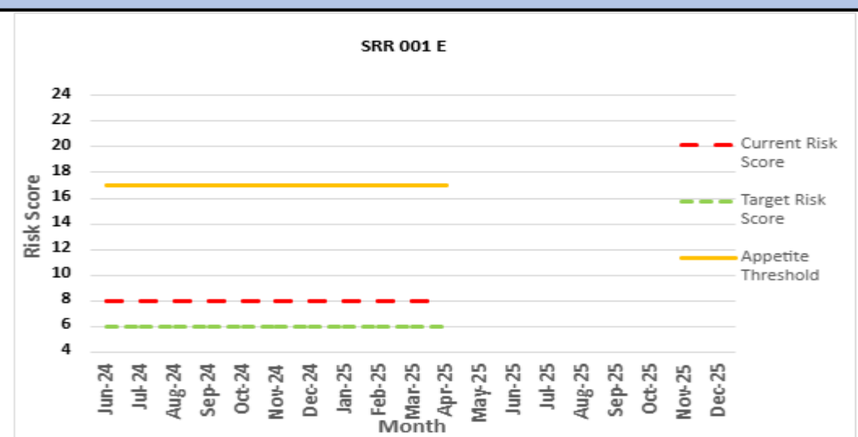
Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness 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 • 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 •	• 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)*

Negative – Insufficient evidence that the controls in place are working effectively.	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**Reasonable Assurance**

RISK THEME	COMPLIANCE AND SAFETY				
SRR 002	**There is a risk that there will be significant failure of the Health Boards Estates.**			**Publication Status**	**Public**
Strategic Threat	**e.** Due to the presence of Reinforced Autoclaved Aeriated Concrete (RAAC) within structures.			**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	• Harm or injury to patients and/or staff. • Adverse impacts on the delivery of care to patients across acute and non-acute settings. • Non-compliance with health and safety legislation. • Loss of estate • Litigation and financial penalties			**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	
				Expected Date Target Score will be Achieved –	
Lead Director	Chief Operating Officer	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee	Partnerships, Public Health & 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 2025	**Risk rating**	**= 15** *(Extreme)*	**= 2** *(Low)*	
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)*
• 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 • Review of existing arrangements to monitor, manage and mitigate issues associated with RAAC is underway with external support and advice from the surveying contractor based on their experiences in NHS England and education bodies. This will inform any additional steps to monitor manage and mitigate led by the RAAC Working Group (chaired by the Director of Estates and Facilities Division)

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. •		• 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** • this has been reported at relevant committee.

Assurance Rating (*Overall Assessment of controls and assurances)*			
Negative – Insufficient evidence that the controls in place are working effectively.	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**Reasonable Assurance**

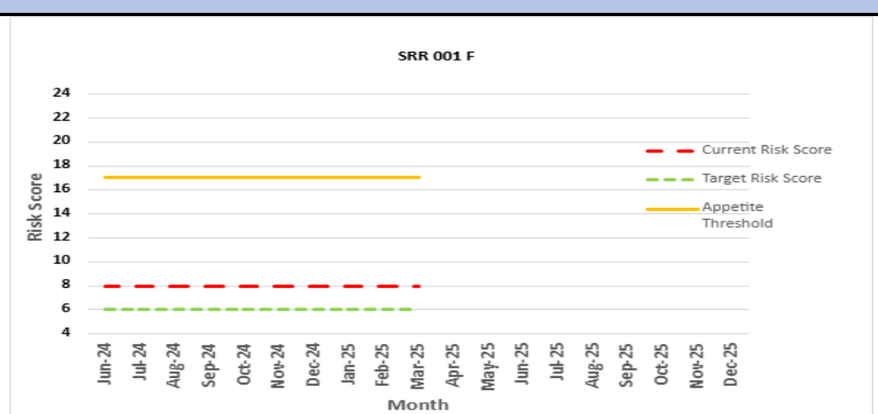
RISK THEME	COMPLIENCE AND SAFETY			
SRR 002	**There is a risk that there will be significant failure of the Health Boards Estates.**		**Publication Status**	**Public**
Strategic Threat	**f.** Due to significant levels of backlog maintenance and structural impairment.			
Impact	• Harm or injury to patients and/or staff. • Adverse impacts on the delivery of care to patients across acute and non-acute settings. • Non-compliance with health and safety legislation. • Litigation and financial penalties. • Loss of estate			
Lead Director	Chief Operating Officer	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	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			

Risk Appetite Level – MINIMAL
Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurrence of the risk after application of controls.

Risk Appetite Threshold – SCORE 8 AND BELOW
Risks relating to all aspects of patient safety but also including safeguarding, staff & public security in addition to risks relating to compliance and/or legal implications.

SUMMARY
The current risk level is **OUTSIDE** of the target level and appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.

Expected Date Target Score will be Achieved –



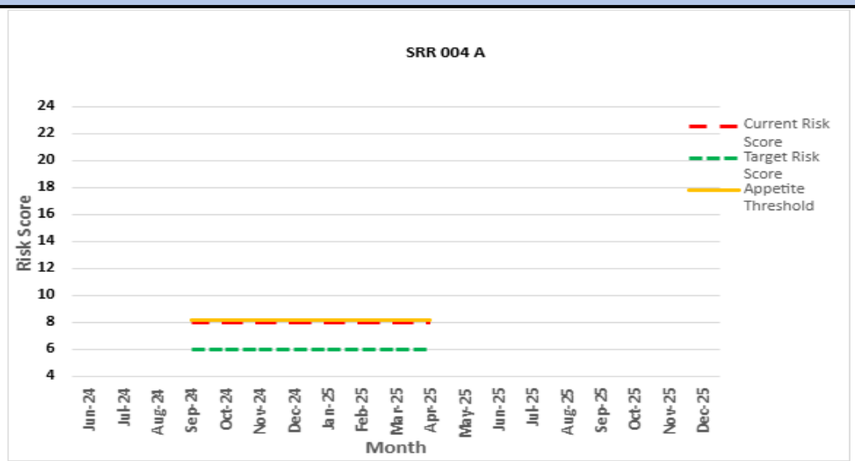
Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, 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.

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		•

Assurance Rating (*Overall Assessment of controls and assurances)*			
Negative – Insufficient evidence that the controls in place are working effectively.	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**Reasonable Assurance**

RISK THEME	COMPLIANCE AND SAFETY				
SRR 004	**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**
Strategic Threat	**A. 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	• Adverse impacts on delivery of care to patients across acute and non-acute settings • • Inability to respond to a major incident to meet needs of those affected • • Harm or injury to patients and/or staff; • • 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.	
				Expected Date Target Score will be Achieved –	
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*)*	3 *(Moderate)*	
Last Reviewed	01 November 2024	**Risk rating**	**= 8** *(Moderate)*	**= 6** *(Moderate)*	
Next Review (Six 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)*
Major Incident Plan and procedures • • Local/Divisional action cards are in place. • • 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 log books 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	• 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.

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)*		
nternal Audit Review(s) • Business Continuity Planning 2023-24 (Q2) outcome report published – included MI response – Reasonable Assurance • Outcome and feedback from national exercises	**Internal Audit Reviews 2023 – 24** • Savings Programmes – Reported to ARAC - Reasonable Assurance • Financial Controls – Reported to ARAC July 2024 – Substantial Assurance • Asset Management Q3 – Reported to ARAC April 2024 - Reasonable Assurance **External Audit Reports 2023 -24** • Efficiency Review 23/24 Q3/Q4 – Not yet reported. • Structured Assessment - Received at ARAC November 2023. • Audit of Financial Statements Q4 2023/24 – True & Fair view given, minor recommendations, qualified on deficit and 3-year IMTP not agreed. • Financial assessment and review reports to Welsh Government – monthly • Enhanced monitoring T.I. meetings with Welsh Government – monthly	•

Assurance Rating (*Overall Assessment of controls and assurances)*							
	Negative – Insufficient evidence that the controls in place are working effectively.		**Reasonable -** adequate evidence that the controls in place are working effectively.		**Positive -** robust evidence that the controls in place are working effectively.	**Reasonable Assurance**

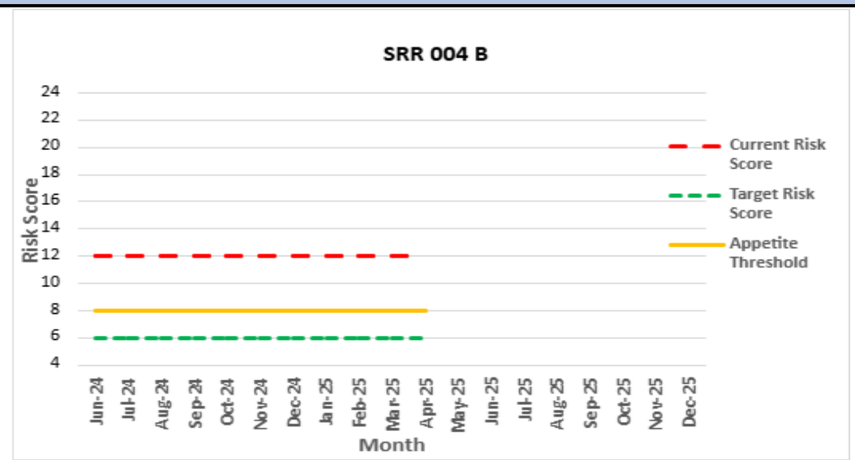
RISK THEME	COMPLIENCE AND SAFETY				
SRR 004	**There is a risk that the Health Board is unable to respond in a timely, efficient, and effective way to a major incident.**			**Publication Status**	**Public**
Strategic Threat	b. Due to ineffective and insufficient arrangements across all service areas to respond to a Business Continuity or Critical Incident.				
Impact	Adverse impacts on delivery of care to patients across acute and non-acute settings; • impact to operational flow if services fail to BC plan against the 5 key themes • Harm or injury to patients and/or staff; • Staff absence (injury, wellbeing) • Financial implications due to staff absence • Loss of infrastructure; • Health Board breaches statutory duties under the Civil Contingencies Act 2004; • Litigation & Financial Penalties; • Reputational damage and loss of public confidence				
Lead Director	Director of Strategy, Planning and Partnerships	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee	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				

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**.**

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.

Expected Date Target Score will be Achieved –

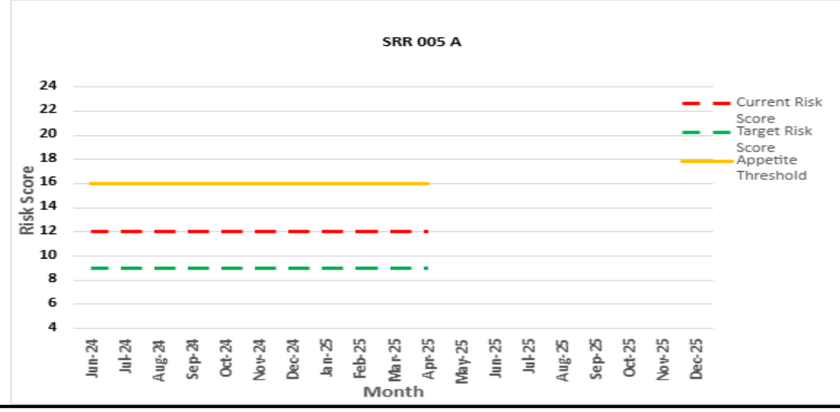


Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
Business Continuity (BC) /Critical Incident • 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.	• 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.

• 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).	

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	**Internal Audit Reviews 2023 – 24** • Savings Programmes – Reported to ARAC - Reasonable Assurance • Financial Controls – Reported to ARAC July 2024 – Substantial Assurance • Asset Management Q3 – Reported to ARAC April 2024 - Reasonable Assurance **External Audit Reports 2023 -24** • Efficiency Review 23/24 Q3/Q4 – Not yet reported. • Structured Assessment - Received at ARAC November 2023. • Audit of Financial Statements Q4 2023/24 – True & Fair view given, minor recommendations, qualified on deficit and 3-year IMTP not agreed. • Financial assessment and review reports to Welsh Government – monthly • Enhanced monitoring T.I. meetings with Welsh Government – monthly	•

Assurance Rating (*Overall Assessment of controls and assurances)*			
Negative – Insufficient evidence that the controls in place are working effectively.	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**Reasonable Assurance**

RISK THEME	SERVICE DELIVERY					
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.**				**Publication Status**	**Public**
Strategic Threat	A. 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	• Avoidable deaths or significant harm • Delays in releasing ambulances from hospital sites back into the community • Delayed discharges from acute and non-acute settings resulting in deteriorating patients; • 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.	
					Expected Date Target Score will be Achieved –	
Lead Director	Chief Operating Officer	**Risk Exposure**	**Current Level**	**Target Level**		
Monitoring Committee	Patient Quality, Safety & Outcomes Committee	**Likelihood**	**3** *(Possible)* X	**3** *(Possible)* X		
Initial Date of Assessment	01 June 2023	**Impact**	**4** *(Catastrophic)*	**3** *(Minor)*		
Last Reviewed	01 February 2024	**Risk rating**	**= 12** *(High)*	**= 9** *(High)*		
Next Review (Quarterly based on risk score)	01 May 2025					

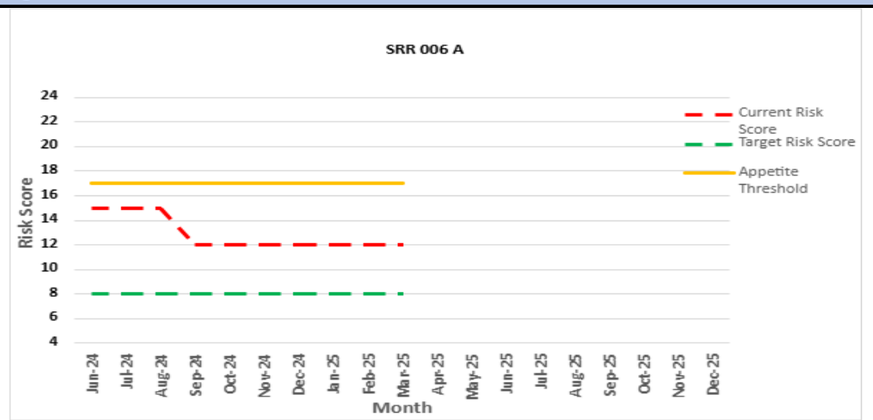
Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Escalation Policy. • Performance and Accountability Framework • 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 o New expanded transfer lounge o New ED extension and reconfiguration o Additional ED consultants coming onboard o 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 is effective 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		• 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)*			
Negative – Insufficient evidence that the controls in place are working effectively.	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**Reasonable Assurance**

RISK THEME	SERVICE DELIVERY			
SRR 006	There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.		Publication Status	Public
Strategic Threat	a. **Due to the full or partial failure of existing digital infrastructure and systems.**		**Risk Appetite Level - OPEN** Willing to consider all potential options, subject continued application and /or establishment of controls; recognising that there could be a high-risk exposure.	
Impact	• Harm or injury to patients and/or staff • Adverse impacts on delivery of care to patients across acute and non-acute settings • 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.	
			Expected Date Target Score will be Achieved –	
Lead Director	Director of Digital	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Finance & 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			



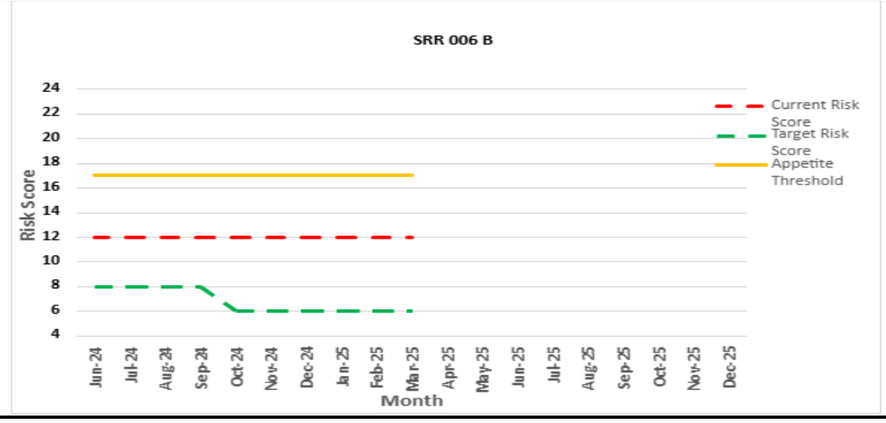
Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	Plans to Improve Control ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• 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. ·	• Implement the recommendations from Templar report: • 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.

• 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.	

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.	• Oversight from NHS Wales Cyber Resilience Unit.	• An assessment against CAF was undertaken by CRU in January '24 and the report along with its recommendations has been circulated to key stakeholders.
• **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.		
• **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies)*		
• Cyber security Audit in April 2023 provided Digital with a substantial audit for its cyber security improvement plan, reporting and backup systems. **Internal Audit 2024/25** • Technical Continuity – planned for Q3	• Latest local survey saw a reduction in staff wellbeing	

Assurance Rating (*Overall Assessment of controls and assurances)*

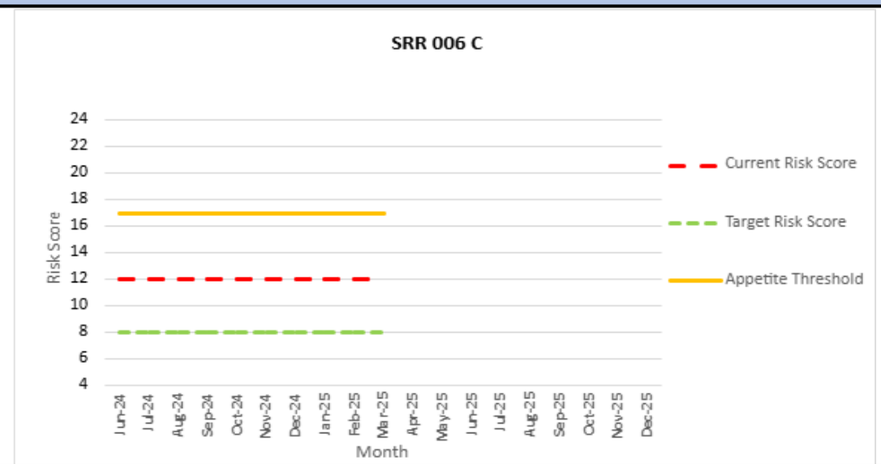
Negative – Insufficient evidence that the controls in place are working effectively.	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**Reasonable Assurance**

RISK THEME	SERVICE DELIVERY					
SRR 006	**There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.**				**Publication Status**	**Public**
Strategic Threat	**b. Due to an adverse impact on service delivery in the implementation of the new digital systems.**				**Risk Appetite Level - OPEN** Willing to consider all potential options, subject continued application and /or establishment of controls; recognising that there could be a high-risk exposure.	
Impact	• Harm or injury to patients and/or staff • Adverse impacts on delivery of care to patients across acute and non-acute settings • 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	
					Expected Date Target Score will be Achieved –	
Lead Director	Director of Digital	**Risk Exposure**	**Current Level**	**Target Level**		
Monitoring Committee	Finance & 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. • Information Governance Sub Committee and Cyber Security Subgroup established • 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

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Project Boards meet monthly and report into the bi-monthly Digital Portfolio Progress Group (DPPG) • Digital Directorate meetings being held monthly to monitor risks to regularly update and to provide assurance over outstanding action plans. • Risk management approach and escalation processes in place in line with the Health Board's Risk Framework	• 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		
• **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies)*		
• Cyber security Audit in April 2023 provided Digital with a substantial audit for its cyber security improvement plan, reporting and backup systems. **Internal Audit 2023/24** • Benefits Management review – Outcome Substantial Assurance • Stakeholder Engagement on IT Projects 2023/24 Q3 – Outcome Substantial Assurance **Internal Audit 2024/25** • Implementation of the Welsh Intensive Care System – planned for Q1		

Assurance Rating (*Overall Assessment of controls and assurances)*			
Negative – Insufficient evidence that the controls in place are working effectively.	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**Reasonable Assurance**

RISK THEME	SERVICE DELIVERY					
SRR 006	**There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.**				**Publication Status**	**Public**
Strategic Threat	**c. 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	• Harm or injury to patients and/or staff • Adverse impacts on delivery of care to patients across acute and non-acute settings • 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	
					Expected Date Target Score will be Achieved –	
Lead Director	Director of Digital	**Risk Exposure**	**Current Level**	**Target Level**		
Monitoring Committee	Finance & 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

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		
• **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies)*		
• Cyber security in April 2023 provided Digital with a substantial audit for its cyber security improvement plan, reporting and backup systems. **Internal Audit 2023/24** • LINC Programme– Outcome **Reasonable assurance** • Network Infrastructure (VPN) - Outcome **Reasonable assurance** **Internal Audit 2024/25** • Electronic document and records management solution -planned for Q4		

Assurance Rating (*Overall Assessment of controls and assurances)*			
Negative – Insufficient evidence that the controls in place are working effectively.	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**Reasonable Assurance**

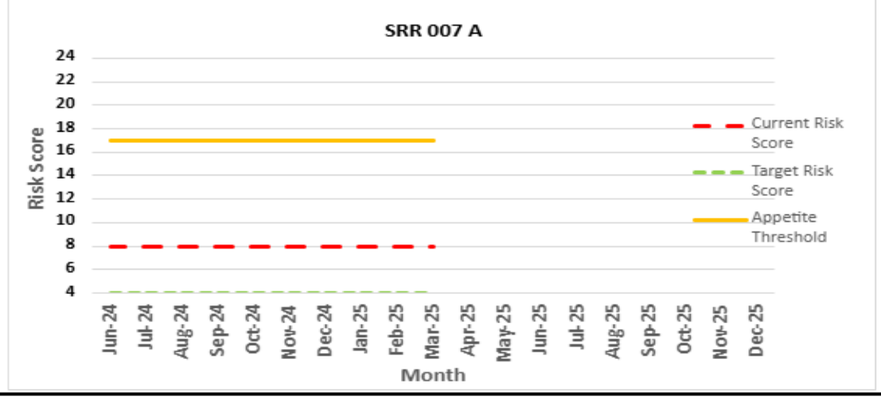
RISK THEME	TRANSFORMATION AND PARTNERSHIP WORKING			
SRR 007	**There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population.**		**Publication Status**	**Public**
Strategic Threat	**A.** Due to the likelihood of further austerity measures impacting effective collaboration with strategic partners across the Health Board footprint.			
Impact	• Unmet patient need resulting in harm • Ineffective use of combined resources • 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			
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 monthly based on risk score)	01 April 2025			

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.

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.

Expected Date Target Score will be Achieved –



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) Not yet undertaken		

Assurance Rating (*Overall Assessment of controls and assurances)*			
Negative – Insufficient evidence that the controls in place are working effectively.	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**Reasonable Assurance**

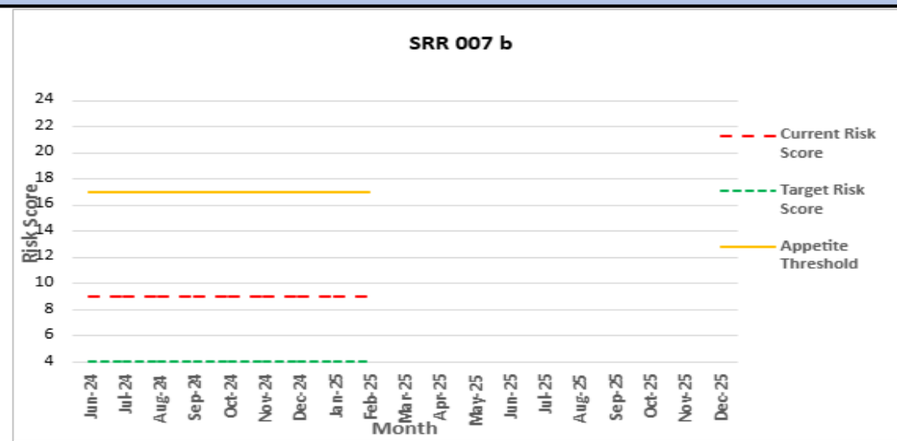
RISK THEME	TRANSFORMATION AND PARTNERSHIP WORKING				
SRR 007	**There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population.**			**Publication Status**	**Public**
Strategic Threat	B. Due to the impact of fragile services across the regional and supra regional geography				
Impact	• Unmet patient need resulting in harm • Ineffective use of combined resources • 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				
Lead Director	Director of Strategy Planning and Partnerships	**Risk Exposure**	**Current Level**	**Target Level**	
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				

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.

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.

Expected Date Target Score will be Achieved –



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	**Internal Audit 2024/25** • Recommendations from the Partnership Arrangements Review (Q1)
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)*		
Internal Audit Plan 2024/25 • Partnership Arrangements Review (Q1) - Not yet undertaken		

Assurance Rating (*Overall Assessment of controls and assurances)*			
Negative – Insufficient evidence that the controls in place are working effectively.	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**Reasonable Assurance**

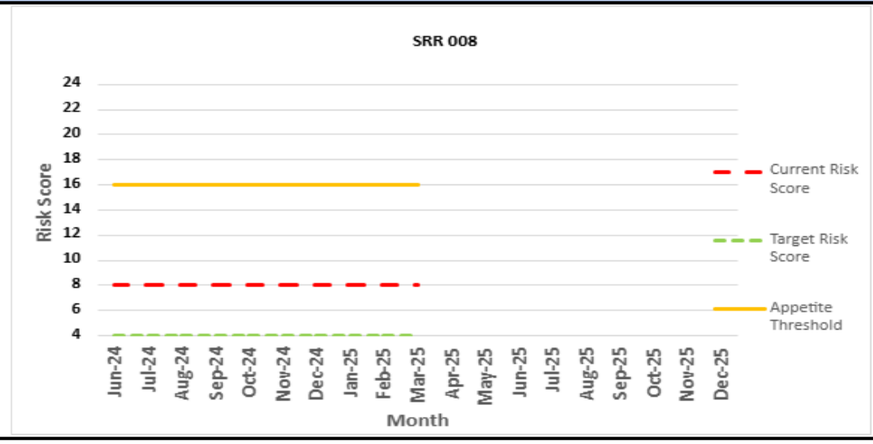
RISK THEME	TRANSFORMATION AND PARTNERSHIP WORKING			
SRR 008	**There is a risk that the Health Board fails to build positive relationships with patients, staff, and the public.**		**Publication Status**	**Public**
Strategic Threat	A. Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement			
Impact	• Unmet patient need resulting in harm • Ineffective use of combined resources • 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			
Lead Director	Director of Nursing	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Patient Quality, Safety & 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			

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.

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.

Expected Date Target Score will be Achieved –



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	• 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.

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)*		
• Patient Experience and Involvement Team oversee patient experience through dedicated work programme and link in with divisional teams. • 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	• 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. • Need to develop bereavement model and improve bereavement offer to meet Bereavement Standards. Resources being scoped.	• 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.

• 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.	• 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.	• 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)*		
• LLais Reports • HIW inspections • Advocacy reports		

Assurance Rating (*Overall Assessment of controls and assurances)*			
Negative – Insufficient evidence that the controls in place are working effectively.	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**Reasonable Assurance**

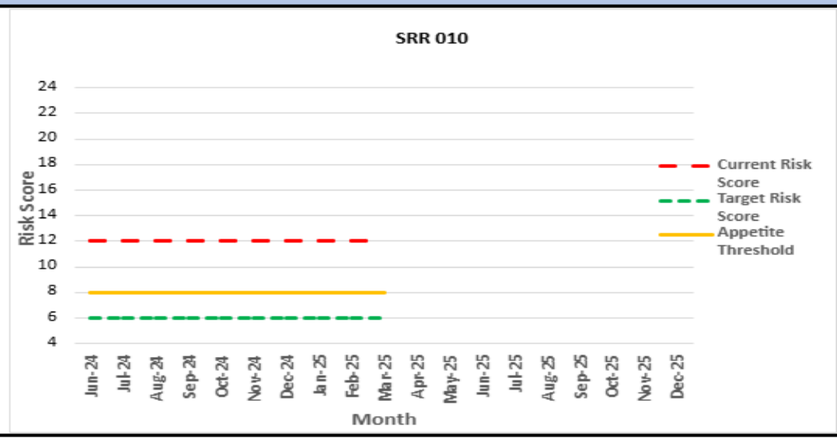
RISK THEME	COMPLIENCE AND SAFETY				
SRR 010	**There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in-line with its duties under the Health and Safety at Work Act 1974**			**Publication Status**	**Public**
Strategic Threat	A. Due to inadequate 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.				
Impact	• Unintended physical harm; • Punitive actions from the Health and Safety Executive (HSE); • Increased levels of staff sickness; • Loss of estate due to unsafe environments; • Financial implications; • Adverse publicity; and, • Reputational damage				
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				

Risk Appetite Level - MINIMAL.
Any risk that has a MINIMAL risk appetite level should be managed to a **Score of 8 or below**.

Risk Appetite Threshold - 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 **OUTSIDE** appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.

Expected Date Target Score will be Achieved –

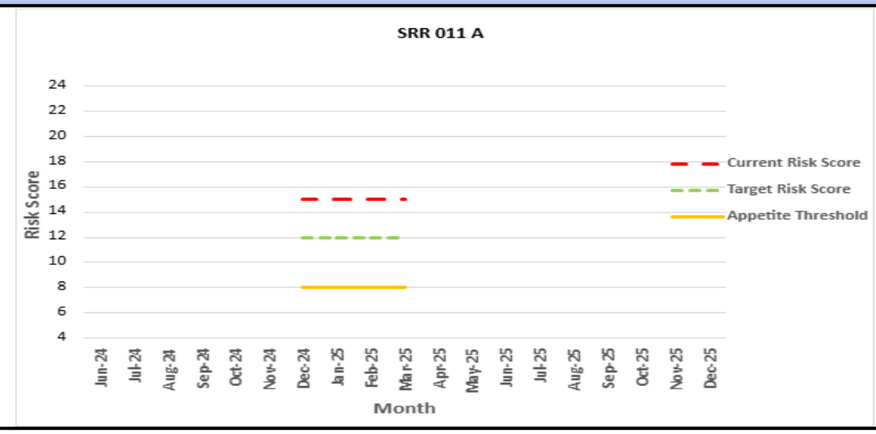


Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, 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		
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
Internal Audit 2024/25 Plan • H&S processes • 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)*			
Negative – Insufficient evidence that the controls in place are working effectively.	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**Negative Assurance**

RISK THEME	SERVICE DELIVERY					
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**
Strategic Threat (Due To)	➢ 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.				**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	➢ 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.	
					Expected Date Target Score will be Achieved – Can Not Be Determined	
Lead Director	Director of Finance and Procurement	**Risk Exposure**	**Current Level**	**Target Level**		
Monitoring Committee	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 March 2025	**Risk rating**	**= 15** ***(Extreme)***	**= 12** ***(High)***		
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)*

• 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 sub groups 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)*

Negative – Insufficient evidence that the controls in place are working effectively.	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**Reasonable Assurance**

Head of Internal Audit Opinion & Annual Report 2024/25

Aneurin Bevan University Health Board



Reasonable Assurance

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Report status:	Final
Draft report issued:	13th May 2025
Final report issued:	13th June 2025
Author:	Stephen Chaney
Audit and Assurance Committee:	24th June 2025

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

1. Executive Summary

1.1 Purpose of this Report

Aneurin Bevan University Health Board's (the Health Board) Board is accountable for maintaining a sound system of internal control that supports the achievement of the organisation's objectives and is also responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system. A key element in that flow of assurance is the overall assurance opinion from the Head of Internal Audit.

This report sets out the Head of Internal Audit Opinion together with the summarised results of the internal audit work performed during the year. The report also includes a summary of audit performance and an assessment of conformance with the Public Sector Internal Audit Standards.

1.2 Head of Internal Audit Opinion 2024/25

The purpose of the annual Head of Internal Audit opinion is to contribute to the assurances available to the Chief Executive as Accountable Officer and the Board which underpin the Board's own assessment of the effectiveness of the system of internal control. The approved Internal Audit plan is focused on risk and therefore the Board will need to integrate these results with other sources of assurance when making a rounded assessment of control for the purposes of the Annual Governance Statement. The overall opinion for 2024/25 is:

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

1.3 Delivery of the Audit Plan

The plan has been delivered substantially in accordance with the agreed schedule and changes required during the year, as approved by the Audit, Risk and Assurance Committee (the 'Committee'). In addition, regular audit progress reports have been submitted to the Committee. Although changes have been made to the plan during the year, we can confirm that we have undertaken sufficient audit work during the year to be able to give an overall opinion in line with the requirements of the Public Sector Internal Audit Standards.

The Internal Audit Plan for 2024/25 year, was presented to the Committee in April 2024. Changes to the plan have been made during the year and these changes have been reported to the Audit, Risk and Assurance Committee as part of our regular progress reporting.

There are, as in previous years, audits undertaken at NWSSP, Digital Health and Care Wales (DHCW) and the new NHS Wales Joint Commissioning Committee (JCC) that support the overall opinion for NHS Wales health bodies (see section 3).

Our latest External Quality Assessment (EQA), conducted by the Chartered Institute of Public Finance and Accountancy (CIPFA) in March 2023, reported in April 2023, stated we

'Fully Conform', and our own annual Quality Assurance and Improvement Programme (QAIP) confirmed that our internal audit work continues to 'generally conform' to the requirements of the Public Sector Internal Audit Standards for 2024/25. We can state that our service 'conforms to the IIA's professional standards and to PSIAS.'

1.4 Summary of Audit Assignments

This report summarises the outcomes from our work undertaken in the year. In some cases, audit work from previous years may also be included and where this is the case, details are given. This report also references assurances received through the internal audit of control systems operated by other NHS Wales organisations (again, see section 3).

The audit coverage in the plan agreed with management has been deliberately focused on key strategic and operational risk areas; the outcome of these audit reviews may therefore highlight control weaknesses that impact on the overall assurance opinion.

Overall, we can provide the following assurances to the Board that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively in the substantial and reasonable areas in the table below.

Where we have given Limited Assurance, management are aware of the specific issues identified and have agreed action plans to improve control in these areas. These planned control improvements should be referenced in the Annual Governance Statement where it is appropriate to do so.

In addition, we also undertook advisory and non-opinion reviews to support our overall opinion. A summary of the audits undertaken in the year and the results are summarised in table 1 below.

Table 1 – Summary of Audits 2024/25

Substantial Assurance	• Declarations of Interest
Reasonable Assurance	• Intelligence Led Organisation (incorporating IMTP) • Facilities Stock • Performance Framework • Divisional Governance Arrangements • Directorate Review – Mental Health and LD • Maternity Services Improvement Plan • End of Life Care • Medical Equipment and Devices (draft report) • Staff Culture • Nevill Hall RAAC • Estates Assurance – Energy Management • Newport HWBC (draft report) • GUH – Emergency Department Extension • Health Board Managed Practices • Technical Continuity • Electronic Document and Records Management System (draft report) • Providing Care to Asylum Seekers and Refugees (2023/24)

	• Newport East Health and Wellbeing Centre (2023/24) • Development of a Regional Radiotherapy Satellite Centre at Nevill Hall Hospital (2023/24)
Limited Assurance	• Embedding of Policies (Speaking up Safely) • Records Management • Job Planning • Health and Safety (draft report)
Unsatisfactory	N/A
Advisory/Non-Opinion	• Follow-up of High Priority Recommendations • Contract Management

Please note that our overall opinion has also considered both the number and significance of any audits that have been deferred during the year (see section 5.8) and other information obtained during the year that we deem to be relevant to our work.

2. Head of Internal Audit Opinion

2.1 Roles and Responsibilities

The Board is collectively accountable for maintaining a sound system of internal control that supports the achievement of the organisation's objectives and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

The Annual Governance Statement is a statement made by the Accountable Officer, on behalf of the Board, setting out:

- how the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives;
- the purpose of the system of internal control, as evidenced by a description of the risk management and review processes, including compliance with the Health & Care Quality Standards; and
- the conduct and results of the review of the effectiveness of the system of internal control including any disclosures of significant control failures, together with assurances that actions are or will be taken where appropriate to address issues arising.

The Health Board's risk management process and system of assurance should bring together all the evidence required to support the Annual Governance Statement.

In accordance with the Public Sector Internal Audit Standards (PSIAS), the Head of Internal Audit (HIA) is required to provide an annual opinion, based upon and limited to the work performed on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. This is achieved through an audit plan that has been focussed on key strategic and operational risk areas and known improvement opportunities, agreed with executive management and approved by the Audit, Risk and Assurance Committee, which should provide an appropriate level of assurance.

The opinion does not imply that Internal Audit has reviewed all risks and assurances relating to the Health Board. The opinion is substantially derived from the conduct of risk-

based audit work formulated around a selection of key organisational systems and risks. As such, it is a key component that the Board considers but is not intended to provide a comprehensive view.

The Board, through the Audit, Risk and Assurance Committee, will need to consider the Head of Internal Audit opinion together with assurances from other sources including reports issued by other review bodies, assurances given by management and other relevant information when forming a rounded picture on governance, risk management and control for completing its Governance Statement.

2.2 Purpose of the Head of Internal Audit Opinion

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

This opinion will in turn assist the Board in the completion of its Annual Governance Statement and may also be considered by regulators, including Healthcare Inspectorate Wales, in assessing compliance with the Health and Care Quality Standards in Wales, and by Audit Wales in the context of both their external audit and performance reviews.

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

2.3 Assurance Rating System for the Head of Internal Audit Opinion

The overall opinion is based primarily on the outcome of the work undertaken during the 2024/25 audit year. We also consider other information available to us such as our overall knowledge of the organisation, the findings of other assurance providers and inspectors, and the work we undertake at other NHS Wales organisations. The Head of Internal Audit considers the outcomes of the audit work undertaken and exercises professional judgement to arrive at the most appropriate opinion for each organisation.

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

We take this approach into account when considering our assessment of our compliance with the requirements of PSIAS.

The assurance rating system based upon the colour-coded barometer and applied to individual audit reports remains unchanged. The descriptive narrative used in these definitions has proven effective in giving an objective and consistent measure of assurance in the context of assessed risk and associated control in those areas examined.

This same assurance rating system is applied to the overall Head of Internal Audit opinion on governance, risk management and control as to individual assignment audit reviews. The assurance rating system together with definitions is included at **Appendix B**.

The individual conclusions arising from detailed audits undertaken during the year have been summarised by the assurance ratings received. The aggregation of audit results gives a better picture of assurance to the Board and also provides a rational basis for

drawing an overall audit opinion. However, please note that for presentational purposes we have shown the results using the eight areas that were previously used to frame the audit plan at its outset (see section 2.4).

2.4 Head of Internal Audit Opinion

Scope of opinion

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

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

This opinion will need to be reflected within the Annual Governance Statement along with confirmation of action planned to address the issues raised from reviews.

Focus should be placed on the agreed response to the Limited Assurance opinions issued during the year and the significance of the recommendations made across other audits (of which there were 24 audits and two advisory / non-rated reviews in 2024/25) as well as addressing the implementation of recommendations from previous year reviews.

Basis for Forming the Opinion

The audit work undertaken during 2024/25, and reported to the Audit, Risk and Assurance Committee, has been aggregated at Section 5.

The evidence base upon which the overall opinion is formed is as follows:

- An assessment of the range of individual opinions and outputs arising from risk-based audit assignments contained within the Internal Audit plan that have been reported to the Audit, Risk and Assurance Committee throughout the year. In addition, and where appropriate, work at either draft report stage or in progress but substantially complete has also been considered, and where this is the case then it is identified in the report. This assessment has taken account of the relative materiality of these areas and the results of any follow-up audits in progressing control improvements.
- The results of any audit work related to the Health & Care Quality Standards including, if appropriate, the evidence available by which the Board has arrived at its declaration in respect of the self-assessment for the leadership standard.

  Other assurance reviews which impact on the Head of Internal Audit opinion

including audit work performed at other organisations (see Section 3).

- Other knowledge and information that the Head of Internal Audit has obtained during the year including cumulative information and knowledge over time; observation of Board and other key Committee meetings; meetings with Executive Directors, senior managers and Independent Members; the results of *ad hoc* work and support provided; liaison with other assurance providers and Inspectors; research; and cumulative audit knowledge of the organisation that the Head of Internal Audit considers relevant to the Opinion for this year.

As stated above, these detailed results have been aggregated to build a picture of assurance across the Health Board.

In reaching this opinion we have identified some reviews during the year concluded positively with effective control arrangements operating in some areas.

From the opinions issued during the year, one was allocated Substantial Assurance, nineteen are allocated Reasonable Assurance, four were allocated Limited Assurance with none allocated an Unsatisfactory assurance opinion. Two advisory or non-opinion reports were also issued.

In addition, the Head of Internal Audit has considered residual risk exposure across those assignments where limited assurance was reported. Further, the Head of Internal Audit has considered the impact where audit assignments planned this year did not proceed to full audits following preliminary planning work and these were either: removed from the plan; removed from the plan and replaced with another audit; or deferred until a future audit year. The reasons for changes to the audit plan were presented to the Audit, Risk and Assurance Committee for consideration and approval. Notwithstanding that the opinion is restricted to those areas which were subject to audit review, the Head of Internal Audit has considered the impact of changes made to the plan when forming the overall opinion.

A summary of the findings is shown below. We have reported the findings using the eight areas of the Health Board's activities that we had previously used to structure our strategic and one-year operational plans.

Corporate Governance, Risk Management and Regulatory Compliance

We have undertaken three reviews in this area, one of which is work in progress, but is planned for inclusion within the 2024/25 opinion.

- **Declarations of Interest:** The audit provided **substantial** assurance on the management of declared interests. The audit reviewed the arrangements for registering and managing potential conflicts of interest within the Health Board. We found that the new automated process for declarations, implemented via Microsoft Forms in October 2024, is effective. However, we highlighted two areas for improvement: ensuring all required staff complete declarations and reminding staff of policy requirements.
- **Divisional Governance Arrangements:** The audit assessed the governance arrangements within the Primary Care and Community Division of the Health Board. The audit concluded with **reasonable** assurance, highlighting the need for improved policies and procedures for escalating key risks. Key findings include the absence of formal guidance on risk escalation, improvements required to the tracking of escalated risks, and the need for a feedback mechanism to ensure issues are addressed.

- **Follow-up of Internal Audit Recommendations** – this review, where we considered timely implementation of a sample of 2023/24 internal audit recommendations, is an **advisory** review. No matters were identified for reporting.

Strategic Planning, Performance Management & Reporting

We have undertaken two reviews in this area.

- **Intelligence Led Organisation:** The audit evaluated the processes in place at the Health Board to deliver information products and maximise the use of analytics securely. We provided **reasonable** assurance on the Health Board's efforts to become an intelligence-led organisation through its Data, Analytics, and Information Management Strategy. Key areas needing attention include prompt strategy approval, a clear data quality policy, and improved coordination of information products. In addition, the report highlights the need for improved digital literacy and the establishment of a central oversight group to address data silos and enhance decision-making.
- **Performance Framework:** The Performance Framework audit assessed the adequacy of the Performance and Accountability Framework (the 'Framework') arrangements put in place at the Health Board. We found that the Framework had largely been implemented as intended, but we raised recommendations over strengthening the arrangements in place, including conducting a formal review of the Framework and a cost benefit analysis of the arrangements and the setting out of further detail over the accountability lines. Overall, we provided **reasonable** assurance against the scope of the audit.

Financial Governance and Management

We have undertaken one review in this area.

- **Contract Management:** The **advisory** review identified good practices in place, with a clear framework of policies and procedures, together with dedicated contract managers in place. However, we raised the following management considerations over:
    - contract registers are not in place
    - resource requirements, including training for existing and future contract monitoring requirements;
    - variations over contract management, performance report and documentation held; and
    - the internal reporting and accountability requirements.

Furthermore, our audit of Financial Sustainability is in progress, which will be reported during 2025/26, but the audit work completed to date has been considered within the Head of Audit Internal Audit Opinion.

Quality & Safety

We have undertaken three reviews in this area.

- **Maternity Services Improvement Plan:** We have provided **reasonable** assurance on the implementation and monitoring of the Maternity Services Action Plan. It highlights the progress made in addressing 124 areas of improvement identified in the 2023 Maternity Neonatal Discovery Phase Report. Key findings include the need for enhanced tracking and accountability, with specific recommendations for improving the monitoring spreadsheet. The report emphasises the importance of regular updates and clear responsibility assignments to ensure effective oversight and transparency in maternity services.
- **End of Life Care:** The audit provided **reasonable** assurance, but highlighted the need for a formal framework to manage Future Care Planning (FCP) documentation and address findings from the 2022 NACEL audit.
- **Medical Equipment and Devices:** We have provided **reasonable assurance** on the management of medical equipment and devices within the Health Board. While policies were found to be comprehensive, issues included missing equipment, incomplete maintenance records, and the absence of oversight from the Medical Devices Committee since 2023. Key risks involve untracked or unmaintained equipment and reduced incident monitoring. Recommendations focus on improving inventory accuracy, ensuring maintenance coverage, and reinstating governance oversight.

Information Governance & Security

We have undertaken three reviews in this area.

- **Records Management:** We provided **limited** assurance over the management of records within the Health Board. Key issues include difficulty retrieving patient records, inappropriate storage conditions, including the security of records, and inadequate strategies for optimising storage space. Minor issues include low uptake of awareness sessions and a lack of centralised tracking for ward clerk availability.
- **Technical Continuity:** We provided **reasonable** assurance on the Health Board's technical resilience, highlighting good recovery capabilities and robust infrastructure. However, recommendations include completing asset records, establishing a technical design authority, and conducting regular failover tests have been raised.
- **Electronic Document and Records Management System (EDRMS):** The audit provides **reasonable** assurance on the effectiveness of the EDRMS used by the Health Board. While the system supports digital record management and improves access and security, key issues include outdated software, limited integration with clinical systems, lack of eForms, and reliance on unsupported infrastructure, with planned upgrades aiming to address these.

Operational Service and Functional Management

We have undertaken five reviews in this area.

- **Facilities Stock:** We provided **reasonable** assurance on the progress of facilities stock management at the Health Board. Significant improvements have been made since the previous audit, including better stock ordering, stock level management, and security. Training on stock processes remains incomplete, though informal training has improved staff understanding.
- **Directorate Review – Mental Health and LD:** The audit reviewed the implementation of the 90-day Improvement Plan for the Mental Health and Learning Disabilities division at the Health Board. The plan aimed to address concerns from HIW inspections and improve the safety and quality of services. While progress has been made, not all actions have been fully implemented. Key issues include the need for clearer governance structures, specific timelines, and accountability. We provided **reasonable** assurance, but highlighted areas for improvement in governance, monitoring, and communication.
- **Health Board Management Practices:** The audit reviewed the process for letting a sample of Health Board managed GP practices in early 2024. We provided **reasonable** assurance of compliance with Welsh Government regulations and internal policies. Key recommendations include developing a detailed standard operating procedure, maintaining records for reduced application timescales, and ensuring consistent stakeholder representation in interview panels.
- **Health and Safety:** We provided **limited** assurance regarding the Health Board's health and safety arrangements. While improvements were noted in inspections, risk reporting, and RIDDOR compliance, a number of issues remain. These include unratified policies, outdated statutory registers, overdue risk actions, and inconsistent RIDDOR reporting. In spite of some progress, key systems and processes are not yet fully embedded, requiring focused management attention.
- **Providing Care to Asylum Seekers and Refugees (2023/24):** We provided **reasonable** assurance over the Health Board's process for managing asylum seekers and refugees. The Health Inclusion Service (HIS) offers strong support and engages with various services to ensure free patient care for refugees and asylum seekers. Key issues identified include delays in completing Blue Book assessments and insufficient staff training.

Furthermore, our audit of Waiting List Management is in progress, although substantially complete, but will be reported during 2025/26. The audit work completed to date has been considered within the Head of Audit Internal Audit Opinion.

Workforce Management

We have undertaken three reviews in this area.

- **Staff Culture:** The audit reviewed actions following completion of the Employee Experience Survey. We provided **reasonable** assurance overall, but raised issues over the absence of a centralised action plan and inconsistent implementation across directorates, risking effective responses to survey findings. Promising initiatives need broader adoption and robust monitoring.

- **Embedding of Policies (Speaking up Safely):** We provided **limited** assurance from our audit of adherence to the Welsh Government Speaking up Safely Framework, due to issues such as lack of dedicated resources, unclear case management, and reliance on manual systems. A new process introduced in December 2024 aims to address these issues with dedicated reporting channels and enhanced accessibility.
- **Job Planning:** We provided **limited** assurance from our audit of adherence to the consultant job planning processes. It highlights low compliance with job planning, with only 38.4% completion against a 90% target set by the Welsh Government. Key issues include incomplete personal and service outcomes in job plans, inconsistencies with the Electronic Staff Record (ESR), and insufficient focus on job planning in operational forums.

Capital & Estates Management

We have undertaken six reviews in this area.

- **Nevill Hall RAAC:** The audit evaluated the management of risks associated with Reinforced Autoclaved Aerated Concrete (RAAC) at Nevill Hall Hospital. The Welsh Government funded £1.158m for RAAC remedial works. We provided **reasonable** assurance, but raised key recommendations over developing a RAAC management strategy, obtaining retrospective approvals, and improving procurement processes. The audit emphasized the need for ongoing monitoring and formalised governance to ensure patient safety and operational continuity.
- **Estates Assurance – Energy Management:** We provided **reasonable** assurance over energy management at the Health Board. It highlighted that the Health Board's energy consumption is significant, representing 17% of NHS Wales' total, with costs of £6.7m for gas and £10.2m for electricity. Key recommendations include finalising the Energy Team's Work Plan, improving data capture efficiency, and enhancing energy awareness training.
- **Newport East HWBC:** The audit provides **reasonable** assurance that the Newport East Health & Wellbeing Centre project largely met its objectives, delivering new integrated health facilities within 1.5% of the original £28.2m budget. Despite an 8-month delay, phased occupancy began in January 2025. Key issues include unresolved lease agreements, increased revenue costs, and incomplete service integration. While equipment procurement and financial controls were strong, some prior audit recommendations remain unaddressed.
- **GUH – Emergency Department Extension:** The audit of the Grange University Hospital Emergency Department extension project concluded with **reasonable** assurance. A minor cost overrun (0.13%) and a one-month delay were noted, but long-term benefits remain unaffected. Governance was effective but requires an enhanced Project Board role and reporting. We found missing Collateral Warranties and Parent Company Guarantees and technical design issues caused delays. We also found that improvements to timely performance reporting was required.
- **Newport East Health and Wellbeing Centre (2023/24):** This audit reviewed the Newport East Health and Wellbeing Centre project from Jan 2023 to Apr 2024. We provided **Reasonable** assurance, but we identified a 14-week delay and a projected overspend of £406k–£620k. Key issues include governance weaknesses,

inconsistent change control documentation, and limited scrutiny of financials by the Project Board. However, quality standards were met, and cost pressures are being managed within discretionary allocations. Recommendations focussed on improving governance, risk management, and documentation.

- **Development of a Regional Radiotherapy Satellite Centre at Nevill Hall Hospital (2023/24):** We reviewed the development of the Regional Radiotherapy Satellite Centre at Nevill Hall Hospital. We identified minor delays and a slight budget overrun, but this was covered by contingency funds. Governance, financial management, and risk monitoring were generally sound, though improvements were recommended with project board oversight, risk assessment, and documentation. Overall, we provided **reasonable** assurance raising recommendations in governance, invoice authorisation, and risk reporting, but found equipping processes to be well-managed.

Furthermore, our subsequent audit of Nevill Hall Hospital – Regional Satellite Centre (2024/25) is in progress, which will be reported during 2025/26. The audit work completed to date has been considered within the Head of Audit Internal Audit Opinion.

2.5 Approach to Follow Up of Recommendations

As part of our Follow-up of Previous Recommendations audit work, we consider the progress made in implementing the actions agreed from our previous reports for which we were able to give only Limited Assurance. In addition, where appropriate, we also consider progress made on high priority findings in reports where we were still able to give Reasonable Assurance. We also undertake some testing on the accuracy and effectiveness of the audit recommendation tracker.

In addition, Audit Committees monitor the progress in implementing recommendations (this is wider than just Internal Audit recommendations) through their own recommendation tracker processes. We attend all audit committee meetings and observe the quality and rigour around these processes.

However, it remains the role of Audit Committees to consider and agree the adequacy of management responses and the dates for implementation, and any subsequent request for revised dates, proposed by Management. Where appropriate, we have adjusted our approach to follow-up work to reflect these challenges.

We have considered the impact of both our follow-up work and where there have been delays to the implementation of recommendations, on both our ability to give an overall opinion (in compliance with the PSIAS) and the level of overall assurance that we can give.

The Health Board's recommendation tracking process continued during 2024/25 although there are recommendations past the advised implementation date.

2.6 Limitations to the Audit Opinion

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems.

In accordance with auditing standards, and with the agreement of senior management and the Board, Internal Audit work is deliberately prioritised according to risk and

materiality. Accordingly, the Internal Audit work and reported outcomes will bias towards known weaknesses as a driver to improve governance risk management and control. This context is important in understanding the overall opinion and balancing that across the various assurances which feature in the Annual Governance Statement.

Caution should be exercised when making comparisons with prior years. Audit coverage will vary from year to year based upon risk assessment and cyclical coverage on key control systems.

2.7 Period covered by the Opinion

Internal Audit provides a continuous flow of assurance to the Board and, subject to the key financials and other mandated items being completed in-year, the cut-off point for annual reporting purposes can be set by agreement with management. To enable the Head of Internal Audit opinion to be better aligned with the production of the Annual Governance Statement a pragmatic cut-off point has been applied to Internal Audit work in progress.

By previous agreement with the Health Board, audit work reported to draft stage has been included in the overall assessment, with all other work in progress rolled-forward and reported within the overall opinion for next year.

Most audit reviews will relate to the systems and processes in operation during 2024/25 unless otherwise stated and reflect the condition of internal controls pertaining at the point of audit assessment.

Follow-up work will provide an assessment of action taken by management on recommendations made in prior periods and will therefore provide a limited scope update on the current condition of control and a measure of direction of travel.

There are some specific assurance reviews which remain relevant to the reporting of the organisation's Annual Report required to be published after the year end. Where required, any specified assurance work would be aligned with the timeline for production of the Health Board's Annual Report and accordingly will be completed and reported to management and the Audit, Risk and Assurance Committee after this Head of Internal Audit Opinion. However, the Head of Internal Audit's assessment of arrangements in these areas would be legitimately informed by drawing on the assurance work completed as part of this current year's plan.

2.8 Required Work

Please note that following discussions with Welsh Government we were not mandated to audit any areas in 2024/25.

2.9 Statement of Conformance

The Welsh Government determined that the Public Sector Internal Audit Standards (PSIAS) would apply across the NHS in Wales from 2013/14.

The provision of professional quality Internal Audit is a fundamental aim of our service delivery methodology and compliance with PSIAS is central to our audit approach. Quality is controlled by the Head of Internal Audit on an ongoing basis and monitored by the Director of Audit & Assurance. In addition, at least once every five years, we are required to have an External Quality Assessment. This was undertaken by the Chartered Institute

of Public Finance and Accountancy (CIPFA) in March 2023, reported in April 2023 stated who concluded we 'Fully Conform' with the Standards.

The NWSSP Audit and Assurance Services can assure the Audit, Risk and Assurance Committee that it has conducted its audit at the Health Board in conformance with the Public Sector Internal Audit Standards for 2024/25.

Our conformance statement for 2024/25 is based upon:

- the results of our internal Quality Assurance and Improvement Programme (QAIP) for 2024/25 which will be reported formally in the Summer of 2025; and
- The results of the External Quality Assessment.

We have set out, in **Appendix A**, the key requirements of the Public Sector Internal Audit Standards and our assessment of conformance against these requirements. The full results and actions from our QAIP will be included in the 2024/25 QAIP report. There are no significant matters arising that need to be reported in this document.

We also note that there have been no impairments to the independence of the Head of Internal Audit or to any other members of NWSSP's Audit & Assurance Service who undertook work on the Health Board's audit programme for 2024/25.

The Head of Internal Audit has unfettered access to the Chief Executive, Chair of the Audit, Risk and Assurance Committee and Chair of the Health Board.

2.10 Completion of the Annual Governance Statement

While the overall Internal Audit opinion will inform the review of effectiveness for the Annual Governance Statement, the Accountable Officer and the Board need to consider other assurances and risks when preparing their Statement. These sources of assurances will have been identified within the Board's own performance management and assurance framework and will include, but are not limited to:

- direct assurances from management on the operation of internal controls through the upward chain of accountability;
- internally assessed performance against the Health & Care Quality Standards;
- results of internal compliance functions including Local Counter-Fraud, Post Payment Verification, and risk management;
- reported compliance via the Welsh Risk Pool regarding claims standards and other specialty specific standards reviewed during the period; and
- reviews completed by external regulation and inspection bodies including Audit Wales, Healthcare Inspectorate Wales and Health and Safety Executive.

3. Other work relevant to the Health Board

As our internal audit work covers all NHS Wales organisations there are a number of audits that we undertake each year which, while undertaken formally as part of a particular health organisation's audit programme, will cover activities relating to other health bodies. These are set about below, with relevant comments and opinions attached, and relate to work at:

- NHS Wales Shared Services Partnership;

- Digital Health and Care Wales; and
- NHS Wales Joint Commissioning Committee.

NHS Wales Shared Services Partnership (NWSSP)

As part of the internal audit programme at NHS Wales Shared Services Partnership (NWSSP), a hosted body of Velindre University NHS Trust, a number of audits were undertaken which are relevant to the Health Board. These audits of the financial systems operated by NWSSP, processing transactions on behalf of the Health Board, derived the following opinion ratings:

Audit	Opinion	Outline scope
Accounts Payable	Reasonable	To review the adequacy of the systems and controls in place for key risk areas in the accounts payable process, including progress in implementing the actions agreed with management to address the issues identified in the previous audit report.
PCS Pharmacy	Substantial	To provide assurance that Primary Care Services is maintaining a robust system to facilitate timely and accurate payments to pharmacy contractors.
Payroll	Substantial	To evaluate the design and operation of the systems and controls in place within payroll services.
Recruitment Services	Substantial	To review the adequacy of systems and controls in place for Recruitment Services.

Please note that other audits of NWSSP activities are undertaken as part of the overall NWSSP internal audit programme. All audits in this programme are reported to the Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership. The overall Head of Internal Audit Opinion for NWSSP is Reasonable Assurance.

Digital Health & Care Wales (DHCW)

As part of the internal audit programme at DHCW, a Special Health Authority that started operating from 1 April 2021, a number of audits were undertaken which are relevant to the Health Board. These audits derived the following opinion ratings:

Audit	Opinion	Outline scope
Financial Sustainability	Substantial	To review the financial management arrangements in place to ensure the ongoing sustainability of services and project delivery, with a particular focus on sustainable funding requirements for projects (e.g. DPIF, WASPI).

Audit	Opinion	Outline scope
Programme Management	Reasonable	To establish the effectiveness of the portfolio management model used by DHCW and the controls that are in place to ensure it operates across the range of active projects.
Mission One – National Data Resource	Reasonable	To provide assurance over the National Data Resource (NDR) Platform programme of work, including progress towards implementing local datastores, and reference, demographics and medicines data.
Mission One – Cloud Services	Substantial	To provide assurance over the programme of work to move live services from datacentres into the cloud.

Please note that other audits of DHCW activities are undertaken as part of the overall DHCW internal audit programme. The overall Head of Internal Audit Opinion for DHCW is Reasonable Assurance.

NHS Wales Joint Commissioning Committee (JCC)

The work at the JCC is undertaken as part of the Cwm Taf Morgannwg internal audit plan. These audits are listed below and derived the following opinion ratings:

Audit	Opinion	Outline scope
Mental Health Quality Commissioning arrangements	Reasonable	The purpose of the review was to assess the effectiveness of the arrangements in the JCC to oversee the quality and safety aspects of the commissioning of mental health and learning disability placements.
Governance	Advisory	To assess the arrangements that have been put in place at the JCC for embedding the statutory governance framework and the establishment of operational governance arrangements to provide effective oversight in the new organisation.
Financial arrangements (Draft Report)	Reasonable	To consider the financial arrangements in relation to financial management and budgetary control, procurement and income.
Review of Traumatic Stress Wales (Draft Report)	Limited	The purpose of the review was to provide information to assist the Director of Commissioning for Mental Health, Learning Disabilities and Vulnerable Groups within the JCC to determine the optimum delivery

Audit	Opinion	Outline scope
		mechanism for the national objective of Traumatic Stress Wales (TSW), by review of the adequacy of the systems and controls in place within TSW and the JCC in relation to its management of TSW. The review sought to provide assurance to the Chief Commissioner via the Director of Commissioning for Mental Health, Learning Disabilities and Vulnerable Groups, that TSW is operating effectively, systems are being managed appropriately, and there is clarity on the purpose and objectives of TSW within the new arrangements for the JCC.

While these audits do not form part of the annual plan for the Health Board, they are listed here for completeness as they do impact on the organisation's activities. The Head of Internal Audit has considered if any issues raised in the audits could impact on the content of our annual report and concluded that there are no matters of this nature.

Full details of the NWSSP audits are included in the NWSSP Head of Internal Audit Opinion and Annual Report. JCC audits are summarised in the Cwm Taf Morgannwg University Health Board Head of Internal Audit Opinion and Annual Report.

4. Delivery of the Internal Audit Plan

4.1 Performance against the Audit Plan

The Internal Audit Plan has been delivered substantially in accordance with the schedule agreed with the Audit, Risk and Assurance Committee, subject to changes agreed as the year progressed. Regular audit progress reports have been submitted to the Audit, Risk and Assurance Committee during the year. Audits that remain to be reported, but are reflected within this Annual Report, will be reported alongside audits from the 2024/25 operational audit plan.

The audit plan approved by the Committee in April 2024 contained 27 planned reviews, 3 IAP capital audits and 3 audits brought forward. Changes have been made to the plan with 1 audit added, 2 audits merged and 5 deferred, including the NHH Regional Satellite Centre that will be reported during 2025/26. These changes have been reported to, and approved by, the Audit, Risk and Assurance Committee.

The assignment status summary is reported at section 5.

In addition, we may respond to requests for advice and/or assistance across a variety of business areas across the Health Board. This advisory work, undertaken in addition to the assurance plan, is permitted under the standards to assist management in improving governance, risk management and control. This activity is reported during the year within our progress reports to the Audit, Risk and Assurance Committee.

4.2 Service Performance Indicators

In order to monitor aspects of the service delivered by Internal Audit, a range of service performance indicators have been developed.

Indicator Reported to Audit, Risk and Assurance Committee	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2024/25	G	April 2024	By 30 June	Not agreed	Draft plan	Final plan
Total assignments reported against adjusted plan for 2024/25	G	100%	100%	v>20%	10%<v<20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	96%	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time taken for management response to discussion & draft report [20 working days]	R	50%	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100%	80%	v>20%	10%<v<20%	v<10%

Key: v = percentage variance from target performance

5. Risk based audit assignments

The overall opinion provided in Section 1 and our conclusions on individual reviews is limited to the scope and objectives of the reviews we have undertaken, detailed information on which has been provided within the individual audit reports.

5.1 Overall summary of results

In total 26 audit reviews were reported during the year. Figure 1 below presents the assurance ratings, and the number of audits derived for each.

Figure 1 Summary of audit ratings

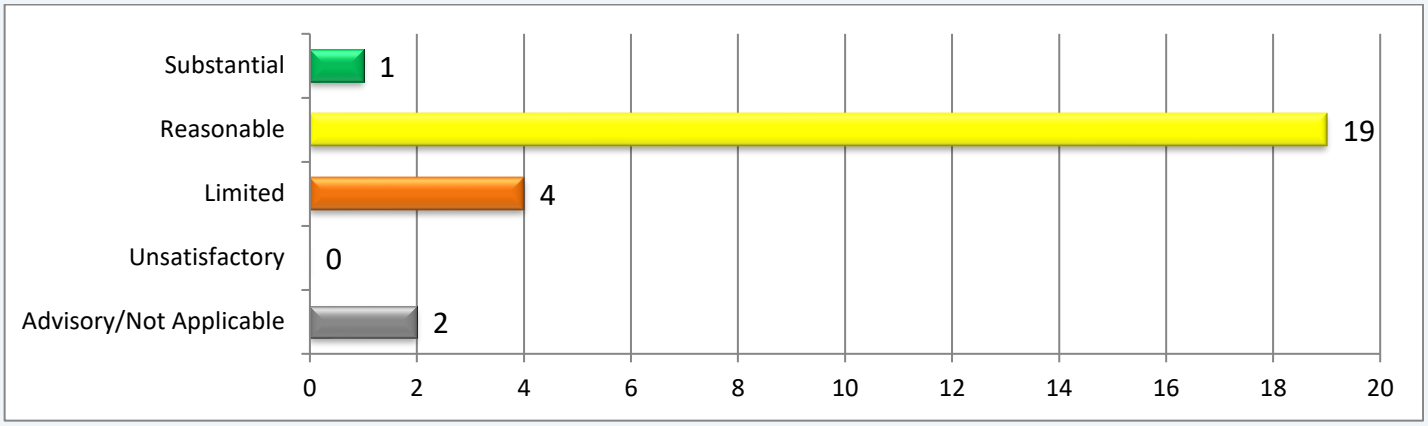


Figure 1 above does not include the audit ratings for the reviews undertaken at NWSSP, DHCW or the NHS Wales Joint Commissioning Committee.

The assurance ratings and definitions used for reporting audit assignments are included in **Appendix B**.

In addition to the above, there were several audits which did not proceed following preliminary planning and agreement with management. These audits are documented in section 5.8.

The following sections provide a summary of the scope and objective for each assignment undertaken within the year along with the assurance rating.

5.2 Substantial Assurance (Dark Green)



In the following review areas, the Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. Those few matters that may require attention are compliance or advisory in nature with low impact on residual risk exposure.

Review Title	Objective
Declarations of Interest	To provide assurance over the arrangements for registering and managing potential conflicts caused by the receipt of gifts, hospitality and external interests.

5.3 Reasonable Assurance (Light Green)



In the following review areas, the Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. Some matters require management attention in either control design or operational compliance and these will have low to moderate impact on residual risk exposure until resolved.

Review Title	Objective
Intelligence Led Organisation	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.
Facilities Stock	A dedicated follow-up review over the implementation progress of the recommendations raised within the 2023/24.
Performance Framework	To provide assurance over the new performance framework, including escalation arrangements.
Divisional Governance Arrangements	A review of the governance arrangements in place within divisions (excl. Mental Health and LD), to ensure key risks / matters arising are escalated and / or managed effectively.
Directorate Review – Mental Health and LD	A review to ensure that arrangements from the 90-day plan for the division have been embedded.
Maternity Services Improvement Plan	A continuation from the 2023/24 internal audit of Maternity Services Action Plan, to ensure that external recommendations raised are on track to being fully implemented.
End of Life Care	To determine if packages of care are appropriately planned in advance for end-of-life patients.
Staff Culture	A review of the actions underway to influence change following on from the NHS Wales Staff Survey results.
Nevill Hall RAAC	The review will focus on the works to manage and address the Reinforced Autoclave Aerated Concrete (RAAC) identified within Nevill Hall General Hospital.
Estates Assurance – Energy Management	Recognising the increase in utility costs and the associated financial risks, the audit will examine the arrangements in place to manage energy consumption, optimisation, conservation and efficiency. The audit will look to gain assurance the appropriate arrangements are in place to gather data, ensuring that the data is of suitable quality/ reliability. The audit will also look at resulting strategies and/ or plans to address key risks.
Newport East Health and Wellbeing Centre	The audit will evaluate whether the Health and Wellbeing Centre, as commissioned, is achieving the

Review Title	Objective
	desired objectives and whether issues raised at prior audits have been addressed.
GUH – Emergency Department Extension	The overall objective of this audit is to evaluate the progression and delivery of the project against the key business case objectives and to assess the adequacy of the systems and controls in place to support the successful delivery of the project.
Health Board Managed Practices	To determine if the Health Board has an appropriate process in place for managing the phased return of Managed Practices to Independent Contractor status and test if the process undertaken to award contracts to Independent Contractors in January 2024 was in-line with due process.
Technical Continuity	Review of the enactment of technical resilience and awareness of fault domains to ensure the Health Board is maximising the potential for resilience within the architecture.
Medical Equipment and Devices	To assess the implementation of the electronic tagging and tracking of medical equipment and devices across the Health Board.
Electronic Document and Records Management System	An opinion over 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.
Providing Care to Asylum Seekers and Refugees (2023/24)	To provide an opinion over the arrangements in place within the Health Board for providing care to asylum seekers and refugees, including that applicable guidance is being adhered to.
Newport East Health and Wellbeing Centre (2023/24)	To evaluate the progression and delivery of the project against the key business case objectives and to assess the adequacy of the systems and controls in place to support the successful delivery of the project.
Development of a Regional Radiotherapy Satellite Centre at Nevill Hall Hospital (2023/24)	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.

5.4 Limited Assurance (Amber)



In the following review areas, the Board can take only **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with moderate impact on residual risk exposure until resolved.

Review Title	Objective
Embedding of Policies (Speaking up Safely)	The review will assess whether the Speaking up Safely: A Framework for the NHS in Wales has been fully implemented.
Records Management	To assess the implementation of the recommendations raised within the 2022/23 internal audit.
Job Planning	To provide assurance that arrangements are in place and operating effectively for consultant job planning.
Health and Safety	To complete a review over how key health and safety risks are managed in accordance with the Health Board's policies and procedures, including RIDDOR reporting relating to falls.

5.5 Unsatisfactory (Red)



No reviews were assigned an 'unsatisfactory' opinion.

5.6 Advisory/Assurance Not Applied (Grey)



The following review was undertaken as part of the audit plan and reported without the standard assurance rating indicator, owing to the nature of the audit approach. The level of assurance given for this review is deemed not applicable – these are reviews and other assistance to management, provided as part of the audit plan, to which the assurance definitions are not appropriate, but which are relevant to the evidence base upon which the overall opinion is formed.

Review Title	Objective
Follow-up of High Priority Recommendations	To assess whether high priority internal audit recommendations have been implemented.
Contract Management	To determine if contract management controls are operating effectively, including engagement with stakeholders.

5.7 Draft Audit Reports

The following audits have been substantially completed, with the draft reports issued. Therefore, the conclusions of our audit work have been taken into account for the 2024/25 Head of Internal Audit Opinion.

Review Title
Medical Equipment and Devices
Electronic Document and Records Management System
Health and Safety
Newport Health and Wellbeing Centre

5.8 Audits not undertaken

Additionally, the following audits were deferred for the reasons outlined below. We have considered these reviews and the reason for their deferment when compiling the Head of Internal Audit Opinion.

Review Title	Objective
Partnership Arrangements	To review the processes and procedures that the Health Board has in place to manage its partnership arrangements. *Deferred due to the inclusion of an additional audit over Health Board Managed GP Practices.*
Welsh Intensive Care Information System	A review of the arrangements in place for implementing the Welsh Intensive Care Information System. *Deferred due to a lack of progress over the funding position, which prevented the audit from progressing in its current form. This will be reviewed during 2025/26 with a different outline audit scope.*

Review Title	Objective
Capital Systems	To review the control framework, systems and processes in place to manage schemes not funded through integrated audit plans. *Deferred into 2025/26 as the project suitable for audit inclusion (Decontamination Unity) has not yet progressed, but will do so in early 2025/26.*
Medical E-rostering	To provide an opinion over the processes for the implementation of the roll-out plan for the management of medical e-rostering. *Deferred due to the significant number of overdue consultant job plans across the Health Board, which is a requirement for the medical e-rostering to proceed. Initial roster plans for Family & Therapies and Mental Health & LD divisions were paused by senior management and as such, the central support team shifted focus to job plan completion. A revised implementation plan prioritises E-rostering rollout to directorates with higher job plan compliance, contingent on improved compliance, which is expected to be completed by May 2026.*
Nevill Hall Hospital – Regional Satellite Centre (2024/25)	To evaluate the progression and delivery of the project against the key business case objectives and to assess the adequacy of the systems and controls in place to support the successful delivery of the project. *Deferred into in Q1 of 2025/26, due to the timing of project progress.*

In addition, at the time of this annual report there were two reviews that were 'work in progress', which are detailed below.

Review Title	Objective
Waiting List Management	To review the arrangements in place to reduce the patient waiting lists of services not reported at a national level.
Financial Sustainability	To determine if appropriate recovery plans are in place to achieve a sustainable financial position, including the impact of any associated reduction in non-recurrent public health funding.

6. Acknowledgement

In closing I would like to acknowledge the time and co-operation given by Directors and staff of the Health Board to support delivery of the Internal Audit assignments undertaken within the 2024/25 plan.

Stephen Chaney
Pennaeth Archwiliad Mewnol/Head of Internal Audit
Gwasanaethau Archwilio a Sicrwydd/Audit and Assurance Services
Partneriaeth Cydwasanaethau GIG Cymru/NHS Wales Shared Services Partnership
Mehefin 2025/ June 2025

Appendix A

ATTRIBUTE STANDARDS	
1000 Purpose, authority and responsibility	Internal Audit arrangements are derived ultimately from the NHS organisation's Standing Orders and Financial Instructions. These arrangements are embodied in the Internal Audit Charter adopted by the Audit, Risk and Assurance Committee on an annual basis.
1100 Independence and objectivity	Appropriate structures and reporting arrangements are in place. Internal Audit does not have any management responsibilities. Internal audit staff are required to declare any conflicts of interests. The Head of Internal Audit has direct access to the Chief Executive and Audit, Risk and Assurance Committee chair. There have been no impairments to our independence during 2024/25.
1200 Proficiency and due professional care	Staff are aware of the Public Sector Internal Audit Standards and code of ethics. Appropriate staff are allocated to assignments based on knowledge and experience. Training and Development exist for all staff. The Head of Internal Audit is professionally qualified.
1300 Quality assurance and improvement programme	Head of Internal Audit undertakes quality reviews of assignments and reports as set out in internal procedures. Internal quality monitoring against standards is performed by the Head of Internal Audit and Director of Audit & Assurance. An EQA was undertaken in 2023.
PERFORMANCE STANDARDS	
2000 Managing the internal audit activity	The Internal Audit activity is managed through the NHS Wales Shared Services Partnership. The audit service delivery plan forms part of the NWSSP integrated medium term plan. A risk based strategic and annual operational plan is developed for the organisation. The operational plan gives detail of specific assignments and sets out overall resource requirement. The audit strategy and annual plan is approved by Audit, Risk and Assurance Committee.

	Policies and procedures which guide the Internal Audit activity are set out in an Audit Quality Manual. There is structured liaison with Audit Wales, HIW and LCFS.
2100 Nature of work	The risk-based plan is developed and assignments performed in a way that allows for evaluation and improvement of governance, risk management and control processes, using a systematic and disciplined approach.
2200 Engagement planning	The Audit Quality Manual guides the planning of audit assignments which include the agreement of an audit brief with management covering scope, objectives, timing and resource allocation.
2300 Performing the engagement	The Audit Quality Manual guides the performance of each audit assignment and report is quality reviewed before issue.
2400 Communicating results	Assignment reports are issued at draft and final stages. The report includes the assignment scope, objectives, conclusions and improvement actions agreed with management. An audit progress report is presented at each meeting of the Audit, Risk and Assurance Committee. An annual report and opinion is produced for the Audit, Risk and Assurance Committee giving assurance on the adequacy and effectiveness of the organisation's framework of governance, risk management and control.
2500 Monitoring progress	An internal follow-up process is maintained by management to monitor progress with implementation of agreed management actions. This is reported to the Audit, Risk and Assurance Committee. In addition, audit reports are followed up by Internal Audit on a selective basis as part of the operational plan.
2600 Communicating the acceptance of risks	If Internal Audit considers that a level of inappropriate risk is being accepted by management, it would be discussed and will be escalated to Board level for resolution.

Appendix B

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.

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 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.

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.

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]

Internal Audit Progress Report

Audit, Risk and Assurance Committee

June 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 and 2025/26 Internal Audit Plans for Aneurin Bevan University Health Board (the 'Health Board') to the June 2025 Audit, Risk and Assurance Committee (the 'Committee');
- seek approval for the deferral of Medical E-rostering, due to the pause in the rollout and revised implementation plan, we are unable to complete testing at this stage;
- provide the final Head of Internal Audit Opinion; and
- provide an overview of other activity undertaken since the previous meeting.

2. Progress against 2024/25 Internal Audit Plan

There were 30 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:	30
Less audit merger	(1)
Less deferral	(5)
Add additional audit	1
Revised total	25
Number of audits at final report stage	19
Number of audits at draft report stage	5
Number of audits work in progress	1

The following final reports have been issued since the meeting of the Audit, Risk and Assurance Committee on 20th May 2025:

AUDIT ASSIGNMENT	**ASSURANCE RATING**
Job Planning	Limited
Contract Management	Advisory
Performance Management	Reasonable
Technical Continuity	Reasonable
Follow-up of High Priority Audit Recommendations	Advisory

The delivery status of the audits is illustrated within Appendix A and further information over the assurance rating detailed above is included within Appendix C.

3. Summary of Findings for Recently Completed Work

Limited assurance reports are considered by the Audit, Risk and Assurance Committee in detail. The following summary provides the Committee with the main conclusions from the reports issued since the last meeting on 20th May 2025.

Job Planning (limited assurance)

The review assessed the effectiveness of the current arrangements for consultant job planning.

The audit revealed a strong focus on compliance and job completion but noted resistance and a lack of engagement from consultants. This, along with historical workforce challenges is negatively impacting the effective completion of job plans. The significant matters requiring management attention from this audit include:

- **Compliance and related risk:** The current completion rate of job plans is low posing a risk of missing the Welsh Government target of 90% by the end of September 2025. The current risk register does not adequately capture the risks associated with job planning or the potential failure to meet the compliance target set by Welsh Government.
- **Personal outcomes:** The job plans do not include personal outcomes for individuals as required by the guidance.
- **ESR reconciliation:** There are discrepancies between job plans and ESR, affecting the accuracy of payments to staff.

Contract Management (advisory)

The review evaluated the adequacy of contract management arrangements within the Health Board. Additionally, this review compared and contrasted the appropriateness of contract management arrangements across eight other organisations, identifying common issues and challenges.

Due to the absence of a comprehensive contract register, reliance was placed on the partial records held within Electronic Contract Management module.

The Health Board adopted various approaches to manage contracts and develop performance reports. However, responsibilities for contract monitoring were not formally assigned, accepted and contract documents were not maintained centrally.

Specific training requirements to support operational contract management were not identified and related training materials were not developed.

In addition, performance measures were not consistently defined, regularly reviewed or reported.

Performance Framework (reasonable assurance)

Our review assessed the appropriateness of the Performance Management and Accountability Framework (PMF) implemented. At the time of our audit, based on a review conducted by the Executive Team during January 2025, none of the divisions were classed as under special measures. The following matters requiring management attention were identified:

- **Framework**: A formal review of the Framework document is overdue.
- **Monitoring and escalation:** The current PMF clearly outlines three key monitoring arrangements: monthly divisional assurance review meetings, quarterly divisional performance review meetings and corporate teams six monthly review meetings. However, the implications of escalation within the three performance domains (Quality & Safety, Operational Delivery and Finance) are not formally defined.
- **Reviews and reporting:** The current review and meeting requirements place significant demand on senior staff. Consequently, updates on the outcomes of the six-monthly and end-of-year reviews were delayed with some reports received 4 to 5 months after the relevant period. This also extended to the accountability letters and quarter four reviews.

  Furthermore, no deep dive reviews have been planned or undertaken since the introduction of the PMF. The PMF also states that assurance reviews for the corporate teams should be held on a six-monthly basis, however, none were conducted in 2024/25.

Technical Continuity (reasonable assurance)

This reasonable assurance report will be presented to the private session of the Audit, Risk and Assurance Committee.

Follow up of High Priority Audit Recommendations (advisory)

We reviewed the process for tracking audit recommendations and tested a sample from 2023/24 to ensure recommendations marked as complete had supporting evidence in place. We did not raise any recommendations regarding this process.

4. Audit for Deferral

Due to the significant number of overdue consultant job plans across the Health Board, which is a requirement for the medical e-rostering to proceed, initial roster plans for Family & Therapies and Mental Health & LD divisions were paused by senior management and as such, the central support team shifted focus to job plan completion. A revised implementation plan prioritises E-rostering rollout to directorates with higher job plan compliance, contingent on improved compliance, which is expected to be completed by May 2026. Therefore, we are unable to proceed with the planned audit and seeking **approval** to **defer** the audit into 2026/27.

5. Progress against 2025/26 Internal Audit Plan

We have commenced planning against the 2025/26 Internal Audit Plan, which is outlined within Appendix B.

6. Summary of Audit Briefs Recently issued

We have commenced planning of the following 2025/26 internal audits. Once agreed, final internal audit briefs will be shared for information.

Audit Title	Status	Outline Scope
GUH – Emergency Dept Extension	Draft brief issued (awaiting approval)	The audit will review the arrangements in place to progress the extension of the Grange University Hospital Emergency Department.
Cyber Security	Planning, draft brief issued	To assess the governance process for cyber security, associated risk statements and the management and delivery of improvement plans.
WICIS	Planning, draft brief issued	To ensure lessons learnt and / or any associated actions regarding the work completed to date on the Welsh Intensive Care Information System are appropriately addressed.
Estates Assurance - Space Utilisation	Planning, draft brief to be issued imminently	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.
Safeguarding	Planning commenced	To ensure key policies and procedures are embedded and adhere to safeguarding regulations.
Subject Access Requests	Planning commenced	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.
Public Health	Planning commenced	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.

7. 2024/25 Final Head of Internal Audit Opinion

The 2024/25 Final Head of Internal Audit Opinion is presented to this Audit, Risk and Assurance Committee and remains as previously indicated, at **reasonable** assurance.

8. 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.

9. Recommendation

The Audit, Risk and Assurance Committee is invited to **note** the above points within the report, **approve** the deferred audit of Medical E-rostering and **receive** the final 2024/25 Head of Internal Audit Opinion for assurance.

Appendix A: Progress against 2024/25 Internal Audit Plan

Reviews	Status	Assurance Rating
1. Financial Sustainability	Work in Progress	N/A
2. IMTP – Service Delivery Plans *(merged with review #24)*	Final Report (merged)	Reasonable
3. Contract Management	Final Report	Advisory
4. Facilities Stock	Final Report	Reasonable
5. Performance Framework	Final Report	Reasonable
6. Embedding of Policies (Speaking up Safely)	Final Report	Limited
7. Declarations of Interest	Final Report	Substantial
8. Divisional Governance Arrangements	Final Report	Reasonable
9. Directorate Review - Mental Health & Learning Disabilities	Final Report	Reasonable
10. Maternity Services Improvement Plan	Final Report	Reasonable
11. End of Life Care	Final Report	Reasonable
12. Health and Safety (comprising of two parts)	Part 1: Complete Part 2: Draf Report	N/A Limited
13. Waiting List Management	Draft Report	Reasonable
14. Partnership Arrangements	Deferred	N/A
15. Health Board Managed Practices	Final Report	Reasonable
16. Medical Equipment and Devices	Draft Report	Reasonable
17. Records Management	Final Report	Limited
18. Job Planning	Final Report	Limited
19. Staff Culture	Final Report	Reasonable
20. Medical E-Rostering	Final Report	Not rated
21. Providing Care to Asylum Seekers and Refugees	Final Report	Reasonable
22. Follow-up of High Priority Recommendations	Final Report	Not rated
23. Welsh Intensive Care Information System	Deferred	N/A
24. Analytics and Information Use (Intelligence Led Organisation) *(merged with review #2)*	Final Report (merged)	Reasonable
25. Technical Continuity	Final Report	Reasonable
26. Electronic document and records management solution	Draft Report	Reasonable
27. Capital Systems/Major Project Provisions	Not started (deferred)	N/A
28. Nevill Hall RAAC	Final Report	Reasonable
29. Estates Assurance – Energy Management	Final Report	Reasonable
30. Newport East HWBC	Draft Report	Reasonable
31. NHH Regional Satellite Centre	Planning (2025/26)	N/A
32. The Grange A&E Expansion	Final Report	Reasonable

Appendix B: Progress against 2025/26 Internal Audit Plan

Reviews	Status
1. Divisional Budgetary Control	Planning for Q3
2. Standing Orders Compliance	Planning for Q1
3. Strategic Risk and Assurance	Planning for Q4
4. Subject Access Requests	Planning for Q1
5. Benefits Realisation (excluding digital)	Planning for Q3
6. Business Continuity Plan	Planning for Q2
7. Capital Projects: Service Readiness	Planning for Q2
8. Falls Management	Planning for Q2
9. Directorate Review - CAHMS	Planning for Q3
10. Professional Staff Registration	Planning for Q2
11. Clinical Audit	Planning for Q4
12. Directorate Review – Ophthalmology / ENT	Planning for Q2
13. Public Health	Planning for Q1
14. Six Goals Programme	Planning for Q3
15. Discharge Planning	Planning for Q4
16. Safeguarding	Planning for Q1
17. Cancer Referral Rates	Planning for Q4
18. Occupational Health	Planning for Q4
19. Overseas Recruitment	Planning for Q4
20. Speaking up Safely	Planning for Q1/Q2
21. Follow-up of High Priority Recommendations	Planning for Q4
22. Cyber Security (Including cyber incident response)	Planning for Q1
23. Shadow IT	Planning for Q2
24. Welsh Intensive Care Information System	Planning for Q2
25. RGH Central Decontamination Unit	Planning for Q2/Q3
26. Estates Assurance – Space Utilisation	Planning for Q2

Appendix C: 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.

Job Planning

Final Internal Audit Report

2024/25

Aneurin Bevan University Health Board



Limited Assurance

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Findings & Agreed Action Plan 3
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Review Reference	ABU-2425-17
Fieldwork	February - March 2025
Executive Sign Off	May 2025
Audit Committee	June 2025
Executive Lead	James Calvert, Medical Director
Audit Team	Stephen Chaney, Head of Internal Audit
	Eifion Jones, Deputy Head of Internal Audit

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Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

To provide assurance that arrangements are in place and operating effectively for consultant job planning.

Overview

Job planning became a key aspect of consultant roles with the agreement of the 2003 amendment to the National Consultant Contract in Wales. Job Plans are mandatory and align the objectives of the NHS and employing organisation with agreed outcomes to allow consultants and the wider NHS team to plan and deliver safe, responsive, efficient and high-quality care. A job plan is a professional and contractual obligation for consultants to set out their duties, accountabilities and outcomes of their role and to establish the support and resources required for the coming year.

The procured L2P system which has been in place in the Health Board since 2024 captures job plans and reports, following the completion of them. It records the work a consultant will undertake for the Health Board, which is split by Direct Clinical Care (DCC) ad Supporting Professional Activities (SPA). The audit found there is a strong organisational focus to ensure compliance and job plan completion, however, there appears to be a resistance and / or lack of engagement from consultants. This issue, combined with historical workforce challenges is negatively impacting the effective implementation / completion of job plans.

We have concluded limited assurance on this area. The significant matters requiring management attention include:

- Job planning compliance is low and there are concerns the Health Board will not meet the Welsh Government target by the deadline.
- Personal outcomes within job plans are not fully completed. In addition, following improved completion of personal outcomes within job plans, focus should move onto the completion of service outcomes.
- Examples, of sessions recorded within job plans are not consistent with ESR.
- The recent operational forums change has led to less focus on job planning compliance, due to operational issues arising.
- More detailed action focus required on the Strategic Risk Register to ensure compliance progress is highlighted and the target met.

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

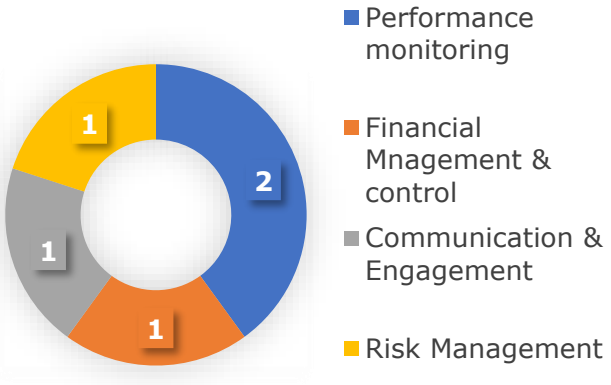
Scope & Assurance Summary

Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	Relevant Health Board guidance and procedures aligned to the All-Wales guidance	-	**Substantial**
2	Job plans accurately reflect requirements and completed in a timely manner	1,2	**Limited**
3	Total sessions reflected accurately in accumulative fields on ESR	3	**Limited**
4	Completion of job plans are monitored, reported and escalated to an appropriate forum	4, 5	**Reasonable**

Management Actions

3	2
High Priority	Medium Priority

Themes



Risk Types

Financial Loss

Legal & Regulatory Non-Compliance

Public Perception & Reputational Risk

Analysis of Job Planning Status

The table below provides detail over the current position of risks assessed across the audit objectives.

Audit Objective	Assurance Rating	Description	Embedded	In progress	Key Findings
1	Substantial	Guidance and process	√	-	-
1	Substantial	Resources and support	√	-	-
2	Limited	Job planning compliance	-	X	1
2	Limited	Quality of approved job plans	-	X	2
3	Limited	Reconciliation with ESR	-	X	3
4	Reasonable	Monitoring and oversight	√	-	4
4	Reasonable	Operational forums	√	-	4
4	Reasonable	Risk register	√	-	5

Findings & Agreed Action Plan

Objective 1: Relevant Health Board Guidance	**Substantial**

Overview / Summary of Observations

The Health Board provides comprehensive job planning guidance for all staff, aligned with All Wales guidance documents. The most recent of these is titled 'The National Health Service in Wales: Effective Job Planning for Consultant Medical and Dental Staff (2014)'. Alongside this framework is the Health Board's 'Consultant Job Planning Procedure', which was introduced in August 2023, with a review due in 2026. This procedure was accompanied by a letter from the Medical Director emphasising the critical importance of completing job plans promptly.

The job planning procedure outlines the Health Board's stance on Direct Clinical Care (DCC) and Supporting Professional Activity (SPA), while also detailing the roles and responsibilities of key individuals involved in the job planning process. In a commitment to continuous improvement, the Health Board is currently reviewing this procedure to ensure it remains current and effective.

The Health Board has established a dedicated page on the intranet. This resource includes a detailed outline of the job planning process, answers to frequently asked questions, a job planning learning pack, information on the escalation process, template letters, and guidelines regarding travel and parking time. Additionally, it provides contact details for the Job Planning team, ensuring that staff have the necessary support and resources.

Objective 2: Completion of Job Plans in a timely manner	**Limited**

Overview / Summary of Observations

A job plan serves as a vital framework for consultants, detailing their responsibilities, accountabilities, and expected outcomes within their roles. It is a professional and contractual commitment that facilitates the establishment of necessary support and resources for the upcoming year and there is adequate SPA (Supporting Professional Activity) time for it to be completed by consultants. As of February 2025, compliance stands at 38.4%. The Welsh Government has set a target of achieving 90% compliance by the end of September 2025. There are pockets of reasonably good compliance, as shown within the February 2025 figures, including Mental Health (58.3%), Clinical Support Services (50.7%) and Urgent Care (48.1%).

The L2P System was introduced in January 2024 which replaced the previous paper-based process. The system captures the details of each job plan, works out the sessional value and generates compliance reports that are essential for monitoring progress. An analysis of the L2P report from the February Dashboard revealed that out of 241 consultants in progress, 141 are greater than 12 months overdue.

The Amendment to the National Consultant Contract in Wales (2003) and the Health Board's job planning procedure stipulate that job plans must incorporate personal outcomes that align with organisational objectives. Our review of a sample of approved job plans revealed that they consistently represented an 8:2 ratio of Direct Clinical Care (DCC) to Supporting Professional Activities (SPA), indicating eight DCC sessions and two SPA sessions within a ten-session week. In cases where the total exceeded 12 sessions, these were authorised by the Assistant Medical Director. However, some job plans lacked information regarding personal outcomes and standard service outcomes are not completed, as this feature has been disabled in the system. The completion of service outcomes should be re-prioritised as the completion of contracted sessions and personal outcomes sections improves.

	Key Findings	Risk & Impact	Agreed Management Action
1	**Job Planning compliance** As of February 25, the compliance rate for the Health Board is 38.4% which means there is work to be done to ensure the Health Board reaches the 90% target set by the Welsh Government for the end of September 2025. Consultants are provided with time within their allocated SPA allocation time for the annual completion of job plans. From February 25 Dashboard out of 552 consultants: (including one consultant added post-fieldwork): • 212 job plans are complete • 245 job plans are in progress (including 141 >12 months overdue) – 44.40% • 26 job plans not started – 4.70% • 141 job plans in progress but are greater than 12 months overdue – 25.54% This highlights the need for immediate attention to ensure that all consultants meet their obligations and contribute to the overall goal of improved compliance.	Resources not being utilised effectively and efficiently to ensure the delivery of high-quality patient care. The Health Board not fulfilling its contractual obligation in relation to job planning.	**Agreed Action:** 1. Discuss accountability for progress to achieving 90% compliance in the bi-annual Divisional Performance reviews. Ensuring actions to address the compliance are captured in the Executive summary of these meetings. 2. The Deputy Medical Director will hold deep dives in targeted areas where compliance is poor, starting with Medicine. 3. Vacant consultant posts will not be replaced until the whole team have an up-to-date job plan. 4. No positive pay impacting changes will be made unless accompanied by an in-date job plan. 5. Financial support for study leave will be withheld for consultants who do not have an up-to-date job plan. A process to facilitate this will be developed. 6. Accountability arrangements will be strengthened to ensure the Directorate Manager has oversight and is responsible for ensuring job planning takes place within the directorate. 7. A further communication will be sent from the Medical Director and Chief Operating Officer to each consultant

			reminding them of their contractual obligation and specifying the organisational approach (points above) to achieving 90% compliance. **Expected Evidence of Implementation:** The actions identified will facilitate 90% compliance with job planning however given the change in approach and the requirement to put processes in place to support this 90% is unlikely to be achieved until the end of quarter two.
		High Priority	**Officer:** 1. Chief Operating Officer 2. Medical Director 3. Director of Finance 4. Director of Finance / Director of Workforce & OD 5. Director of Finance / Director of Workforce & OD 6. Chief Operating Officer/Medical Director 7. Chief Operating Officer/Medical Director **Target Implementation Date:** 1. Immediate and on-going 2. Medicine 6th May 2025, remainder July 2025 3. June 2025 4. June 2025 5. June 2025 6. July 2025 7. May 2025
	Theme: Performance Monitoring	Control Operation	
2	**Quality of approved of job plans** Our testing of approved job plans showed: • 10 out of the 20 job plans did not contain personal outcomes for individuals even though this is stipulated in the guidance. The L2P function for recording service outcomes is not currently activated and thus, not being recorded. This position should be reviewed once the compliance position with contracted sessions and personal outcomes has been improved. These aspects need to be improved to ensure contractual obligations are adhered to and they are completed correctly	Job plans not reflecting responsibilities, outcomes and expectations resulting in an operational risk to the Health Board	**Agreed Action:** 1. Work with L2P to establish whether the outcome section can be a mandatory field, preventing sign off until such time as this section is completed. 2. The Service outcome section in L2P will be activated once all consultants have an up-to-date job plan on the system and have identified personal job planning outcomes. Personal outcomes are based on the individual doctor's needs (career development etc.) and the service needs are discussed at the job plan review meeting. 3. A reminder to complete the outcome section with SMART objectives will be included in the communication referred to in Section 1, to the consultant and the Directorate Managers. The

			requirement is included in the job planning training which all consultants should have undertaken.
			Expected Evidence of Implementation: SMART objectives are evident in the operational section of each job plan. Job plans are not signed off until these are complete.
		High Priority	**Officer:** 1. Director of Workforce 2. Medical Director/Director of Workforce & OD 3. Medical Director/Chief Operating Officer **Target Implementation Date:** 1. Dependent on ability of the L2P system and any additional cost, review June 2025 2. Review October 2025 3. June 2025
	Theme: Performance Monitoring	Control Operation	

Objective 3: Reconciliation with ESR	**Limited**

Overview / Summary of Observations

The L2P system, implemented as a stand-alone solution for capturing job plans, has been operational within the Health Board since 2024. The system operates independently from the Electronic Staff Record (ESR) or payroll system. If any changes are made to sessional amounts after the job planning process is completed, it is the manager's responsibility to complete a change form and submit this to the payroll team, alongside the consultant's job plan for the change to be made. This is to ensure that payment details accurately reflect the number of sessions completed.

A sample of 20 approved job plans was reviewed, alongside data extracted from the L2P system. This data, derived from a report detailing the number of clinical sessions assigned to consultants within their job plans from January 2024 to February 2025, this was then cross-referenced with the information available on ESR. The testing revealed inaccuracies that require further review to guarantee that payments are processed correctly and in alignment with the actual sessions worked.

Key Findings		Risk & Impact	Agreed Management Action
3	**ESR Reconciliation** Testing completed of the job plans and L2P found the following inaccuracies when reconciling to ESR: • 5 job plans out of 20 did not reconcile with ESR (4 underpayment and 1 overpayment on ESR) Records need to be correct to ensure actual sessions are being paid and there is no underpayment or overpayment taking place.	Financial risk of sessional changes in job plans not being recorded correctly in ESR resulting in inaccurate payments being made	**Agreed Action:** 1. There is already an alert icon in the L2P system that identifies a sessional change in the job plan. Work with L2P to establish whether the current alert can be used to provide a reminder that a change form needs to be completed and submitted to pay roll. It may also be possible to add a link to the Change form. 2. Once all job plans are on the L2P system for a directorate it will be possible for Directorate Managers and BPAs to easily identify job planned session in L2P and compare with ESR. Monthly comparisons for completed job plans will be undertaken within the directorate 3. The reminder to complete change forms to ensure sessions in the job planned are paid accurately will be included in the communication to Directorate Managers **Expected Evidence of Implementation:** When there is a variation to job planned session, this will be reflected in ESR to ensure Consultants are accurately paid.
		High Priority	**Officer:** 1. Director of Workforce & OD

	Theme: Finance Management & Control	Control Design	2. Chief Operating Officer/Director of Finance 3. Chief Operating Officer/Medical Director **Target Implementation Date:** 1. Dependent on ability of the L2P system and any additional cost, review June 2025 2. Review June 2025 3. June 2025

Objective 4: Monitoring, reporting and escalation	**Reasonable**

Overview / Summary of Observations

Job Planning compliance is regularly reported to the Board and other committees (People and Culture Committee and Audit, Risk and Assurance Committee). This allows for high level oversight and scrutiny. Clear escalation routes exist, both for individual disputes and broader compliance concerns, which helps address issues promptly when they arise. Monthly updates at divisional assurance meetings and updates to Executive and divisional directors ensure job planning compliance is monitored at a divisional level.

The Medical E-Systems Programme Board had a role in overseeing medical systems for clinicians, but this was stood down due to low attendance and is now part of the broader Medical Leaders' Group. This group meets weekly, job planning compliance is discussed but not in detail due to time constraints and focus on other operational issues, potentially affecting overall effectiveness. The Job Planning Consistency Group aims to improve consistency of job planning implementation and compliance but has seen a decline both in attendance and frequency. A possible refresh of these forums along with deep dives in service areas, rotational discussions on crucial job planning elements and sharing of good practice may help in improving compliance.

Job planning is listed as a strategic risk but without concrete actions or a clear path towards achieving the Welsh Government target of 90% by the end of September 2025.The risk is recognised, but there appears to be a gap between acknowledgment and proactive efforts to address the issue.

	Key Findings	Risk & Impact	Agreed Management Action
4	**Operational forums** The changes in the Medical E-Systems Board, Medical Leaders Group and infrequency and low attendance of the Job Planning Consistency Group has led to a lack of focus on job planning and compliance. These forums are key in ensuring actions are implemented along with risks and issues discussed in an appropriate forum. A possible refresh in these forums along with deep dives, rotational discussions on job planning elements and sharing of good practice within these forums could also assist with improving compliance and engagement.	Lack of oversight and consistency with regards compliance.	**Agreed Action:** 1. The Deputy Medical Director will hold deep dives in targeted areas where compliance is poor, starting with the division of Medicine. 2. The terms of reference for the Job Planning Consistency Group will be reviewed and include identification of when to stand down a meeting and what action to take for persistent non-attendance. Good practice and key issues sections will be included in the agenda going forward. 3. The Chief Operating Officer and Divisional Directors will escalate strategic issue highlighted through Performance meetings to the Deputy Medical Director. Operational issues will be dealt with within the division. 4. Regular performance reports will be submitted to Performance Oversight Committee section of the Executive Committee.

			Expected Evidence of Implementation: Change in focus and culture such that job planning is seen as a vehicle to support demand capacity planning and delivering service objectives. Improved compliance.
		Medium Priority	**Officer:** 1. Medical Director 2. Medical Director 3. Chief Operating Officer 4. Medical Director / Director of Workforce & OD **Target Implementation Date:** 1. Medicine 6th May 2025, remainder July 2025 2. July 2025 3. July 2025 4. Bi-annually
	Theme: Communication & Engagement	Control Operation	
5	**Risk Register** Noting the current low level of compliance 38.40% and the pace that is required to reach the Welsh Government target of 90% by the end of September 2025; there is a risk that this will not be achieved. Therefore, the profile and prominence of the job planning process should be further escalated across divisions / directorates to ensure job plans are completed. This should be completed via the risk management process throughout the Health Board, with responsible officers assigned within each applicable service area for the mitigation / accountability of this risk.	The risk not being appropriately managed to ensure the compliance rate reaches Welsh Government target.	**Agreed Action:** 1. In discussion with the Director of Corporate Governance identify the appropriate risk register for job planning compliance to be identified in. 2. Risk related to compliance will be included in divisional risk registers.
			Expected Evidence of Implementation: Clearly identified risks on the appropriate risk register, regularly reviewed and monitored.
		Medium Priority	**Officer:** 1. Medical Director/Chief Operating Officer 2. Chief Operating Officer **Target Implementation Date:** 1. June 2025 2. June 2025
	Theme: Risk 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 presents 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]

Contract Management

Final Advisory Report

2024/25

Aneurin Bevan University Health Board

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Findings & Management Considerations 3
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Review Reference	ABU-2425-03
Fieldwork	February 2025 – April 2025
Executive Sign Off	June 2025
Audit Committee	June 2025
Executive Lead	Rob Holcombe, Director of Finance, Procurement & Value
Audit Team	Stephen Chaney, Head of Internal Audit; Eifion Jones, Deputy Head of Internal Audit

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Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

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

An assurance rating has not been applied to this review, recognising the consistency of approach with the BCUHB review, and that actions raised will need to be taken forward in partnership with other NHS Wales organisations, including NWSSP Procurement Services. These actions, alongside those specific to the Health Board, are aimed at improving and/or enhancing expected controls in contract management arrangements.

Overview

Noting the absence of a Health Board contract register, for the purposes of this audit, sample testing was based on the Electronic Contract Management module of the Bravo e-tendering system. Contract selection was undertaken to ensure consistency with similar reviews undertaken at several NHS Wales organisations. All Wales Contracts were excluded from our sample; in addition to Capital and Estates contracts noting that separate Capital Systems reviews have been undertaken by our Specialist Services Unit (SSU) at several NHS organisations as part of the 2024/25 Internal Audit Plan – the coverage of which has also included contract management.

The following management considerations have been identified:

- Comprehensive contract registers were not in place with reliance placed on the partial records held within Electronic Contract Management module.
- A mechanism to determine the capacity and support needed to meet existing and future contract monitoring requirements, with appropriate training provision.
- Responsibility for contract management should be formally assigned and accepted.
- Variations in the formality of contract management, performance reporting, and documentation, which indicates a level of inherent risk which could be addressed by increasing the robustness of the control environment.
- The minimum internal reporting, accountability and escalation requirements should be considered and defined at the outset of contracts.

The Health Board should ensure appropriate arrangements are in place to engage with wider NHS Wales organisations and NWSSP Procurement Services in developing a coordinated agreed action plan via the Directors of Finance forum (or other appropriate forum), to address the common themes and issues identified within this and corresponding reports.

Full details of matters arising for management consideration are detailed within the Findings & Management Considerations section.

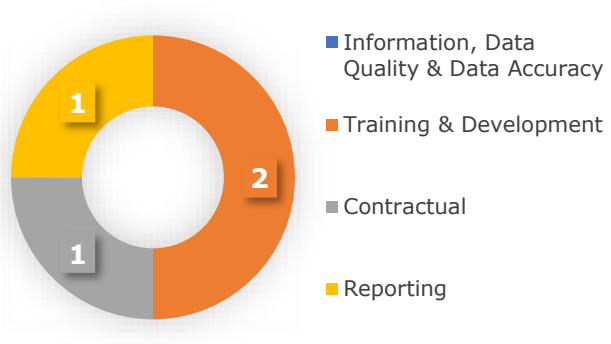
Scope & Actions Summary

	Objectives	Related Actions
1	There is a clear framework of policies, procedures and processes for contract management, with roles and responsibilities clearly defined.	
2	Contract registers are used as the basis for effective contract management and procurement planning.	1
3	Contract managers have access to relevant training and development.	2
4	Service levels/deliverables are specified in the contract, with standard terms and conditions applied, and are linked to service needs and monitored by the assigned contract manager/end user.	3
5	Contract performance and risk is reported and managed within the Health Board's governance structure.	4

Management Considerations

4

Themes



Risk Types

Public Perception & Reputational Risk

Financial Loss

Quality or Safety Issues

Legal & Regulatory Non-Compliance

Findings & Management Considerations

Objective 1: There is a clear framework of policies, procedures and processes for contract management, with roles and responsibilities clearly defined.

The Health Board's Standing Financial Instructions (SFIs) includes a section on contract management. Section 11.16.1 outlines that the relevant budget holder is responsible for overseeing and managing each contract on behalf of the Health Board to ensure that implicit obligations are met. This includes:

- *Retaining accurate records;*
- *Monitoring contract performance measures;*
- *Engaging suppliers to ensure performance delivery;*
- *Implementing contractual sanctions in the event of poor performance in conjunction with advice from Procurement Services; and*
- *Permitting stage payments as part of a formally agreed implementation/delivery plan which must be supported by written evidence issued by the budget holder.*

In addition to the above, there is an All-Wales Procurement e-manual, which contains contract management guidance, available via the Health Board 'Oracle' system home page. In discussion with staff, this document is not a regular point of reference.

In addition, the Health Board has a Contract Management Financial Control Procedure that further sets out requirements and expectations of contract managers. This specifies a Contract Management Plan for all contracts of £100,000 or greater and this provides the basis for a standardised approach to contract management across the Health Board. The Contract Management Plan will identify various elements of the process including (but not limited to):

- ABUHB and 3rd Party lead contacts;
- Timetable of delivery expectations and responsibilities;
- Schedule of Suppliers meetings and memberships;
- Communications Plan from the Contract Manager to key stakeholders ;
- Contract Objectives;
- Benefits Realisation Plan;
- Mobilisation Plan / Contract entry with timeframes;
- Key Performance Indicators / Management Information Reporting;
- Contract Variation Process;
- Escalation process / procedures for non-delivery;
- Opportunities for Continuous Improvement / Service Improvement / Innovation; and
- Exit Plan.

Objective 2: Contract registers are used as the basis for effective contract management and procurement planning.

A contract register is important as it provides:

- Contract Tracking: to track important dates, such as start and end dates, renewal periods, and milestones associated with each contract.
- Compliance and Risk Management: to ensure that the organisation stays compliant with contract terms and legal requirements; and to help identify any potential risks by keeping a record of contract clauses, obligations, and renewal terms.
- Audit Trail: provided for each contract, including amendments and performance evaluations. This makes it easier to track changes and decisions related to a contract.
- Centralised Repository: allowing easier access for teams like legal, procurement, and finance when they need to refer to specific terms, obligations, or other contract details.
- Improved Communication: enhances communication across departments, as everyone involved can refer to the register to ensure that they are aware of their obligations and responsibilities under various contracts.
- Budget and Financial Tracking: for financial management to track contract values, payment terms, and other financial aspects to ensure proper budgeting and forecasting.

The Social Partnership and Public Procurement (Wales) Act 2023 states that a contracting authority must create, maintain, and publish a contract register.

Within our sampled contracts, no contract managers indicated a directorate contract register was currently in place, nor is there a Health Board wide register - sample testing was based on Electronic Contract Management module of the Bravo e-tendering system – however this listing is not comprehensive and does not include all the information prescribed above.

Management Consideration 1: Contracts register

A Health Board-wide contract register should be prepared to record and manage contract records and information.

Objective 3: Contract managers have access to relevant training and development.

This audit, and similar reviews at other NHS Wales Organisations, observed that contract management was undertaken by a combination of:

- Dedicated contract managers;
- To fulfil an existing element of a job description / role profile; and
- As an unspecified additional responsibility.

The demands on staff was dependent on the specific performance monitoring requirements of the contract and varied significantly.

For the sampled contracts, there was no evidence of an assessment of the capacity / capability requirements to fulfil the role and / or the identification of any training requirements to address any gaps. Similarly, no specific contract monitoring training had been provided for the contract managers within our sample.

The Health Board's SFIs include within Section 11.16.3 that 'Advice on best practice on Contract Management is available from NWSSP Procurement Services.'

Management Consideration 2: Training

A mechanism should be established to ensure senior managers identify any specific training requirements to support operational contract management – reflecting the capacity / capability of individuals and requirements of the specific contracts.

The Health Board should engage with NHS Wales Organisations to develop contract management training, to ensure staff are equipped with the tools and skills to manage the key stages and lifespan of contracts.

Objective 4: Service levels/deliverables are specified in the contract, with standard terms and conditions applied, and are linked to service needs and monitored by the assigned contract manager/end user.

Standing Financial Instructions (11.6.1) require that "*The relevant budget holder, shall oversee and manage each contract on behalf of the Health Board so as to ensure that these implicit obligations are met*."

A sample of eight contracts were selected from the contract management module of the Bravo e-tendering system, and this audit was undertaken in conjunction with reviews taking place at other NHS Wales organisations to provide consistency of service/contract type where possible. Through discussion and review of documentation with contract managers who had provided material we identified the following:

Designated responsible officer/contract ownership

Whilst the audit was directed to certain individuals by the Health Board procurement lead, for the contracts sampled in the audit, not all these had been formally assigned responsibility for contract monitoring. Within our sample of contracts, we identified two managers who performed a dedicated contract management role, others were operational staff. Anecdotally, contract management ownership is more accepted in the non-clinical Divisions than in the clinical areas, the latter taking more the view that contract management is a Procurement responsibility so there is push-back from staff to take on these responsibilities.

The recording of Senior Responsible Officer and budget holder within contract documentation varied in the documentation reviewed, and this alongside the differences in the contract leads recorded within Bravo indicates a need for the Health Board to progress its own contract register (see **Objective 2**).

Contract documentation

Within our sample, there were several contracts where a signed 'final' contract was not available. Health Board managers noted that these had not been provided by Procurement Services, but prior to audit fieldwork had not identified this gap. We noted that in some cases a suppliers completed ITT user requirement specification (URS) documentation was used as a reference document for contract management purposes (deliverables specification, targets and KPIs, performance monitoring) but there is a risk in doing so that changes or amendments that arose in finalising the contract and therefore are not reflected in the URS document are overlooked.

Contract deliverables/performance measures in contract documentation

Review of contract documentation established that in half the cases examined there were no contract provisions, schedules or clauses that prescribed what form performance monitoring should take for the contract but that in all but one case, there was a level of performance monitoring taking place.

Contract management/monitoring

In half the cases we saw an expected level of appropriate contract performance monitoring against contractual KPIs taking place, in 2 other cases basic monitoring of activity in terms of uptime/ downtime was active and in a further case, regular monitoring meetings had suspended the established performance monitoring agenda, that being temporarily replaced with a breach management agenda.

Management Consideration 3: Contracts

In respect if contracts:

- Responsibility for monitoring the contract should be formally assigned and the expected responsibilities should be accepted (for example utilising a formal appointment form). Consideration should also be given to instances where responsibility may be handed on to other individuals i.e. when the officer responsible for the tender process will not be the assigned contract management for ongoing performance review.
- The Health Board should ensure that final, signed, full contract documents are obtained from Procurement Services and retained centrally; with the contract register updated accordingly.
- The Health Board should ensure that performance measures are in place within contracts, that there are appropriate regular contract performance meetings taking place to monitor the achievement of these and that there is a process to address any underperformance identified.

Objective 5: Contract performance and risk is reported and managed within the Health Board's governance structure.

The SFIs relating to contract management (section 11.6) do not provide information on the expected minimum reporting, accountability and escalation arrangements in relation to contracts, nor does the Health Board's Contract Management Plan template.

Risk Management is not an explicit element of the contract monitoring by the contract manager, although the threat to service delivery from contract business interruption is appreciated by contract managers. Risk to the service receiving the contracted activity posed by the contract is however always managed by the receiving service and we were advised that Service risk management (although not in the scope of this audit) is active across the Health Board through the DATIX platform, cited by all contract managers in the sample we examined.

Performance monitoring is structured around metrics agreed between the service and the provider but, as noted above, is not always specified in the contract detail. Reporting was found to be exception based and escalation routes determined by the established pathways of the services/ divisions in question.

Management Consideration 4: Reporting, Escalation and Risk Management Arrangements

Expected internal monitoring / reporting arrangements should be defined at the outset of the contract taking into account the risk, value, complexity and strategic importance of the contract.

Appendix A: Assurance Opinion & Prioritisation of Findings

Assurance Opinion

 **Substantial**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
 **Reasonable**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
 **Limited**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
 **Unsatisfactory**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
 **Advisory**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

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Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership]

Performance & Accountability Framework

Final Internal Audit Report

2024/25

Aneurin Bevan University Health Board



Reasonable Assurance

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Fieldwork	April – May 2025
Executive Sign Off	June 2025
Audit Committee	June 2025
Executive Lead	Hannah Evans, Director of Strategy, Planning and Partnerships
Audit Team	Stephen Chaney, Head of Internal Audit
	Eifion Jones, Deputy Head of Internal Audit

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Executive Summary

Purpose

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

Overview

The audit provides **reasonable** assurance over the adequacy of the Framework document and that it had largely been implemented as intended over the period.

Recognising this, management focus should be on strengthening arrangements and ensuring full implementation of proposals, in particular:

- The Performance Management and Accountability Framework was overdue a formal review.
- There should be consideration towards including potential ramification and detail over accountability lines within the Framework document.
- The benefit of the existing arrangements should be reviewed in the context of the resource required to service the requirements.
- Consideration should be given to the timing of meetings (particularly end-of-year reviews) to ensure target setting and onward reporting are timely.
- Deep dive reviews have not been initiated since the introduction of the Framework.

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	To ensure the performance and accountability framework had been adequately defined and was sufficiently robust.	1,2	**Reasonable**
2	The performance processes were regularly monitored and there was clear accountability demonstrated to drive performance improvement.	3,4,5,6	**Reasonable**
3	The Board was provided with regular updates consistent with the intent of the performance framework to assist in managing key strategic risks.	7	**Reasonable**

Management Actions

0	7
High Priority	Medium Priority

Themes



Risk Types

Financial Loss

Public Perception & Reputational Risk

At a Glance – Performance and Accountability Framework

Background

The purpose of the Performance Management and Accountability Framework (PMF) is to establish and maintain an effective performance management mechanism that enables, monitors, and achieves the delivery of Aneurin Bevan University Health Board's strategic priorities and operational plans.

The Framework outlines the following key monitoring arrangements:

1. Monthly Divisional Assurance Review Meetings

Chaired by the Chief Operating Officer.

2. Quarterly Divisional Performance Review Meetings

Q1 - Chaired by Chief Operating Officer.

Q2 – Six-Monthly Review – Chaired by Chief Executive Officer.

Q3 – Chaired by Chief Operating Officer.

Q4 – End of Year Review – Chaired by Chief Executive Officer.

3. Corporate Teams 6 Monthly Review Meetings

Chaired by the Chief Executive Officer.

The framework also has arrangements for divisions or corporate teams to be put into an escalation arrangement based on concerns relating to Quality & Safety, Operational Delivery and Finance domains. There are three levels of escalation:

Supported Autonomy.

Enhanced Monitoring.

Special Measures.

At the time of review, based on a review conducted by the Executive Team during January 2025, none of the divisions were classed as under special measures, but seven of the eight were under enhanced monitoring for one or more of the domains.

Findings & Agreed Action Plan

Objective 1: To ensure the performance and accountability framework had been adequately defined and was sufficiently robust. **Reasonable**

Overview / Summary of Observations

The Performance Management and Accountability Framework (the 'Framework') was formally approved by the Board during September 2023. The Framework outlined that it should be reviewed on an annual basis and was therefore overdue a review at the time of the audit. It is recognised that arrangements were currently under review, lessons learnt had been reported to the Finance & Performance Committee in February 2025 and a Committee session had been agreed to review existing arrangements.

The Framework adequately included:

- Guiding Principles;
- Performance Principles;
- Oversight and Accountability Expectations;
- Escalation Arrangements; and
- Key Roles and Responsibilities.

Whilst the Framework outlined examples of the type of escalation arrangements that could be applied, the document may benefit from a more explicit implications from escalation under all three of the domains (Quality & Safety, Operational Delivery and Finance).

Key Findings		Risk & Impact	Agreed Management Action
1	**Framework Document** The Performance Management and Accountability Framework was overdue a formal review. The review should consider the findings of this audit and those reported to the Finance & Performance Committee in December 2024.	The Framework does not reflect the current working arrangements/ practices.	**Agreed Action:** The PMF is undergoing a full review expected to conclude in Q2 with a revised Framework for consideration going to September Board
			Expected Evidence of Implementation: Outcomes of the review, recommendations and redrafted Framework
		Medium Priority	**Officer: Assistant Director Planning & Performance/Director of Strategy, Planning and Partnerships** **Target Implementation Date: 30/09/2025**
	Theme: Policies & Procedures	Control Operation	
2	**Accountability** Consideration should be given to developing explicit implications of escalation under all three of the performance domains (Quality & Safety, Operational Delivery and Finance), for	The implications of non-performance are not understood	**Agreed Action:** All escalations domains to be reviewed and included in the PMF review. Feedback to be drawn from Operational, Corporate, Executive and Board

	example linkage to Financial Control Procedures in respect of financial performance.	or inconsistently applied.	**Expected Evidence of Implementation:** Outcomes of the review, recommendations and redrafted Framework
		Medium Priority	**Officer: Assistant Director Planning & Performance/Director of Strategy, Planning and Partnerships** **Target Implementation Date: 30/09/2025**
	Theme: Policies & Procedures	Control Design	

Objective 2: The performance processes were regularly monitored and there was clear accountability demonstrated to drive performance improvement.	**Reasonable**

Overview / Summary of Observations

The Framework outlined the following review arrangements:

- Monthly Divisional Assurance Reviews;
- Quarterly Divisional Performance Reviews;
- Corporate Teams – Assurance Review Meetings (six-monthly); and
- Deep Dives (ad-hoc).

Both the monthly and quarterly divisional meetings were chaired by either the Chief Executive Officer or Chief Operating Officer – the latter also requiring attendance of the Executive Team at the six-month and end-of-year reviews. A standard agenda, data pack and slide deck were produced for each meeting, and each meeting concluded with actions notes and/or accountability letters.

Monthly Divisional Reviews – from the sample for the audit these were conducted in accordance with the Framework document requirements.

Quarterly Divisional Performance Reviews - the Framework document outlines that these should be concluded in July, October, January and April of each year. It was observed that the 2023/24 end of year reviews were concluded in April-June 2024 and the 2025 end of year reviews were planned for May-June 2025. An important facet of these meetings is to discuss the delivery plans for the year ahead; accordingly, it is important these are conducted as early as possible. There is also an impact on onward reporting to committees as noted at **Objective 3** below.

Corporate Team and Deep Dives – these had not been conducted since the implementation of the Framework.

	Key Findings	**Risk & Impact**	**Agreed Management Action**
3	**Resource Implications** The current review/ meeting requirements places significant demand on senior staff. This may be reflected in that several executives sent deputies to the mid-year reviews. There is also a significant burden on the Corporate and Divisional teams to manage these arrangements and to produce supporting documents (e.g. slide packs, agendas, notes, accountability letters etc.).	The resource required does not equate to the value added.	**Agreed Action:** The PMF is undergoing a full review expected to conclude in Q2 with a revised Framework for consideration – this will consider the burden vs benefit of reviews - noting that the requirement for executives to attend is twice a year
			Expected Evidence of Implementation: Outcomes of the review, recommendations and redrafted Framework
		Medium Priority	**Officer: Assistant Director Planning & Performance/Director of Strategy, Planning and Partnerships** **Target Implementation Date: 30/09/2025**
	Theme: Resourcing	Control Operation	

4	**Timings** The Framework document outlines that quarter 4 reviews should be concluded in April of the corresponding year to enable discussion on the delivery plans for the year ahead. It was observed that the end-of-year reviews for 2023/24 were completed between April and June 2024. They are to be completed between May and June 2025 for the 2024/25 year. It was also apparent that the accountability letters were issued later than expected for both Executives and Divisions.	Information received is not timely/ current	**Agreed Action:** Timeliness of reviews is noted. End of Year reviews are planned for June – July. Our learning is that April is too early as we do not have the management information (performance or financial Timings of reviews and accountability letters will be considered in the review and refresh of the PMF. The PMF is undergoing a full review expected to conclude in Q2 with a revised Framework for consideration
			Expected Evidence of Implementation: Outcomes of the Review, recommendations and redrafted Framework
		Medium Priority	**Officer: Assistant Director Planning & Performance/Director of Strategy, Planning and Partnerships** **Target Implementation Date: 30/09/2025**
	Theme: Planning, Delivery & Deadline Management	Control Operation	
5	**Corporate Team Reviews** The Performance and Accountability Framework outlines that Corporate Teams Assurance Review Meetings would be held on a six-monthly basis for the following: • Public Health; • Planning; • Digital; • Corporate Governance; • Therapies and Health Science; • Finance; • Medical; • Nursing; and • Workforce & OD. Corporate Team reviews were not conducted in 2024/25. Subject to Board approval, these should be removed as a requirement from the Framework document or should be instated in full as required by the Framework document.	The framework is not applied to all aspects of the organisation.	**Agreed Action:** This recommendation will be considered as part of review. It is important that all elements of the organisation have accountability arrangements and consideration will be of frequency. Corporate Team reviews are scheduled for Q1 and Q2 2025
			Expected Evidence of Implementation: Outcomes of the Review, recommendations and redrafted Framework Evidence of the review an actions
		Medium Priority	**Officer: Assistant Director Planning & Performance/Director of Strategy, Planning and Partnerships** **Target Implementation Date: 30/08/2025**
	Theme: Performance Monitoring	Control Operation	
6	**Deep Dives**	Key risks are not fully understood	**Agreed Action:** The use of Deep Dives to support performance improvement and assurance has not been consistent. The

	No Deep Dives had been planned or undertaken since the introduction of the Performance and Accountability Framework. A schedule of priorities for deep dives should be developed for 2025/26 and agreed by an appropriate forum.	and/or corrective action agreed.	Executive team did do Deep Dives into a number of surgical specialities. Reviewing use and role of these will be picked up as part of PMF Review
			Expected Evidence of Implementation: Deep Dive slides and actions
		Medium Priority	**Officer: Assistant Director Planning & Performance** **Target Implementation Date: 30/06/2025**
	Theme: Lessons Learnt	Control Operation	

Objective 3: The Board was provided with regular updates consistent with the intent of the performance framework to assist in managing key strategic risks.	**Reasonable**

Overview / Summary of Observations

In practice, the role of overseeing the implementation of the Framework had been delegated to the:

- Patient Quality Safety and Outcomes Committee (PQSOC) – bi-monthly oversight via Quality Outcomes Framework;
- Finance and Performance Committee (F&P) – quarterly oversight via Outcomes Framework and Financial Report; and
- People and Culture Committee – quarterly oversight via Workforce Report.

The Finance and Performance Committee also received a summary of the six-monthly and end-of-year Divisional reviews. It is recognised that the report summarising the end-of-year reviews for 2023/24 was received at committee in September 2024 and similarly the report summarising the six-monthly reviews (for the period up to October 2024) was received in February 2025.

The Framework notes that the Executive Team takes responsibility for setting escalation levels, based on the outcomes of the six-monthly and end-of-year reviews. Based on a review conducted by the Executive Team in January 2025, none of the divisions were classified as under special measures, but seven of the eight were under enhanced monitoring for one or more of the domains.

	Key Findings	Risk & Impact	Agreed Management Action
7	**Timely Committee Reporting** It is important that committees received timely updates on the outcomes of the six-monthly and end-of-year reviews. The Finance & Performance Committee are currently receiving reports between four and five months after the period to which they relate.	Timely reporting is important to ensure effective management and decision making.	**Agreed Action:** There is a challenge with alignment of corporate calendar and reviews. It is accepted that consideration of status post reviews can be more timely and as part of PMF review can include some reporting standards. The PMF is undergoing a full review expected to conclude in Q2 with a revised Framework for consideration, this includes the resourcing load, timeliness and time to administer and implement
			Expected Evidence of Implementation: Outcomes of the Review, recommendations and redrafted Framework Evidence of the review an actions
		Medium Priority	**Officer: Assistant Director Planning & Performance** **Target Implementation Date: 30/09/2025**
	Theme: Reporting	Control Operation	

Appendix A

Assurance Opinion

 **Substantial**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
 **Reasonable**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
 **Limited**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
 **Unsatisfactory**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
 **Advisory**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

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Follow Up of Previous Audit Recommendations

Final Internal Audit Report

2024/25

Aneurin Bevan University Health Board



Advisory

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Review Reference	AB-2425-20
Fieldwork	May – June 2025
Executive Sign Off	Rani Dash, Director of Corporate Governance
Audit Committee	June 2025
Executive Lead	Rani Dash, Director of Corporate Governance
Audit Team	Stephen Chaney, Head of Internal Audit
	Rhian Gard, Principal Auditor

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Executive Summary

Purpose

To assess whether a sample of high and medium priority internal audit recommendations have been implemented by Aneurin Bevan University Health Board (the 'Health Board').

Overview

We reviewed a sample of recent internal audit recommendations, scheduled to be completed by October 2024, to ensure appropriate evidence supported the position reported. We found that the evidence was consistent with the recommendation position reported.

Furthermore, we tested the completeness of the Audit Recommendation Tracker (the 'Tracker') and found that it is regularly updated for each Audit, Risk and Assurance Committee (the 'Committee'). The position of outstanding actions is regularly updated, with status updates provided to the Committee and further information recorded for deadline extensions.

Extensions are presented and discussed at the Committee, with appropriate challenge taking place when required. We also confirmed that where multiple extensions occur, these are tracked and reported to the Committee. Overall, we found that the process for updating the Tracker and extending recommendation deadlines is appropriate.

Finally, we tested to ensure that our sample of audit reports was correctly recorded within the Tracker. We identified one exception, which was actioned during the review. There were no further anomalies to report.

We were informed that the Health Board is implementing an automated solution using Microsoft Lists, to assist with the efficient management and tracking of audit recommendations. Currently, a large spreadsheet is utilised, which increases the risk of manual errors. As part of the migration, the Health Board is planning to review the Tracker information, to ensure it remains accurate and up-to-date.

Appendix A

Assurance Opinion

	**Substantial**	**Follow up:** all recommendations implemented and operating as expected.
	**Reasonable**	**Follow up:** all high priority recommendations implemented and progress on the medium and low priority recommendations.
	**Limited**	**Follow up:** no high priority recommendations implemented but progress on most of the medium and low priority recommendations.
	**Unsatisfactory**	**Follow up:** no action taken to implement recommendations.
	**Advisory**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
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Audit, Risk and Assurance Committee Update – Aneurin Bevan University Health Board

Date issued: June 2025

Document reference: 3997A2024

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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.	Final accounts audit underway	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.	Planning underway	Audit Plan to be presented to the Sept 25 Charitable Funds Committee.

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
All-Wales thematic review of planned care	Chief Operating Officer	This work follows on from the national report on tackling the planned care backlog. It considers: • 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.	Final report to the June Committee	June 2025

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Urgent and Emergency Care	Chief Operating Officer	This work examined different aspects of the unscheduled care system and included analysis of national data sets to present a high-level picture of how the unscheduled care system is currently working. The work included 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 have also reviewed the 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 – Clearance with Health Board	April 2025 June 2025
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	September 2025

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
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.	Fieldwork	December 2025
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.	Planning	December 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	March 2026

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
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	March 2026
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
Cost Savings Arrangements – A checklist for NHS Board Members	**June 2025**
The Wales Infrastructure Investment Strategy	**May 2025**
No time to lose: Lessons from our work under the Well-being of Future Generations Act	**April 2025**
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 There have been no corporate documents published by Audit Wales since the last committee update.

8 There are no relevant Audit Wales consultations currently underway.



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Archwilio Cymru
Audit Wales

Tackling the Planned Care Challenges – Aneurin Bevan University Health Board

Date issued: May 2025

Document reference: 4621A2024

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Summary report

About this report

1 This report sets out the findings of work on planned care recovery that we have undertaken at Aneurin Bevan University Health Board (the Health Board) to examine the progress it is making in tackling its planned care challenges and reducing its waiting list backlog. The work has been undertaken to help discharge the Auditor General's statutory duty under section 61 of the Public Audit (Wales) Act 2004 to be satisfied that the Health Board has proper arrangements in place to secure the efficient, effective, and economic use of its resources. Our work was delivered in accordance with INTOSAI[1] audit standards. This report excludes any examination of waits relating to cancer diagnosis and treatment, which are the subject of a separate examination by the Auditor General.

2 Tackling the planned care waiting list backlog is one of the biggest challenges facing the NHS in Wales. NHS waiting time targets in Wales have not been met for many years and the COVID-19 pandemic made an already challenging situation considerably worse as planned care services were initially postponed and then slowly re-started to allow the NHS to focus its attention on dealing with those seriously ill with the virus. Since the onset of the pandemic, the overall size of the NHS waiting list has grown significantly and at the end of February 2025 there were 614,150 individual patients waiting for treatment.

3 In April 2022, the Welsh Government published its Programme for Transforming and Modernising Planned Care and Reducing Waiting Lists in Wales. The programme includes £170 million recurring funding to support planned care recovery, together with an additional £15 million funding per year over four years to support planned care transformation. Welsh Government subsequently allocated a further £50 million between September 2024 and October 2024 to reduce the longest waiting times[2]. The programme includes specific targets and Ministerial priorities:

- that no one should wait longer than a year for their first outpatient appointment by the end of 2022 (**target date revised to December 2023**[3]);
- to eliminate the number of people waiting longer than two years in most specialties by March 2023 (**target date revised to March 2024**);
- people should receive diagnostic testing and reporting within eight weeks and therapy interventions within 14 weeks by Spring 2024; and

[1] INTOSAI is the International Organization of Supreme Audit Institutions

[2] Health Secretary response to latest NHS Wales performance data. The £50 million additional allocation comprised £28 million in September and £22 million in October 2024.

[3] Health boards did not achieve the original targets for first outpatient appointment and number of people waiting longer than two years for treatment. As a result, the Welsh Government agreed to set interim targets (**in bold**, above).

- to eliminate the number of people waiting longer than one year in most specialties by Spring 2025.

4 In May 2022, the Auditor General for Wales published a commentary on "Tackling the Planned Care Backlog in Wales" which estimated that it could take up to seven years for the overall waiting list in Wales to return to pre-pandemic level. The commentary highlighted key areas for action, including:

- having strong and aligned local leadership to deliver the national vision for recovering planned care services;
- having a renewed focus on system efficiencies and new technologies;
- building and protecting planned care capacity; and
- communicating effectively with patients who are waiting for treatment and having systems in place to manage the clinical risks to those patients while they are waiting.

5 Our work has considered the progress Heath Board is making in tackling its planned care challenges and reducing its waiting list backlog, with a specific focus on:

- action that the Health Board has taken to tackle the planned care backlog;
- waiting list performance; and
- understanding and overcoming the barriers to improvement.

6 We undertook our work between July 2024 and February 2025. The methods we used are summarised in **Appendices 1 and 2**. **Appendix 3** provides some additional data analysis on planned care services and **Appendix 4** contains the Health Board's response to any recommendations arising from our work.

7 The Health Board is currently Level 4 escalation for finance, strategy and planning under the NHS Wales escalation and oversight framework. The financial position has a direct bearing on the affordability, sustainability and recovery of planned care services.

Key facts

£96.3m the amount of additional funding the Health Board has received from Welsh Government between 2022-23 and 2024-25 to support planned care improvement.

144,246 the overall size of the waiting list at February 2025.

63% the percentage growth in the overall waiting list between April 2019 and February 2025.

15,096 the number of patient pathways waiting more than 1 year for their first outpatient appointment at February 2025 against a national target of zero waiting. The number of 1 year waits for an outpatient appointment has increased by 54%, since April 2022.

1,623 the number of patient pathways waiting more than 2 years for treatment at February 2025 against a national target of zero waiting. The number of 2-year waits has reduced by 78% since April 2022.

90% the percentage diagnostic test waits that are within 8 weeks at February 2025 against a national target of 100%. The Health Board has achieved a 62% reduction of ‘over 8 weeks’ diagnostic waits since April 2022.

98% the percentage of therapy waits that are within 14 weeks at February 2025 against a national target of 100%. The Health Board has achieved an 56% reduction of ‘over 14 week’ therapy waits since April 2022.

26,280 number waiting more than one year for treatment at February 2025 against a national target of zero for most specialties by Spring 2025. This has increased by 24% since April 2022.

Key messages

Overall conclusion

8 Overall, we found **with the assistance of additional short-term funding the Health Board has made good progress in reducing the longest waits, however the overall number of patients waiting remains high. The Health Board needs to develop more sustainable planned care improvements to meet demand. It also needs to accelerate the introduction of arrangements to support patients who are waiting and to improve how it reports on harm resulting from planned care delays.**

Key findings

Action that the Health Board is taking to tackle the planned care challenge

- The Health Board has had some success protecting planned care capacity from wider unscheduled care pressures. However, delayed discharges continue to limit what would otherwise be available capacity for planned care services.
- The Health Board is spending its additional Welsh Government planned care allocation in line with its plans. Not all is being spent on securing additional planned care capacity or service modernisation.
- Whilst the Health Board has set out clear plans for securing short-term waiting list improvements, it has yet to sufficiently describe actions needed to secure more sustainable improvements to planned care services.
- The Health Board has started to deliver more efficiencies but there remain opportunities, particularly in relation to increasing the use of virtual appointments, improving utilisation of theatres and increasing the use of day surgery.
- The Health Board has been slow to implement the Welsh Government's Promote, Prevent and Prepare policy fully; and reporting on the incidence of harm associated with planned care waits needs to be improved.

Waiting list performance – is the action taken resulting in improvement?

- In overall terms, the continued growing backlog of people waiting to be treated presents a substantial problem for the Health Board. There are now over 144,000 open treatment pathways.

- The Health Board has not met the majority of recent national planned care recovery targets, but has recently made good progress addressing the longest waits:
  - The number waiting over a year for their first outpatient appointment increased has from 9,805 patient pathways in April 2022 to 15,096 in February 2025;
  - The number waiting over 2 years for treatment reduced from 7,483 patient pathways in April 2022 to 1,623 in February 2025;
  - The Health Board did not meet the target of increase the speed of diagnostic testing and reporting to eight weeks and 14 weeks for therapy interventions by Spring 2024. In February 2025, there remained 1,619 patients waiting over 8 weeks for diagnostics and 320 patients waiting for therapies over 14 weeks.

Barriers to improvement

- There are a number of barriers to further planned care improvement. These include growing service demand, competing financial and service pressures, workforce shortfalls in key areas including anaesthetics, radiology, ophthalmology and ultrasound diagnostics.
- The Health Board recognises these challenges and is introducing a range of actions to help address these issues. Some of these are delivering improvements but the Health Board needs to continue to embed these arrangements, and review and monitor progress to ensure positive results and value for money.

Recommendations

9 We have set out recommendations arising from this audit in **Exhibit 1**. The Health Board's response to our recommendations is summarised in **Appendix 4**.

Exhibit 1: recommendations

Recommendations
Planning
R1 The Health Board should develop a detailed Planned Care improvement plan which aims to both design and deliver sustainable planned care services in the medium to longer term and to take advantage of opportunities for further regional working. The plan should be costed, with realistic but challenging milestones within it. This could form part of wider Health Board planning developments, if sufficiently detailed and costed **(Exhibit 2).**

Recommendations

Monitoring impact of additional funding

R2 The Heath Board should strengthen its reporting on the use and subsequent impact of the additional Welsh Government planned care funding (**Paragraph 24**).

Efficiency and productivity

R3 There are opportunities to improve productivity and efficiency. The Health Board should:

- 3.1 Develop and rollout approaches to increase the use of virtual appointments, where clinically appropriate (**Exhibit 6**).
- 3.2 Review and improve its approach to pre-operative assessment and patient reminders to reduce the number of theatre cancellations where patients are either unfit for the procedure, or do not attend **(Exhibit 6).**
- 3.3 increase use of day surgery to GIRFT recommended level of 85% (**Exhibit 6**).

Promote, Prevent and Prepare for Planned Care policy

R4 The Health Board should:

- 4.1 Complete the establishment of the 'Promote, Prevent and Prepare (3P's) for Planned Care' contact centre **(Exhibit 7).**
- 4.2 Complete the rollout of the 3Ps service to cover all specialties (**Exhibit 7**).

Risk/ harm

R5 In order to strengthen its arrangements for managing the clinical risks associated with long waits, the Health Board should:

- 5.1 Building on the arrangements in ophthalmology services, develop and implement a consistent methodology across specialties for assessing the risk of harm to patients caused by long waits (**Exhibit 7**).
- 5.2 Develop a routine report to be presented at the Quality and Safety Committee that effectively report risks and actual incidents of harm resulting from delays in access to treatment **(Exhibit 7).**

Detailed report

Action that the Health Board is taking to tackle the planned care challenge

10 We considered whether the Health Board is effectively planning and delivering planned care improvement, is appropriately utilising and monitoring the impact of Welsh Government funding and is supporting patients who are at most risk of harm as a result of a delay.

11 We found that **the Health Board is focussing its efforts on securing planned care improvements and service development. However, its wider financial position is constraining the extent that it is seeking to secure the capacity necessary to significantly reduce the waiting list backlog. It needs a clear plan to support the development of affordable service models to meet current and future demand and improve efficiency. It also needs to strengthen its reporting on harm associated with long waits.**

Planned care improvement plans and the programme to deliver them

12 It is important that the Health Board has a clear plan for tackling the waiting list backlog and delivering sustainable planned care improvement. We considered whether the Health Board has:

- clear, realistic and costed improvement plans for planned care that align with the national recovery plan ambitions and Ministerial priorities; and
- appropriate programme management arrangements to support planned care improvement, supported by clear accountabilities and clinical leadership and reporting to committees and the Board.

Planned care improvement plans

13 We found that **the Health Board's planned care developments are currently set out within its Annual Plan which is necessarily focussed upon short-term improvements. The absence of a dedicated, longer-term plan for planned care recovery means the Health Board has yet to set out the actions it will take to secure more sustainable improvements to planned care services.**

14 The findings that underpin this conclusion are summarised in **Exhibit 2**.

Exhibit 2: the Health Board's approach to planned care improvement planning

Audit question	Yes / No / Partially	Comments
Has the Health Board developed a clear plan to support planned care recovery?	**No**	The Health Board's Annual Plan 2024-25 which includes a 'Three Year Intent to develop sustainable services by 2027' sets out the priority for planned care. However, this is overly short-term focused and lacks the necessary consideration of longer-term sustainable planned care services. There is no separate stand-alone planned care recovery plan **(Recommendation 1).**
Is the approach for delivering planned care improvement costed and affordable?	**No**	The Annual Plan 2024-25 provides a financial plan for the organisation and sets out the Health Board's financial position. However, there is no costed planned care plan or route-map to financially sustainable services.
Are the Health Board's planned care priorities appropriately aligned to the national planned care recovery plan and Ministerial priorities?	**Yes**	The Annual Plan 2024-25 is sufficiently aligned to the ministerial priorities and the national 'transforming and modernising planned care and reducing NHS waiting lists' recovery plan.
Has the Health Board set out realistic yet challenging targets and milestones for planned care?	**Partially**	The Health Board has developed improvement trajectories and system indicators aligned to Welsh Government escalation requirements. However, the plan lacks longer-term planned care ambitions.
Are the Health Board's planned care priorities informed by analysis and modelling of capacity and demand?	**Yes**	The plan was developed following detailed discussions with directorates on demand and capacity analysis.

Audit question	Yes / No / Partially	Comments
Has the Health Board set out how it will transform its clinical service models to make them more sustainable in the future?	**Partially**	Whilst, the Health Board's health pathways, outpatient transformation and diagnostics workstreams are focussing on service modernisation and transformation, there is little detail set out on the future shape of services, plans to ensure services are affordable or when these will be delivered.
Are plans for planned care improvements aligned to other key corporate plans such as the IMTP and plans for workforce, digital and estates?	**Partially**	The Annual Plan 2024-25 refers to high-level enablers including, workforce, estates and digital services, with some alignment to planned care improvement aims. However, this does not contain the level of detail needed to support sustainable planned care recovery.
Do the Health Board's planned care priorities align with those in other health boards and identify regional solutions to planned care recovery?	**Yes**	The Health Board has aligned its plans with its partners to develop regional capacity in some areas. Regional partnerships between Aneurin Bevan, Cardiff and Vale and Cwm Taf Morgannwg University Health Boards are making some progress. Aneurin Bevan are responsible for hosting the regional ophthalmology (cataracts) programme. Cardiff and Vale and Cwm Taf Morgannwg University Health Boards are starting to introduce regional orthopaedic arthroplasty and diagnostic services in the Llantrisant Health Park. There is a bi-monthly regional oversight board with regional delivery board taking place monthly.

Source: Audit Wales fieldwork

Planned care programme delivery and oversight

15 We found **that the Health Board has effective and appropriate planned care programme and leadership arrangements in place to support planned care improvement in the short term.**

16 The findings that have led us to this conclusion are summarised in **Exhibit 3**.

Exhibit 3: the Health Board's approach to the programme management of planned care improvement

Audit question	Yes / No / Partially	Comments
Does the Health Board have a clear and appropriately resourced improvement programme to support planned care recovery?	**Yes**	The Health Board's Planned Care Recovery Programme Board provides appropriate strategic oversight, sets the direction and monitors delivery progress. Several workstreams support the programme. These include a focus on theatres, outpatients, diagnostics, waiting well, health pathways and the planned care academy. These are all clearly defined with terms of references and appropriately resourced. The programme board is chaired by the Deputy Chief Operating Officer with the attendance of the Executive Director for Strategy, Planning and Partnerships.
Is planned care recovery supported by clearly defined operational accountabilities and effective clinical leadership?	**Yes**	The Chief Operating Officer has overarching operational responsibility for planned care, supported by the Deputy Chief Operating Officer. The Health Board's divisional directors take the lead for planned care delivery within their own areas and are held to account for the delivery of trajectories. Clinical leads support the planned care programme board and programme workstreams. We found evidence of clinical engagement across a range of initiatives including orthopaedics, physiotherapy and consultant engagement in spinal service developments, and outpatient transformation.

Audit question	Yes / No / Partially	Comments
Has the Health Board undertaken a risk assessment to understand the issues that could prevent delivery of planned care improvement aims?	**Partially**	The Health Board's workstreams and directorates all report and escalate risks to the Planned Care Programme Board via their updates which are then incorporated into the Planned Care Recovery update report to Board and Finance and Performance Committee. However, there is no Planned Care Programme Board specific risk register, which may result in some risks or mitigating actions not being effectively tracked or prioritised. It also makes it more difficult to assess whether mitigating actions are effective.
Is performance on planned care recovery routinely reported to the appropriate committee/s and to the board?	**Yes**	The Board and committees effectively oversee planned care performance and improvement. Board and committee performance reports track and monitor planned care targets, including the ministerial priorities and contain good quality data. Targeted Intervention performance reporting also adds further scrutiny to planned care targets.

Source: Audit Wales fieldwork

Utilisation of additional Welsh Government funding

17 We have looked at the Health Board's use of the additional planned care allocation that it has received from the Welsh Government. This section considers:

- the overall amount of additional planned care funding the Health Board has received from Welsh Government over the last three years;
- how the Health Board spent the money; and
- the Health Board's arrangements for overseeing how it has spent additional funding.

Use of additional funding

18 We found **that since 2022-23 the Health Board has received a total of £96.3 million in additional Welsh Government funding. While it is spending this in line with its plans, not all is being spent on securing additional planned care capacity or service modernisation.**

19 To support planned care recovery over and above existing funding, the Health Board received a total additional Welsh Government allocation of £96.3 million between 2022-23 and 2024-25 (**Exhibit 4**).

Exhibit 4: the Welsh Government's allocation to the Health Board to support planned care improvement

Financial year	Annual allocation (£m)
2022-23	33.9
2023-24	30.2
2024-25	27.1
Additional in-year Welsh Government allocation	5.1[4]
Total allocated	96.3

Source: Health Board financial self-assessment returns

20 The Health Board can fully account for the Welsh Government planned care funding it has received. Health Board officers have indicated initial guidance on the use of this funding was quite broad and not specifically ring-fenced to planned care improvement. However, some areas of spend appear to continue to sit outside the remit of planned care **(Exhibit 5).** During 2023-24, the Health Board was allocated £30.2 million for planned care recovery. The Health Board has indicated that from its allocation it has spent £470,000 for Birthrate Plus[5], £3.9 million on inter-site transport, £4.0 million on safer staffing. The Health Board also allocated an additional £8.9 million on core activity, but did not provide any further specific details on what this purchased.

21 During 2023-24, the Health Board made the decision to significantly reduce any elective Waiting List Initiatives as part of financial recovery programme (other than cancer related diagnostics and procedures, 156 week waits and ENT). This decision supported the financial plan but will have affected the pace of waiting list recovery. The Health Board's use of Welsh Government allocations is broadly the same for 2024-25 although the Health Board allocated an additional £1 million to support the longest waiting planned care patients.

22 With recent additional Welsh Government funding, the Health Board restarted Waiting List initiatives to deal with elective waiting times late in 2024-25. Specific work has been undertaken to tackle 2 year waits in orthopaedics, ENT as well as

[4] In November 2024, the Welsh Government allocated the Health Board a further £3.8 million non-recurrent funding to reduce 104-week waits for orthopaedics, and a further £1.3 million for diagnostic schemes in neurophysiology, cardiology and endoscopy.

[5] Birthrate + is a workforce planning tool for maternity workforce planning.

ophthalmology. The Health Board has also targeted activity to diagnostics to support cancer services. The Health Board has indicated that when additional non-recurrent in-year funding is provided and confirmed at short-notice later in the financial year, it is sometimes challenging to spend because of difficulty setting up short-notice contracts with providers. Despite the additional Welsh Government funding, the Health Board continues to face ongoing financial pressures which may continue to affect planned care recovery.

Exhibit 5: use of the 2023-24 Welsh Government additional financial allocation

	Performance improvement funding (£m)	Regional working and transformation funding (£m)	Transformation funding (£m)
Regional working – Ophthalmology and Endoscopy		6.04	
3P's implementation			0.80
Clinical leads SLA			0.23
Planned care recovery fund – Transformation, SLA, pathway editors	1.50		
Planned and Unscheduled Care Sustainability:			
• Inter-site transport	3.99		
• Birthrate+	0.47		
• Safer staffing	4.01		
• Core activity	8.93		
• Radiology outsourcing	1.21		
• Enhanced care	1.42		
• Increased levels of variable pay	2.54		
• Laboratory Information Network Cymru (LINC)	0.03		
Subtotal	24.10	6.04	1.03
Continued Regional Schemes spend	9.42		
Total	**33.52**	**6.04**	**1.03**

Source: Health Board self-assessment returns

Monitoring impact of additional funding

23 We found that **the Health Board has limited arrangements in place for overseeing its use of the additional Welsh Government planned care financial allocation and its expected impact.**

24 We have considered the extent that Health Board oversees the use of the Welsh Government planned care financial allocations. The Board and the Finance and Performance Committee receive regular reports aligned to its Annual Plan delivery, this includes its financial planned care commitments and performance targets for the current year. The Health Board's Planned Care Recovery Programme Board reviews the progress of the planned care workstreams. This includes financial commitments by speciality, regionally funded programmes and use of funding to increase service capacity. However, we have not seen evidence of detailed monitoring of how the additional £96 million has been spent or reporting on the extent that specific investments have delivered the expected planned care improvements **(Recommendation 2).**

Operational management of planned care

25 Alongside the well-planned use of additional funding, health boards' ability to secure meaningful and sustainable planned care improvements will be dependent on them optimising their routine operational arrangements for planned care. In this section we consider the actions the Health Board is taking:

- to maximise its use of existing resources; and
- to protect and increase its planned care capacity.

Maximising the use of existing resources

26 We have examined some opportunities that exist for the Health Board to improve efficiency and productivity, and the actions it is taking to maximise the use of its existing resources. We found **that the Health Board is taking reasonable action to make services more efficient, but there is much more to do. It needs to increase use of virtual outpatient appointments, improve utilisation of theatres and increase the use of day surgery.**

27 **Exhibit 6** identifies efficiency and productivity opportunities that could help maximise the use of existing resources within the Health Board to support planned care improvements.

Exhibit 6: efficiency and productivity opportunities

Opportunity area	Audit findings
Responding to Getting it Right First time (GIRFT) reports	The Health Board received reviews on its gynaecology, trauma and orthopaedics, general surgery, ophthalmology, urology and theatres/elective optimisation. The individual specialties are responsible for responding to the recommendations in the reviews. Progress is monitored through the Productive and Effective Elective Pathways Plan with the Planned Care Recovery Programme Board providing oversight. The Health Board is making reasonable progress in responding to GIRFT reviews in trauma and orthopaedics and ophthalmology, with further work ongoing in theatres.
Arrangements for measuring and managing productivity of services	The Health Board is focussing on improving productivity of services through its productive and effective elective pathway plan and the road map to sustainability. This includes initiatives that are focussing on health pathways, patient access, outpatient transformation, diagnostics, elective capacity and theatre utilisation and the development of a planned care academy. The Health Board is also engaged in the Welsh Government elective optimisation programme. These arrangements include: • establishment of theatres utilisation group and theatre maximisation programme. • work to reduce 'Did Not Attends' in outpatients. • day surgery maximisation Group. • medical e-system to provide greater transparency and to inform demand and capacity modelling. • pooled waiting lists, which may enable better theatre scheduling. Our analysis of efficiency data below and in **Appendix 3** suggests greater opportunity to release further planned care efficiencies.
Reducing non-attendance at outpatient appointments	The Health Board is working to reduce non-attendance at outpatient appointments by actively monitoring 'Did Not Attend' rates via monthly reporting to the planned care programme board. The outpatient transformation team have led monthly task and finish group with directorates to monitor progress, share good practice and troubleshoot areas of high rates. **Exhibit 18** shows some recent improvement in outpatient Did Not Attend rates. Nevertheless, for the 12-month period to February 2025, Did Not Attends represented around 5.5% of total outpatient clinic activity equating to approximately 31,900 lost patient appointments. This represents a lost opportunity cost of around £4.8 million. If the Health Board could reduce its outpatient Did Not Attend rates by 20%, it could potentially save around £0.96 million.

Opportunity area	Audit findings
Making use of “virtual” outpatient appointments	Virtual outpatient appointments can have a positive impact in reducing the need for travel and the risk of hospital acquired infections. **Exhibit 19** shows that the Health Board’s utilisation of virtual outpatient appointments for the since the start of the 2024-25 to February 2025 was 15.7% of all outpatient appointments. The Health Board should seek to make better use of virtual outpatient appointments **(Recommendation 3.1**).
Reducing the number of cancelled operations	The Health Board increased focus on cancelled operations is delivering improvements. The Theatre Utilisation Group has been tasked with reducing the number of cancellations. It has set a target of reducing cancellations with less than 4 weeks’ notice outside of avoidable reasons to 0%. Its arrangements are resulting in improvements and the percentage had fallen from 41% in April 2024 to 23% in October 2024. There remains work to do but the improvement is encouraging. Our most recent analysis indicates that the Health Board has the second lowest short-notice surgical cancellations in Wales. Nevertheless, around 9% of surgery (2500 procedures) were cancelled at short notice (within 24 hours) in the 12-month period to February 2025 suggesting a significant productivity loss **(Exhibit 20)**. The main reasons were patients being unfit for procedure, did not attend, inconvenient appointment and clinical staff unavailability **(Exhibit 21**). This suggests a need to improve pre-operative assessment, strengthening arrangements to remind the patient of their appointment and building resilience into staffing resourcing models where possible **(Recommendation 3.2).**
Improving operating theatre utilisation	There are clear arrangements for monitoring and managing theatre utilisation, and these are starting to deliver improvements. The theatre utilisation group established in January 2024-25, is responsible for monitoring and improving theatre scheduling, and utilisation of theatre capacity. This is supported by weekly theatre scheduling and patient focussed scheduling meetings. The GIRFT target for theatre utilisation stands at 85%. The Health Board has indicated that its average theatre utilisation was 89.1% over 2024-25.

Opportunity area	Audit findings
Making more use of day case surgery	The Health Board is not maximising its use of day case surgery. Between the start of the financial year and February 2025, 69% of all elective surgery cases within the Health Board were day case (**Exhibit 22**). This is below the 'All Wales' average of 74% and the Getting it Right First Time 85% target **(Recommendation 3.3).** The Health Board has established a day surgery maximisation group with engagement across surgical specialties. This group has undertaken a review of surgical procedures with the specialties identifying opportunities for increasing day case surgery levels. It has also reinforced guidance to clinicians to reduce unnecessary admission prior to the day of surgery and the requirement for same day discharge unless it is unsafe.
Effective consultant job-planning	Job planning arrangements are not effective. At the time of our work only 20.5% of consultants had an up-to-date job plan. The Health Board recognises that it needs to improve and is working to address this through increasing resources to job planning. Individual and team-based job planning creates the opportunity to shape services so that they become more efficient, set out productivity expectations and can help clinical engagement in service modernisation. The Health Board's Internal Audit Service are planning to review consultant job planning in more detail in 2025.
Pooled lists within a Health Board speciality to ensure it treats its patients in turn	The Health Board has introduced pooled lists in a small number of specialties, including, surgery, rheumatology, dermatology, urology, ENT, maxfax, and upper and lower gastrointestinal (day case) but recognises there is more work to do. The Health Board also needs to improve its treat in turn processes and is currently working to improve its practice in this area.

Source: Audit Wales fieldwork including analysis of NHS Wales data and Health Board self-assessment and data returns

Protecting and increasing planned care capacity

28 We examined the actions the Health Board is taking to protect planned care capacity by separating out elective and emergency activity. We also looked at the actions the Health Board is taking to increase its planned care capacity.

29 We found that the **Health Board, while facing challenges, is attempting to protect planned care capacity through its elective site model. It is also securing some additional planned care capacity and making some progress with regional working but unless these significantly increase the Health Board is unlikely to reduce the overall waiting list and associated long waits.**

30 The Health Board is taking action to protect planned care from emergency pressure, with protected, ring-fenced elective capacity at Royal Gwent and Nevill Hall hospitals. However, there is anecdotal evidence that theatres at Nevill Hall are underutilised, with capacity not being used effectively. The Health Board is also struggling to ensure effective patient flow. Our regional review of patient flow out of hospital indicates that delayed discharges present significant challenge, with on average 250 beds lost at any given time. This is limiting what would otherwise be available capacity for planned care services.

31 The Health Board is outsourcing to boost planned care capacity to help it meets its short-term needs. In 2023-24 the Health Board secured additional radiology reporting capacity and spent £8.9 million on core activity (2,583 treatments and 7,711 outpatient appointments) which has continued into 2024-25. However, at the same time, the Health Board reduced its waiting list initiatives particularly for orthopaedics as this was seen as financially unsustainable. While Waiting List Initiatives have recently restarted, the consequence of insufficient capacity and productivity is that this is limiting the pace of waiting list recovery. This is a particular concern for orthopaedics and ophthalmology services, where the backlog has increased.

32 Regional working is making reasonable progress. Aneurin Bevan, Cardiff and Vale and Cwm Taf Morgannwg University Health Boards have agreed to develop regional ophthalmology, diagnosis, orthopaedics and stroke services. The Health Board is the 'host' organisation leading on the development of a regional eyecare solution for ophthalmology. This is currently focussing on development of regional cataracts services although the intent is to provide a wider range of specialist eye care services in the longer term. Audit Wales are currently undertaking a review of eye care services in the Health Board which it plans to report on by April 2025.

Managing clinical risk and harm associated with long planned care waits

33 Long patient waits increases the risk of preventable irreversible harm. Patients' health may deteriorate while waiting, they may be waiting in pain and with anxiety and uncertainty not knowing when they will finally receive treatment. They may also not be able to work or support or care for others while they are waiting. We considered whether the Health Board has sound arrangements to:

- identify, manage, and report on clinical risk and harm associated with long waits; and
- effectively communicating with patients who are on a waiting list and to manage potential inequalities in access to care.

34 We found that **the Health Board has been slow to implement the Welsh Government's Promote, Prevent and Prepare policy and it needs to strengthen its reporting on harm resulting from long planned care waits.**

35 The findings which have led us to this conclusion are summarised in **Exhibit 7**.

Exhibit 7: the Health Board's approach to managing clinical risks and communicating with patients on waiting lists

Audit question	Yes / No / Partially	Comments
Has the Health Board implemented the first phase of the Welsh Government's Promote, Prevent and Prepare for Planned Care policy[6]?	**No**	The Health Board has been slow to implement the first phase of Welsh Government's Promote, Prevent and Prepare policy (3Ps) for planned care. The current 'keeping well' service provides limited signposting to other resources and a new telephone service does not allow incoming calls so there is no way of the patient being able to contact the service with their queries **(Recommendation 4.1).** The Health Board are preparing a phased launch of a Single Point of Contact service for ENT, however, there were delays due to workforce recruitment challenges. We understand that the roll out of a phone number for all specialties could also take time **(Recommendation 4.2).**
Is the Health Board assessing the risk to patients waiting the longest?	**No**	The Health Board uses the DATIX system to record clinical risk resulting from a delay in treatment. However, there is no consistent methodology throughout specialties to assess risk and inform reporting on the risk of harm or instances of recorded harm **(Recommendation 5.1).**
Is the Health Board capturing and reporting evidence of harm resulting from waiting list delays and is reporting on it to the Patient Quality, Safety and Outcomes Committee?	**Partially**	The Health Board has reported to the Patient Quality, Safety and Outcomes Committee regarding incidents of harm associated with Ophthalmology. However, The Health Board does not routinely report evidence of harm resulting from waiting list delays. Given the high numbers of patients waiting, particularly upon follow-up outpatient lists, many within specialties managing high-risk conditions, we remain concerned about the level of risk and potential harm coming to these patients **(Recommendation 5.2).**
Is the Health Board effectively balancing the tension between eliminating long waits and managing clinical	**Partially**	The Health Board has a Treat in Turn Policy and are working to improve compliance. The Health Board have established a methodology to provide data prospectively allowing service managers to improve treat in turn which can be quantified to measure progress.

[6] Promote, Prevent and Prepare for Planned care policy to ensure that support and information is easily accessible to those waiting for appointments and interventions

Audit question	Yes / No / Partially	Comments
risks in its approach to prioritising patients?		
Does the Health Board monitor and record how many patients are leaving planned care waiting lists in favour of private treatment?	**No**	The Health Board has acknowledged that some patients will seek private treatment outside of the NHS due to the long waits that they have experienced. However, the Health Board does not have a mechanism of recording or monitoring how many patients may have left the waiting list in favour of private treatment. In November 2024 the Board approved a policy for private practice which set out clearly the expectations of consultants undertaking private practice, as well as the principles as well as the governance and rights of patients who transfer from private sector care back to the NHS.

Source: Audit Wales fieldwork

Waiting list performance – Is the action taken resulting in improvement?

36 We analysed current 'Referral to Treatment'[7] waiting list performance and trends to determine whether the Health Board is:

- reducing the overall levels of waits; and
- meeting Ministerial priorities and Welsh Government national targets.

37 We found that **the Health Board is not meeting Welsh Government performance targets and at the same time, overall numbers of waits remain substantially higher than before the pandemic.**

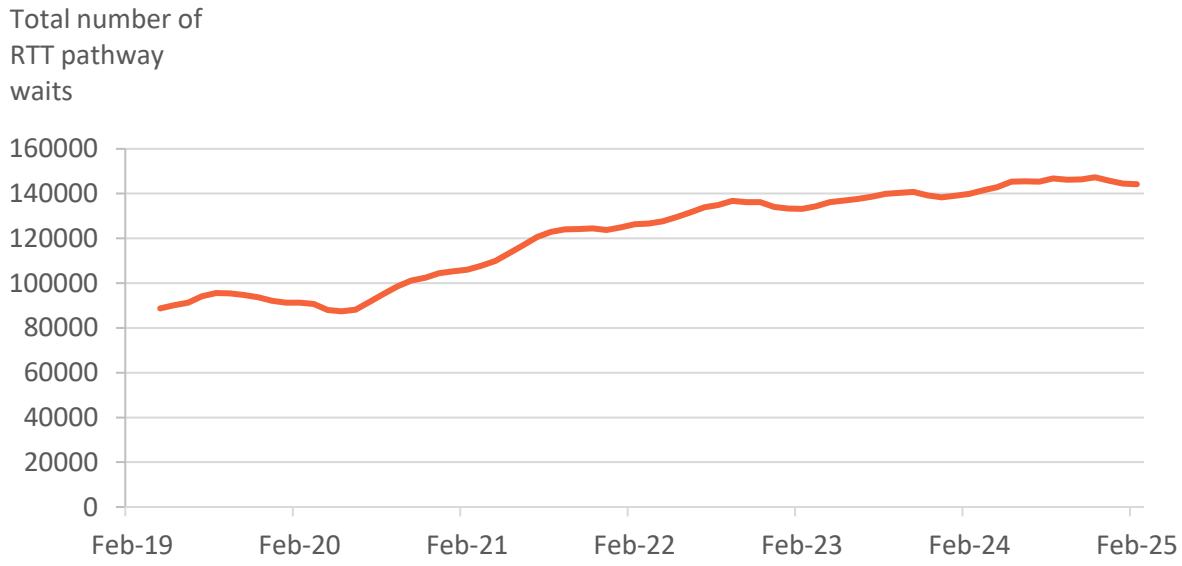
[7] Referral to Treatment is how the NHS records the timeliness of planned care. It starts when a Health Board receives a referral and finishes when it has treated the patient. During that patient pathway, the NHS records distinct stages, including new outpatient appointment, diagnostic, follow up appointment or therapeutic intervention and treatment.

The scale of the waiting list

38 Across Wales, the scale and extent of waits substantially increased following the Covid-19 pandemic. We have looked at these changes in terms of the overall size of the waiting list. We have also considered both the volume of waits for diagnostics and therapy services and trends in referral rates. We found that **the long-term growth in backlog of people waiting to be treated presents a substantial problem for the Health Board. Noting some recent improvements, there remain over 144,000 open treatment pathways[8].**

39 **Exhibit 8** shows the overall trend of planned care waits for the Health Board since April 2019. This indicates a 63% increase in the number of waits from 88,697 in April 2019 to 144,246 in February 2025.

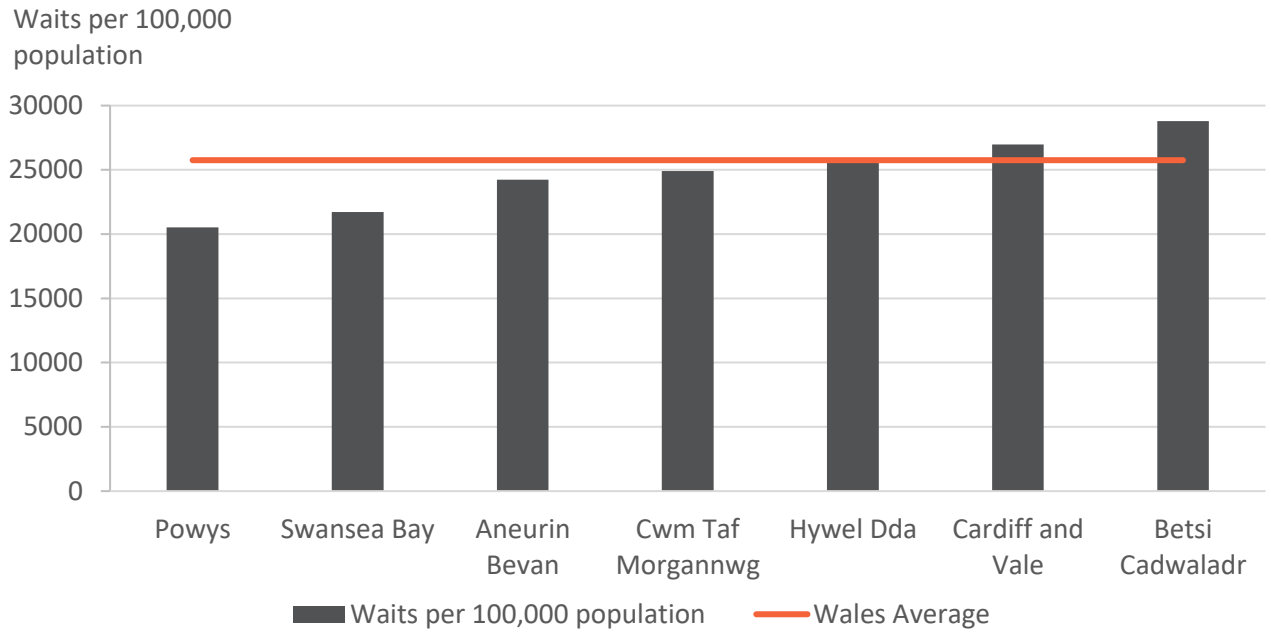
Exhibit 8: planned care waiting list size by area of residence, Aneurin Bevan University Health Board



Source: Welsh Government, Stats Wales

40 **Exhibit 9** provides a comparative picture of the volume of waits across Wales. This shows that Aneurin Bevan is slightly below the all-Wales average.

Exhibit 9: Waits per 100,000 population, by health board of residence, February 2025



Source: Welsh Government, Stats Wales. Note: Powys data is for December 2024.

Performance against national targets/priorities

41 We looked at the progress that the Health Board is making against the Welsh Government's aims[9]. These are:

- No one waiting longer than a year for their first outpatient appointment by the end of 2022 (**target date revised to December 2023**[10]).
- Eliminate the number of people waiting longer than two years in most specialties by March 2023 (**target date revised to March 2024**[6]).
- Increase the speed of diagnostic testing and reporting to eight weeks and 14 weeks for therapy interventions by Spring 2024.
- Eliminate the number of people waiting longer than one year in most specialties by Spring 2025.

[9] We have not included the Welsh Government performance on Cancer services as this is outside the scope of this review.

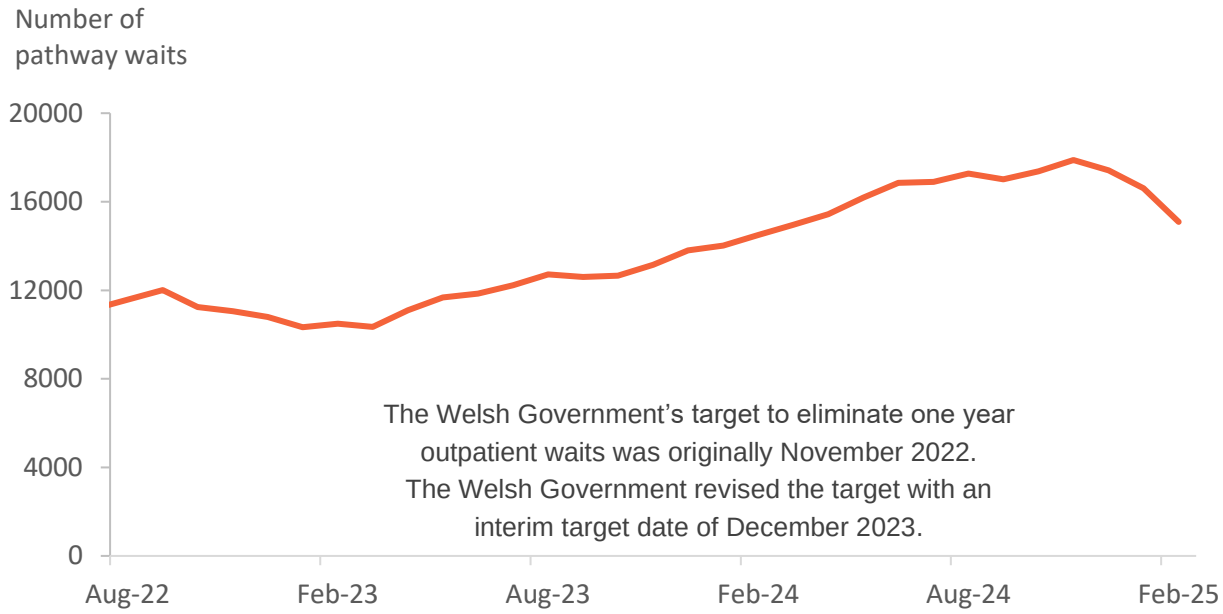
[10] Health boards did not meet the original targets for first outpatient appointment and number of people waiting longer than two years. As a result, the Welsh Government agreed to set interim targets (**in bold**, above).

42 We found that **the Health Board is not meeting the majority of the Welsh Government's national planned care recovery targets.**

No one waiting longer than a year for their first outpatient appointment

43 **Exhibit 10** shows Health Board waiting list performance for first (new) outpatient appointments. The Health Board did not meet the target to reduce 52-week outpatient waits by December 2023. After long period of growth in 2023 and 2024, the Health Board has now started to notably improve.

Exhibit 10: the number of first (new) outpatient appointments waits that are over a year since referral, by Health Board of residence, Aneurin Bevan University Health Board

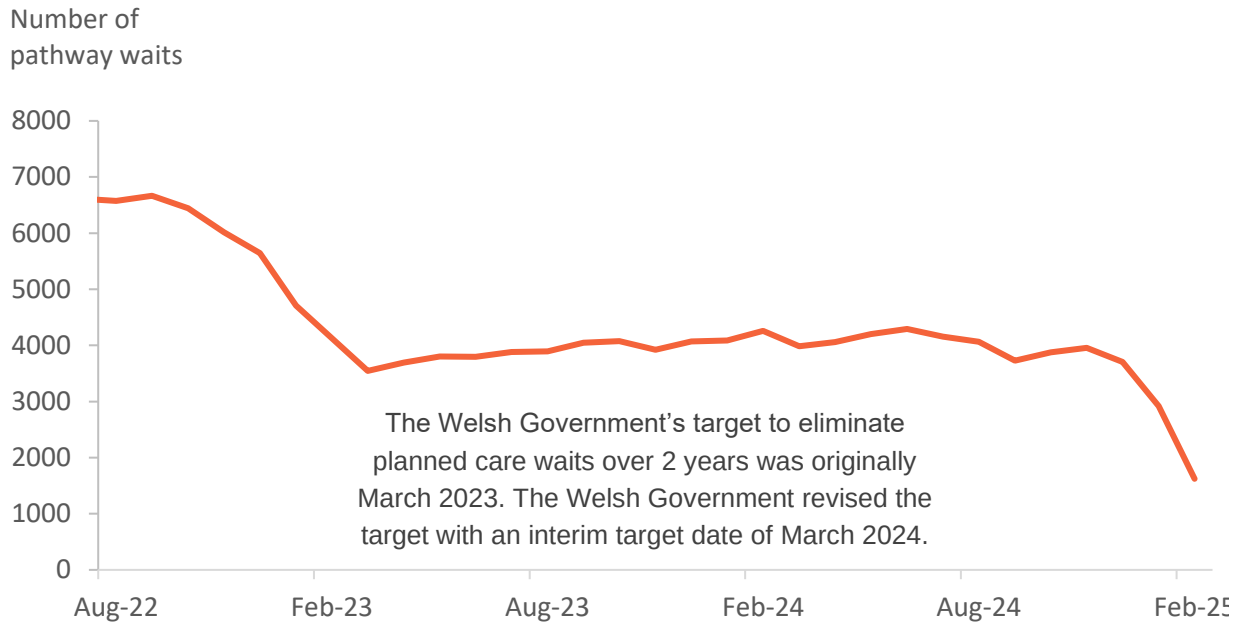


Source: Welsh Government, Stats Wales

Eliminate the number of pathways longer than two years in most specialties by March 2023

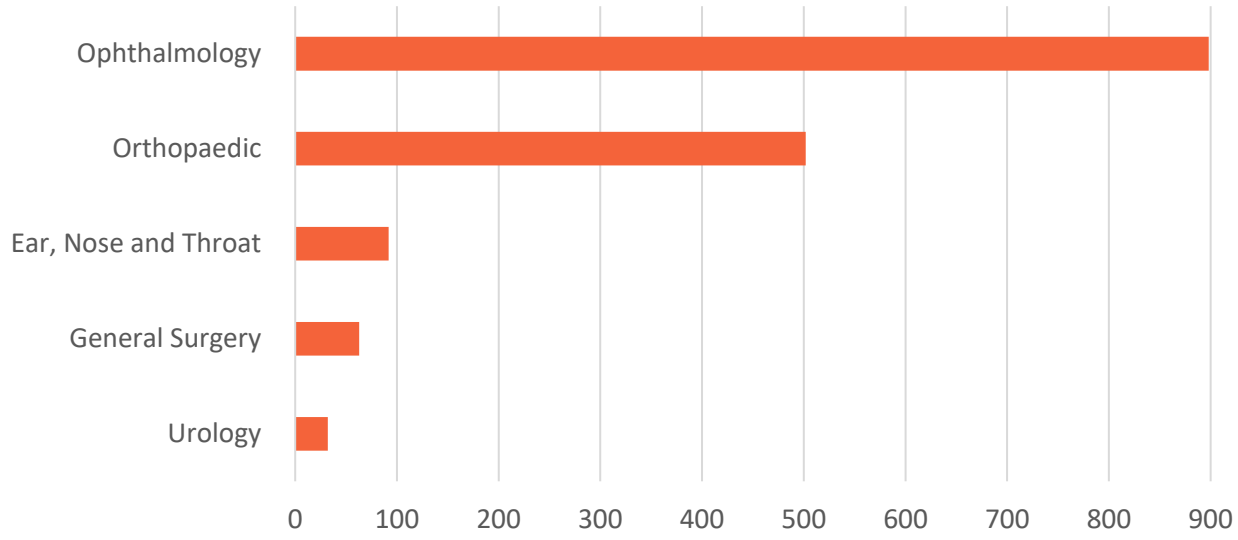
44 **Exhibit 11** shows that the Health Board did not meet the revised Welsh Government target to eliminate waits over 2 years by March 2024. While making good initial improvement, performance has remained static over the last year and has again made notable improvements since December 2024. Of those waits currently over 2 years, **Exhibit 12** shows that the most extreme waits are in a small number of specialties. ENT, orthopaedics and ophthalmology are clear specialties of concern but long waits in other specialties may also present an elevated risk of harm resulting from treatments delays.

Exhibit 11: the number of planned care waits over 2 years, by Health Board of residence, Aneurin Bevan University Health Board.



Source: Welsh Government, Stats Wales

Exhibit 12: the number of planned care waits over 2 years by specialty as of February 2025, by Health Board of residence, Aneurin Bevan University Health Board

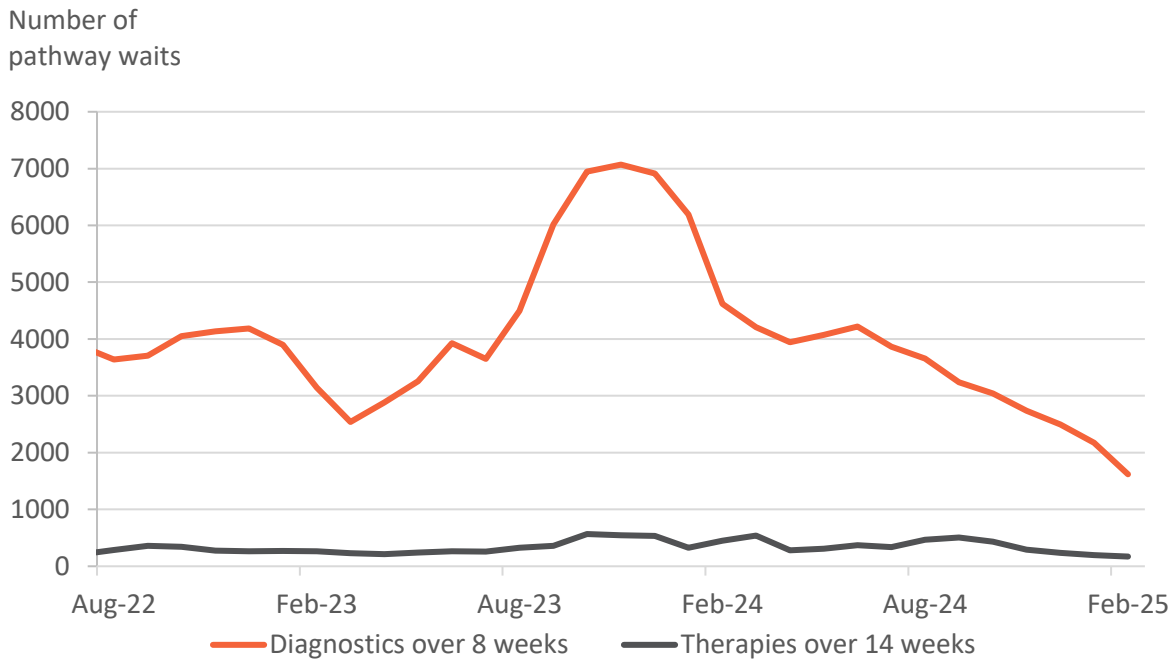


Source: Welsh Government, Stats Wales

Increase the speed of diagnostic testing and reporting to eight weeks and 14 weeks for therapy interventions by Spring 2024

45 The Welsh Government sought to increase the speed of diagnostic testing and reporting to eight weeks and 14 weeks for therapy interventions by Spring 2024. While there are a small number of long therapies waits, the position is steady. Whilst the Health Board did not meet the target for diagnostic services there is an improving position. The it should eliminate over 8-week diagnostic waits during 2025 if recent trends continue **(Exhibit 13)[11].** Of its diagnostic services, diagnostic endoscopy and neurophysiology diagnostics are the areas of greatest concern because of the volume and proportion of long waits in those areas.

Exhibit 13: the number of diagnostic and therapy pathway waits that breach Welsh Government targets (Diagnostic waits is an 8-week target, therapies waits is a 14-week target), Aneurin Bevan University Health Board



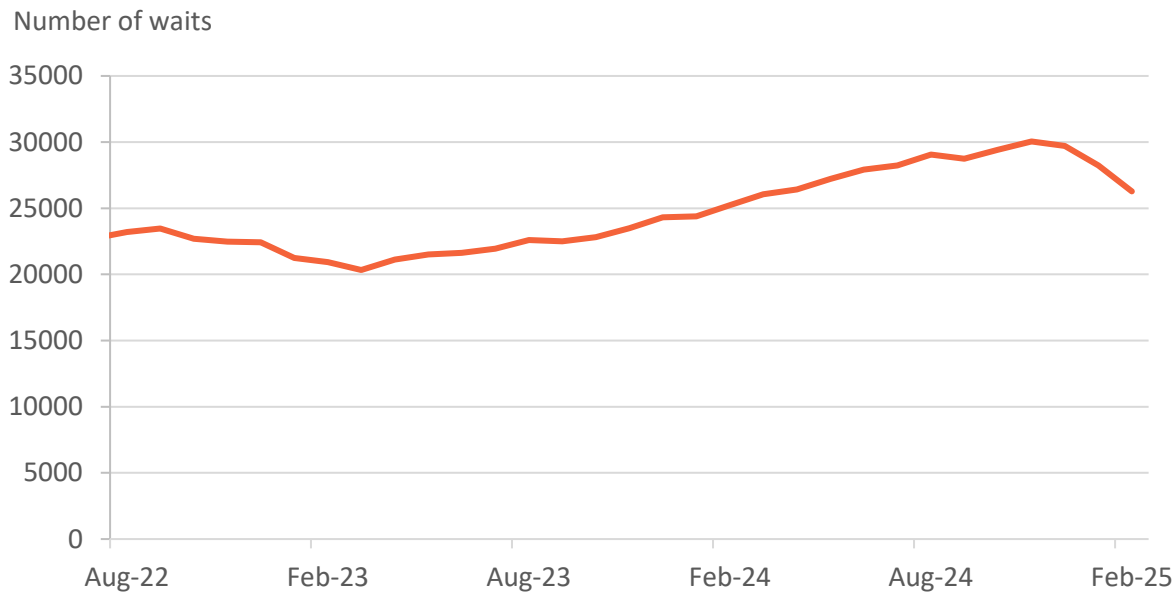
Source: Welsh Government, Stats Wales

[11] Neurophysiology data for Aneurin Bevan local health board became available in June 2023, adding around 1,000 pathways that had not been reported previously. Neurophysiology diagnostic services were provided by Aneurin Bevan before June 2023, however those data are not available. This affects the comparability of diagnostics data for Aneurin Bevan over time.

Eliminate the number of people waiting longer than one year in most specialties by Spring 2025

46 The Welsh Government's longer-term ambition was to eliminate waits over 1 year in most specialties by the Spring of 2025. **Exhibit 14** shows some recent improvement since December 2024 following a long period of deterioration. Despite the recent improvement, the Health Board will struggle to meet the Welsh Government target across most specialties. There remain significant numbers of open patient pathways in trauma and orthopaedics, ophthalmology, ENT, general surgery, oral surgery and urology.

Exhibit 14: the number of pathway waits that are over a year, Aneurin Bevan University Health Board



Source: Welsh Government, Stats Wales

Barriers to further improvement

47 We have considered the factors that are affecting the Heath Board's ability to tackle its waiting list backlog and secure sustainable improvements in planned care, together with actions that it is taking to address them.

48 We found that **the Health Board will need to address a number of challenging issues if it is to secure more sustainable planned care improvements.**

49 Our fieldwork has found challenges in the following areas:

- **Demand for planned care services** – There is increasing demand for services, partly as a legacy from the pandemic and partly because patients are waiting longer and deteriorating, are adding to pressures. Patient referral levels have increased over the last five years, but medical and surgical admissions only returned to 2019 levels in 2023-24 **(Exhibits 16 and 17, page 36**). This suggests that the Health Board may continue to experience a mismatch where demand outstrips capacity and for which it does not yet have a sustainable solution or plan. It has carried out deep dive reviews within specialties to understand the issues and is developing action plans.
- **Financial pressures** - The Health Board has significant financial pressures and is currently in Level 4 Targeted Intervention for finance, strategy and planning. This has resulted in the organisation facing challenging decisions on the extent that it can afford to fund planned care to the levels needed. This is likely to slow the pace of recovery.
- **Workforce capacity** – The Health Board has identified that staffing issues are presenting operational challenges. This includes recruitment to key roles such as anaesthetists. This has resulted in difficulties optimising theatre capacity. We were also informed of recruitment challenges in radiology, ophthalmology and ultrasound diagnostics. Officers also suggested that morale and staff sickness are also affecting planned care improvement.

50 The Health Board has taken action to address some of these barriers. To address issues with productivity the Health Board is implementing its effective elective pathway plan and the road map to sustainability. This includes initiatives that are focussing on health pathways, patient access, outpatient transformation, diagnostic and elective capacity and theatre utilisation as described in **Exhibit 6**. The Health Board is also developing its planned care academy to address the lost experience amongst teams in managing planned care. The academy provides training and support to operational teams to help improve waiting list management, support for career development. guidance on the effective use of business intelligence and how to use the Welsh patient administration system correctly (WPAS).

51 The Health Board has had success with improving the utilisation of its theatres and is progressing well with its effective elective pathway plan. The Health Board needs to continue to embed these arrangements, and review and monitor progress to ensure positive results and value for money

Appendix 1

Audit methods

Exhibit 15 sets out the methods we used to deliver this work. Our evidence is based on the information drawn from the methods below.

Exhibit 15: audit methods

Element of audit methods	Description
Documents	We reviewed a range of documents, including: • Planned Care Performance Trajectory Plans • Annual Plan 2024/25 3-year intent • Route map to service and financial sustainability • Public Board Meeting papers • Planned Care Recovery Programme Board papers • Performance & Finance Committee papers • Patient Quality, Safety & Outcomes Committee papers • Performance Reports • Targeted Intervention Updates • GIRFT reviews • Internal Audit Reports • Terms of References • Corporate Risk Register
Self-assessment	We issued and then analysed a self-assessment completed by the Health Board.
Interviews	We interviewed the following: • Chief Operating Officer • Deputy Chief Operating Officer • Divisional Director for Clinical Support Services • Divisional Director for Surgery Division • Deputy Medical Director • General Manager for Surgery Division and Outpatients Transformation Lead • General Manager for Clinical Support Services

Element of audit methods	Description
	• Chair of Patient Quality, Safety & Outcomes Committee • Assistant Finance Director
Observations	We observed the Planned Care Recovery Board Group in August 2024.
Data analysis	We analysed key data on: • waiting list performance; • financial spend; and • outpatient and inpatient efficiencies.

Appendix 2

Audit criteria

Main audit question: **Is the Health Board effectively managing its planned care challenges?**

Level 2 questions	Level 3 questions	Audit Criteria (what good looks like)
Is the Health Board's waiting list performance improving?	What is the scale of the challenge? Is the Health Board meeting Welsh Government targets/ambitions?	The Health Board has: • made progress reducing the overall number of referral to treatment waits for planned care services; and • met Ministerial priorities and national targets that were set by the Welsh Government.
Does the Health Board have a clear plan and a programme of action to support planned care waiting list recovery?	Does the Health Board have a clear, realistic, and funded plan in place for planned care recovery? Is there a clear programme structure to deliver planned care improvement?	The Health Board has: • clear, realistic and funded plan in place for planned care recovery in the short and longer term; and • a programme structure that appropriately supports the delivery of the plan.

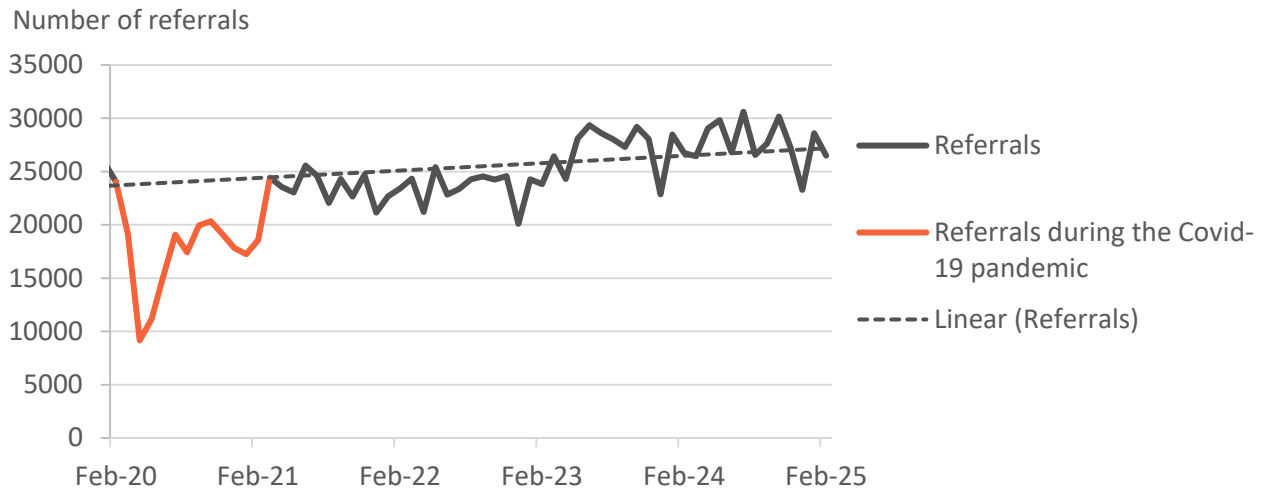
Level 2 questions	Level 3 questions	Audit Criteria (what good looks like)
Is the Health Board maximising the impact of its funding to address the planned care backlog?	Is it clear what additional monies have been received by the Health Board? Is it clear what the additional waiting list monies has been spent on? Did the Health Board aim to use all the money on planned care improvement? Can the Health Board clearly demonstrate that the money has resulted in performance improvement, enabled service efficiency and/or new ways of working? Is the Health Board's overall financial position affecting its ability to deliver sustainable planned care recovery?	• There is sufficient evidence that the Health Board spent the money as intended by the Welsh Government (i.e. addressing waits and transforming services). • The Health Board can clearly demonstrate that the spend has resulted in improvement. • The Health Board's overall financial position is not affecting its ability to support planned care recovery.
Does the Health Board have effective operational management arrangements to drive improvement and	Is the Health Board improving its operational management of planned care services? How does the Health Board capture information on clinical risk relating to long planned care waiting lists?	The Health Board is: • improving the operational management of planned care services; and • capturing information and managing clinical risks and harm related to long planned care waiting lists.

Level 2 questions	Level 3 questions	Audit Criteria (what good looks like)
management of clinical risks?	How does the Health Board capture information on clinical risk relating to long planned care waiting lists? Is the Health Board sufficiently managing clinical risks resulting from delays to treatment? Is the Health Board proactively ensuring clear routes of communication when patients are concerned that they are deteriorating?	The Health Board: • has sound arrangements to identify, capturing, and report on clinical risk and harm associated with long waits; • is proactively managing clinical risks resulting from delays to treatment and effectively communicating with patients.
Does the Health Board sufficiently understand barriers to improvement and what needs to be done to address them?	Does the Health Board understand the barriers it has experienced to improvement in planned care performance? (Capacity, funding, recruitment & retention, estates/use of facilities, commissioning external healthcare?) What mechanisms and interventions have been put in place by the Health Board to address these barriers? Is the Health Board learning and sharing good practice where things have gone well?	The Health Board has: • identified its risk and barriers and acted on these to address long planned care waiting lists in the short term and sustainable service models in the longer term. • good arrangements for seeking good practice and sharing and applying learning to improve planned care services.

Appendix 3

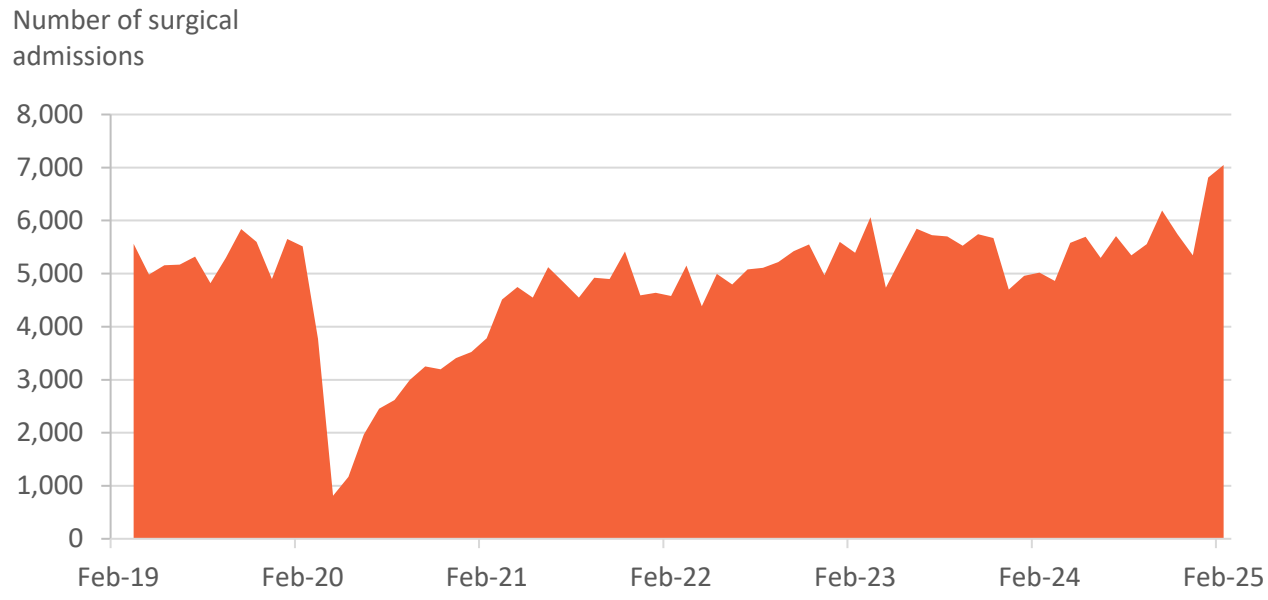
Additional data analysis on planned care

Exhibit 16: trend of monthly referrals to Aneurin Bevan University Health Board



Source: Welsh Government, Stats Wales

Exhibit 17: Monthly elective medical and surgical admission levels, Aneurin Bevan University Health Board

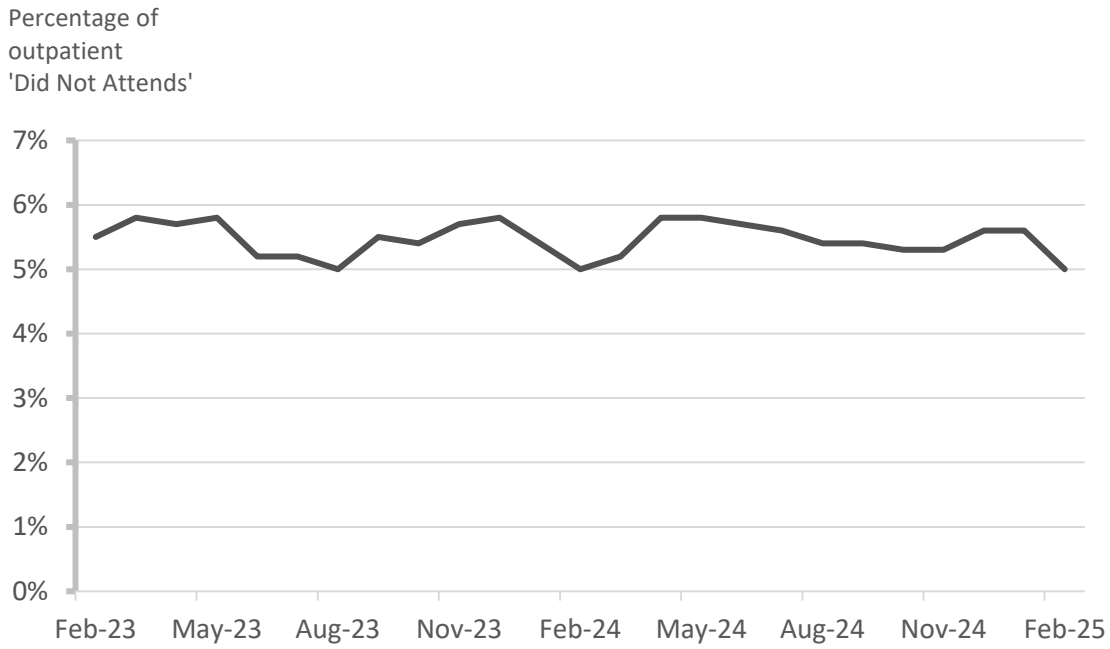


Source: Digital Health and Care Wales secondary care dashboard

Outpatient services

52 Outpatient appointments where a patient 'did not attend' is inefficient. **Exhibit 18** shows that the Health Board's 'Did Not Attends' over the last 12 months on average is around 5.5% of total outpatient clinic activity. This equates to around 31,900 lost patient appointments. It represents a lost opportunity cost of around £4.8 million (£150 per appointment[12]). If the Health Board could reduce its outpatient Did Not Attends by 20%, it could potentially save around £0.96 million.

Exhibit 18: the number and percentage of outpatient 'Did Not Attends', Aneurin Bevan University Health Board

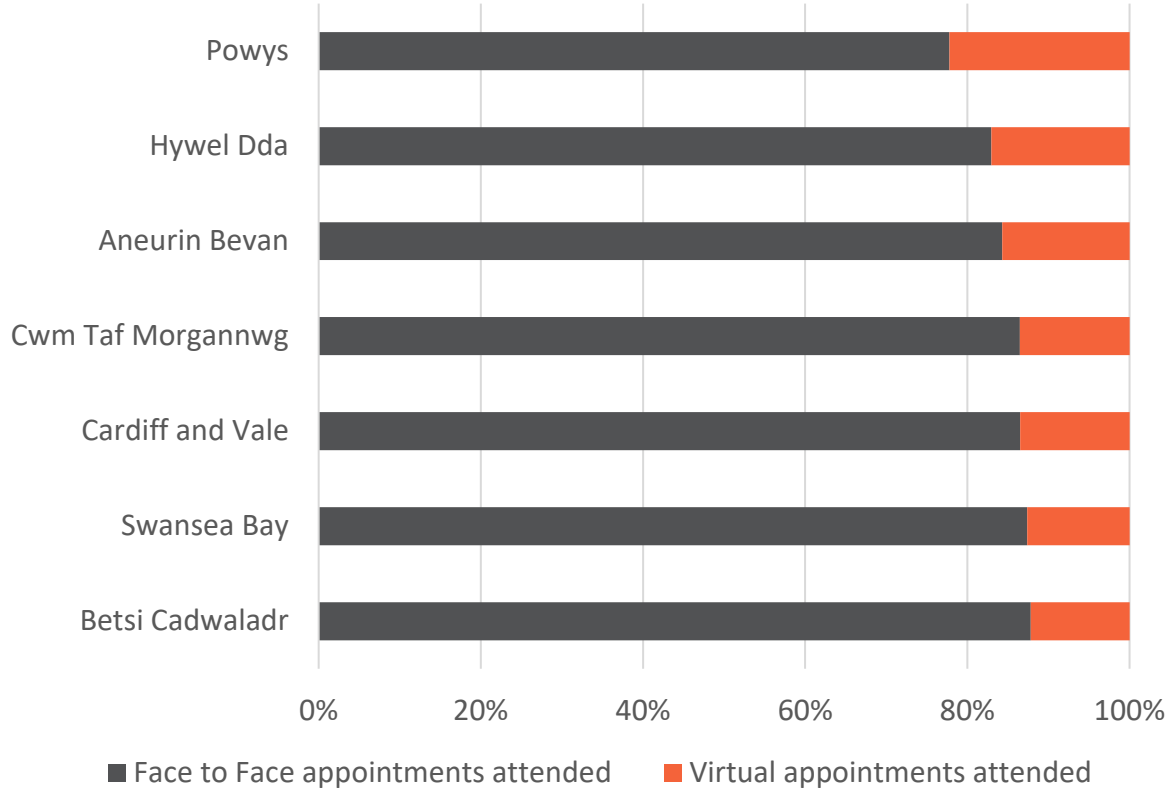


Source: Digital Health and Care Wales secondary care dashboard and datasets

[12] We have adjusted the 2018 NHS England cost of an outpatient appointment (£120) by Bank of England CPI rates to estimate current average outpatient costs in 2024.

54 NHS bodies can use virtual outpatient appointments for some but not all patients. **Exhibit 19** shows that the 'virtual' consultation approach is not well-adopted in most health boards.

Exhibit 19: proportion of outpatient attendances that are virtual appointments, for the period April 2024 to February 2025

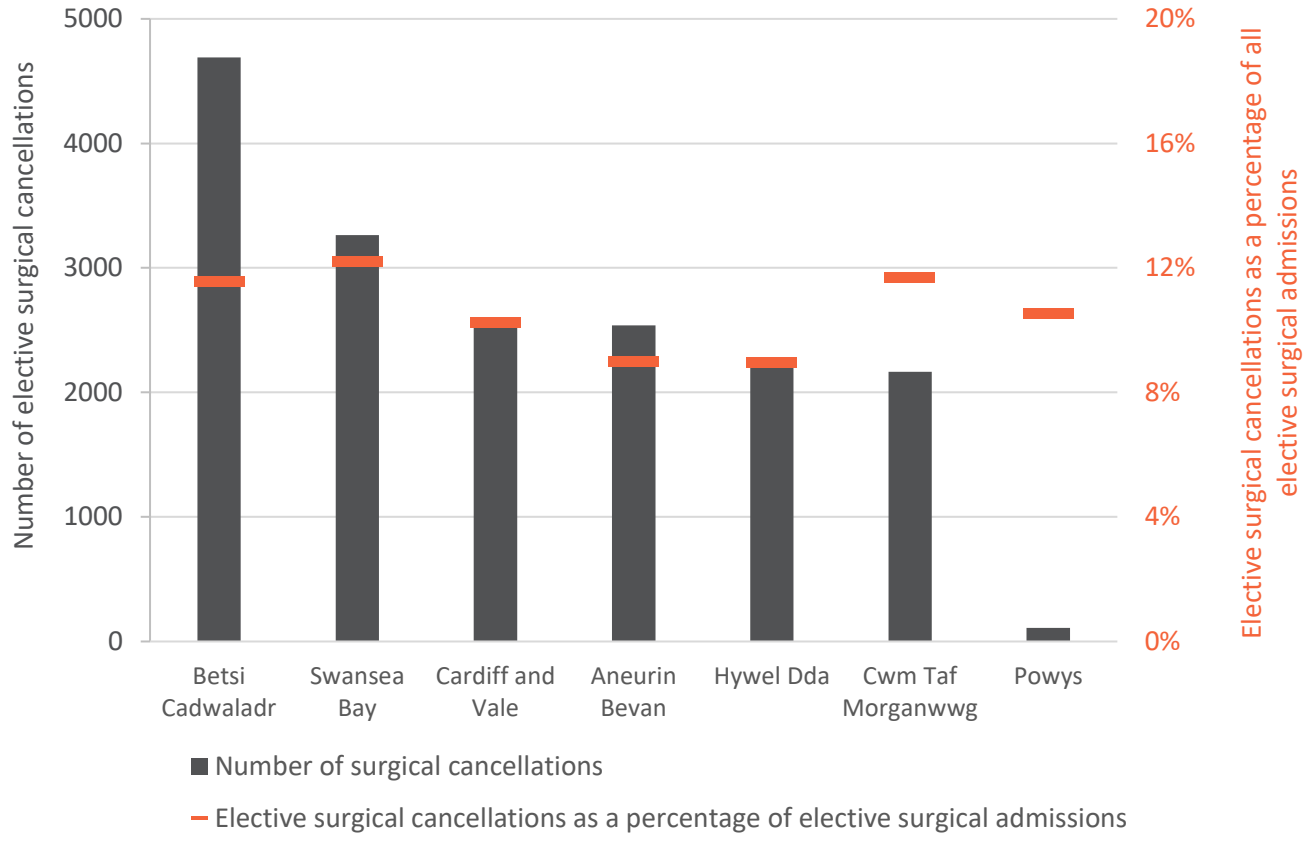


Source: Digital Health and Care Wales secondary care dashboard and datasets

Surgical cancellations

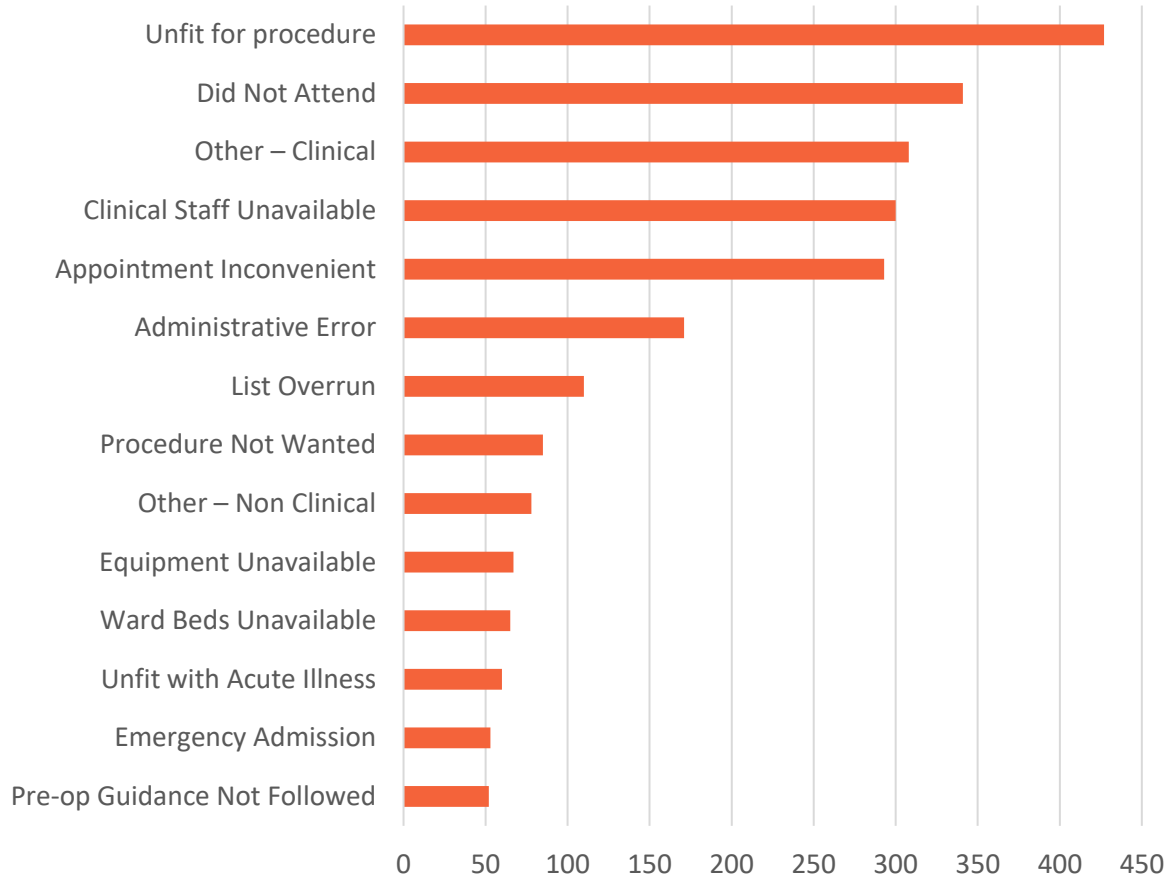
55 Short notice cancellations result in significant inefficiency because operating theatre sessions cannot be easily backfilled with other patients. The total number of surgical cancellations for the Health Board exceeded 2,500 for the period March 2024 to February 2025 (**Exhibit 20**). **Exhibit 21** identifies the cancellation reasons.

Exhibit 20: the number of short notice (within 24 hours) surgical cancellations alongside cancellations as a percentage of all elective surgical admissions, March 2024 to February 2025



Source: Health Board submissions to the Welsh Government and Digital Health and Care Wales

Exhibit 21: number of short notice (within 24 hours) surgical cancellations for the latest 12-month reporting period (March 2024 to February 2025), by reason, Aneurin Bevan University Health Board

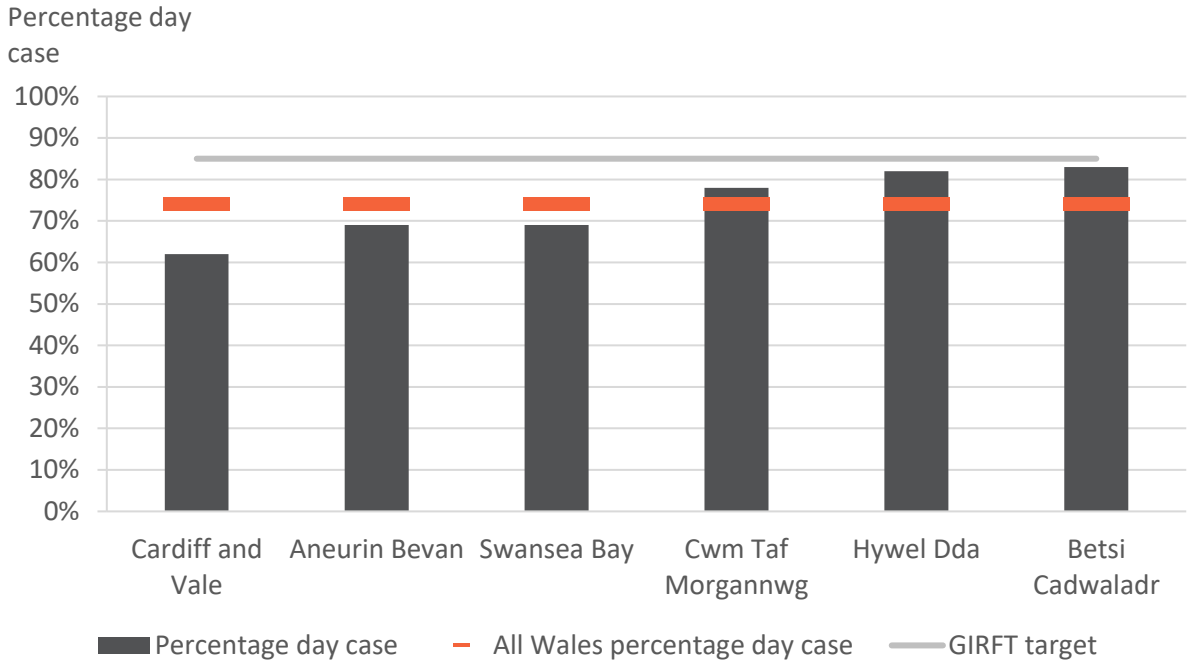


Source: Health Board submissions to the Welsh Government

Day case surgery

56 Day case surgery offers the potential for improved efficiency, lower costs, lower carbon footprint per patient[13] and a better patient experience when compared with inpatient services. Getting It Right First Time recommends that on average 85% of all elective[14] surgery should be day case[15]. Our analysis in **Exhibit 22** indicates that 69% of the Health Board's recent elective surgery is day case.

Exhibit 22: proportion of elective surgery undertaken as day case for the period April 2024 to February 2025



Source: Digital Health and Care Wales secondary care dashboard and datasets

[13] Paper outlines GIRFT's 'unique position' in supporting the NHS drive for net zero carbon emissions - Getting It Right First Time - GIRFT

[14] Elective surgery is the type of surgery associated with a planned care patient pathway.

[15] Getting it Right First Time - Elective Recovery High Volume Low Complexity guidance for health systems

Appendix 4

The management response to audit recommendations

Exhibit 25 below sets out the Health Board's response to our audit recommendations.

Recommendation	Management response	Completion date	Responsible officer
Planning R1 Over and above the commitments signalled within its annual plans, the Health Board should develop a detailed Planned Care improvement plan which aims to both design and deliver sustainable planned care services in the medium to longer term and to take advantage of opportunities for further regional working. The plan should be costed, with realistic but challenging milestones within it. (Exhibit 2)	The Health Board is in the process of developing a Sustainability and Transformation plan which will outline improvement aims and requirements to invest in key planned care specialities to meet the needs of our population over the coming years. An outline proposal will be delivered to the Executive Committee in June 25 with the detail to be developed through Q2.	September 2025	Chief Operating Officer (Deputy Operating Officer – to implement the plan)

Recommendation	Management response	Completion date	Responsible officer
Monitoring impact of additional funding R2 The Heath Board should strengthen its reporting on the use and subsequent impact of the additional Welsh Government planned care funding (Paragraph 24)	There is now a robust information management process in place to monitor and report on additional activity and the impact on waiting lists. This is tracked formally monthly through the Planned Care Board, through Exec Committee, Finance & Planning Committee, Board and WG IQPD meeting. In addition, weekly reports are shared with WG and NHS Exec colleagues.	Complete	Chief Operating Officer
Efficiency and productivity R3 There are opportunities to improve productivity and efficiency. The Health Board should: 3.1 Develop and rollout approaches to increase the use of virtual appointments, where clinically appropriate. (Exhibit 6)	These recommendations and priorities for efficiencies also need to be considered alongside the NHS Executive review of opportunities against Enabling Actions and the priorities from that work. The Health Board will include in the sustainability plans its response to the clinical implementation network (CIN) optimisation frameworks and the enabling actions in the IMTP. Via the Outpatient Transformation Programme, the opportunities for virtual appointments will be further explored. These opportunities will be rolled out in a phased approach.	March 2026	Chief Operating Officer (Deputy Operating Officer – to implement the plan)

Recommendation	Management response	Completion date	Responsible officer
3.2 Review and improve its approach to pre-operative assessment and patient reminders to reduce the number of theatre cancellations where patients are either unfit for the procedure, or do not attend (Exhibit 6)	This will be taken forward as part of two aspects of work: • Theatres Utilisation Group – to be formally re-launched in in Q4 2025/26 • PAC transformation and development through the Clinical Support Service division	March 2026	Chief Operating Officer (Deputy Operating Officer – to implement the plan)
3.3 Increase use of day surgery to GIRFT recommended level of 85%. (Exhibit 6)	This will be worked towards through the ongoing work on the development of Nevill Hall Hospital as a Day Surgery centre of excellence alongside the maximisation of the outpatient treatment unit. This will be tracked through the Theatres Utilisation Group	March 2026	Chief Operating Officer (Deputy Operating Officer – to implement the plan)

Recommendation	Management response	Completion date	Responsible officer
Promote, Prevent and Prepare for Planned Care policy R4 The Health Board should: 4.1 Complete the establishment of the 'Promote, Prevent and Prepare (3P's) for Planned Care' contact centre. (Exhibit 7)	The Keeping Well Team was established in 2024 and the won a highly commended award at the national 3P's conference. A rollout plan by specialty is set out in 4.2. The aim is to achieve incoming calls by March 26. The roll out plan by specialty and approach has been shared with Welsh Government and learning from Hywel Dda's gradual approach taken onboard. The staged approach allows for stability and sustainability and our management of risk noting some of the challenges experienced to date in terms of workforce stability and turnover.	March 2026	Chief Operating Officer
4.2 Complete the rollout of the 3Ps service to cover all specialties (Exhibit 7)	The roll out plan leading to March 26 inbound calls is in order of T&O knees, T&O Spines, Ophthalmology and then Urology. This approach incorporates local and wider learning and also support our approach to management of risk on waiting lists. The timings and plan will need to be reviewed following confirmation of additional monies to support outsourcing of outpatients' activity for quarters 2 to 4 as this may impact on volumes of patients by specialty or capacity of this team	March 2026	Chief Operating Officer (Deputy Operating Officer – to implement the plan)

Recommendation	Management response	Completion date	Responsible officer
Risk/ harm R5 In order to strengthen its arrangements for managing the clinical risks associated with long waits, the Health Board should: 5.1 Develop and implement a consistent methodology for assessing the risk of harm to patients caused by long waits across specialties. (Exhibit 7)	In terms of retrospective assessment of harm, the Health Board conducts thorough harm reviews on incidents and as appropriate reports as Nationally Reportable Incident according to relevant national frameworks or through pertinent external bodies. Incidents are also logged into the Datix system. The Quality & Patient Safety (QPS) team lead reviews which feed into the Quality Assurance processes to identify themes and trends. This includes Executive huddles. In addition, individual incidents of harm are investigated on a case-by-case basis when reported through Datix, as part of the national governance process. In Ophthalmology, any incidents involving moderate or greater harm are investigated through the harm review route. This process includes compiling a comprehensive patient timeline that incorporates all ophthalmology input. The timeline is then sent back to the clinician, allowing them to review the entire pathway and assess the harm. We utilise an ophthalmology-specific harm criteria for this purpose. In addition to the retrospective and thematic review outlined above the learning from ophthalmology and other best practice will be drawn on to inform a bespoke review of the long waiters across the Health Board.	In place September 2025	Chief Operating Officer (Deputy Operating Officer – to implement the plan)

Recommendation	Management response	Completion date	Responsible officer
	This review will be overseen by the Planned Care Board and will focus on the following areas: • Cancer • RTT • Follow-up • Unreported lists As outlined above, our model for the Keeping Well Service will also complements this process as it is a systematic and phased approach to all long waiting patients with clinical oversight and opportunity to escalate. This is also universal and contacts all patients rather than responding to only those patients who self-select to call in (a benefit of the outbound proactive model)		
5.2 Develop a routine report to be presented at the Quality and Safety Committee that effectively report risks and actual incidents of harm resulting from delays in access to treatment. (Exhibit 7)	The Health Board has established procedures to ensure adherence to the Duty of Candour, including the development of a standardised methodology for evaluating the risk of harm (The Duty of Candour is triggered when an adverse patient safety event occurs, resulting in unintended or unexpected harm that is more than minimal (moderate, severe, or death), and the provision of healthcare was or could have been a factor in that harm occurring). Additionally, the Health Board has introduced a Quality Outcome Framework which aims to systematically measure, monitor, and enhance healthcare quality. This framework	Complete	

Recommendation	Management response	Completion date	Responsible officer
	tracks outcomes to identify improvement areas, establish benchmarks, promote evidence-based practices, and ensure compliance with standards and regulations. It encompasses waiting lists, the number of patients on waiting lists exceeding 36 weeks, and metrics related to outpatient and surgical waiting lists. Quality Patient Safety Teams collaborate with Divisions/Directorates whenever any instances of identified harm occur. The Patient Quality, Safety, and Outcomes Committee receives the Performance Report as a standard item. The presentation covers the Quality and Safety Pillars, including Incident Reporting, Patient Safety Incidents, National Reportable Incidents, Near Misses, Duty of Candour, and escalated Risk Concerns. In addition, to strengthen our long waiters process, we have the following plans in place: • A quarterly QPS agenda item will be included at the Divisional Assurance Meetings to assess risk and the number of incidents, and to inform plans to mitigate risk. • Subsequent reports will be sent to PQSOC for scrutiny. • By September 2025, we will conduct a bespoke review of the long waiters across the health board. This review will be reviewed at the Planned Care Board and will focus on the following areas: • Cancer	September 2025	Chief Operating Officer (Deputy Operating Officer – to implement the plan)

Recommendation	Management response	Completion date	Responsible officer
	• RTT • Follow-up • Unreported lists • A comprehensive review of the Risk Registers will be undertaken.		



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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.

GIG CYMRU NHS WALES – Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	**CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING**

DYDDIAD Y CYFARFOD: DATE OF MEETING:	24 June 2025
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Clinical Audit Plan 2025/26 and Annual Clinical Audit Activity Report 2024/25
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Dr James Calvert, Medical Director
SWYDDOG ADRODD: REPORTING OFFICER:	Joanne Stimpson – Clinical Audit Lead Leeanne Lewis, Assistant Director for Quality & Patient Safety

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

Clinical audit is one tool available for assessing whether clinical services are safe and effective. It is one input into our Quality Management System (QMS). Clinical audit provides assurance against compliance with clinical standards and provides an opportunity to identify and minimise risk, waste, and variation in clinical practice from guideline defined standards of care. The results of audit are used to plan and prioritise domains of care requiring improvement with the aim of improving patient outcomes.

The Health Board's focus has been to ensure mandatory participation in the Welsh National Clinical Audit and Outcomes Review Plan. This includes complying with the requirements of Welsh Government by participating in all mandatory national clinical audits. Our audit plan balances national audit priorities with directorate/ division/ service/ clinician priorities. This enhances patient safety, care quality and compliance with statutory obligations. The plan integrates the use of the Audit

Management and Tracking (AMaT) system to streamline audit processes and improve governance.

This paper provides the Audit, Risk and Assurance Committee with assurance that the Health Board has a robust, risk-informed, and strategically aligned Clinical Audit Plan in place for 2025/26, and that audit activity during 2024/25 has been effectively governed and delivered in line with statutory and quality obligations.

Cefndir / Background

The National Clinical Audit and Outcome Review Plan (NCAORP) is published by Welsh Government (WG) annually.

The plan is one of the cornerstones in the drive to improve quality and safety of healthcare in Wales. It sets out in detail how findings from national clinical audit projects and outcome reviews are to be used to measure the quality and effectiveness of healthcare provided to patients and to assess year on year improvements.

The plan details the full list of national audit projects that all healthcare organisations must fully participate in, where those services are provided. The Health Board's audit plan is based on NCAORP and supports the National Clinical Audit and Patient Outcome Programme (NCAPOP). Clinical effectiveness is a key component of the Health Board's Quality Strategy.

Work this year has included:

- Producing standardised audit reporting templates, which has enabled more consistent reporting and improved scrutiny of action plans.
- Further implementation of the web-based Audit Management and Tracking system (AMaT) has helped facilitate tracking of audit results and the development of action plans.
- The team have trained over 800+ staff and AMaT now has 2,330 users across the Health Board.
- Divisional engagement has improved with structured reporting and raising awareness of the agenda in advance.
- Focusing on a mature and integrated approach to clinical audit with clear governance and reporting to the Clinical Standards and Effectiveness Group (CSEG), Patient Quality and Safety Outcomes Committee (PQSOC) and Audit, Risk and Assurance (ARA) Committee.

All audit is to be recorded on AMaT. AMaT has been used to build audit proformas, capture data, produce results and develop SMART action plans, all within the same platform. Local audit plans are being developed by Directorates and Divisions. are recorded in AMaT.

There is a robust structure underpinning the reporting of Clinical Audit, with Executive Leadership delegated to the Medical Director. Assurance is provided through reporting to the Patient Quality and Safety Outcomes Committee (PQSOC) which provides scrutiny of National Clinical Audit performance and monitoring of improvement plans.

Clinical audit is an important component of our commitment over the next three years to enable delivery of the Duty of Quality, as mapped to the six domains of quality. This will support the delivery of a sustainable and resilient health and care system.

Asesiad / Assessment

The updated Clinical Audit Plan for 2025/26 and Clinical Activity Report for 2024/25 is now available. The Health Board's Annual Clinical Audit Plan and Clinical Audit Activity report is to be ratified by Patient Quality and Safety Outcomes Committee (PQSOC) in June. The activity report summarises all the audits presented at CSEG for the last twelve months between April 2024 – March 2025.

There is now a well-defined process for the scrutiny of National Clinical Audit Reports, which utilises completion of standardised audit reporting templates in AMaT to clearly delineate examples of good practice, practice that needs improvement and SMART action plans required to address these areas.

Audit reports are then presented to the Clinical Standards and Effectiveness Group (CSEG) following publication. Clinical Lead(s) for the service(s) are informed of the report due date on publication. The Medical Director's Quality and Patient Safety (QPS) clinical audit team registers the audit in the Clinical Audit Area via the web-based Audit Management and Tracking system (AMaT). The relevant documentation is provided to Clinical Leads, who provide CSEG with an analysis of local performance benchmarked against national recommendations. They then provide a "SMART" improvement plan for the Health Board which is available in AMaT so completion deadlines can be tracked.

The nine-month publication schedule for the NCACORP – covering the National Clinical Audit (NCA) programme and also the Clinical Outcome Review Programmes (CORP) has been shared with Directorates. The dates align with presentation of results at Clinical Standards and Effective Group (CSEG). The annual audit plan will continue to ensure mandatory participation in all national clinical audits and national confidential enquiries, including participation in audits on the National Clinical Audit and Patient Outcomes Programme (NCAPOP).

AMaT is also utilised to record compliance with NICE guidance and HTW adoption, which can then be used to identify areas for future clinical audits.

Once National Clinical Audits (NCA) are published on the Healthcare Quality Improvement Partnership (HQIP) webpage, they form part of our annual audit plan.

The Health Board are currently reviewing participation in these audits and ensuring these are discussed at CSEG. Where audits are discussed at other Groups or Boards (e.g. Stroke, End of Life Care Board) we are ensuring completion on AMaT. This provides assurance on completion of key results, audit actions and improvement plans. We will be requesting for these to be reported to CSEG and placed on AMaT to align with the reporting of all other audits in the future.

Audit Management and Tracking (AMaT) is also being widely used across the Health Board for conducting and reporting on local audits agreed in the audit plan. The volume of audits being undertaken and the number of action plans being recorded is rising.

As part of the implementation of the Clinical Audit Strategy; directorate and clinical leads are being asked to confirm their list of audits in advance and identify any other projects that relate to clinical priorities where audit work will support the improvement of patient care. This includes audits that are required arising from clinical incidents, complaints or risks. With the lack of resource in the Medical Director's team to undertake audit this must be managed internally as the corporate team cannot support.

The audit team will continue to work collaboratively with Divisions, clinicians, service managers, divisional governance and quality managers as well as clinical staff to ensure that the clinical audit programme for their directorate meets all clinical, statutory, regulatory, commissioning and other Health Board requirements.

Ongoing training in the use of AMaT will ensure healthcare professionals are enabled to participate in clinical audit in order to satisfy the demands of their relevant professional bodies (for example, for revalidation and professional development).

Governance structures are in place to ensure scrutiny and escalation of audit findings, including reporting to the Clinical Standards and Effectiveness Group (CSEG), PQSOC, and ARAC. These steps include consideration of improvements (planned and delivered) and an escalation process to ensure the executive board is made aware when issues around participation, improvement and risk identification against recommendation are identified.

The Health Board is required to participate in all National Clinical Audits. In instances where a notification of non-participation is received, the Medical Director formally communicates with the relevant specialty to reiterate that participation is mandatory. A response is currently being developed in collaboration with respiratory based on non-participation in the National Respiratory Audit Programme, with an action plan determine appropriate to address the issues.

Currently, AMaT operates without a dedicated, recurring funding stream. Licensing has been maintained through successful biennial bids. A proposal was previously put forward to distribute the cost across all Executive portfolios, recognising the system, is widely used by all staff, not just those under the Medical Directors. The system

covers the broader audit function and data demonstrates it is used by all Divisions. This proposal has not been actioned and will be revisited in 2025/26 to ensure continuing of licensing and to avoid disruption of services.

Over the next twelve months, as the Quality Strategy is refreshed to incorporate a greater emphasis on Clinical Effectiveness, clinical audit will play a critical role in providing assurance around patient outcomes. This work will involve close collaboration with the Value-Based Healthcare and Patient Engagement and Involvement teams to explore how audit findings can be triangulated with other data sources to offer a comprehensive view of the quality of clinical services as part of our Quality Management System (QMS). Additionally, audit insights will be systematically shared through the Learning and Improvement Forum to ensure that lessons learned are effectively disseminated across all clinical areas, supporting continuous learning and improvement.

Argymhelliad / Recommendation

The Audit, Risk and Assurance Committee is asked to:

- Agree to the Clinical Audit Plan for 2025-2026; and,
- Receive the Audit Activity Report for 2024-2025 for assurance that the Health Board is meeting its obligation to undertake clinical audit.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	Clinical Audit is a mechanism for identifying risks and ensuring robust management and escalation where appropriate.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2.1 Managing Risk and Promoting Health and Safety 2.6 Medicines Management 2.9 Medical Devices, Equipment and Diagnostic Systems 3.1 Safe and Clinically Effective Care
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Getting it right for children and young adults Adults in Gwent live well healthily and age well
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety

Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prrioritise areas where evidence shows take up of services is lower or outcomes are worse Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	NA – National Average CA – Case Ascertainment
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Clinical Standards and Effectiveness Group

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

Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Involvement - The importance of involving people with an interest in achieving the well-being goals, and ensuring that those people reflect the diversity of the area which the body serves Choose an item.

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Aneurin Bevan

Aneurin Bevan University Health Board

ANNUAL CLINCIAL AUDIT ACTIVITY REPORT 2024/2025



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Introduction

Welcome to the Aneurin Bevan University Health Board Clinical Audit Activity Report 2024/2025.

Clinical audit is a cornerstone in building the highest quality health and care system for Wales, ensuring everyone receives safe, effective, and reliable care at the right place and time. By systematically evaluating clinical practices against established standards, clinical audits enhance patient outcomes across medical, surgical, and mental health specialties. Engaging healthcare professionals in this process provides invaluable insights into the quality of care and highlights areas for improvement.

Audit is part of clinical effectiveness, as mapped in the Duty of Quality. Audit is crucial for improving patient care, as it ensures that healthcare practices are based on the best available evidence, leading to better patient outcomes, enhanced safety, and higher quality of care.

This report highlights our achievements, challenges, and ongoing commitment to delivering high-quality, safe, and effective care to the population of Gwent. We are proud to share our progress and the positive impact of our initiatives over the past year.

This report showcases the clinical audit activities undertaken within Aneurin Bevan University Health Board during 2024/2025, reflecting our commitment to excellence in patient care.

What is Clinical Audit?

Clinical Audit is integral to improving clinical practice standards. Audit topics reflect national and local priorities, such as Cancer Services, National Service Frameworks, incident reporting, or best practice introductions. Clinical audits measure care delivery against agreed standards, identifying and implementing improvements to enhance reliability and outcomes.
Key benefits include:

- High-quality, safe care for patients
- Cost-effective and sustainable clinical services
- Local engagement in National Audits
- Compliance with NHS Wales Health and Social Services and Public Health Wales regulations
- Assurance through compliance reports
- Quality improvement projects aligned with Health Board priorities
- Demonstrable NICE compliance and best practice implementation



Smart. Measurable. Attainable. Realistic. Timely.

The Health Board demonstrates through Clinical Audit that:

- Patients receive the highest standards of care based on the best available evidence.
- Clinical teams identify opportunities to improve patient care quality.
- Processes are tested to ensure they effectively enhance patient outcomes, experience, safety, and quality of care.
- Re-audits are conducted to ensure sustained improvements in patient care quality.
- Health Board outcomes exceed the national average by participating in National Clinical Audits within the NCAPOP and making data available per HQIP guidance.
- The Health Board can show stakeholders that clinical audits are managed and actioned in line with NHS standards and are available for scrutiny by Public Health Wales (PHW) and other external agencies.

Six Domains of Quality

PERSON CENTRED care involves patients, relatives, families, carers, and system partners in the planning delivery of care and opportunities to improve patient safety. We care about the wellbeing of individuals, families, carers and staff, ensuring everyone is treated with compassion, kindness, dignity and respect. Audits ensure that care is tailored to individual patient needs and preferences, enhancing patient satisfaction and engagement.

SAFE – reduce harm, prevent errors, and deliver consistently safe care through increased visibility and insight from multiple sources of patient safety information. Care delivered by capable and competent staff. Maximising things that go right and learning from when things that go wrong to prevent reoccurrence. Audits identify and mitigate risks, promoting patient safety and preventing harm

TIMELY care, ensuring people have access to the high-quality advice, guidance and care they need quickly and easily, in the right place, first time. We will care for those with the greatest health need first, and where treatment is identified as necessary, we treat people based on their identified and agreed clinical priority. Audits ensure that patients receive care promptly, reducing delays and improving overall health outcomes.

EFFECTIVE care – Deliver consistently effective and reliable care, based on evidence-based best practice which is delivered in a culture that encourages and enables innovation to **Improve** outcomes. Audits ensure that clinical practices are evidence-based and aligned with best practices, leading to optimal patient outcomes

EFFICIENT by taking a value-based approach to improve outcomes that matter most to people in a way that is as sustainable as possible and avoids waste. We will make the most effective use of resources to achieve best value, doing only what is needed, ensuring any interventions represent the best value that will improve outcomes for people. Audits help eliminate waste and improve resource utilization, ensuring sustainable and cost-effective services.

Provide **EQUITABLE** care, ensuring equal opportunities for individuals to attain their full potential for a healthy life which does not vary in quality and is non-discriminatory. We will embed equality and human rights and promote and protect the welfare and safety of children and adults who become vulnerable or at risk at any time. Audits promote equal access to high-quality care for all patients, regardless of personal characteristics.

Six Quality Enablers

Clinical audit is essential for improving patient care and ensuring compliance with the Wales Health and Care Quality Standards. It systematically evaluates clinical practices against established standards, providing insights into the quality of care and identifying areas for improvement. This can be demonstrated below:

LEADERSHIP

Ensure visible and focused leadership at all levels, with its activities driven by the organisations' vision and values for quality. Our leaders and managers take a long-term, stakeholder-centric view to develop a clear organisational vision. They have the appropriate skills and capacity to create the conditions for a functioning quality management system. We ensure our governance, leadership and accountability is effective in sustainably delivering care.

WORKFORCE

Recruit, retain, develop and extend roles to ensure we have enough, confident people with the right knowledge and skills available at the right time to deliver safe care. We value our people and the commitment and resilience they demonstrate in the care they provide. We care about their wellbeing, protect their rights and support them to feel well and happy at work; and provide them with the tools, systems and environment to work safely and effectively. Our workforce planning focuses on investing in our people and nurturing, growing and transforming our workforce to create a sustainable

CULTURE

Create the right climate and culture to nurture and encourage quality and system safety, valuing people in a supportive, collaborative and inclusive workplace so that our people feel psychologically safe to raise concerns and try out new ideas and approaches. Relationships within teams and with the people we serve are effective and based on transparency, accountability, ethical behaviour, trust and just culture, where people can thrive.

INFORMATION

Ensure information is available and shared appropriately for all who need it. We turn data to knowledge by triangulating quantitative and qualitative performance, experience and outcome measures to understand the quality of services, efficacy of improvement work and impact of decisions made. We monitor, report and escalate indicators through our governance structures to ensure that appropriate action is taken at every level in terms of learning, improvement and accountability.

LEARNING, IMPROVEMENT RESEARCH

Create the conditions and capacity for an organisation and system-wide approach to continuous learning, quality improvement and innovation, which it actively promotes. We use new knowledge to influence improvements in practice and to inform our decision-making. We ensure our learning and improvement activity is linked to our strategic vision to deliver transformational, organisation-wide change. We commit to participating in research because research-active organisations provide improved quality of care and outcomes for people.

WHOLE SYSTEMS APPROACH

Ensure safety in healthcare goes beyond individual patient safety. We will look within and beyond our organisational boundaries to learn how we can continually, reliably and sustainably meet the evolving needs of people. We will strengthen relationships and work with all of our partners to achieve good outcomes. Our policies incorporate the broader ambitions within the seven well-being goals and five ways of working in the Well-being of Future Generations Act.

Pillars of Quality

The six pillars of quality have been integral to Aneurin Bevan University Health Board's quality journey by providing a comprehensive framework to assess, monitor, and continuously improve care standards. Each pillar addresses a critical aspect of healthcare, contributing to a holistic approach to quality and safety. Here's how Clinical Audit is supporting to drive improvements in our Pillars of Quality Programme:

Patient and Staff Experience:	Clinical audits prioritise patient and staff experiences, ensuring care remains person-centred and fostering a positive environment for healthcare workers. This is essential for delivering compassionate and effective care, which audits help to measure and improve.
Incident Reporting:	Systematically tracking incidents like falls, pressure ulcers, medicines management, and mortality allows clinical audits to identify patterns, address systemic issues, and prevent recurrence. This enhances patient safety by ensuring that care practices are continuously evaluated and improved.
Complaints, Concerns, and Compliments:	Engaging with feedback through clinical audits enables the Health Board to identify areas for improvement and replicate effective practices. This strengthens trust and accountability by demonstrating responsiveness to patient and family experiences.
Health, Safety, and Security:	Clinical audits ensure that facilities and processes meet the highest standards to protect patients, staff, and visitors. This supports a safe environment for care delivery by regularly evaluating and improving safety protocols.
Infection Control and Prevention:	By addressing infection control as a dedicated pillar, clinical audits enhance practices that reduce healthcare-associated infections. This improves overall patient outcomes by ensuring that infection control measures are effective and consistently applied.
Safeguarding:	Placing safeguarding as a core pillar in clinical audits ensures that vulnerable individuals receive necessary protection and support. This aligns care with ethical standards and legal obligations, ensuring that safeguarding practices are regularly reviewed and improved.



Aneurin Bevan University Health Boards Participation in National Clinical Audit (NCA) Programme mapped to the Integrated Medium-Term Plan (IMTP)

PRIORITY 1 – EVERY CHILD HAS THE BEST START IN LIFE - We believe that every child deserves the opportunity to have the very best start in life.

PRIORITY 2 – GETTING IT RIGHT FOR CHILDREN AND YOUNG ADULTS - Young people are an important group and nurturing of future generations is crucial for our communities.

National Clinical Audits (NCAs) participated in and support priorities 1 & 2:

- National Pregnancy in Diabetes
- National Paediatric Diabetes Audit
- National Clinical Audit of Seizures and Epilepsies for Children and Young People
- National Paediatric Diabetes Audit
- National Maternity and Perinatal Audit
- National Child Mortality Database
- National Neonatal Audit Programme
- Paediatric Asthma – National Respiratory Audit Programme

PRIORITY 3 – ADULTS IN GWENT LIVE HEALTHILY AND AGE WELL - We want our citizens to enjoy a high quality of life into old age we want them to be empowered to take more responsibility for their own health and care, so that they can retain independence.

NCAs participated in and support priority are:

- National Cancer Audits – Bowel, Breast, prostate and more
- Nation Respiratory Audits – COPD, Asthma Adults and Paediatrics
- National Diabetes Audits – Type 1 and Type 2 in young people and adults

PRIORITY 4 – OLDER ADULTS ARE SUPPORTED TO LIVE WELL AND INDEPENDENTLY

NCAs participated in that support this priority are:

- National Audit of Dementia
- Falls and Fragility audits
- National Early Inflammatory Arthritis Audit



PRIORITY 5 – DYING WELL AS A PART OF LIFE

NCA participated in that support this priority:

- National Audit of Care at the End of Life

Audit Goals – Achievements and Progress 2024/2025

Achievements We're Proud Of	
Goal	Status
✓ Provided assurance to the Audit, Risk and Assurance Committee with a part-year report evidencing achievements to date	Achieved
✓ Improved clinical engagement and attendance at the Clinical Standards and Effectiveness Group	Achieved
✓ Ensured continued mandatory participation in National Clinical Audit and Patient Outcomes Programme (NCAOP) and local engagement	Achieved
✓ Secured future funding stream for AMaT	Achieved
✓ Delivered on the Duty of Quality by embedding clinical audit to drive high-quality, safe, and effective care	Achieved
✓ Completed local corporate audits relating to Consent, DNACPR, and Nasogastric Feeding Tube	Achieved

The Health Board has made strong strides this year—successfully achieving six of our key goals and progressing steadily on the rest. These achievements reflect a committed effort across teams to embed quality, safety, and learning through audit at every level.

Audit Goals – Achievements and Progress 2024/2025

Ongoing Commitments We're Building On	
Goal	Status
❑ Develop local audit plan with Divisions	🔄 **Ongoing**
❑ Continue to fully embed AMaT, including governance structure completion	🔄 **Ongoing**
❑ Ensure audit actions and findings are monitored and used to inform service improvement and future planning	🔄 **Ongoing**
❑ Align national clinical audits with Health Board planning and Integrated Medium-Term Plan (IMTP)	🔄 **Ongoing**
❑ Triangulate learning from clinical audits to drive service improvement	🔄 **Ongoing**
❑ Complete data acquisition project to enhance clinical audit participation	🔄 **Ongoing**

We remain committed to driving continuous improvement through our ongoing audit initiatives. Current priorities focus on embedding robust governance structures, aligning clinical audit activity with strategic planning, and ensuring that learning from audits is effectively translated into service improvement. These efforts are vital to sustaining high-quality, safe, and patient-centred care across the Health Board

Challenges in 2024/25

- The original plan, as outlined in the Clinical Audit Strategy 2022-2025, envisioned divisions taking ownership of their audit work. However, due to time, pressures and resource constraints within the divisions, the Quality and Patient Safety Team has continued to manage this responsibility.

- Resource pressures are also felt within the Medical Director's Quality and Patient Safety Audit team, which currently has 1WTE supporting the training and management of all modules of AMaT. This includes chasing overdue actions and obtaining evidence to mark actions as complete. Additionally, the team are responsible for training all Health Board staff on all aspects of AMaT.

- Risks reported in AMaT have been updated to align with the Health Board's Risk Assessment and Scoring Guidance, providing four levels of assurance and five levels of risk. Details are provided in slide 16 of this report.

- The Healthcare Quality Improvement Partnership (HQIP) plans nine months ahead, and the Audit team uses this schedule to organise CSEG meetings throughout the year, ensuring an even spread across the CSEG programme and proper management of mandated reports. Non-participation is highlighted internally, and outlier status is attributed to the audit owner, such as the Royal College of Surgeons.

- Tracking the completion of audit action plans is challenging. When actions are not completed with evidence by the due date, they become overdue. The Clinical Audit Team makes every effort to communicate with clinical leads to ensure actions are appropriately updated.

- Clinical priorities often supersede audit responsibilities, posing a challenge for busy clinical teams.

- A recurring funding stream for AMaT that is distributed across all Executive portfolios.

Our EFFECTIVE Commitments as mapped to the Quality Strategy for 2023-2026

Clinical audit helps the Health Board deliver consistent, evidence-based care by reducing variation, promoting best practice, and ensuring reliable, high-quality outcomes for patients.

This Annual Report outlines the National Clinical Audits (NCAs) undertaken by the Health Board between April 2024 and March 2025. The findings are embedded within the Health Board's evolving Quality Management System, developed in response to the Duty of Quality introduced in April 2023.
These audits play a vital role in supporting the 'Effectiveness' domain of the Duty of Quality, helping ensure care is consistently evidence-based and outcome-driven.

Provide effective care

- Deliver care that is consistently effective and reliable, following best practices.
- Foster a culture that encourages innovation to improve outcomes.
- Ensure patient care is based on the best available evidence.
- Support divisions in driving improvement priorities through learning.

Implement the mandatory National Audit Programme

- Participate in relevant national audits to ensure effective care delivery.
- Use audit findings to support continuous quality improvement by sharing learning and best practices across the organization.
- Develop action plans to monitor and ensure that audit-related actions are measurable and achievable.

Building audit capability across the organisation through skills development

- Create a training programme that encompasses all staff groups.
- Enhance audit capabilities across the organisation by implementing the web-based Audit Management and Tracking System (AMaT).
- Leverage Clinical Audit expertise to provide the evidence base and measurement functions that drive quality improvement initiatives.

To increase engagement with audit and clinical effectiveness work

- Enhance the visibility of clinical audit results by implementing the Clinical Audit Strategy.
- Develop an internal registry as part of this strategy.

Implement NICE Guidance and adoption of Health Technology Wales guidance

- Regularly assess and implement relevant NICE and specialist national guidance to deliver interventions based on the best possible evidence.
- Utilise best practice evidence and benchmark data to improve outcomes.

Annual Reflection on National Clinical Audit across Aneurin Bevan University Health Board

- The Health Board's strategic focus on National Clinical Audit has ensured mandatory participation in the Welsh National Clinical Audit and Outcomes Review Plan (NCAORP).
- Over the past 12 months, the Quality and Patient Safety (QPS) audit team have collaborated with clinical leads to discuss National Clinical Audit results at the Clinical Standards and Effectiveness Group (CSEG).
- In 2024/2025, participation in NCAORP increased, with clinical leads providing S.M.A.R.T. actions based on national reporting recommendations and allocating assurance levels and risk status.
- Additionally, several National audits, such as those on stroke and falls, were discussed at various Boards and Committees throughout the Health Board, reflecting our commitment to continuous improvement and excellence in patient care.
- Standardised templates for local data ensured consistent reporting across NCAORP programmes, aligning with AMaT's Audit Management and Tracking areas. This allowed clinical leads to provide the Clinical Standards and Effectiveness Group (CSEG) with necessary assurances for submission to the Patient Quality and Safety Outcomes Committee (PQSOC). Divisional management teams were kept informed and actively participated in these processes.
- With the expansion of our Audit Management and Tracking (AMaT) system, registered users grew to 2,394, including 118 users who could create proformas and register audits. Ongoing training ensured AMaT's effective use across the Health Board.
- Divisional teams identified clinical audits as part of their local audit plans, allowing scrutiny and assurance of quality and safety risks from Datix, complaints, and care outcomes.
- Collaboration with Aneurin Bevan Continuous Improvement (ABCi), Value Based Health Care Team (VBHC), and Research and Development ensured Health Board staff understood where their projects fit within the organisational structure.

Examples of National Clinical Audits:

National Clinical Audits presented to the Clinical Standards and Effectiveness Group in 2024/25, showcasing both successes and areas of concern. These findings are shared with the Patient Quality and Safety Operational Committee.

AUDIT TITLE	Celebrating Success - 2024/2025	Areas for improvement for 2025/2026
National Oesophago-Gastric Cancer Audit (NOGCA) - State of the Nation Report	✓ A lower proportion of cancers diagnosed as emergency (compared to Wales and England) ✓ Higher proportion diagnosed within 28 days of referral (compared to Wales and England)	❑ 62-day referral to treatment time needs improvement to meet target time ❑ Delays in pathway out with local control e.g. CT-PET
National Lung Cancer Audit (NLCA) - State of the Nation Report 2024 **ALL ACTIONS COMPLETED & AUDIT CLOSED**	✓ Non-small cell lung cancer treated curatively rose from 31.7% to 57.1% ✓ Exceptional Lung Cancer Nurse Specialist input with plans to see inpatients	❑ Surgical resection rates are under target, although have improved since 2021 ❑ High rate of emergency presentations
National Audit of Dementia (NAD) - Care in General Hospitals 2022-2023 Round 5 Audit Report	✓ Delirium screening and pain assessment has improved (previously an outlier) ✓ Discharge planning now initiated within 24 hours	❑ Improvements considered for how to enhance carer communication ❑ Work to define a measure to record proportion of people with Dementia having falls on DATIX
Fracture Liaison Service Database (FLS-DB) Annual report - You've had a fracture; how can we prevent another?	✓ AB FLS continued to recommend bone treatment for 65% of patients (target 50%) ✓ AB FLS has increased identification by 200% since 2021, this year reaching 70% (target 80%)	❑ 16 weeks adherence remains under 50% ❑ 52 weeks adherence remains under 25%

Examples of Audit Actions Fully Completed in 2024/2025

(all actions can be viewed on AMaT)

🎯 Focused on embedding improvements – patient safety, clinical excellence, and system change.

Audit Title	Action Taken	Outcome
NRAP – Breathing well: Paediatric Asthma	Smoking status now recorded on proforma; cessation advice included in discharge pack	✅ Smoking advice integrated into care templates
NELA – Emergency Laparotomy	MDT and risk assessments enhanced for elderly/frail patients	✅ Ongoing input from CoTE and service development supported
MBRRACE – UK Perinatal Mortality	Developed maternity improvement plan; linked to IMTP and public health	✅ Forms part of IMTP; digital audit and cessation data embedded
National Hip Fracture Database	Theatre delays escalated; Medical Director involved	✅ Escalated to Exec level for improvement action

Throughout 2024/25 the Clinical Audit team has focused on ensuring clinical audit actions are completed and recorded by embedding them into AMaT with clear ownership, deadlines, and oversight, providing robust assurance to governance committees

The National Clinical Audit and Patient Outcomes Programme (NCAPOP)

- NCAPOP is commissioned and managed by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS Wales.
- The programme includes over 30 national audits related to common conditions, collecting and analysing data from local clinicians to provide a national picture of care standards.
- Locally, NCAPOP audits offer individual benchmarked reports to trusts and health boards, highlighting compliance and performance, and providing comparative findings to identify necessary improvements.
- Most projects involve services in England and Wales, with some also including Scotland and Northern Ireland.
- In addition to the national clinical audits, NCAPOP includes the four Clinical Outcome Review Programmes (CORP), which assess healthcare quality and stimulate improvement by learning from adverse events and other relevant data.

What is our Clinical Audit Strategy?

The Health Board has a Clinical Audit Strategy which sets out the vision for clinical audit for the Health Board. The vision is to be recognised as the best healthcare provider in our class, consistently performing within the top 10% nationally. The mission is to safeguard the health and well-being of the population we serve and to abide by our Health Board values.

The values we aim to show are:

People First

Personal Responsibility

Passion for Improvement

Pride in What We Do

The Health Board Audit Strategy has Four Priorities:

- ❖ Scrutiny of National Clinical Audit performance with robust development, monitoring, and progression of improvement plans
- ❖ Divisions to identify clinical audits that allow scrutiny and assurance associated with quality and safety risk
- ❖ Trainees are supported to participate in meaningful clinical audits that support clinical governance
- ❖ Groups and committees across the Health Board will commission clinical audit to support effective assurance where no other evidence is available.

Clinical Audit Governance and Reporting Arrangements

- The Medical Director's Quality and Patient Safety (QPS) team coordinates delivery of the Clinical Audit Plan with Clinical Leads. This ensures mandatory compliance with the National Clinical Audit and Patient Outcomes Programme (NCAPOP), commissioned by HQIP, and the NHS Wales National Clinical Audit Outcome Review Plan (NCAOPR). The team collaborates with Divisional structures to document and track audit participation.

- At the operational level, **the Clinical Standards and Effectiveness Group (CSEG)** is multidisciplinary forum that is focused on reviewing audit data, identifying risks to clinical effectiveness and patient safety, and promoting improvements in care. This group ensures clinical audit findings are discussed in a system-wide context, facilitating shared learning and cross-divisional alignment.

From a governance perspective, the reporting routes are clearly defined and set out below:

- The **Patient Quality, Safety, and Outcomes Committee (PQSOC)** looks at audit outcomes and the improvements made as a result. It focuses on how findings translate into better patient care and safety, aligning with the Health Board's commitment to continuous improvement.

- The **Audit, Risk, and Assurance Committee (ARAC)** oversees the governance and assurance framework supporting the clinical audit programme. It ensures the plan is robust, informed by risk, and aligned with strategic priorities. ARAC also seeks assurance that audit findings are being actioned appropriately and that the process is leading to demonstrable change.

- By maintaining these distinct but complementary oversight functions, the Health Board ensures that both assurance and improvement are built into the audit cycle, connecting front-line clinical practice with corporate risk governance

Health Board results - National Clinical Audit Outcome Review Plan (NCAORP)

Participation in NCAORP 2024/2025 and presentation at CSEG	Number of audits
NCAORP 2024/2025	
Published Apr 24 – March 25	**48**
Presented at CSEG to date 2024/2025	26
Arranged for future CSEG (May & Jul 2025)	10
NHS England (not applicable)	8
ABUHB Non-participation	4
	48
%	
Presented at CSEG 2024/2025	54%
Arranged for future CSEG (May & Jul 2025)	21%
NHS England (not applicable)	17%
ABUHB Non-participation	8%
	100%

Total number participated in is 36. to date, 26 presented at CSEG and 10 will be presented throughout 2025.
Total of non-participation is 16 and reasons are:

- NHS England data only (8 audits).
- The Health Board has not participated in the National Respiratory Audit Programme (3 audits). Due to non participation the Health Board has received an outlier notification. The Medical Director has formally written to the relevant specialty, reinforcing the participation is mandatory. An action pan will be developed to address the issues. This is under review to ensure 2025/26 participation.
- National Confidential Enquiry into Patient Outcome for the audit – 'Death on Planning for the End' – under review of the quality of care provided to adult patients (1 audit).

Assurance and Risk Levels:

Assurance		Risk	
Full	**6%**	None	**6%**
None	**0%**	Minor	**56%**
Significant	**56%**	Moderate	**25%**
Limited	**38%**	Major	**13%**
Very Limited	**0%**	Catastrophic	**0%**
	100%		100%

Risk and Governance

In the Health Board risk refers to the potential for any event or action to adversely affect the achievement of the organisation's objectives, including patient safety, service delivery, and overall organisational performance. Effective risk management is crucial for identifying, assessing, and mitigating these risks to ensure high-quality healthcare services.

As part of the audit plan Clinical Leads completed the risk level and assurance level for the Clinical Audit. To reduce risk across the Health Board, high level risk areas must be added to the relevant risk register and risks analysed, evaluated and treated.

The risk levels were adjusted during 2024/2025 to align with the Healths Boards Risk Scoring Matrix, in collaboration with the Health Board's Corporate Governance team:

Risk Level	
None	Standards met and findings demonstrate no risk to patient safety
Minor	Overall treatment or service suboptimal - Minor implications for patient safety if unresolved
Moderate	Treatment or service has significantly reduced effectiveness - Moderate risk to patient safety if not acted upon
Major	Non-compliance with national standards with significant risk to patients if unresolved – Major risk to patient safety
Catastrophic	Totally unacceptable level or quality of treatment/service - Gross failure to meet national standards – Gross failure to meet standards



Assurance Level	
Full	The project has fully achieved the standards or criteria being audited against
Significant	The project has mostly achieved the standards or criteria being audited against
Limited	The project did not achieve the standards or criteria being audited against
Very limited	The project failed to achieve the standards or criteria being audited against

Assurance and Risk Levels

Risks reported to CSEG for 2024/25 for National Clinical Audit Programme

CSEG Date	Audit title	Assurance	Risk	Update
May-24	National Lung Cancer Audit State of the Nation report (01/01-31/12/2022 data; Eng & Wales)	Significant	Minor	All report recommendations have been achieved. Actions are fully completed by Clinical Lead.
May-24	National Audit of Dementia - Care in General Hospitals 2022-2023 Round 5 Audit Report	Limited	Major	The Clinical Lead is actively collaborating with site leads and support staff across the Health Board to drive improvements. However, there are some overdue actions that need to be addressed to ensure the service meets its goals.
May-24	Fracture Liaison Service Database (FLSDB) Annual Report 2024: Improved FLS identification with gaps in monitoring: a call to action for national and regional planners (January-December 2022)	Limited	Major	Two out of three actions are fully complete, while one remains partially complete and overdue due to staffing resource issues. Over five years, the total annual cost for ABUHB FLS, including staff, overheads, and prescribing costs, is estimated to be between £450,376 and £883,488. The annual benefits across acute care are £1,439,436, with total benefits, including community and social care, reaching £2.1 million.
Jul-24	National Diabetes Foot Care Audit (NDFA) State of the Nation report, 01/04/2021-31/03/2022 TBC; Eng & Wal.	Significant	Minor	Continuous Quality Improvement (QI) work is being carried out to enhance patient care. All report recommendations are being successfully achieved.
Sep-24	National Respiratory Audit State of the Nation report - PAEDIATRIC ASTHMA	Significant	Minor	One action has been completed. There will be a meeting to discuss the joint pathways with Primary Care and Adult Services.
Sep-24	NCEPOD - Endometriosis	Significant	Moderate	There is a comprehensive action plan in place which is to be completed by 31st March 2025.
Sep-24	MBRACCE-UK Perinatal mortality surveillance July 2024 - State of the nation report	Significant	Minor	All recommendations have been achieved.
Nov-24	National Emergency Laparotomy Audit State of Nation report 2024	Significant	Minor	Presented to CSEG in November 2024, with actions related to COTE consultant expansion and patient-level data entry both set to be resolved by 2026

Risks reported to CSEG for 2024/25 for National Clinical Audit Programme

CSEG Date	Audit title	Assurance	Risk	Update
Nov-24	National Ovarian Cancer Audit (NOCA) - State of the Nation	Limited	Minor	A new audit has been submitted to NATCAN, with ongoing actions planned throughout 2025. This audit is more advanced in England, so there are expectations for improved data for Wales moving forward
Nov-24	National Neonatal Audit Programme 2024 report	Significant	Minor	The metrics within the audit are improving year on year and are continously monitored using the updated Dashboard.
Nov-24	National Primary Breast Cancer Audit (NaoPri) - State of the Nation	Significant	Minor	Two recommendations have been completed within the Health Board and three actions are planned to be completed during 2025.
Nov-24	National Metastatic Breast Cancer Audit (NaoMe) - State of the Nation	Limited	Moderate	Three actions are to be completed during 2025.
Jan-25	National Hip Fracture Database (NHFD)	Limited	Moderate	Presented to CSEG in January 2025 and three actions are to be completed during 2025.
Jan-25	Epilepsy12 State of the National report, England and Wales (2021-23)	Significant	Minor	Business case submitted to improve EEG waiting times in Neurophysiology. Ongoing discussions across the team to improve services.
Jan-25	National Early Inflammatory Arthritis Audit State of the Nation 2024 Annual Report	Full	None	All report recommendations are in place and the service has improved from previous outlier status.
Jan-25	National Pregnancy in Diabetes (NPID) Annual Data Only Release and Dashboard Update (2023; Eng Only)	Significant	Minor	No recommendations were provided as this was dashboard release only.
Jan-25	National Respiratory Audit Programme Primary Care Report (cohort TBC)	Limited	Moderate	Presented to CSEG in January 2025 there is an extensive action plan of which some recommendations have been fully completed and other actions are to be completed during 2025.

Summary of Completed Actions in the National Clinical Audit and Patient Outcomes Programme (NCAPOP)

Total Number of actions presented to CSEG	
Number fully completed	18
Number partially completed (overdue)	16
Number ongoing (not overdue)	27
No longer relevant	2
Number overdue	26
	89

% fully completed	20%
% partially complete	18%
% ongoing	30%
% overdue	29%
(3% no longer relevant)	**100%**

Those fully completed were completed within 12 months.
However, only 7% (5 of 70) were completed within the stated timeframe
All overdue actions are being highlighted to the Clinical Leads and the Divisional triumvirates.

ACTIONS

A SMART action plan is completed on AMaT based upon the report recommendations and/or the Clinical Leads local recommendations.

Some of the report recommendations may already be achieved within the Health Board – these are noted as already achieved.

Ongoing actions may be actions that take a longer time to put in place or could have had a shorter deadline which has then been extended.

All actions for National Clinical Audits are monitored by the Medical Director's Clinical Audit QPS team and chased with the relevant nominated responsible person and are updated accordingly in AMaT.

The Clinical Audit team have produced an escalation SOP and will look at how this is enacted for actions that are overdue to ensure completion and follow up.

Audit Management and Tracking System (AMaT)
Update on AMaT Implementation

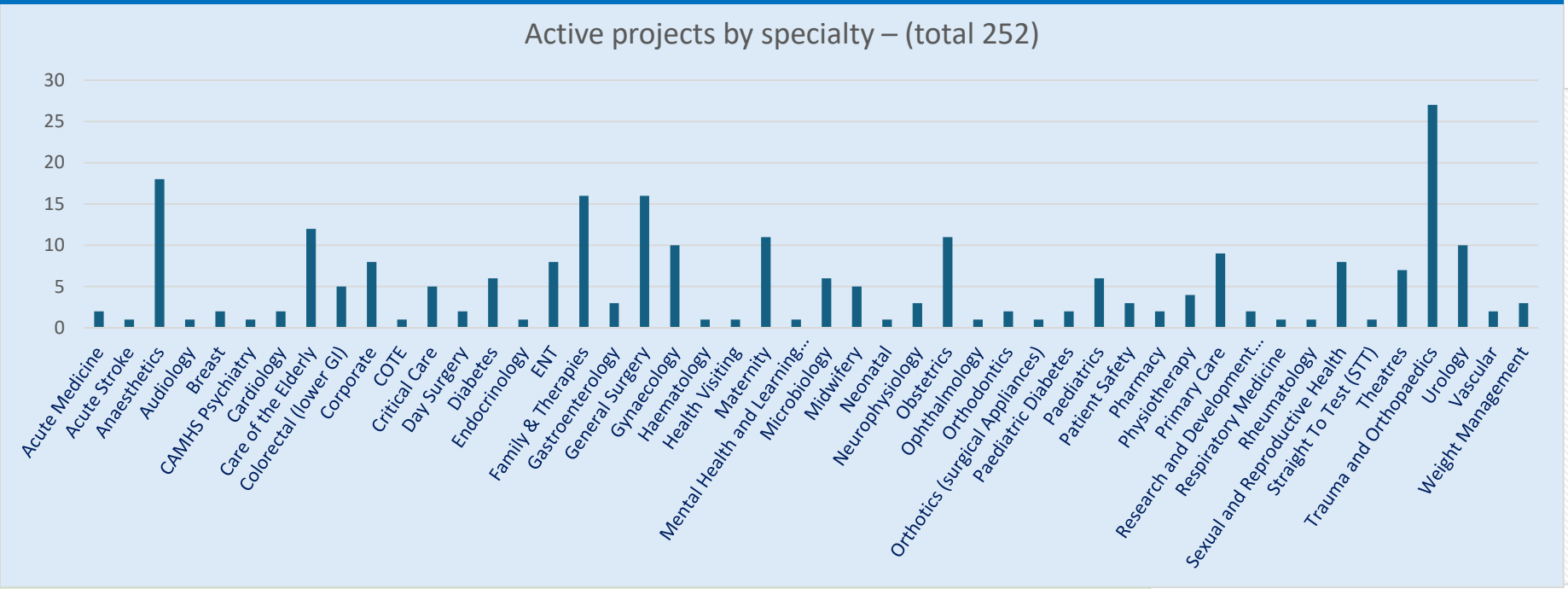
- Purchased in 2022, as part of the Clinical Audit Strategy the Medical Director's team has been implementing use of the system and carrying our training for staff.

User Statistics:
- 2,330 registered users have been trained to use AMaT, contributing to the audit programmes.
- 115 staff members can create audit questionnaires.
- 6 SUPER USERS can maintain the data management area.

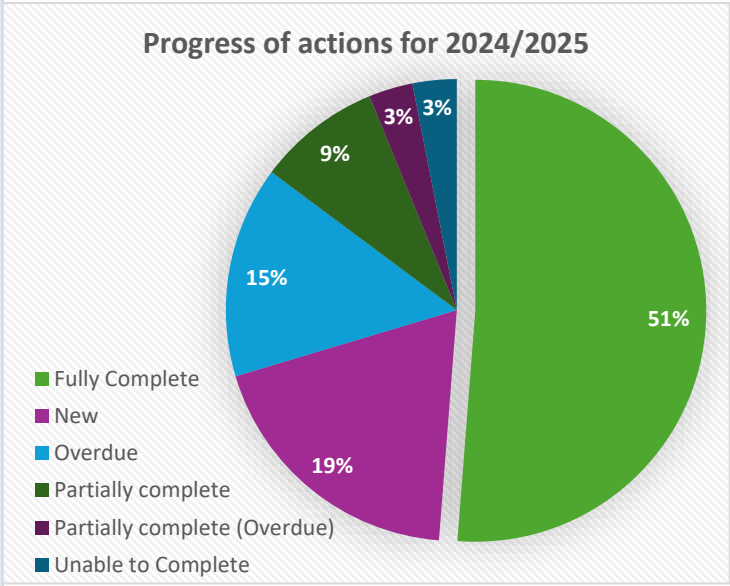
Inspection Area Usage:
- 16 inspections registered with actions:
  - 8 In Progress
  - 1 Partially Complete and Overdue
  - 42 Overdue
  - 352 Completed (awaiting approval)
  - 34 Completed

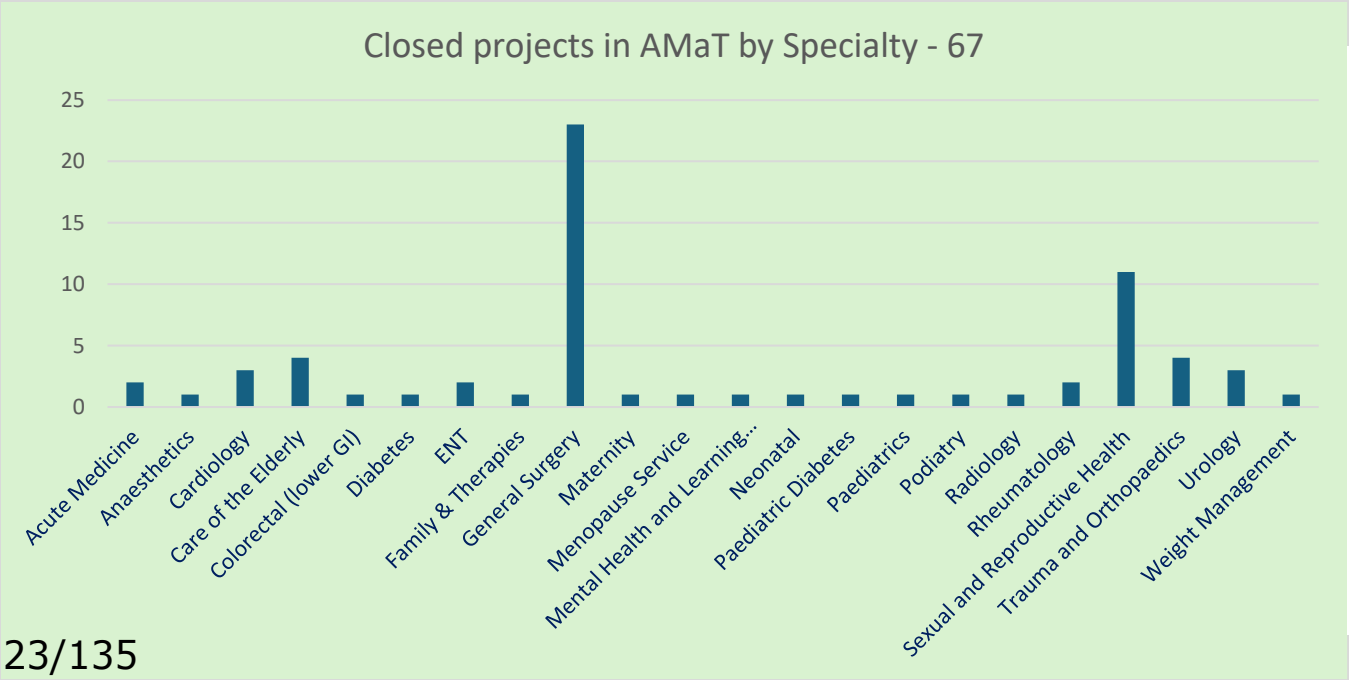
Guidance Module:
- 15 guidance statements:
  - 10 Achieved
  - 3 Overdue
  - 1 Partially Achieved – Acceptable status (PAA)
  - 1 Not applicable

LOCAL AUDIT - AUDIT MANAGEMENT AND TRACKING (AMaT) – CLINICAL AREA



AMaT
Audit Management and Tracking





- Through the accessibility of AMaT to all staff, there are currently 252 active projects across local and national levels, with 67 projects closed and signed off.
- In 2024/2025, 51% of allocated actions have been fully completed.
- The Quality and Patient Safety team monitors these actions.
- Efforts are underway to use AMaT for capturing National Clinical Audit Data, specifically for the NICOR Heart Failure audit.

LOCAL AUDIT
AUDIT MANAGEMENT AND TRACKING (AMaT) – WARD AREA

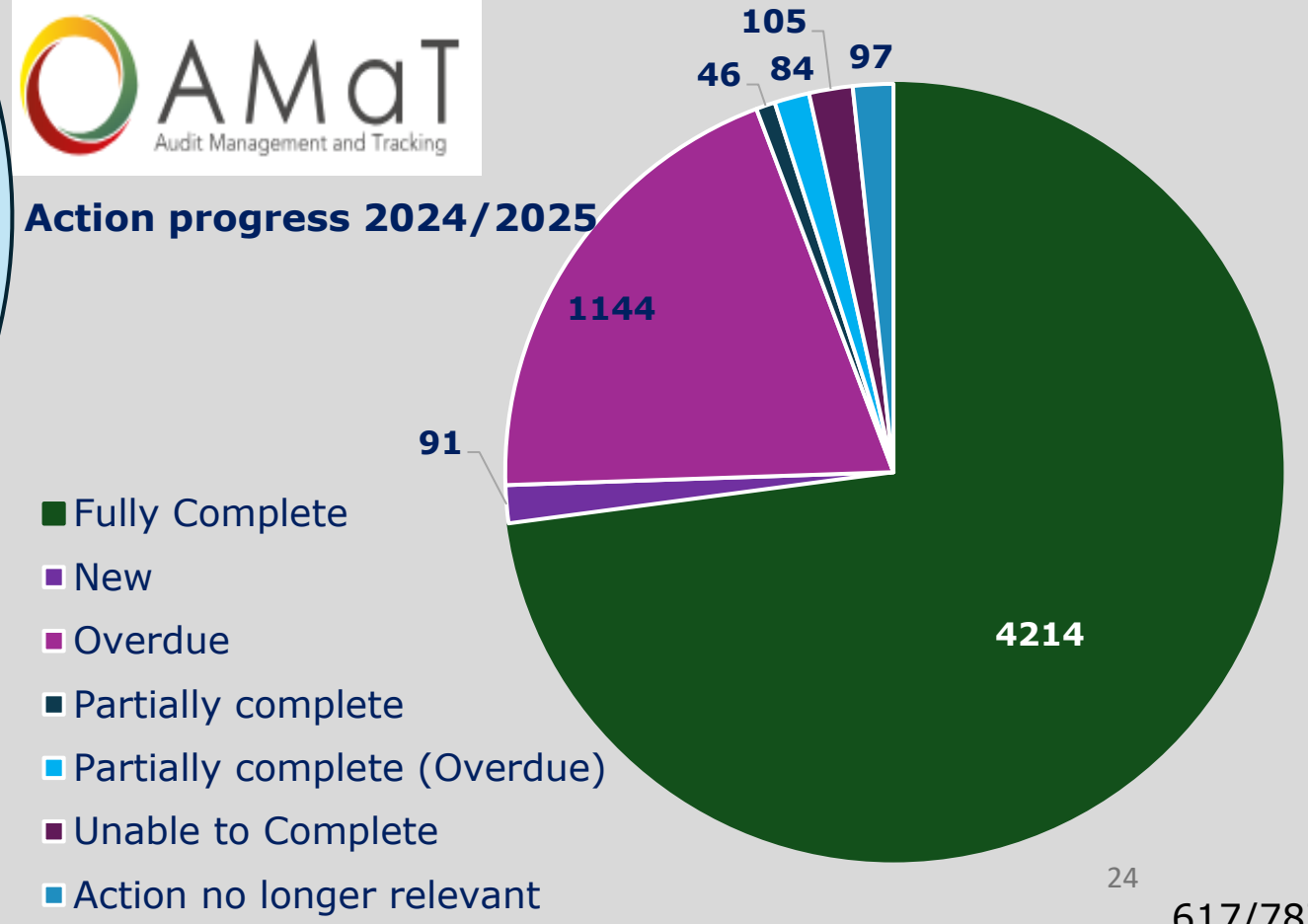
- In 2023/2024, 20 projects were recorded in the Ward Area of AMaT. This doubled to 40 projects in 2024/2025. Each project may encompass multiple audits—for example, the Ward Accreditation project includes 15 audits spanning up to 62 clinical areas.
- A total of 5,781 audits have been registered, with 4,212 actions completed. However, 233 of these actions remain without supporting evidence, and 1,228 actions are currently overdue.
- Across all audits, 10,122 clinical areas have completed assessments and can view their results. Of these, 3,165 achieved a score of 100%, while 7,347 scored 90% or above, demonstrating strong overall performance and engagement.

Examples of Completed Actions:

- All staff are compliant with the *Bare Below the Elbows* policy
- The patient's *First Language Spoken* is recorded in the clinical record
- The *Mental Health Section* of the documentation has been fully completed
- Staff are wearing *Personal Protective Equipment (PPE)* correctly and consistently
- Evidence of *Discharge Planning* is documented in nursing/medical records or on the PSAG board
- The *Care Plan* is regularly reviewed and updated
- *Dementia-friendly signage* is clearly visible and appropriately placed on the ward

AMaT
Audit Management and Tracking

Action progress 2024/2025



Patient Experience captured through audit

Increasing Patient Involvement:

- More audits are incorporating patient feedback. The Health Board are asking family, carers, and friends about their views on the treatment provided by the Health Board and how we can improve.
- As usage of CIVICA to capture patient experience increases, work with the Patient Experience and Involvement Team is vital to ensure feedback can be incorporated into Audit results.

Dimensions of Person-Centred Care: Through this strategy, the Health Board is committed to:

- Respecting people's values, preferences, and expressed needs.
- Improving information and education.
- Enhancing access to care.
- Providing emotional support to relieve fear and anxiety.
- Involving family, friends, and significant others in patient care.
- Ensuring continuity and smooth transitions between healthcare settings.
- Providing physical comfort.
- Delivering coordinated care.

Working is needed with the value-based healthcare team to understand any measures collected on patient experience. In the context of healthcare, PREM stands for Patient Reported Experience Measures. These measures capture patients' experiences and perceptions of the care they receive, providing valuable insights into the quality of healthcare services from the patient's perspective. PREMs are used to inform improvements in patient care and service delivery.

National Audits with patient related quality improvement measures are:
• National Early Inflammatory Arthritis Audit (NEIAA)
• National Audit of Care at End of Life (NACEL)
• National Dementia Audit (NAD)
• National Neonatal Audit Programme (NNAP)

Audit Goals and Key Objectives for 2025/26

These goals and objectives aim to build on the successes of the previous year while addressing ongoing areas for improvement.

Enhance Clinical Engagement - Improve clinical engagement and attendance at the Clinical Standards and Effectiveness Group.

Expand Audit Participation - Ensure mandatory participation in NCAPOP and NCAORP.

Develop Local Audit Plans - Collaborate with Divisions to develop comprehensive local audit plans. Build stronger connections with Divisional Management Teams.

Embed AMaT - Fully integrate the Audit Management and Tracking System (AMaT) into the governance structure. Run additional training sessions and raise audit awareness. Improve governance and reporting structures within AMaT.

Monitor Audit Actions - Monitor actions and findings from national clinical audits to inform future planning. Promote ownership and tracking of audit results and recommendations in AMaT.

Inform Future Planning - Use national clinical audits to inform the Health Board’s future planning and integrate them into the annual Divisional Integrated Medium-Term Plan (IMTP).

Triangulate Learning - Triangulate learning from clinical audits to drive service improvements. Evaluate mechanisms to triangulate learning from clinical audits and other sources.

Complete Data Acquisition Project - Finalise the data acquisition project for effective participation in clinical audits. Evaluate Medical Director's quality and safety structures and resources within the audit team.

Quality and Effectiveness Commitment - Maintain the commitment to delivering high-quality care, patient safety, patient experience, and clinical effectiveness through clinical audits.

Collaborative Efforts - Work with the Value-Based Healthcare team to review the impact of measures that complement audit and benchmarking results. Collaborate with the Patient Experience and Involvement team to strengthen audit data with CIVICA and patient experience data.

Secure a dedicated funding stream for AMaT that is shared across Executive Directors.

Conclusion

- The Clinical Audit Quality and Patient Safety Team has elevated the profile of clinical audit across the Health Board. By actively engaging with Divisional Management Teams and Clinical Leads for National Audit programmes. This has supported evidence-based results and ensured tracked implementation of SMART actions based on recommendations. Despite the challenges posed by competing priorities and high service demands, the team has made remarkable strides.
- Throughout 2024/25, there has been a focus on ensure Clinical Audit is integrated into core services, making it "business as usual." The embedding of AMaT has greatly improved the efficiency of audit completion and the effectiveness of monitoring actions arising from audits. The use of AMaT to produce standardised reporting templates and SMART action plans has provided robust assurance to CSEG and PQSOC.
- This report includes a comprehensive collection of national audit reports from the past 12 months. Future efforts will focus on ensuring that learning from audits is shared across the Health Board and communicated to both staff and patients.
- Patient experience, quality, and safety are central to our work, driving improvements in the quality of care and services we deliver, and enhancing outcomes for the population we serve.
- Clinical audit continue to be a vital component of our commitment to EFFECTIVE care, supporting the delivery of the Duty of Quality as mapped to the six domains of quality.
- Clinical Effectiveness will soon become a Pillar of Quality and this will support the work on Clinical Audit.

Appendix One – HQIP

National Quality Improvement Programmes

- The Healthcare Quality Improvement Partnership (HQIP) has been a cornerstone in the landscape of national healthcare quality improvement since its establishment in 2007. As an independent, not-for-profit organisation, HQIP is led by the Academy of Medical Royal Colleges and the Royal College of Nursing. Its mission is to enhance health outcomes through evidence-based, patient-centred quality improvement initiatives.
- One of HQIP's flagship responsibilities is managing and commissioning the National Clinical Audit and Patient Outcomes Programme (NCAPOP) on behalf of NHS England, the Welsh Government, and occasionally other devolved authorities. NCAPOP is a comprehensive programme that encompasses two main sub-programmes: the National Clinical Audit Programme and the Clinical Outcome Review Programmes. These initiatives are pivotal in driving improvements in clinical practice and patient outcomes across the UK.
- HQIP's relationship with NHS Wales Health Boards is integral to the success of these national quality improvement programmes. By collaborating closely with these health boards, HQIP ensures that the audits and reviews are tailored to meet the specific needs and challenges faced by healthcare providers in Wales. This partnership fosters a culture of continuous improvement and accountability, ultimately leading to better patient care and outcomes.
- In practice, HQIP supports improved health outcomes by commissioning national clinical audits and outcome review programmes, as well as providing registry data and resources. These efforts are complemented by a range of other quality improvement and patient engagement activities, all aimed at fostering a healthcare system that is responsive to the needs of patients and grounded in robust clinical evidence.

Appendix One

National Quality Improvement Programmes

- For the last 12 months, the publication list for 2024/2025 outlined the projects scheduled for presentation at the Clinical Standards and Effectiveness Group (CSEG). However, it is important to note that some projects may be presented in 2025/2026 due to various factors such as meeting schedules, clinical commitments, or decisions by clinical leads to delay the scheduled dates. This flexibility ensures that the quality and relevance of the audits and reviews are maintained, allowing for the most accurate and impactful findings to be shared with the healthcare community.
- The HQIP publication programme for 2024/2025 identified 56 audits. However, the Health Board did not need to provide assurance for all these publications. Some audits used only English data or published quarterly dashboards, and if these services were not part of the Health Board's daily operations, they were not included in the Clinical Standards and Effectiveness Group (CSEG) process.
- Of the 48 audits, 26 were presented to CSEG. The remaining 10 are due in 2025.
- Additionally, the NICOR National Cardiac Audit Programme (NCAP) included:
  - National Audit of Cardiac Rhythm Management (NACRM)
  - National Heart Failure Audit (NHFA)
  - National Audit of Percutaneous Coronary Interventions (NAPCI)
  - Myocardial Ischaemia National Audit Project (MINAP)
- These audits were previously commissioned by HQIP with annual reports but were later available as interactive reports on the NICOR website. All four sub-specialty clinical leads were requested to attend the CSEG meeting in September 2025.

Appendix Two – Audit Plan 2024/25. Publication Date and when presented at CSEG

HQIP Ref.	Abb	PROJECT NAME	FULL REPORT TITLE	PUBLICATION DATE	CSEG
536	NCEPOD	Child Health Clinical Outcome Review Programme	Juvenile Idiopathic Arthritis report	13/02/2025	Jul 2025
473	Epilepsy12	Epilepsy12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People	Epilepsy12 State of the National report, England and Wales (2021-23)	11/07/2024	Jan 2025
521	FLS-BD	FFFAP - National Falls & Fragility Fracture Audit Programme	Fracture Liaison Service Database 2024 State of the Nation report	09/01/2025	Feb 2025
469	FFFAP	FFFAP - National Falls & Fragility Fracture Audit Programme	National Hip Fracture Database State of the Nation 2024	12/09/2024	Jan 2025
561	FFFAP	FFFAP - National Falls & Fragility Fracture Audit Programme	National Hip Fracture Database (NHFD)	31/10/2024	Jan 2025
459	NCEPOD	Medical and Surgical Clinical Outcome Review Programme	Endometriosis report	11/07/2024	Sep 2024
472	NCEPOD	Medical and Surgical Clinical Outcome Review Programme	Medical and Surgical Clinical Outcome Review Programme: End of Life Care report 2024	14/11/2024	End of Life (NCEPOD)
500	MNI	MNI - Maternal, Newborn and Infant Clinical Outcome Review Programme	Saving lives, improving mothers care report (2021-2023, UK wide)	10/10/2024	July 2025
501	MNI	MNI - Maternal, Newborn and Infant Clinical Outcome Review Programme	Perinatal confidential enquiry	12/12/2024	May 2025
497	NAD	NAD - National Audit of Dementia	Annual report 2024	12/12/2024	Feb 2025

HQIP Ref.	Abb	PROJECT NAME	FULL REPORT TITLE	PUBLICATION DATE	CSEG
516	NOGCA	NATCAN - National Cancer Audit Collaborating Centre	National Oesophago-Gastric Cancer Audit (NOGCA) State of the Nation report (England & Wales)	09/01/2025	Feb 2025
517	NPCA	NATCAN - National Cancer Audit Collaborating Centre	National Prostate Cancer Audit (NPCA) State of the Nation report (England & Wales)	09/01/2025	Feb 2025
518	NBOCA	NATCAN - National Cancer Audit Collaborating Centre	National Bowel Cancer Audit (NBOCA) State of the Nation report (England & Wales)	09/01/2025	Feb 2025
465	NKCA	NatCan - National Cancer Audit Collaborating Centre	National Kidney Cancer Audit (NKCA) - State of the Nation	12/09/2024	Feb 2025
463	NPaCA	NatCan - National Cancer Audit Collaborating Centre	National Pancreatic Cancer Audit (NPaCA) - State of the Nation	12/09/2024	Feb 2025
464	NNHLA	NatCan - National Cancer Audit Collaborating Centre	National Non-Hodgkin Lymphoma Audit (NNHLA) - State of the Nation	12/09/2024	May 2025
462	NOCA	NatCan - National Cancer Audit Collaborating Centre	National Ovarian Cancer Audit (NOCA) - State of the Nation	12/09/2024	Nov 2024
461	NaoMe	NatCan - National Cancer Audit Collaborating Centre	National Metastatic Breast Cancer Audit (NaoMe) - State of the Nation	12/09/2024	Nov 2024
460	NaoPri	NatCan - National Cancer Audit Collaborating Centre	National Primary Breast Cancer Audit (NaoPri) - State of the Nation	12/09/2024	Nov 2024
453	NVR	NVR - National Vascular Registry	National Vascular Registry state of the nation report 2024	14/11/2024	Nov 2024
466	SSNAP	SSNAP - Sentinel Stroke National Audit Programme	Sentinel Stroke National Audit Programme State of the Nation 2024	14/11/2024	Nov 2024

HQIP Ref.	Abb	PROJECT NAME	FULL REPORT TITLE	PUBLICATION DATE	CSEG
567	NCAP	NCAP - National Clinical Audit of Psychosis	State of the Nation report (Bespoke data)	13/02/2025	May 2025
553	NCISH	NCISH - Mental Health CORP	National Confidential Inquiry into Suicide and Safetyin Mental Health: Annual Report 2025 UK patient and general population data 2012-2022	13/02/2025	Jul 2025
478	NCMD	NCMD - National Child Mortality Database	Child Death Reviews Data year ending 31/03/2024	14/11/2024	Jul 2025
540	NDA	NDA - National Diabetes Audit (adults)	Young Type 2 Annual Data Only Release and Dashboard Update (2022-23; Eng and Wales)	12/09/2024	Jan 2024
539	NDA	NDA - National Diabetes Audit (adults)	National Pregnancy in Diabetes (NPID) Annual Data Only Release and Dashboard Update (2023; Eng Only)	08/08/2024	Jan 2025
543	NDA	NDA - National Diabetes Audit (adults)	Complications and Mortality Annual Data Only Release and Dashboard Update (Up to 2023; Eng and Wales)	14/11/2024	Jan 2025
544	NDA	NDA - National Diabetes Audit (adults)	National Diabetes Audit (NDA) Core Annual Data Only Release and Dashboard Update (2023-24; Eng and Wales)	12/12/2024	Jan 2025
533	NDA	NDA - National Diabetes Audit (adults)	National Diabetes Foot Care Audit (NDFA) State of the Nation report, 01/04/2021- 31/03/2022 TBC; Eng & Wal.	09/05/2024	Jul 2024
428	NEIAA	NEIAA - National Early Inflammatory Arthritis Audit	National Early Inflammatory Arthritis Audit State of the Nation 2024 Annual Report	10/10/2024	Jan 2025
413	NELA	NELA - National Emergency Laparotomy Audit	National Emergency Laparotomy Audit State of Nation report 2024	10/10/2024	Nov 2024

HQIP Ref.	Abb	PROJECT NAME	FULL REPORT TITLE	PUBLICATION DATE	CSEG
444	NLCA	NLCA - National Lung Cancer Audit	National Lung Cancer Audit State of the Nation report (01/01-31/12/2022 data; Eng & Wales)	11/04/2024	May 2024
498	NNAP	NNAP - National Neonatal Audit Programme	National Neonatal Audit Programme 2024 report	10/10/2024	Oct 2024
496	NPDA	NPDA - National Paediatric Diabetes Audit	Parent and Patient Reported Experience Measures (PREMS) report 2024 (24/07/2023 - 23/01/2024)	14/11/2024	Nov 2024
535	NPDA	NPDA - National Paediatric Diabetes Audit	Annual Core State of the Nation Report (Year 3)	13/03/2025	Mar 2025
434	NRAP	NRAP - National Respiratory Audit Programme	State of the Nation report (01/03/2022–31/03/2023, England & Wales)	11/07/2024	Jul 2024
541	NRAP	NRAP - National Respiratory Audit Programme (was NACAP)	National Respiratory Audit Programme Primary Care Report (cohort TBC)	12/09/2024	Sep 2024
434	NRAP	NRAP - National Respiratory Audit Programme (was NACAP)	National Respiratory Audit State of the Nation report - PAEDIATRIC ASTHMA	11/07/2024	Jul 2024
440	NRAP	NRAP - National Respiratory Audit Programme (was NACAP)	National Respiratory Audit Programme Combined Organisational Report	14/11/2024	Nov 2024
434	NRAP	NRAP - National Respiratory Audit Programme (was NACAP)	National Respiratory Audit State of the Nation report - ADULT ASTHMA	11/07/2024	Jul 2024
434	NRAP	NRAP - National Respiratory Audit Programme (was NACAP)	National Respiratory Audit State of the Nation report - COPD	11/07/2024	Jul 2024

Appendix Three – Patient Quality Safety and Outcomes Committee submissions

Date of Meeting:	Monday 2nd September 2024
Tuesday 30 April 2024 – Presented on March 2024	Tuesday 12th November 2024
Tuesday 4th June 2024 – no Clinical Audit update	Monday 20th January 2025
Tuesday 30th July 2024 – no Clinical Audit update	Monday 31st March 2025



The **Patient Quality, Safety, and Outcomes Committee (PQSOC)** looks at audit outcomes and the improvements made as a result. It focuses on how findings translate into better patient care and safety, aligning with the Health Board's commitment to continuous improvement.

Audits Presented to Clinical Standards and Effectiveness Group (CSEG) and Patient Quality and Safety Outcomes Committee (PQSOC)	
1	National Oesophago-Gastric Cancer (NOGCA) Audit - State of the Nation Report - Data -1 Apr 2020 – 31 Mar 2022
2	National Lung Cancer Audit (NLCA) - State of the Nation Report 2024 - An audit of care received by patients diagnosed with Lung Cancer in England and Wales during 2022
3	National Audit of Dementia (NAD) - Care in General Hospitals 2022-2023 - Round 5 Audit Report
4	Fracture Liaison Service Database (FLS-DB) - Annual report – Improved Fracture Liaison Service (FLS) identification with gaps in monitoring: a call to action for national and regional planners
5	National Paediatric Diabetes Audit (NPDA) - Report on Care and Outcomes 2022/23
6	National Diabetes Foot Care Audit (NDFA) - Are services providing effective diabetes foot care?
7	Report on the 2022 National Audit of Quality Standards for Adult Hearing Rehabilitation Audiology (Wales)
8	SSNAP Annual Report 2023 - Sentinel Stroke National Audit Programme – State of the Nation - Stroke care received between April 2022 to March 2023
9	Audit Title: MBRRACE-UK - Perinatal mortality surveillance 2024 - State of the nation report - UK

Audits Presented to Clinical Standards and Effectiveness Group (CSEG) and Patient Quality and Safety Outcomes Committee (PQSOC)	
10	NCEPOD - Twist and Shout - Testicular Torsion
11	Paediatric Asthma - Breathing well - An assessment of respiratory care in England and Wales
12	NCEPOD - Endometriosis: A Long and Painful Road - A review of the quality of care provided to adult patients diagnosed with endometriosis
13	NELA - Ninth Patient Report of the National Emergency Laparotomy Audit - December 2021 to March 2023
14	National Ovarian Cancer Audit - State of the Nation Report 2024 - An audit of care received by women diagnosed with ovarian cancer in England in 2021 and in Wales in 2022
15	National Neonatal Audit Programme (NNAP) - Summary report on 2023 data
16	National Audit of Primary Breast Cancer - State of the Nation Report 2024 An audit of care received by people diagnosed with primary breast cancer in England and Wales during 2019-2021
17	National Audit of Metastatic Breast Cancer (MBC) - State of the Nation Report 2024 - An audit of care received by people diagnosed with metastatic breast cancer in England and Wales during 2019-2021
18	National Hip Fracture Database (NHFD) - A broken hip – three steps to recovery, a report on using

Audits Presented to Clinical Standards and Effectiveness Group (CSEG) and Patient Quality and Safety Outcomes Committee (PQSOC)	
19	National Hip Fracture Database (NHFD) - A broken hip – three steps to recovery, a report on using the National Hip Fracture Database (NHFD)
20	National Pancreatic Cancer Audit State of the Nation Report 2024
21	National Oesophago-Gastric Cancer Audit (NOGCA) - State of the Nation Report - Data collection period: 1 April 2021 – 31 March 2023
22	National Bowel Cancer Audit - State of the Nation Report - An audit of care received by people with bowel cancer in England and Wales focusing on people diagnosed between 1 April 2022 and 31 March 2023.
23	National Vascular Registry 2024 - State of the Nation Report - Results for people who had vascular procedures during 2023 in NHS hospitals in England, Wales, Scotland and Northern Ireland.
24	National Audit of Dementia - Care in General Hospitals 2023-24: Round 6 Audit Report
25	Fracture Liaison Service Database (FLS-DB) Annual report - You've had a fracture; how can we prevent another? Data from 1 January 2023 – 31 December 2023
26	Epilepsy12 - 2024 combined organisational and clinical audits: Report for England and Wales. Cohort 5 – The first year of care for children and young people after a first paediatric assessment between 1 Dec 2021 and 30 Nov 2022
27	Audit Title: National Early Inflammatory Arthritis Audit (NEIAA) State of the Nation Summary Report 2024 - Data Collection Period: 1 April 2023 – 31 March 2024 Year 6
28	National Pregnancy in Diabetes Audit Dashboard 2023 (01 January 2021 to 31 December 2023)

Audit Title:	National Oesophago-Gastric Cancer (NOGCA) Audit State of the Nation Report Data -1 Apr 2020 – 31 Mar 2022 Published January 2024	Clinical Lead: Miss Tamsin Boyce, Consultant, Surgery
Rationale:	NOGCA is commissioned by Healthcare Quality Improvement Partnership (HQIP) as part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP).	
Objectives:	It aims to promote quality improvement in patient outcomes, and to increase the impact that clinical audit, outcome review programmes and registries have on healthcare quality in England and Wales.	

Presented at Clinical Standards and Effectiveness Group 23rd May 2024

Upper GI cancer treatment is not delivered in ABUHB. Treatment centralised within Cardiff and Vale UHB (CVUHB). Radiotherapy undertaken at Velindre Cancer Centre (VCC). The Health Board is only responsible for the front end of the patient pathway. Referral to Treatment times (RTT) has increased over the last 10 years due to improved staging and diagnostics as well as an increase in demand.

	ABUHB	National
Patients diagnosed after an emergency admission (lowest rate in Wales SBUHB 20.4% & CVUHB 21.6%)	14.1%	13.1%
% of patients who waited >62 days form urgent referral to 1st treatment	83.3%	
Patients having a treatment plan for curative treatment	32.4%	37.2%
Patients having a treatment plan for non-curative treatment	67.6%	62.8%
Patients with non-curative plans having chemotherapy or radiotherapy	42.8%	34.7%

100% of ABUHB patients completed Radiotherapy

Key Success and Concerns

Report Successes:	
1	Doing well with CT Staging, (96.9%) higher than the national rate.
2	Of the patients with a plan for non-curative treatment, 42.8% are having chemotherapy or radiotherapy, nationally this is 34.7%.
3	With higher diagnosis rate in the Health Board compared to the rest of Wales, the Health Board maintained face to face contacts and MDT's during the pandemic.
4	Lower rates of diagnosis after emergency admissions than other organisations across Wales, although not as good at the UK national rate. ABUHB 14.1% v National 13.1%.
5	Straight To Test endoscopy CT scans done same day if applicable.

Report Concerns:	
1	Lower rates of patients having a plan for curative treatment than the national rate, the Health Board being 32.4% and nationally 37.2%.
2	The Health Board has a lower rate for patients having a plan for non-curative treatment at 67.6% compared to nationally 62.8%
3	Increase in RTT 62-day measure, form 80 days in 201/-2020 to 82.5% in 2020/2022.

Assurance Level

Limited - The project did not achieve the standards or criteria being audited against

Risk Level

Major - Non-compliance with national standards/Significant risk to patients if unresolved

Not on Risk Register within the Health Board as much of the pathway is outside of the Health Boards control - Upper GI cancer treatment delivered in CVUHB and radiotherapy in VCC.

	Report Recommendations:	S.M.A.R.T Actions: Responsible: Due Date: Progress:
1	Cancer Alliances and Wales Cancer Network should review patient pathways in their region to identify opportunities to intervene and reduce high and variable rates of diagnosis following emergency admission and late-stage diagnosis. *Action by*: Cancer Pathway Boards, Cancer Alliances, Welsh Health Boards, Wales Cancer Network	Ongoing work across Wales (National Optimal Pathway) to reduce late-stage diagnosis.
2	Review oesophago-gastric (OG) cancer care pathways against best practice guidance to identify ways to reduce the proportion of patients with OG cancer waiting more than 62 days from urgent referral to first treatment. *Action by*: Cancer Pathway Boards, Cancer Alliances, Welsh Health Boards, Wales Cancer Network	Ongoing work with National Optimal Pathway. Update to Service Level Agreement (SLA) in progress and obtain 2022/2023 data to see accurate performance
3	Explore reasons for non-completion of palliative chemotherapy regimens, including review of patients with OG cancer who died within 90 days of starting treatment, and review patient selection for palliative chemotherapy where appropriate. Action by: Cancer Pathway Boards, Cancer Alliances, Welsh Health Boards, Wales Cancer Network	Specialist OG dietician already present in clinic, there is definitely the workload for further input, there is also OG Dietetic cover in the MDT.
4	Given the often profound impact of OG cancer on patients' nutritional status, Cancer Alliances and Wales Cancer Network should review specialist dietetic provision across their region, and ensure OG cancer units are resourced according to national specifications to ensure that all patients have access to appropriate dietetic input. *Action by*: Cancer Pathway Boards, Cancer Alliances, Welsh Health Boards, Wales Cancer Network	Specialist OG dietician already present in clinic, there is definitely the workload for further input, there is also OG Dietetic cover in the MDT.
5	In Cancer Alliances with low rates of active treatment for high-grade dysplasia (HGD), review reasons for non-treatment and determine if more patients with HGD could be eligible for endoscopic therapy Action by: Cancer Alliances	Numbers are so small it is difficult provide a comment. There have been issues, 2 patients delayed pathways for HGD due to uncertainties regarding funding. This is delivered by Cardiff and not specifically covered in the SLA. This caused delays in treatment resulting in more advanced disease at treatment. This has since improved, and processes are less complicated and protracted. Long term funding and workforce remains fragile.

Audit Title:	State of the Nation Report 2024 An audit of care received by patients diagnosed with Lung Cancer in England and Wales during 2022 National Lung Cancer Audit (NLCA)	Clinical Lead: Dr Mat Jones Medical Consultant
Rationale:	Aim of NLCA is to evaluate the patterns of care and outcomes for patients with lung cancer in England and Wales. To support services to improve the quality of care for these patients.	
Objectives:	Management of patients with lung cancer is informed by various national guidelines. The NLCA evaluates current patterns of care against standards. These standards were defined in publications from: The National Institute for Health and Care Excellence (NICE) QS17, Roy Castle Lung Cancer Foundation's national commissioning guidance, the National Optimal Lung Cancer Pathway and the 2022 "Getting it Right First Time" (GIRFT) report. The NLCA has developed a set of indicators to reflect these and encourages healthcare professionals to review the findings of this report and to understand why unwarranted differences in practice exist.	
Presented at Clinical Standards and Effectiveness Group – 23rd May 2024		

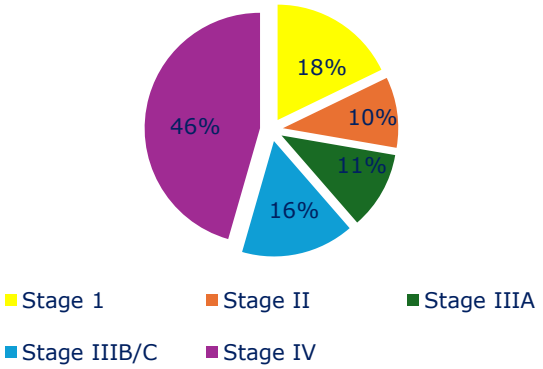
The Health Board has the largest number of patients with 100% data quality on key data items:

- 100% for basis of diagnosis,
- 100% for tumour morphology,
- 100% for disease stage, and
- 100% for performance status.
- 100% of records had data on whether a lung cancer nurse specialist was present at diagnosis.

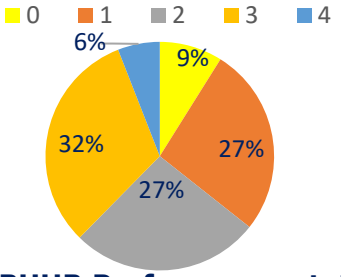
There are two cohorts: a) Small Cell Cancer – 12%, b) Non-Small Cell Lung Cancer (NSCLC) – 88%. There are 5 stages of disease:

- Stage I – 18%
- Stage II – 10%
- Stage III – 27%
- Stage IV – 46%

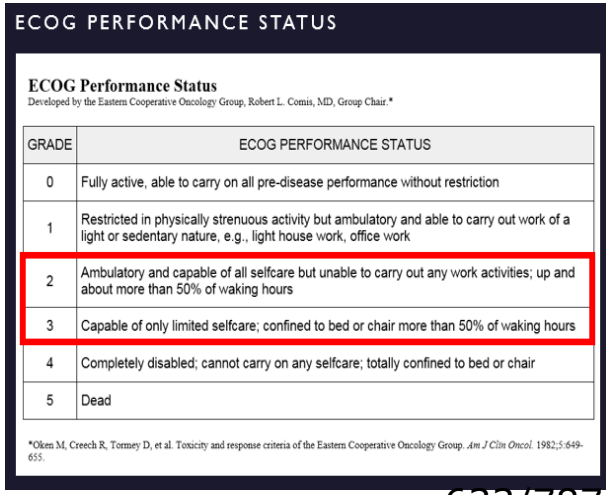
Unfortunately, the highest numbers are in the late stage of lung cancer disease due to late presentation or being asymptomatic at the time of detection.



There are 4 Performance Status (PS) levels, which is based on patients' daily capabilities from independent to bed bound. Low numbers present with a low PS.



ABUHB Performance status (per cent of known values)



ECOG PERFORMANCE STATUS

ECOG Performance Status

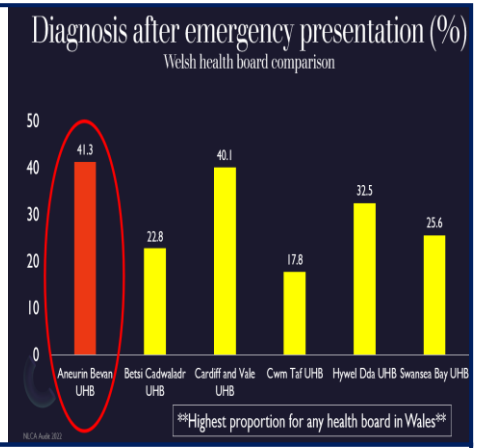
Developed by the Eastern Cooperative Oncology Group, Robert L. Comis, MD, Group Chair.*

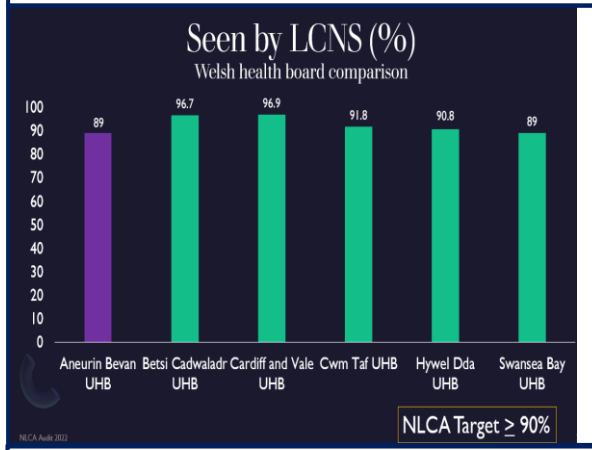
GRADE	ECOG PERFORMANCE STATUS
0	Fully active, able to carry on all pre-disease performance without restriction
1	Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work
2	Ambulatory and capable of all selfcare but unable to carry out any work activities; up and about more than 50% of waking hours
3	Capable of only limited selfcare; confined to bed or chair more than 50% of waking hours
4	Completely disabled; cannot carry on any selfcare; totally confined to bed or chair
5	Dead

*Oken M, Creech R, Tormey D, et al. Toxicity and response criteria of the Eastern Cooperative Oncology Group. *Am J Clin Oncol.* 1982;5:649-655.

- The Health Board has a lower proportion of PS 0/1 compared to All Wales data, above the average proportion of patient in PS 3 & 4, 38% compared to 35.3%. These are not often suitable for curative treatments and more suited to palliative management as have higher rates of co-morbidities with increased risk of side effects from treatments. This ultimately impacts the HB treatment rates. PS 2 for the Health Board is 27% compared to Wales mean of 23.5%.
- Patients with Stage I/II with PS 0-1 - Confirmed pathological staging NLCA target is >90% within the Health Board was 89.4% (74.5% in 2021) compared to a Wales mean of 89.1%.
- NSCLC patients having surgical resection NLCA target > 17%, the Health Board 15.5% (adjusted for co-morbidities and deprivation), increased from 10.9 & in 2021 and above the Wales mean of 14.3%. In NHS England this is around 18% due in part to increased diagnosis at the early stage through lung cancer screening which is not yet carried out across Wales outside of a pilot Lung Health Check in CTUHB. Ambitions should be to achieve 20%.
- NSCLC patients Stage I/II with PS 0-2 having curative treatment is not always possible due to many factors. These include patient choice, co-morbidities, deterioration during investigation and factors relating to the tumour. The NLCA target >80%, the Health Board rate is 77.9% and improved from 2021 (66.7%) and higher than the Wales mean of 75.8%.
- For SCLC (more aggressive tumours) patients having chemotherapy ,the Health Board treatment rate was 50% in 2021 and in 2022 increased to 61.7% compared to Wales mean of 71.2%. The NCLA target is set at >70%. The Health Board had a high proportion of patients, 47 in total, which was 12% of our whole cohort who presented with small cell cancer. This is a higher-than-average proportion, and these patients are very challenging, often very co-morbid and often present through hospital and emergency settings.
- For NSCLC patients Stage IIIA with PS 0-2 (more advanced disease associated with further spread to Lymph Nodes) the Health Board is pushing boundaries with regards to cancer management. For those achieving curative treatment in this group, the Wales mean is 59.3% with the Health Board achieving 57.1% in 2022 compared to 31.7% in 2021, possibly linked to the pandemic and restriction in treatments during that time.
- NSCLC patients Stage IIIB/IV with PS 0-1 (advanced disease spread to outside the lung) having Systemic anti-cancer treatments (SACT) improved from 2021 rate of 56.6% to 57.8% in 2022 with a Wales mean of 61.8%. This suggests that people are potentially being missed due to challenges such as pathology waiting times and being reliant upon oncology services outside of the Health Board.

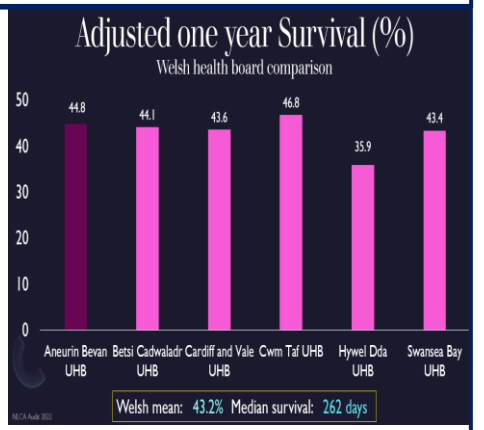
The Health Board has the highest proportion of diagnosis after emergency presentation across Wales with 41.3% presenting in this way, which was interesting compared to the emergency admission rate for NOGCA. However, lung cancer patients generally present with a higher bulk of disease, more co-morbidities, advanced age and poorer PS status when they present in this way. In England, emergency presentations are reduced due to the screening programme. Last year's data was low at 6.3%, but the data was inaccurate and since then the data recording has been managed carefully to ensure the data was robust this year.





The NCLA target for patients being seen by a Lung Cancer Nurse Specialist (LCNS) is 90% and the Health Board is at 89%. This is an improvement on the previous year's data however this is impacted upon by patients presenting as an emergency. This is being addressed to try and bring LCNS into seeing inpatients, to support patients and aid decision making, as the LCNS are pivotal in the management of lung cancer patients and without them the service would not be able to run efficiently. There are plans to develop the LCNS roles going forward.

Looking at how all this impacts patient survival, we know that lung cancer outcomes have been poor in recent years, and with developments in detection and treatments, survival rates have increased. In the Health Board although 1 year survival is still low at 44.8% it is above the Welsh mean at 43.2%, second only to Cwm Taf UHB who do have a screening programme at pilot stage, which may be impacting on survival outcomes. The Welsh median survival in days is 262 which is less than England 327 potentially due to the emergence of screening and reduced deprivation indices as a whole. The chart demonstrates the survival associated with disease stage, highlighting the importance of early detection.



Successes
Introduction of Physician of the week to prioritise lung cancer patients
Improved curative rates for early-stage disease and excellent pathological confirmation rates for early-stage disease and good PS.
More patients with SCLC having chemotherapy
Large increase from 31.7% to 57.1% of NSCLC with stage IIIA and PS 0-2 receiving curative treatment.
Lung Cancer Nurse Specialist input very good with plans to seen inpatients.
Adjusted one year survival rate is second best in Wales at 44.8%.

Concerns
Below target treatment rates for surgical resection in NSCLC, SCLC chemotherapy and NSCLC advanced stage good PS treated with SACT (but all improved from 2021). Concerning numbers presenting as emergency admissions.
Many of the HB patients have high PS and present with advance disease making curative treatment less viable.
Surgical resection rates are under target, although have improved since 202, under the 17% target set by NLCA.
High rate of emergency presentations (41.3%).

Key Messages ABUHB compared to Wales	Wales (n=2211)	ABUHB (n=400)
Curative treatment rates of NSCLC patients with stage I/II and good performance status (0-2)	76.2%	77.9% ↑
Curative treatment rates of NSCLC patients with stage IIIA and good performance status (0-2)	61.2%	57.1% ↓
Surgical resection rate (adjusted) for patients with NSCLC	14.3%	15.5% ↑
Proportion of patients with lung cancer diagnosed after an emergency presentation	29.4%	41.3% ↑
Proportion of patients seen by a Lung Cancer Nurse Specialist	92.4%	89% ↓
Use of systemic anti-cancer therapy for stage IIIB/IIIC–IV NSCLC patients (PS 0–1)	60.1%	57.8% ↓

Conclusions

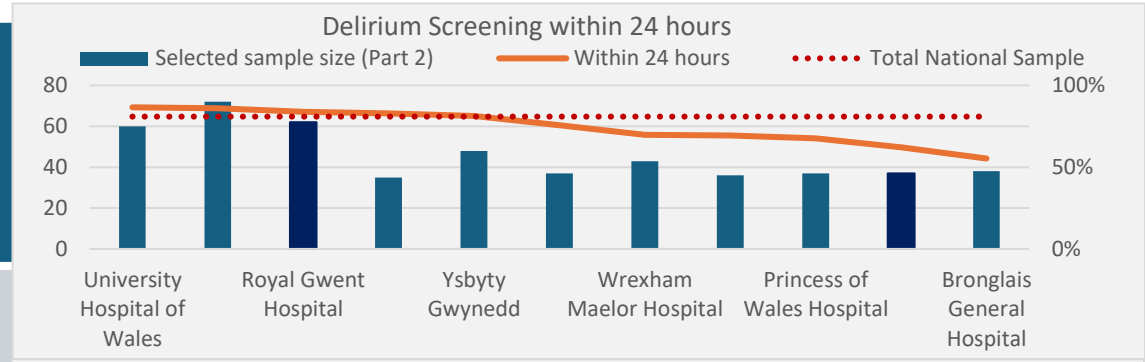
- The ABUHB lung cancer service diagnoses 400 cases of lung cancer per annum [>1 per day]
- The service also deals with abnormal imaging, large numbers of suspected malignancy and metastatic disease
- It is an expanding service with ever changing challenges including a population with severe co-morbidities/ frailty
- Improving indices compared to 2021 data
  - Better curative rates for early-stage disease
  - Excellent confirmation pathological confirmation rates for early stage, good performance status (PS)
- Below target treatment rates for surgical resection in NSCLC, SCLC chemotherapy and NSCLC advanced stage good PS treated with SACT (*but all improved from 2021)*
- Concerning number presenting as emergency admissions – more advanced disease, frailty

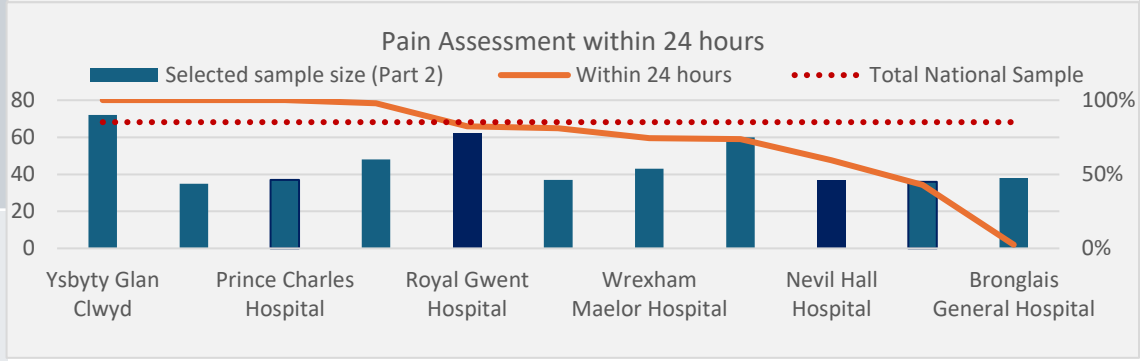
	Report Recommendations:	Progress:
1	Ensure services are implementing targeted lung cancer screening for people aged 55 to 74 who are at high risk of lung cancer.	Lung Health Check Pilots No imminent HB plans
2	Ensure providers have thoracic surgery capacity to meet both current demand for curative surgery and to accommodate the increase in activity caused by the national rollout of the Targeted Lung Health Check programme. Wales: 14% of NSCLC patients diagnosed in 2022 had a lung resection, compared with 16% in 2019	Surgical resection rate below NLCA target No issues with access – but waiting times >4 weeks
3	Ensure NHS hospitals have the necessary resources and capacity (1) to reduce the proportion of patients waiting more than 21 days from diagnosis to first treatment, and (2) for biomarker testing and the timely delivery of results for patients considered for systemic anti-cancer therapy (SACT) Wales: For patients with stage IV NSCLC, the median time from diagnosis to SACT was 52 days (47 days in 2021). For patients with SCLC, the median was 21 days (16 days in 2021).	Ongoing oncology and surgical delays Improved pathological services – PD-L1 in-house from next month, QuicDNA ctDNA project pioneers
4	Ensure at least 70% of patients with NSCLC stage IIIB-IVB and PS 0-1 receive systemic anti-cancer therapy (SACT) in line with NICE guidance. Wales: 60% of patients with NSCLC stage IIIB-IVB and PS 0-1 had SACT, increased from 57% in 2021 - ABUHB: 57.8%	SACT for advanced stage disease below NLCA target Complex patients, frail, multi-morbidity, patient choice
5	Aim to achieve high levels of data completeness in the cancer registration datasets, particularly the Rapid Cancer Registration Dataset and Cancer Outcome and Services Dataset (COSD) in England. Wales: Completeness of data was excellent overall, 98-100%, in key data items (97-100% in 2021)	The only Data Quality measure that the Health Board is not meeting is Morphology (all Patients) 69% Likely transposition error – rates of NSCLC not specified (NOS) remains small

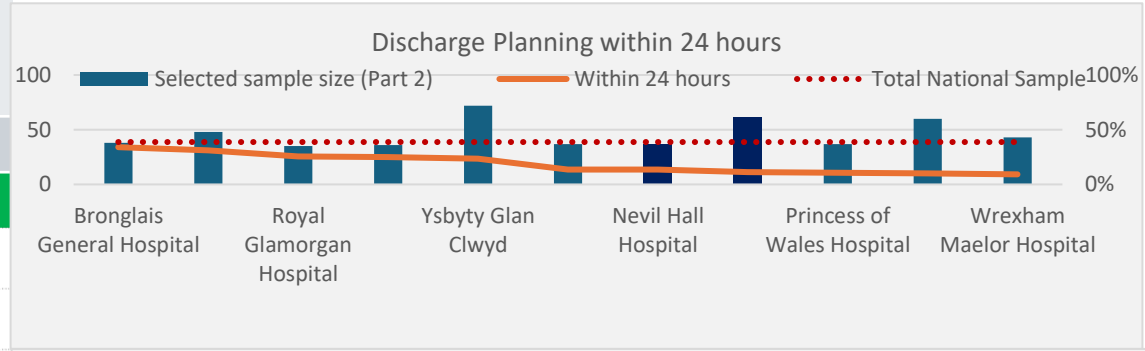
Audit Title:	National Audit of Dementia (NAD) Care in General Hospitals 2022-2023 Round 5 Audit Report **Published August 2023**	**Clinical Lead: Dr Inder Singh** **Site Leads:** **Dr Sheriff (RGH)** **Dr Subhan (YYF)** **Dr Adel (NNH)**
Rationale:	Report presents results of the 5th round of the NAD. Improving dementia care remains a key national priority for health services in England and Wales, highlighted in the Prime Ministers Challenge on Dementia 2022 and the Welsh Government Dementia Action Plan. An extremely high proportion (92%) of eligible hospitals participated in this important audit once again. For the first time the audit was undertaken prospectively, enabling hospitals to take earlier action to improve patient care and experience.	
Objectives:	NAD measures the performance of general hospitals in England and Wales against standards relating to care delivery which are known to impact people with dementia while in hospital. Standards include NICE Quality Standards and guidance, the Dementia Friendly Hospitals Charter, and reports from the Alzheimer's Society, Age Concern and Royal Colleges. Standards are updated for every round of audit.	

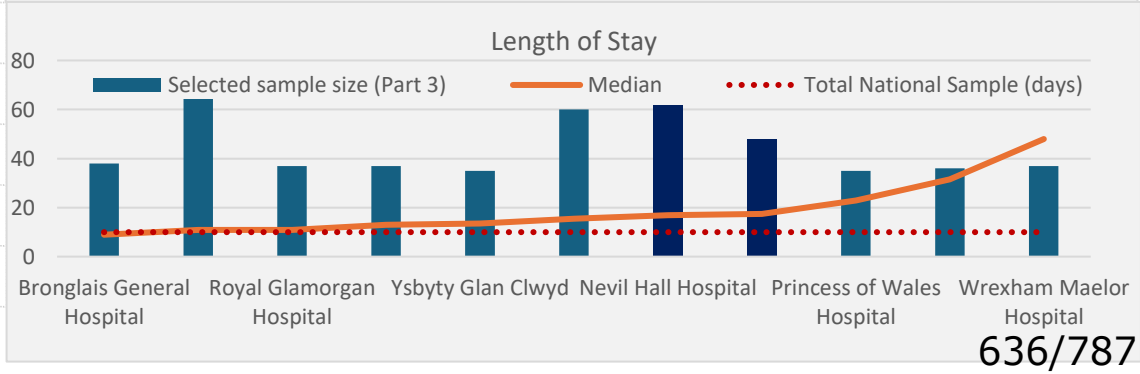
Presented at Clinical Standards and Effectiveness Group – 23rd May 2024.

Key Metrics National Round 5	National	RGH	NHH	YYF
% Delirium screen (inc. noted on admission)	87%	98%	70%	94%
% Pain assessment	92%	100%	69%	82%
% Pain reassessment	92%	100%	59%	22%
% Pain tool – question only	61%	0%	100%	100%
% Initiation of discharge plan in first 24 hours*	45%	11%	14%	19%
Carer rating overall care quality	66%	100%	75%	85%
Carer rating communication	60%	67%	72%	88%

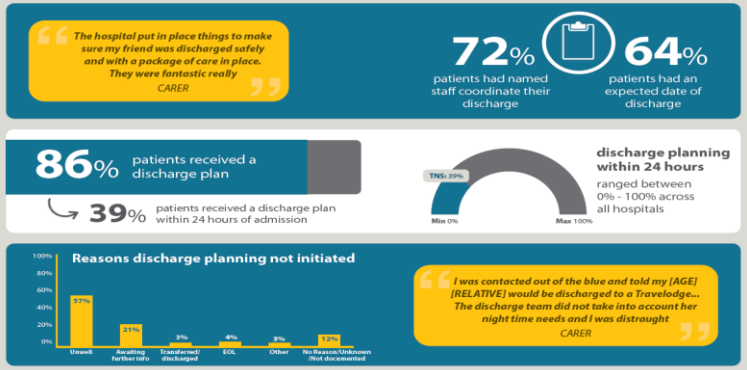








Discharge Planning



Discharge Information

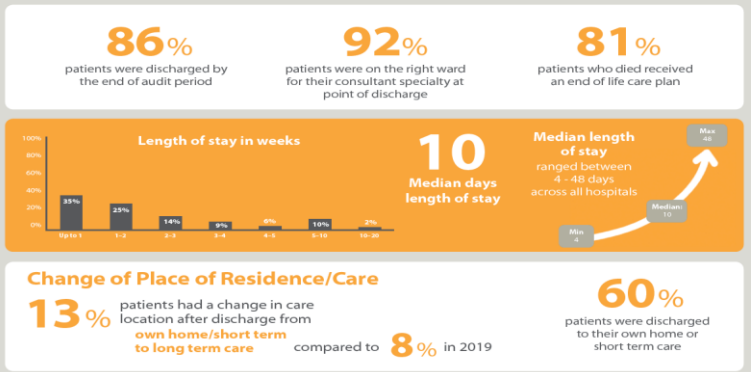
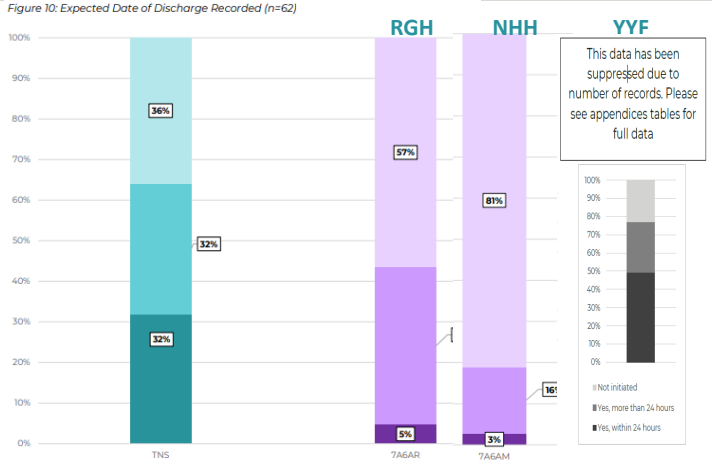
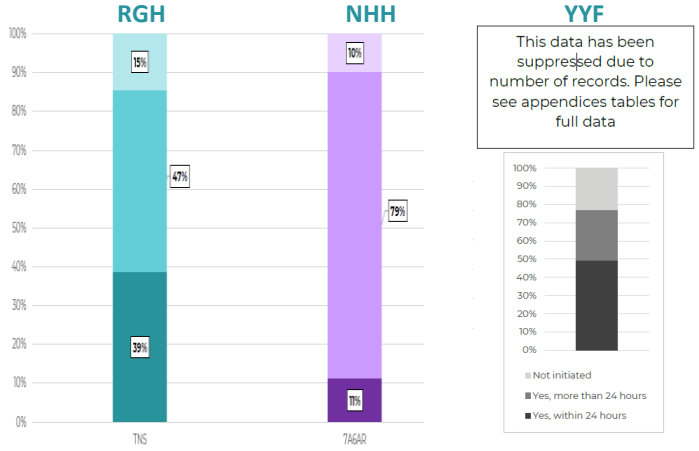


Figure 10: Expected Date of Discharge Recorded (n=62)





Assurance level	
Limited	The project did not achieve the standards or criteria being audited against

Risk level	
Moderate	Repeated failure to meet internal standards/Major patient safety implications if findings are not acted on

Not in risk register as actions and improvement work remain ongoing

Discharge Information RGH

National R5 Median Length of Stay (days):	7A6AR R5 Median Length of Stay (days):
10	17

National R5 Patients discharged by end of audit period:	7A6AR R5 Patients discharged by end of audit period:
86.4%	88.7%

National R5 Patients were on the right ward:	7A6AR R5 Patients were on the right ward:	National R5 Patients who received an end of life care plan:	7A6AR R5 Patients who received an end of life care plan:
92.5%	88.7%	80.6%	100%

NB. EOL care plan information was only collected for patients who died during admission

Discharge Information NHH

National R5 Median Length of Stay (days):	7A6AM R5 Median Length of Stay (days):
10	13

National R5 Patients discharged by end of audit period:	7A6AM R5 Patients discharged by end of audit period:
86.4%	45.9%

National R5 Patients were on the right ward:	7A6AM R5 Patients were on the right ward:	National R5 Patients who received an end of life care plan:	7A6AM R5 Patients who received an end of life care plan:
92.5%	100%	80.6%	83.3%

NB. EOL care plan information was only collected for patients who died during admission

Discharge Information YYF

National R5 Median Length of Stay (days):	7A6AV R5 Median Length of Stay (days):
10	33

National R5 Patients discharged by end of audit period:	7A6AV R5 Patients discharged by end of audit period:
86.4%	64.3%

National R5 Patients were on the right ward:	7A6AV R5 Patients were on the right ward:	National R5 Patients who received an end of life care plan:	7A6AV R5 Patients who received an end of life care plan:
92.5%	100%	80.6%	66.7%

NB. EOL care plan information was only collected for patients who died during admission

Report Successes:	
1	Pain Assessment and re-assessment in RGH at 100% and YYF pain assessment 82%
2	Delirium Screening noted on admission - RGH 98% and YYF 94% compared to national 87%

Report Concerns:	
1	Expected discharge date (EDD) - RGH - 5% within 24 hours, 39% more than 24 hours, 57% initiated NHH - 3% within 24 hours, 16% more than 24 hours, 81% not Initiated - difficulties with EDD due to patient complexities and delays in social measures YYF - not enough data to analysis
2	Pain Assessment NHH 69% (outlier notification received for NHH data)
3	Lack of use of the Abbey Pain Score tool
4	Discharge planning not carried out within 24 hours for RGH and not completed in NHH - lack of data for YYF
5	Length of Stay median: RGH 17 days, NHH 13 days, YYF 33 days
6	Pain re-assessment for YYF 22%
7	Delirium Screening NHH - 70%

Clinical Leads Local Recommendations: (if applicable)		S.M.A.R.T Actions:	Responsible:	Due Date:	•Progress:
Carer feedback	Improve Carer questionnaire completion across the HB	Use the teams currently across the wards (volunteers, PALS etc.) to encourage the carers to complete the questionnaire	Sonya Foley	31/03/2024	
End of Life	End of life care for patients with Dementia	Regular teaching sessions for doctors and nurses across all sites, by palliative care team – Dr Subhan has discussed this option with Palliative Care Consultant. Palliative care team is interested to provide this focused teaching as part of their palliative care teaching	Dr Subhan	31/03/2024	Ongoing

Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date/Progress:
1	**Integrated Care Boards/Welsh Government should seek assurance from Trusts/Health Boards regarding their actions and progress with recommendation one.**	Reported to Clinical Standards and Effectiveness Group and Patient Quality and Safety Group	Dr Inder Singh	Ongoing
2	**<u>Comprehensive pain assessment</u>** **The National Report recommends the Medical Director and Chief Nurse should ensure that staff are trained and supported in the use of appropriate tools for comprehensive pain assessment (e.g. e-lfh Pain Management Programme)** **This should include:** • Understanding the need for structured pain assessment. • How pain interacts with symptoms of dementia, and that people with dementia may not articulate pain. • The regular use of an appropriate pain tool for assessing people with dementia on the ward.	Need to introduce and improve structure pain assessment across HB sites (use of the ABBEY if clinically indicated) Link with Education team to review current training	Dr Inder Singh, Sue Pearce (Divisional Nurse), Amanda Whent	Ongoing

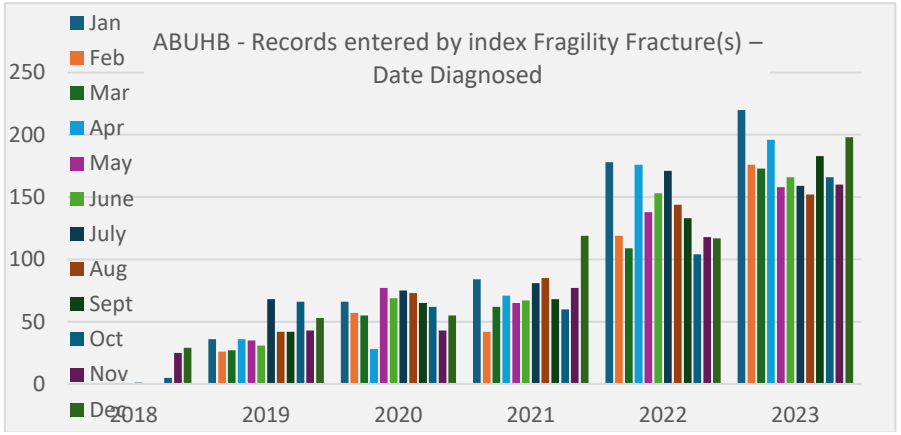
Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
3	The Chief Executive Officer should ensure that the Trust/Health Board has a nominated Board member responsible for dementia in addition to the clinical lead, whose responsibilities will include: • Establishing and implementing hospital systems capable of 1) identifying people with dementia admitted to the hospital and 2) showing the proportion of people with dementia affected by falls, delayed discharges, readmissions, pressure ulcers and incidents of violence/aggression, so that accurate figures may be supplied to NHS England Emergency Dashboard and other national dashboards. • Monitoring the proportion of ward-based staff who have received Tier 2 level training in dementia, and assessing the impact this has on quality of care, as experienced by patients and carers. • Scrutinising feedback from patients and carers and reports of NAD. • Tabling the Trust/Board Annual Dementia Statement for review. • Providing regular reports to the Integrated Care Board/Welsh Government relating to the appropriate governance and monitoring of care of people with dementia. • Developing action plans based on areas identified for improvement in care and patient experience, including ensuring that personal information about their care preferences and needs has been gathered and is available at the bedside; regular review of the environment against "Dementia Friendly" criteria using a standardised tool (e.g. Enhancing the Healing Environment, The King's Fund (kingsfund.org.uk); Patient-Led Assessments of the Care Environment (PLACE) – NHS Digital)	Dementia alert on CWS in practice and currently linking with Improvement Cymru in establishing a benchmark (once achieved CL will be establishing other metrics inc. IP Falls) Dementia training and awareness is ongoing. Good Work Learning and Development Framework level 1. • Informed level 86% on ESR • Skilled level bi-annual reporting to WG • Influencer level presenting on boards, meetings and conferences Feedback review is led by Sue Pearce. Dr Singh and Amanda Whent report to the Board Dementia care plan and environment – Sue Pearce and Amanda Whent	Dr Inder Singh – Clinical Lead Amanda Whent – Dementia Lead Nurse Sue Pearce – Senior Divisional Nurse	6 months	All ongoing

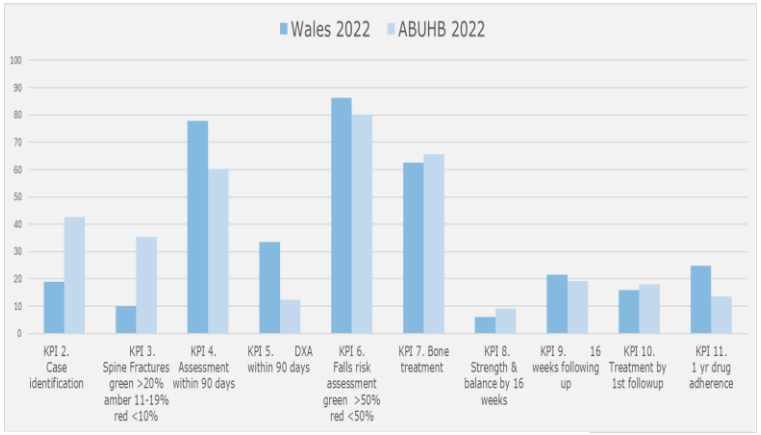
Clinical Leads Local Recommendations: (if applicable)		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
Dementia alert	To promote the use of dementia alert (136) in Welsh PAS (Myrddin)	• Promote Ward Clerks entering the Dementia Code (136) into WPAS	• Sue Pearce	31/08/2024	Ongoing
Delirium screening and care plan	ABUHB - Quarterly point prevalence audit for the duration of 1 week on assessed for Delirium screening on patient with Dementia	• To provide LoS on the Delirium Audit carried out quarterly	• Dr Singh	31/08/2024	Ongoing
		• Review the if diagnosis of delirium also have dementia and assess for:- EDD was established, DC planning commenced within 24 hrs, and time (total number of days) away from home.	• Dr Singh	31/08/2024	Ongoing
	Improve nursing attendance and engagement with Delirium training – SQID, 4AT	• Continuing with Delirium teaching every 8 weeks (led by Dr Z Subhan) – target audience doctors, staff nurses, HCSW	• Kertrina Collins, Natalie Webb, Helen Price	31/08/2024	Ongoing
		• Involve senior nurses for individual sites to encourage nurse attendance	• Dr Subhan	31/08/2024	Ongoing
		• To deliver focused delirium teaching (SQID) in the ward settings – Dr Subhan to explore this with senior nurses	• Dr Subhan	31/08/2024	Ongoing
	Measure the outcome of Delirium teaching and training	• Encourage Delirium Champions from each ward in YYF, who will help with the teaching and training for the nurses	• Dr Subhan	31/08/2024	Ongoing
		• A QIP on Delirium Time Bundle has already commenced – to complete the first cycle and present the result to the stakeholders			
		• Delirium training attendance certificate to help with re validation - using AMaT certificate function	• Joanne Stimpson	Ongoing	Ongoing
	Measure the outcome of Delirium teaching and training Improving assessment of delirium in hospital and communication of diagnosis to all teams/carers	• Compliance of recording delirium diagnosis on quarterly basis using IT (WPAS) - link with Kathleen Hyde.	• Joanne Stimpson	Ongoing	Ongoing

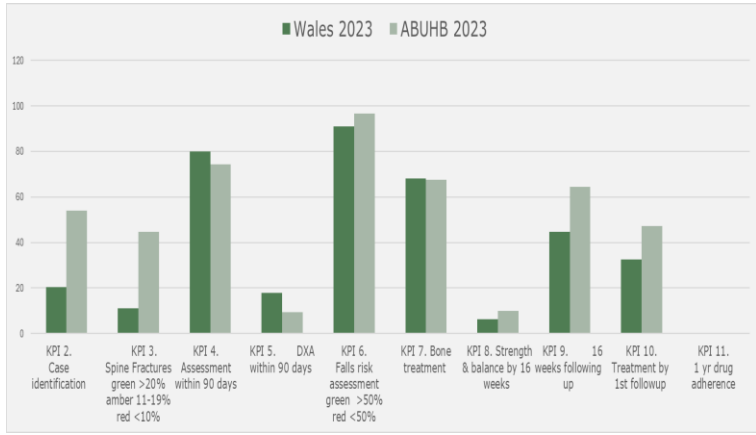
Clinical Leads Local Recommendations: (if applicable)		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
Pain assessment/ Re-assessment	Quarterly one day Audit all patients who scored on pain assessment	• Proportion of patients who had dementia to be assessed for pain using a recommended ABBEY pain scales	• Dr Singh	31/10/2024	Ongoing
	Improve pain assessment and re-assessment	• Training and teaching of Abbey Pain score for nurses Dr Subhan has already discussed this with Palliative care Consultant, Dr Patten. Dr Patten has agreed to deliver this training with the help of Palliative care CNS. Dr Patten to discuss with her CNS and update Dr Subhan	• Dr Subhan/Dr Patten	31/03/2024	Ongoing
		• To continue with pain assessment using Care Flow question only assessment	• Dr Subhan/ Dr Adel	31/03/2024	Ongoing
		• After standard clinical assessment and pain score assessment should be used for patient who cannot communicate pain - has been Further work needed to decide on what pain score screening tool is going to be used across the HB - to ensure continuity.	• Dr Singh	31/03/2024	Ongoing
Dementia training	Look at compliance figures on ESR for mandatory All Wales dementia module by site.	• To be looked at in the senior nurse monthly/cross divisional nurse meetings to see if this is beneficial information	• Sue Pearce	31/03/2024	Ongoing
Discharge planning/EDD	Improve compliance in completing the Estimated Discharge Date (EDD)	• DISCHARGE PLANNING TO BE COMMENCED IN 80% OF PATIENTS WITHIN 24 HOURS - to prevent de-conditioning in the hospital (goal 5 and goal 6). To encourage all staff to agree EDD in the post take round/MAU board rounds. Discharge coordinators/ward managers to take the initiative in putting an EDD for every patient during board rounds. This should also be discussed in the weekly MDT.	• Dr Subhan/Dr Adel/Dr Sheriff	31/03/2024	Ongoing
	Look at HB LoS wide rather than episode	• Compare LoS from episode to HB LoS	• Dr Singh	31/04/2024	Ongoing

Audit Title:	Annual report – Improved Fracture Liaison Service (FLS) identification with gaps in monitoring: a call to action for national and regional planners Data - Jan 2022 to 31 Dec 2022 Published - Feb 2024	Clinical Lead: Dr Inder Singh
Rationale:	FLS ensures that patients aged 50 and over who sustain a broken bone after a fall have their bone health and falls risk checked and managed to lower their risk of a subsequent fracture. The FLS is made up of a team of healthcare professionals led by a Clinical Lead who liaise with wider teams to provide bone health care plan. FLSs bring clear benefits to the patient and the system in the long term and have been shown to be clinically and cost-effective.	
Objectives:	Fractures after a fall from standing height or less in adults aged 50 years and over often indicate osteoporosis and increased falls risk. Without urgent management, the risk of serious fractures due to osteoporosis will increase. Fracture liaison services (FLSs) deliver secondary fracture prevention using clear pathways to identify those with potential osteoporotic fractures, deliver systematic assessment, treatment recommendations in line with national guidelines, and monitoring to ensure recommendations are initiated and adhered to. The delivery of this pathway is mapped across key performance indicators (KPI) to support local FLSs to check and improve their local services.	
Presented at Clinical Standards and Effectiveness Group – 23rd May 2024		

The Health Board has improved on all but one KPI from 2022 to 2023 with two of the KPI's moving up into the higher metric grouping:	
KPI 2	Case Identification has increased from 22.6% in 2021 to 42.6% in 2022 with a further increase in 2023 to 54.1%, and from 2022 to 2023 increased from red into amber and is performing better than Wales and National average.
KPI 3	Spine Fractures metric is >20% is green, and in 2021 was 26.1%, in 2022 the increased to 35.4% and a further increase in 2023 to 44.6%
KPI 4	Assessment within 90 days has increased from 21.3% and red in 2021 to 60.3% and amber in 2023 remained amber but increased to 74.2% and although worse than the Wales average is better than the National average
KPI 5	Dexa scan with 90 days was 23.3% in 2021, this decreased in 2022 to 12.4% and a further decrease in 2023 to 9.4%
KPI 6	Falls risk assessment was 34.7% in 20021 however significantly increased to 80.2% in 2022 and a further increase in 2023 to 96.6%, this measure green if over 50%
KPI 7	Bone treatment has a lesser growth although all years are in the green at 57.7% in 2021, 65.7% in 2022 and 67.5% in 2023
KPI 8	Strength and balance by 16 weeks is red for all years at 4.8% in 2021 and 9.1% in 2022 and 10% in 2023 which is increasing and is performance better than the Wales and National average
KPI 9	16 week follow up have significantly improved from 1.4% in 2021 to 19.1% in 2022 and a significant increase to 64.4% in 2023 and performing considerably better than the Wales and National averages
KPI 10	Treatment by 1st Follow up although remains in the red, the performance has increased from 8.3% to 18.1% to 47.3%
KPI 11	1 Year drug adherence for 2022 the Health Board is under performing compared to the Wales and National average at 13.6%. No comparison data for 2023 is available to date







National, Wales and ABUHB data for all KPI's for 2021, 2022 & 2023

green as 80% amber as 50-79% red as <50%		KPI 2. Case identification	KPI 3. Spine Fractures green >20% amber 11-19% red <10%	KPI 4. Assessment within 90 days	KPI 5. DXA within 90 days	KPI 6. Falls risk assessment green >50% red <50%	KPI 7. Bone treatment	KPI 8. Strength & balance by 16 weeks	KPI 9. 16 weeks following up	KPI 10. Treatment by 1st followup	KPI 11. 1 yr drug adherence
National Average 2023	68341	34.7	23	65.5	31.7	61.7	56.9	7.8	28.6	29.2	Not applicable
National Average 2022	80015	40.6	22.5	63.2	29.2	62	56.6	6.8	27.1	28.9	21.9
National Average 2021	74647	37.9	20.3	66.5	31.2	60.8	55.2	5.6	24.5	29	22.3
Wales 2023	3403	20.4	11.1	79.9	17.8	90.9	68.2	6.2	44.6	32.6	Not applicable
Wales 2022	3152	18.9	10.1	77.8	33.5	86.3	62.5	6	21.4	16	24.9
Wales 2021	2030	12.2	6.6	65.2	22.9	61.6	56.7	3.9	13.8	10.3	30.3
ABUHB 2023	2097	54.1	44.6	74.2	9.4	96.6	67.5	10	64.4	47.3	Not applicable
ABUHB 2022	1649	42.6	35.4	60.3	12.4	80.2	65.7	9.1	19.1	18.1	13.6
ABUHB 2021	875	22.6	26.1	21.3	23.3	34.7	57.7	4.8	1.4	8.3	18.4

Resource and Costs by Staff Band

	WTE required				Annual cost £				
	Nursing	Admin	Radiology	Consultant	Nursing	Admin	Radiology	Consultant	Total
Band 1									£0
Band 2									£0
Band 3		2.5				£77,581			£77,581
Band 4			0.4				£13,518		£13,518
Band 5									£0
Band 6	2.0		0.2		£96,489		£9,649		£106,138
Band 7	2.7				£158,438				£158,438
Band 8a									£0
Band 8b									£0
Band 8c									£0
Band 8d									£0
Band 9									£0
Consultant				0.2				£21,705	£21,705
Total Staff	4.7	2.5	0.6	0.2	£254,927	£77,581	£23,167	£21,705	£377,380
Overheads					£38,239	£11,637	£3,475	£3,256	£56,607
Total	4.7	2.5	0.6	0.2	£293,166	£89,218	£26,642	£24,961	£433,987

Financial benefits

	Year	Hip fracture (inpatient)	Other fracture site (inpatient)	Other fracture site (outpatient)	Clinical vertebral	Total	Average benefit per year
Acute care	2024	£585,330	£34,599	£7,961	£19,780	£647,670	
	2025	£995,061	£52,809	£12,151	£35,604	£1,095,625	
	2026	£1,424,303	£67,377	£15,503	£49,450	£1,556,633	
	2027	£1,697,457	£80,124	£18,436	£57,362	£1,853,379	
	2028	£1,873,056	£87,408	£20,112	£63,296	£2,043,872	
	All years	£6,575,207	£322,317	£74,163	£225,492	£7,197,179	£1,439,436

Estimate of service costs

The Royal Ostoporosis Society has a separate tool to help clinicians, managers and commissioners accurately calculate the costs of your FLS service for the number of patients shown in this FLS Benefits Calculator. The costs shown below are an approximation of the likely range of a what a service would cost for the number of patients expected in your service. **These are approximations only and must not be used in a business case.** For an accurate calculation using local salary, tariff activity, MFF and prescribing data please talk to your Royal Osteoporosis Society contact. All costs are for year 1 only.

	Lower estimate	Upper estimate
Estimate of staffing costs	£378,810	£635,559
Trust overhead charge of 15% applied to staff costs	£56,822	£95,334
Estimate of additional prescribing costs*	£14,744	£152,595
Total costs of FLS	£450,376	£883,488

* Prescribing costs will increase as the number of patients on osteoporosis therapy increases cumulatively each year

Assurance level	Description
Limited	The project did not achieve the standards or criteria being audited against

Risk level	Description
Moderate	Repeated failure to meet internal standards/Major patient safety implications if findings are not acted on

National, Wales and ABUHB data for all KPI's for 2021, 2022 & 2023

green as 80% amber as 50-79% red as <50%		KPI 2. Case identification	KPI 3. Spine Fractures green >20% amber 11-19% red <10%	KPI 4. Assessment within 90 days	KPI 5. DXA within 90 days	KPI 6. Falls risk assessment green >50% red <50%	KPI 7. Bone treatment	KPI 8. Strength & balance by 16 weeks	KPI 9. 16 weeks following up	KPI 10. Treatment by 1st followup	KPI 11. 1 yr drug adherence
National Average 2023	68341	34.7	23	65.5	31.7	61.7	56.9	7.8	28.6	29.2	Not applicable
National Average 2022	80015	40.6	22.5	63.2	29.2	62	56.6	6.8	27.1	28.9	21.9
National Average 2021	74647	37.9	20.3	66.5	31.2	60.8	55.2	5.6	24.5	29	22.3
Wales 2023	3403	20.4	11.1	79.9	17.8	90.9	68.2	6.2	44.6	32.6	Not applicable
Wales 2022	3152	18.9	10.1	77.8	33.5	86.3	62.5	6	21.4	16	24.9
Wales 2021	2030	12.2	6.6	65.2	22.9	61.6	56.7	3.9	13.8	10.3	30.3
ABUHB 2023	2097	54.1	44.6	74.2	9.4	96.6	67.5	10	64.4	47.3	Not applicable
ABUHB 2022	1649	42.6	35.4	60.3	12.4	80.2	65.7	9.1	19.1	18.1	13.6
ABUHB 2021	875	22.6	26.1	21.3	23.3	34.7	57.7	4.8	1.4	8.3	18.4

Risk level	Description
Moderate	Repeated failure to meet internal standards/Major patient safety implications if findings are not acted on

Resource and Costs by Staff Band

	WTE required				Annual cost £				
	Nursing	Admin	Radiology	Consultant	Nursing	Admin	Radiology	Consultant	Total
Band 1									£0
Band 2									£0
Band 3		2.5				£77,581			£77,581
Band 4			0.4				£13,518		£13,518
Band 5									£0
Band 6	2.0		0.2		£96,489		£9,649		£106,138
Band 7	2.7				£158,438				£158,438
Band 8a									£0
Band 8b									£0
Band 8c									£0
Band 8d									£0
Band 9									£0
Consultant				0.2				£21,705	£21,705
Total Staff	4.7	2.5	0.6	0.2	£254,927	£77,581	£23,167	£21,705	£377,380
Overheads					£38,239	£11,637	£3,475	£3,256	£56,607
Total	4.7	2.5	0.6	0.2	£293,166	£89,218	£26,642	£24,961	£433,987

Financial benefits

	Year	Hip fracture (inpatient)	Other fracture site (inpatient)	Other fracture site (outpatient)	Clinical vertebral	Total	Average benefit per year
Acute care	2024	£585,330	£34,599	£7,961	£19,780	£647,670	
	2025	£995,061	£52,809	£12,151	£35,604	£1,095,625	
	2026	£1,424,303	£67,377	£15,503	£49,450	£1,556,633	
	2027	£1,697,457	£80,124	£18,436	£57,362	£1,853,379	
	2028	£1,873,056	£87,408	£20,112	£63,296	£2,043,872	
	All years	£6,575,207	£322,317	£74,163	£225,492	£7,197,179	£1,439,436

Estimate of service costs

The Royal Ostoporosis Society has a separate tool to help clinicians, managers and commissioners accurately calculate the costs of your FLS service for the number of patients shown in this FLS Benefits Calculator. The costs shown below are an approximation of the likely range of a what a service would cost for the number of patients expected in your service. **These are approximations only and must not be used in a business case.** For an accurate calculation using local salary, tariff activity, MFF and prescribing data please talk to your Royal Osteoporosis Society contact. All costs are for year 1 only.

	Lower estimate	Upper estimate
Estimate of staffing costs	£378,810	£635,559
Trust overhead charge of 15% applied to staff costs	£56,822	£95,334
Estimate of additional prescribing costs*	£14,744	£152,595
Total costs of FLS	£450,376	£883,488

* Prescribing costs will increase as the number of patients on osteoporosis therapy increases cumulatively each year

	Report Recommendations:	S.M.A.R.T Actions:	Responsible: Due Date: Progress:
1	More FLSs are now delivering over 80% identification rates for non-spine fractures. FLS that have prioritised improvement in KPI 2 and 3 should contact these services to share best practice for funding and identification pathways.	Based on the annual activity/no. of fragility fractures ABUHB FLS of 4209, The HB needs • 4.7 - WTE nursing staff • 2.5 - admin • 0.6 - radiology staff (dexa scan) • 0.2 consultant. The total annual cost for this is £433,987. The Medical Division has invested 2 WTE CNS and 1 WTE Administrator (147K). Over the period of 5 years the total annual cost for ABUHB FLS including staff cost, overhead charge of 15% and prescribing costs be approx. £450,376 to £883,488. The annual benefits across acute care is equal to £1439,436 and all benefits inclusive of community and social care will be 2.1 Million.	Dr Inder Singh Ongoing
2	To meet the healthcare recovery targets from the pandemic, FLS funding should be prioritised based on expected number of avoided fractures from a comprehensive service. FLSs should describe their capacity gaps and the expected benefit vs effort from re-organising pathways to ensure that at least 80% of higher risk patients are checked within 16 weeks of their fracture. *This may result in lower rates of identification for lower fracture risk patients.*		
3	FLSs should work with their local DXA providers to ensure access to DXA is based on patient need. This may require FRAX before DXA pathways, increasing follow up based on evidence and using FRAX only recommendations to clear backlogs of patients that are unlikely to be cleared in the next four months.		
4	FLS care pathways should acknowledge that specific patient groups need a personalised approach to assessment, decision-making and support. This includes providing patient-facing materials that reflect the languages of their local population.		
5	All senior executive decision-makers should hold a key stakeholder meeting to explore how local needs for fragility fracture patients can be met. Patient representatives and members of the Royal Osteoporosis Society should be invited to the meeting, and it should plan for effective and sustainably resourced FLSs based and designed on the KPIs from the FLS-DB.	FLS is regularly discussed in the Falls and Bone Health Committee but with Patient representation and ROS representation	Peter Carr 8th April 2024 To be discussed

	Clinical Leads Local Recommendations: (if applicable)	Responsible:	Due Date:	Progress:
1	FLS for the ABUHB continues to be a centralised service and this is already achieved, however this needs to be continued.	Dr Singh	Ongoing	Improving
2	Wider partnership with Community Team, Primary Care and third sector.	Dr Singh	Ongoing	Improving

Audit Title:	National Paediatric Diabetes Audit (NPDA) Report on Care and Outcomes 2022/23	Clinical Lead: Dr Davida Hawkes, Consultant Paediatrician
Rationale:	The National Paediatric Diabetes Audit (NPDA) has published a report on care and outcomes 2022/23. It found that the prevalence of children and young people cared for in Paediatric Diabetes Units (PDUs) in England and Wales has increased from 33,251 in 2021/22 to 34,371 in 2022/23, despite a fall in the incidence of new cases. It also found that the percentages of children and young people with Type 1 and Type 2 diabetes receiving all six key annual healthcare checks have increased, but there remains much variability between PDUs (and completion rates for those with Type 2 remain lower than for those with Type 1). The report also states that, despite improvements in outcomes and use of technologies across different ethnicities and areas of deprivation, inequalities remain evident. In terms of rtCGM use, the inequality gap by deprivation has reduced, however the difference in use between Black and White children with Type 1 diabetes has widened from 8.6% in 2021/22 to 14% in 2022/23.	
Objectives:	• Build on and improve the previous joint adult and paediatric audit • Collect a clinically meaningful dataset • Engage clinicians, patients and parents • Improve awareness of NPDA findings and maximise their use to drive national policy • Develop the use of NPDA data in local and national quality improvements • Use a regional network approach to data collection • Capture patients' experiences • Collaborate with the suppliers of the adult audit to ensure information around transition to adult care is captured • Report at timely and regular intervals • Develop user-friendly tools to interrogate the dataset • Support centres wishing to develop local action plans to improve diabetes care • Maximise the use and availability of data for research	
Presented at Clinical Standards and Effectiveness Group – 25th July 2024		

Key messages

The prevalence of children and young people cared for in PDUs in England and Wales has increased from 33,251 (2021/22) to 34,371 (2022/23), despite a fall in the incidence of new cases.

The overall median HbA1c for England and Wales has fallen from 60.5mmol/mol (2021/22) to 60.0mmol/mol, but excessive PDU (paediatric diabetes units) variability in this outcome measure still persists.

The percentages of children and young people with Type 1 and Type 2 diabetes receiving all six key annual healthcare checks has increased but there remains much variability between PDUs, and completion rates for those with Type 2 remain lower than for those with Type 1.

Use of diabetes related technology has increased in 2022/23 with around half of children and young people with Type 1 diabetes using insulin pumps (45.3%, compared to 40.3% in 2021/22) and half (48.6%, compared to 30.0% in 2021/22) using a real time continuous glucose monitor (rtCGM).

Use of hybrid close loop systems doubled since the previous audit year, with 14.7% now using this technology compared to 7.5% in 2021/22.
Lower HbA1c was associated with use of a hybrid closed loop system or rtCGM.

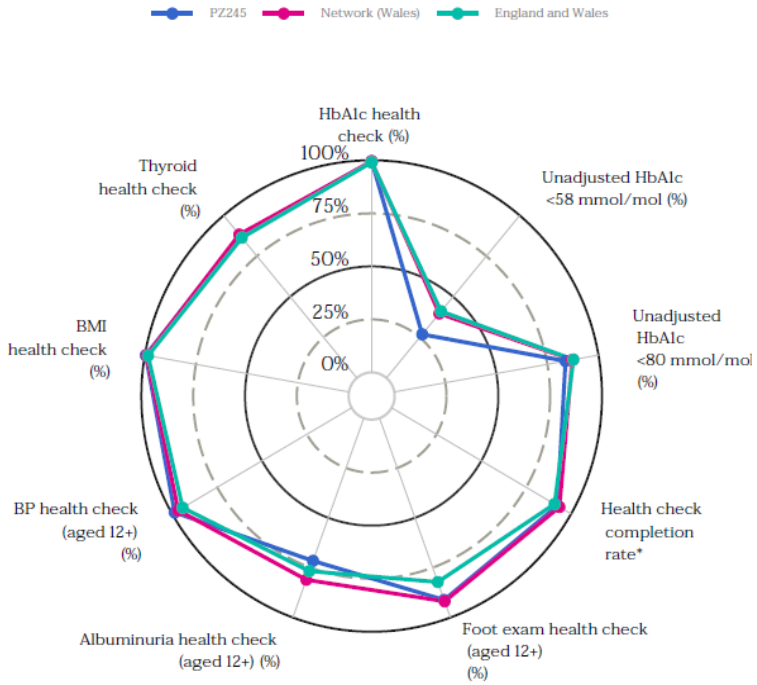
Percentages of young people with **early signs of micro and macrovascular complications** for both Type 1 and Type 2 diabetes show very little change in 2022/23 compared to the previous audit year.
Despite improvements in outcomes and use of technologies across different ethnicities and areas of deprivation, **inequalities remain evident.**

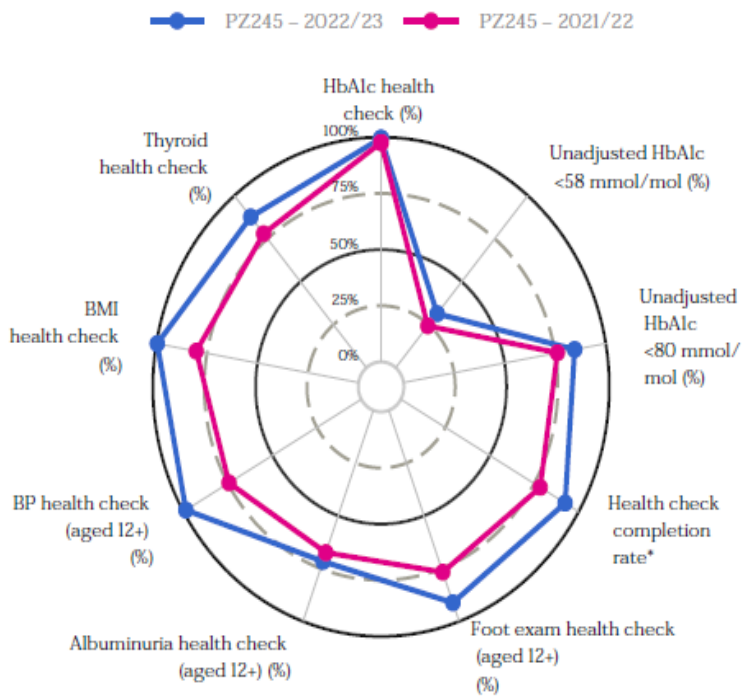
In terms of rtCGM use, the inequality gap by deprivation has reduced however the difference in use between Black and White children with Type 1 diabetes has widened from 8.6% in 2021/22 to 14% in 2022/23.

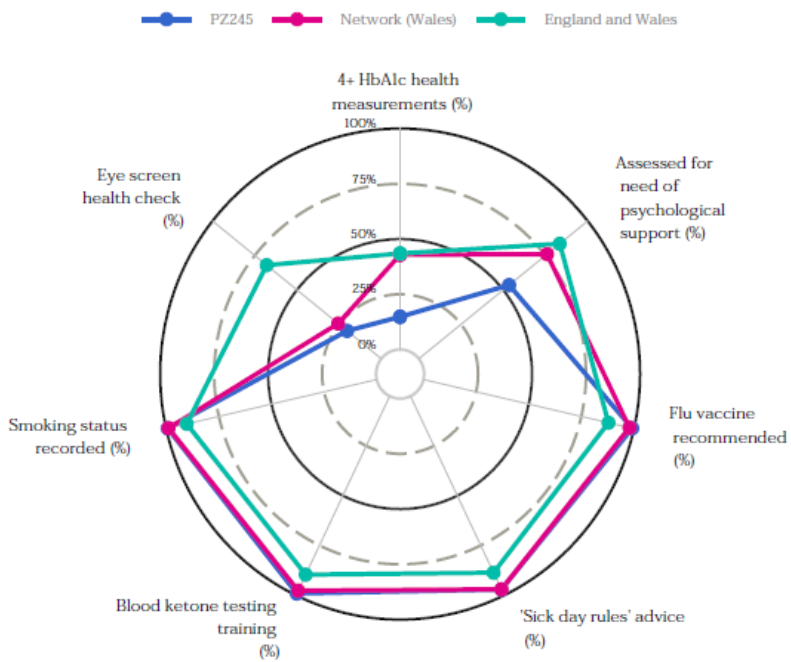
GRANGE UNIVERSITY HOSPITAL

A total of 328 children and young people (CYP) with diabetes who received treatment at The grange university hospital were included in the 2022/23 audit. A small number of people for whom data was provided were not included in the audit as they did not meet the audit criteria or did not have the minimum demographic data required. The charts below show the age and type of diabetes distribution.

Radar plot showing PDU, region and national performance on the six key health checks, % achieving an HbA1c of below 58 mmol/mol and % achieving an HbA1c of below 80 mmol/mol	Figure 2: Radar plot showing PDU performance in 2021/22 and 2022/23 on the six key health checks, % achieving an HbA1c of below 58 mmol/mol and % achieving an HbA1c of below 80 mmol/mol	Figure 3: Radar plot showing PDU, region and national performance on additional health checks







*The health check completion rate is calculated by dividing the total number of health checks completed in each PDU by the total expected number of health checks: each patient aged 12 and above with Type 1 diabetes who completed a full year of care should receive 6 health checks. Children under 12 with Type 1 diabetes who completed a full year of care should receive 3 health checks (see section 3 for further information about health checks).
In previous years, the health check completion rate metric excluded children under the age of 12.

HbA1c - All the data presented on HbA1c relates to the results for the 280 children and young people with Type 1 diabetes who had one or more valid HbA1c measurements in the audit period. This may differ from the number of children and young people included in the denominator for HbA1c as a health check as it includes those who have had a valid HbA1c at least 90 days after diagnosis irrespective of whether they had a complete year of care. Where more than one valid HbA1c was recorded during the year per child or young person, the median value was used. The NPDA recommends using the PDU median to compare your year-on-year progress towards lower average HbA1c, as the median is less affected by extreme results than the mean (see Figure 19).

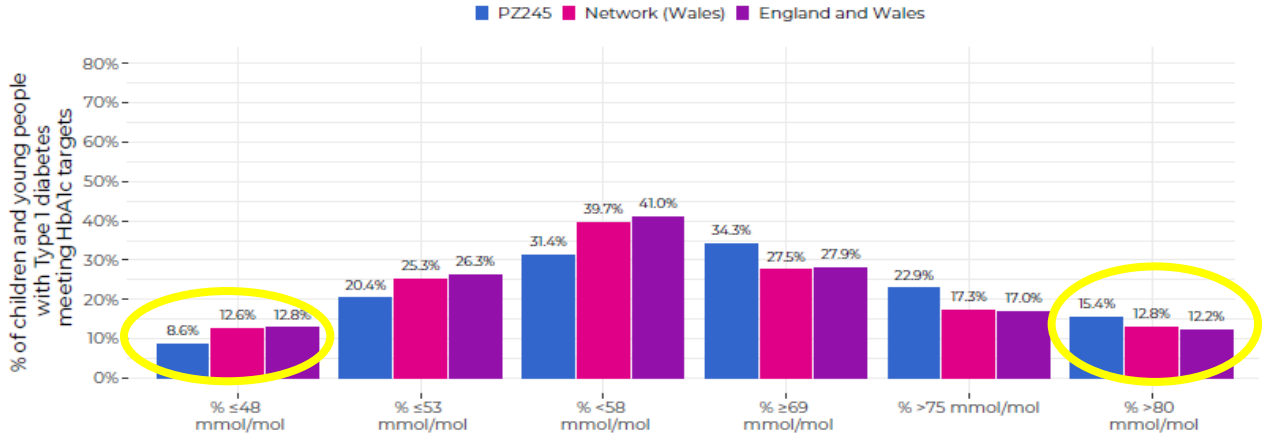


Figure 19: Percentage of children and young people with Type 1 diabetes meeting HbA1c targets

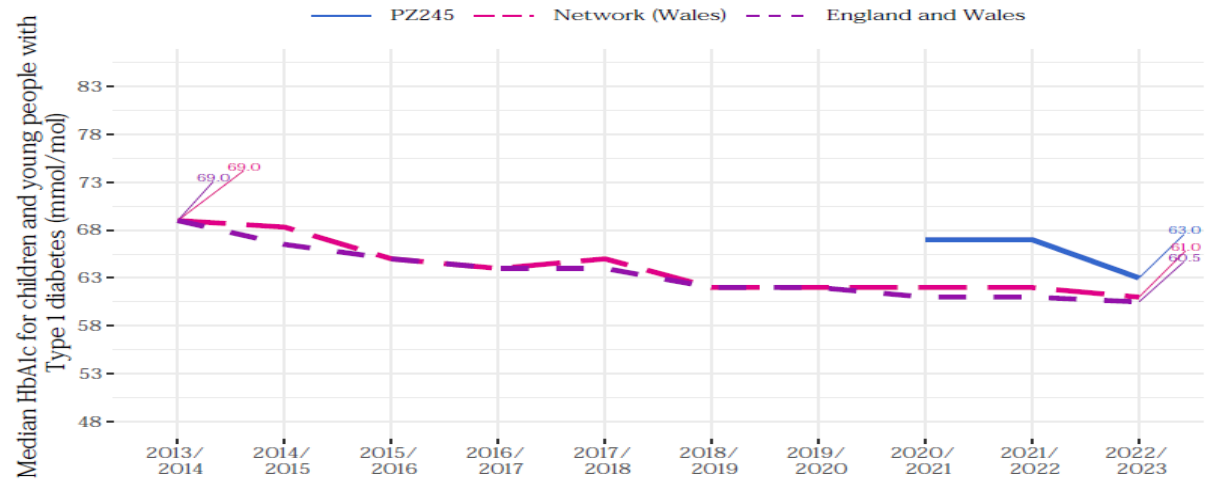
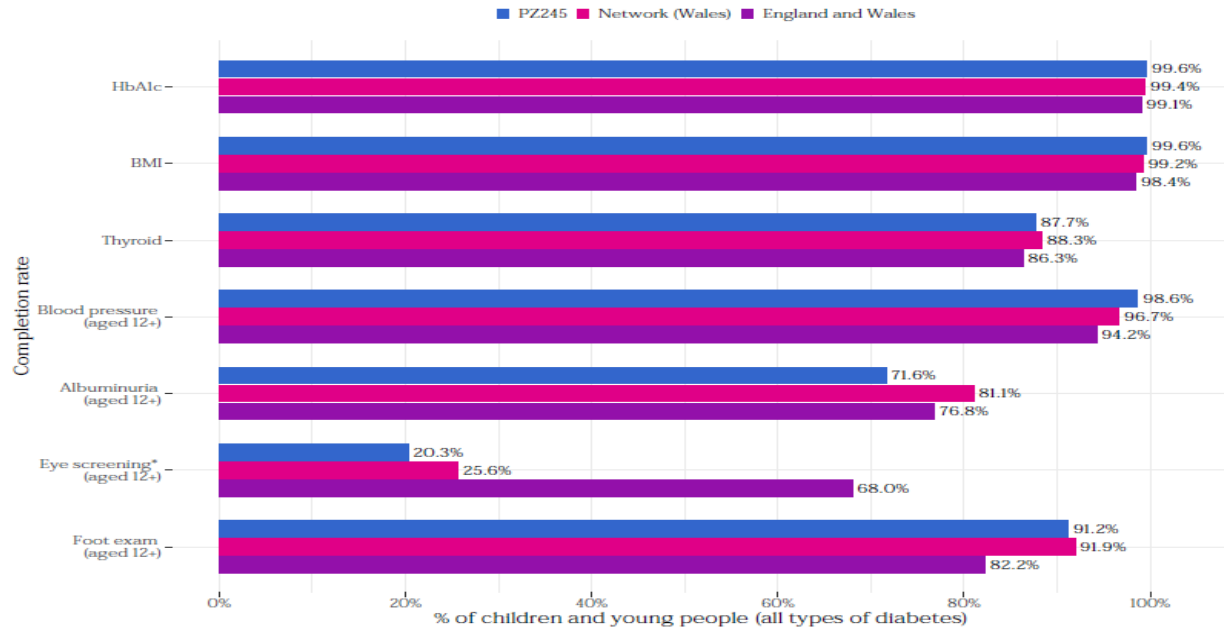


Figure 20: Median HbA1c for children and young people with Type 1 diabetes

3.1 Key health check completion



Percentage of children and young people with Type 1 diabetes with a complete year of care who received additional health checks – 4+ HbA1c measurements poor – can be impacted by late booking



The outlier status of The Grange University Hospital on the performance indicator Adjusted Mean HbA1c for 2022/23 is: Alert.

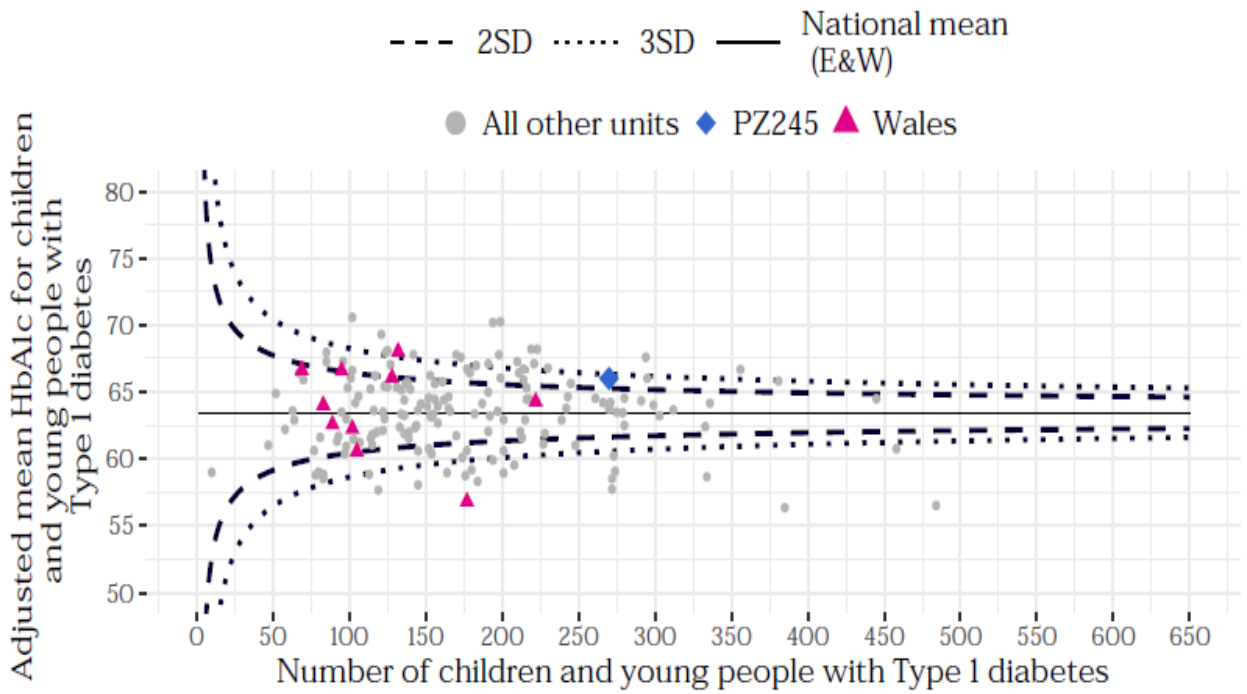


Figure 21: Adjusted mean HbA1c

The NPDA defines services with a result above two standard deviations of the expected value on this metric as an 'alert', and above three standard deviations as an 'alarm', which confers negative outlier status in accordance with HQIP guidance (2017). In Figure 21 above, PDUs above the top dotted line (3SD) are considered 'alarm' outliers as their adjusted mean HbA1c is significantly higher than the overall mean in England and Wales. Conversely, services with results below three standard deviations are considered positive outliers on this metric.

The Health Board Adjusted Mean HbA1c in 2021/2022 was an Alarm status (3SD) for 2022/2023 the Health Board has improved, however remains an outlier, at Alert level (2SD). HDUHB is a positive outlier and ABUHB will visit HDUHB for learning.

8.1 Treatment regimen

The data presented below is for the 302 children and young people with Type 1 diabetes in PZ245 who had a valid treatment regimen recorded.

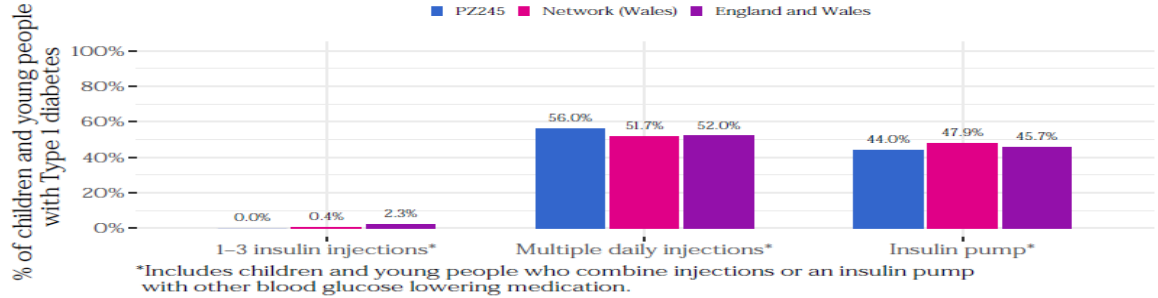


Figure 29: Treatment regimen of children and young people with Type 1 diabetes

8.4 Closed-loop system

At The Grange University Hospital, 5.4% of all children with Type 1 diabetes were using a closed-loop system.

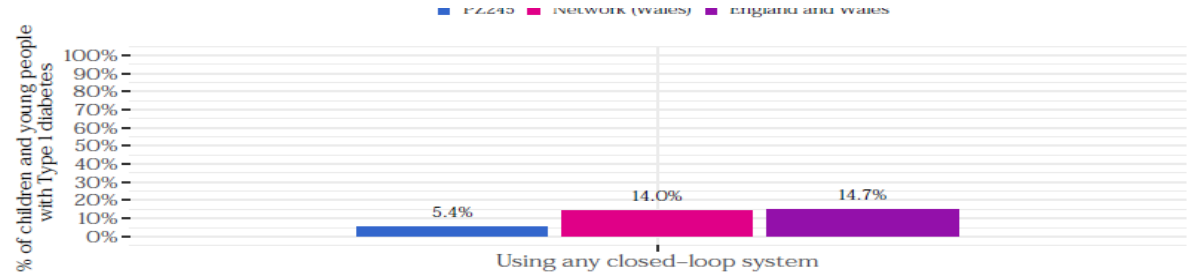


Figure 35: Percentage of children and young people using a closed-loop system

8.2 Continuous glucose monitoring

In GUH, 250 children and young people with Type 1 diabetes were reported as either using or not using rtCGM with alarms within the audit period. The proportion recorded as using rtCGM at last visit is reported below

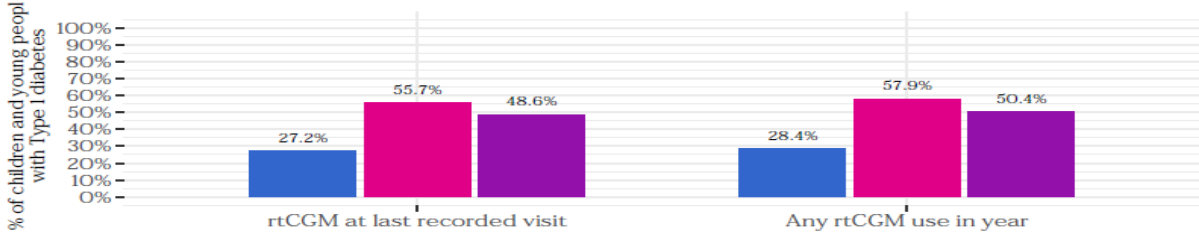


Figure 32: Percentage of children and young people using rtCGMs with alarms

Assurance and Risk

Assurance level	Description
Limited	The project did not achieve the standards or criteria being audited against

Risk level	Description
Moderate	Repeated failure to meet internal standards/Major patient safety implications if findings are not acted on

Has this audit been placed on a Risk Register (N/A if above risk is None)	YES

Key Success and Concerns

Report Successes:	
1	ABUHB paediatric diabetes team continue to reduce HbA1c, reducing to Alert status and no longer Alarm status and we are Reducing the gap

Report Concerns:	
1	Other teams continue to improve so always playing catch up
2	Business case has not resulted in investment in the service to date

NPDA Recommendations and Health Board actions:

Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Commissioners of care should make sure that multidisciplinary diabetes teams are adequately staffed to manage the growing numbers of children and young people with Type 1 and Type 2 diabetes since 2020. These teams should be trained to encourage the best use of new diabetes-related technologies. **Action by:** Integrated Care Boards across England and Local Health Boards across Wales.	Business case was submitted prior to the last audit period	Requires Health Board Approval	Immediately	Ongoing
2	Children and young people with Type 1 and Type 2 diabetes should have equitable access to diabetes care, regardless of social deprivation, ethnicity, or geography. Action is required to increase the proportion of those with Type 2 diabetes receiving recommended key annual health checks and to improve equity of access to diabetes treatment technology for Type 1 diabetes. **Action by:** Integrated Care Boards across England; Local Health Boards across Wales, and the RCPCH, to provide a better understanding of ethnic and social deprivation variability.				
3	Young people with diabetic retinopathy recorded in their previous annual screen should be invited for annual re-screening. Paediatric diabetes teams should be aware of which patients in their service have retinopathy and encourage them and their family to attend screening appointments when offered so that diabetes management advice can be appropriately tailored. **Action by:** NHS Diabetic Eye Screening Programme in England (DESP), Diabetic Eye Screening Wales (DESW), Clinical teams within paediatric diabetes units in NHS Trusts and Local Health Boards across England and Wales.	*Eye screening was reduced to biennial frequency in many NHS Trusts in England and Health Boards in Wales from 2020/21 and has been excluded from compound 'key annual check' reporting by the NPDA since (section 3.2). However, the denominator for this metric includes all children and young people with Type 1 diabetes who completed a full year of care.			

Audit Title:	National Diabetes Foot Care Audit (NDFA) Are services providing effective diabetes foot care? England and Wales, 2018–23 Published 9 May 2024	Clinical Lead: Melissa Blow - Clinical Lead for Podiatrist Diabetes and Tissue Viability
Rationale:	NDFA enables all services that treat people with diabetes related foot disease to measure their performance against National Institute for Health and Care Excellence (NICE) guidance.	
Objectives:	The NDFA aims to: 1. Measure factors associated with increased risk of ulcers and adverse ulcer outcomes. 2. Provide data on diabetes related foot disease that can be used by service providers, local commissioners and national policy makers to monitor patient outcomes and to benchmark against peers. 3. Share best practice information to enable the highest quality of care of diabetes related foot disease in England and Wales. National Diabetes Foot Care Audit - NHS England Digital Diabetic foot problems: prevention and management NICE guideline [NG19]	
Presented at Clinical Standards and Effectiveness Group – 25th July 2024		

The audit looks at three key areas:

1 Structures
Are the nationally recommended care structures in place for the management of diabetes related foot disease?

2 Processes
Does the treatment of active diabetes related foot disease comply with nationally recommended guidance?

3 Outcomes
Are the outcomes of diabetes related foot disease optimised?

NDFA - Key finding One

Shorter times to First Expert Assessment (FEA) led to greater chance of being alive and ulcer free at 12 weeks.

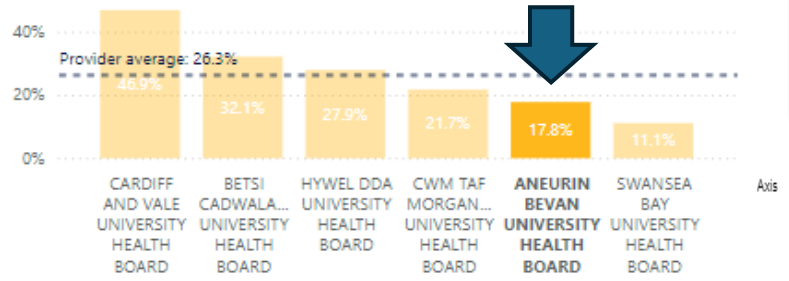
Early expert assessment of all new foot ulcers is important. The NDFA has shown that faster referral to specialist foot care services leads to fewer severe ulcers and greater chance of being alive and ulcer free (AAUF) at 12 weeks.

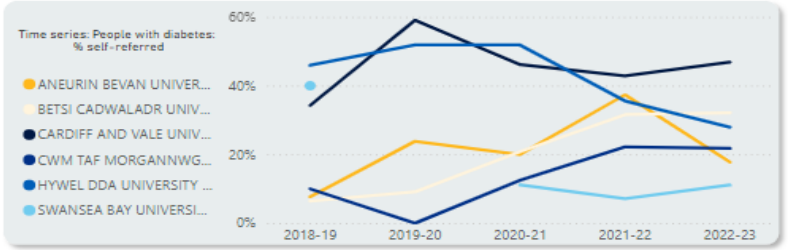
Twelve weeks after the First Expert Assessment (FEA), foot care services record whether:
- The person is alive.
- The ulcer is healed.
- The person does not have new foot ulcers.

Recommendation 1:

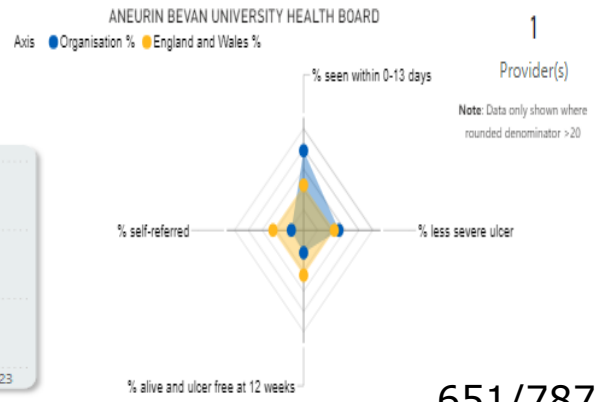
Integrated care boards (ICBs) and Welsh local health boards (LHBs) should ensure that health care providers (HCPs)
arrange early expert assessment of all new foot ulcer episodes following either health care professional referral or self-referral. In every ICB or LHB more than **70%** of new ulcers should receive FEA within 0-13 days by 2026.

ABUHB % Self-Referral

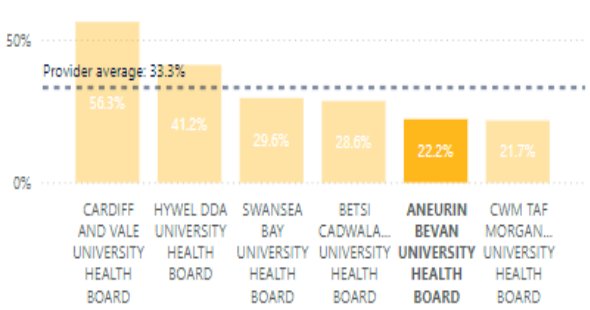


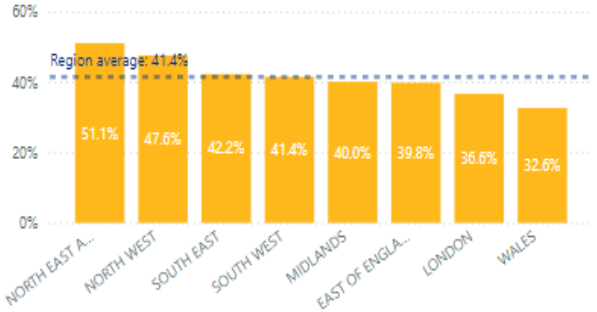


The best outcomes are for patients who self-refer into a service. Over half of those who self-refer are AAUF at 12 weeks.

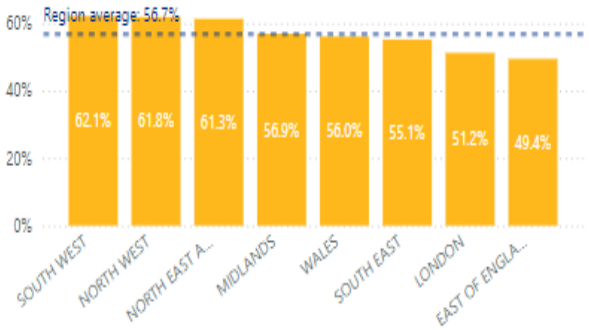


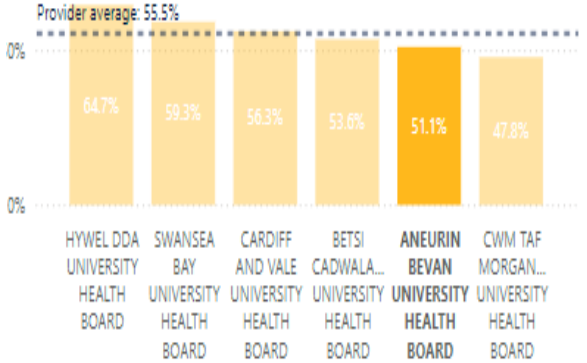
Alive And Ulcer Free (AAUF) at 12 weeks





% less severe ulcer

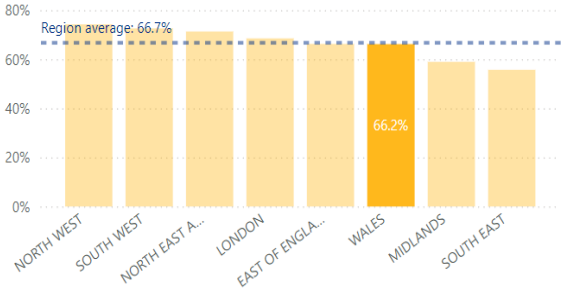


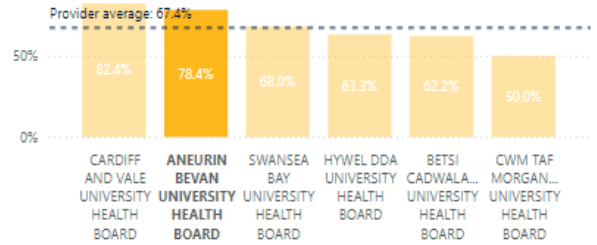


Key finding Two

There is a marked difference between regions, ICBs, LHBs and services in terms of assessment and outcomes.

First Expert Assessment (FEA), 0-13 days



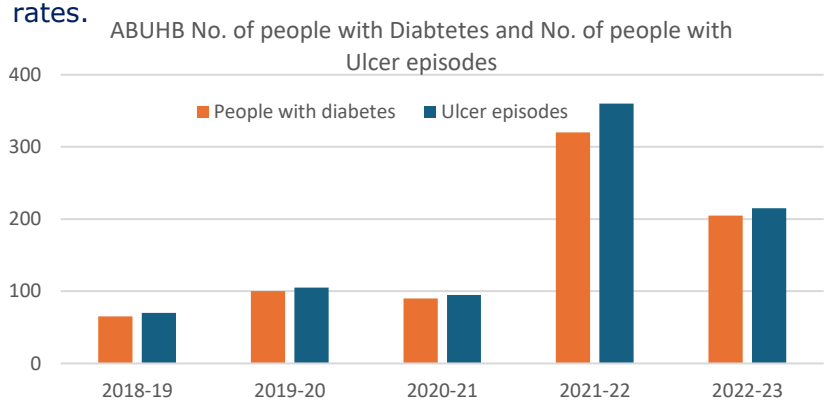


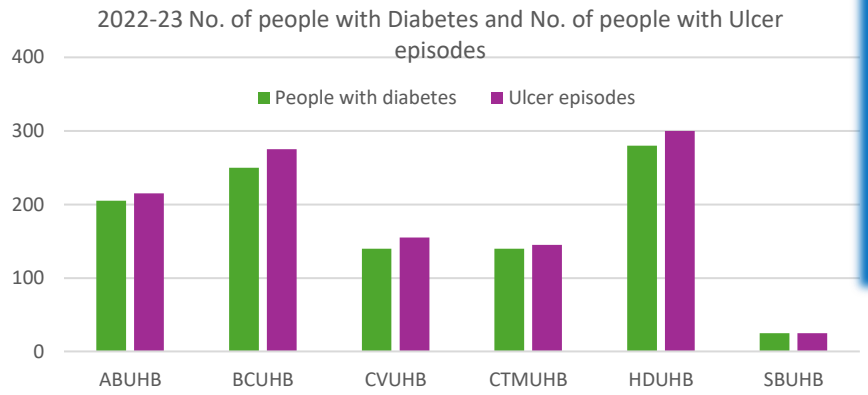
Recommendation 2:

ICBs ICBs and Welsh LHBs should make sure they are aware of local diabetes foot care pathways and understand reasons for variability. They should ensure that specialist clinical foot care services are accessible to all people with diabetes related foot ulcers and are appropriately resourced.

Key finding Three

There are wide-ranging differences between regions, ICBs and services in ulcer registration rates.

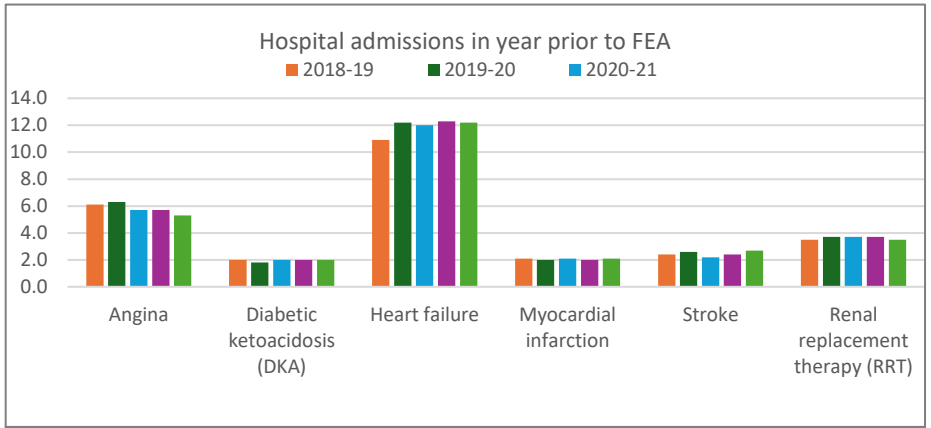


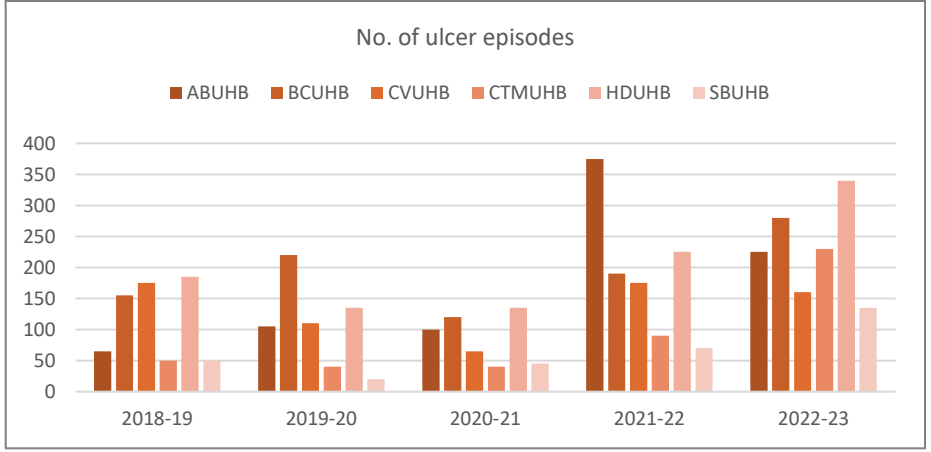


Recommendation 3:

ICBs and Welsh LHBs should mandate all providers to submit data to the NDFA and, using the NDFA dashboard, review their provider organisations benchmarked processes and outcomes. These should include the number of ulcer registrations, time to FEA, ulcer severity at FEA and 12 week outcomes.

Additional Data





Assurance and Risk Level

Assurance level	Description
Significant	The project has mostly achieved the standards or criteria being audited against

Risk level	Description
Low	Peripheral element of treatment or service suboptimal

Has this audit been placed on a Risk Register (N/A if above risk is None) - No

Report Successes:	
1	ABUHB First Expert Assessment (FEA) within 0-13 days after referral during 2022-23 was 78.4% within a range of 82.4% - 50.0% across Wales. The target has been set at being more than 70% (0-13 days) by 2026. (Professional and Self-referrals)

Report Concerns:	
1	ABUHB AAUF rate was 22.2% and this ranged from 56.3% to 21.7% across Wales – although the data does not reflect the complexities of ABUHB patients in 12 weeks (less severe ulcer in more complex patients) – work planned to improve on this result
2	% self-referrals for ABUHB was 17.8%, with a range of 46.9% to 11.1% across Wales. Self-referral access generates higher levels of AAUF at 12 weeks – Each HB was recording self referral different and national agreement on this has been achieved

The service does not have electronic processes and uses paper processes which affects staff workloads and can impact data recording. Ascertainment rates are continuously promoted and monitored.

Report Recommendations:		Progress:
1	Integrated care boards (ICBs) and Welsh local health boards (LHBs) should ensure that health care providers (HCPs) arrange early expert assessment of all new foot ulcer episodes following either health care professional referral or self-referral. In every ICB or LHB more than 70% of new ulcers should receive FEA within 0-13 days by 2026.	Already achieved and continue monitoring the HB 7-day target
2	ICBs and Welsh LHBs should ensure that specialist clinical foot care services are accessible to all people with diabetes related foot ulcers and are appropriately resourced.	Achieved across the 5 boroughs and looking to introduce a drop-in clinic in Newport, Caerphilly and Monmouthshire.
3	ICBs and Welsh LHBs should review their provider organisations, using the NDFA dashboard including the number of ulcer registrations, time to FEA, ulcer severity at FEA and 12-week outcomes to improve referral rates.	Achieved

Audit Title:	Report on the 2022 National Audit of Quality Standards for Adult Hearing Rehabilitation Audiology (Wales)	Clinical Lead: Wendy Trump
Rationale:	To provide an overview of Aneurin Bevan University Health Board on the performance of their Adult Audiology service against the Quality Standards for Adult Audiology (Wales) version 2. During November 2022, all Adult Audiology Services in Wales were audited using version 2 of the Quality Standards for Adult Audiology (2016).	
Objectives:	The audit process includes 83 criteria which are; • Deliberately limited to audit items that are specific to Audiology or are particularly worthy of emphasis • Provide a specific and evidence-based contribution to help define a good quality service that will provide the best outcomes for patients. • Describe good practice and use of tools to provide evidence of health outcomes. • Compliance with the standards should not be used in isolation to quantify the efficacy of services in terms of health outcomes and patients' satisfaction.	
Presented at Clinical Standards and Effectiveness Group 25th July 2024		

The audit process

These Quality Standards are relating to the step changes which were audited in November 2022:

- Increase in target minimum assessment scores, from 75% for each individual standard in 2017 to 80% in 2019 and from 75% overall in 2017 to 85% in 2019.
- The scoring sheet used was updated to Version 3.4, which includes the self-assessment scores and the actual audit scores on the day in the same spreadsheet.

As in previous years:

- Audiology Heads of Services were asked to complete a self-assessment for each of their services; these were forwarded to the audit teams by the Audit Coordinator prior to the audit visits.
- All Health Boards had one audit visit, except for Powys, where the service is split between three Health Boards.
- Each audit team was led by a Senior Audiologist from an external Health Board. Local patient representatives were invited to attend each audit. An independent, external 3 auditor, recruited from the third sector, also attended every audit to ensure consistency in scoring.
- Following audit visits, the audit team produced a report on the assessed service performance. Summary reports were sent to the Chief Executive of the respective Health Board and Head of Service.
- An All-Wales report, incorporating the Quality Standards Adult Audiology Rehabilitation Services results for all services, has been provided to Audiology Standing Specialist Advisory Group (ASSAG) for approval prior to submission to the Welsh Government.

QS outcome reflects a high standard of delivery but has not identified the high-risk factor to patient due to extremely long waiting times

The individual standards, criteria and marking scheme used are the same as used for the external audit in 2017. The target minimum assessment scores have, however, increased since 2017, from 75% for each individual standard to 80% and from 75% overall to 85%.

There were 83 individual criteria. Low scoring criteria were judged as those scoring less than 2 on the Quality Rating Tool (QRT).

0 = No elements of the quality statement are met (or not evident)
1 = Few elements of the quality statement are met
2 = Meets around half of the elements of the quality statement criteria
3 = Almost fully meets the quality statement criteria
4 = Fully compliant with good to best practice as indicated by quality statement criteria

8 out of 9 services met, or exceeded, the compliance target of an overall score of 85%.

The Quality Standards are arranged as 9 standards:	
QS	**ABUHB results**
1. Accessing the Service	85%
2. Communicating with Patients	94.64%
3. Assessment	96.43%
4. Developing an Individual Management Plan	100%
5. Implementing an Individual Management Plan	91.67%
6. Clinical Effectiveness	100%
7. Clinical Skills and Expertise	96.43%
8. Collaborative Working	96.43%
9. Service Improvement	100%

Clinical Leads Local Recommendations: (if applicable)		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	To reduce waiting time for new and existing patients	To liaise with the Directorate management to increase capacity	Wendy Trump/Directorate management team	Review at CSEG Nov 2024	New
2	Address low scoring criteria linked to long waiting times.				
3	Version 3 is out for consultation to address weakness in V2 and include changes to Audiology practices.				

Assurance level	Description
Significant	The project has mostly achieved the standards or criteria being audited against
Limited	The project did not achieve the standards or criteria being audited against

Risk level	Description
Major	Non-compliance with national standards/Significant risk to patients if unresolved

Has this audit been placed on a Risk Register (N/A if above risk is None) - YES

Report Successes:	
1	1a.1 Excellent detailed pathways were seen throughout the audit. Ideal for new and existing staff to refer to.
2	2a.6 Good evidence of feedback from service users.
3	3a.7 Staff are always being supported and encouraged to participate in learning new processes and to review existing.
4	5c.2 Good referral pathway to Hearing Therapy services.

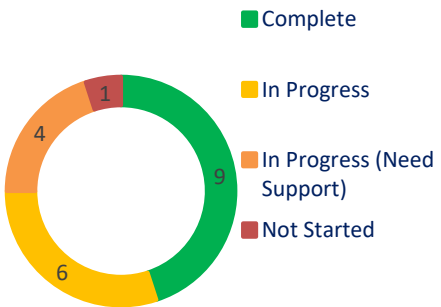
Report Concerns:	
1	Accessing the service one criteria scored 0 - Since Covid the department have been unable to maintain 14-week RTT for existing and new patients. Covid also led to the suspension of the volunteer service. Plans are in place to address the above.
2	Implementing an Individual Management Plan one criteria scored 0 - No plans to currently offer a 3 years reassessment - This applies to all Audiology Services across Wales

Audit Title:	SSNAP Annual Report 2023 Sentinel Stroke National Audit Programme – State of the Nation Stroke care received between April 2022 to March 2023	Clinical Lead(s): Dr Yaqoob Bhat – Acute Dr Jonathan Hewitt - Stroke Rehab
Rationale:	SSNAP measures both the processes of care (clinical audit) provided to stroke patients, as well as the structure of stroke services (organisational audit) against evidence-based standards. The overall aim of SSNAP is to provide timely information to clinicians, commissioners, patients, and the public on how well stroke care is being delivered. Processes of care are measured against evidence-based quality standards referring to the interventions that any patient may be expected to receive.	
Objectives:	SSNAP's information is used as a tool to improve the quality of care that is provided to patients. Healthcare professionals involved in audit have voted SSNAP the most effective national clinical audit in the UK every year since 2012.	
Presented at Clinical Standards and Effectiveness Group – 25th July 2024. SNAP reported to the Stroke Board and Executive Committee and actions have been added to AMaT.		

The GIRFT Report

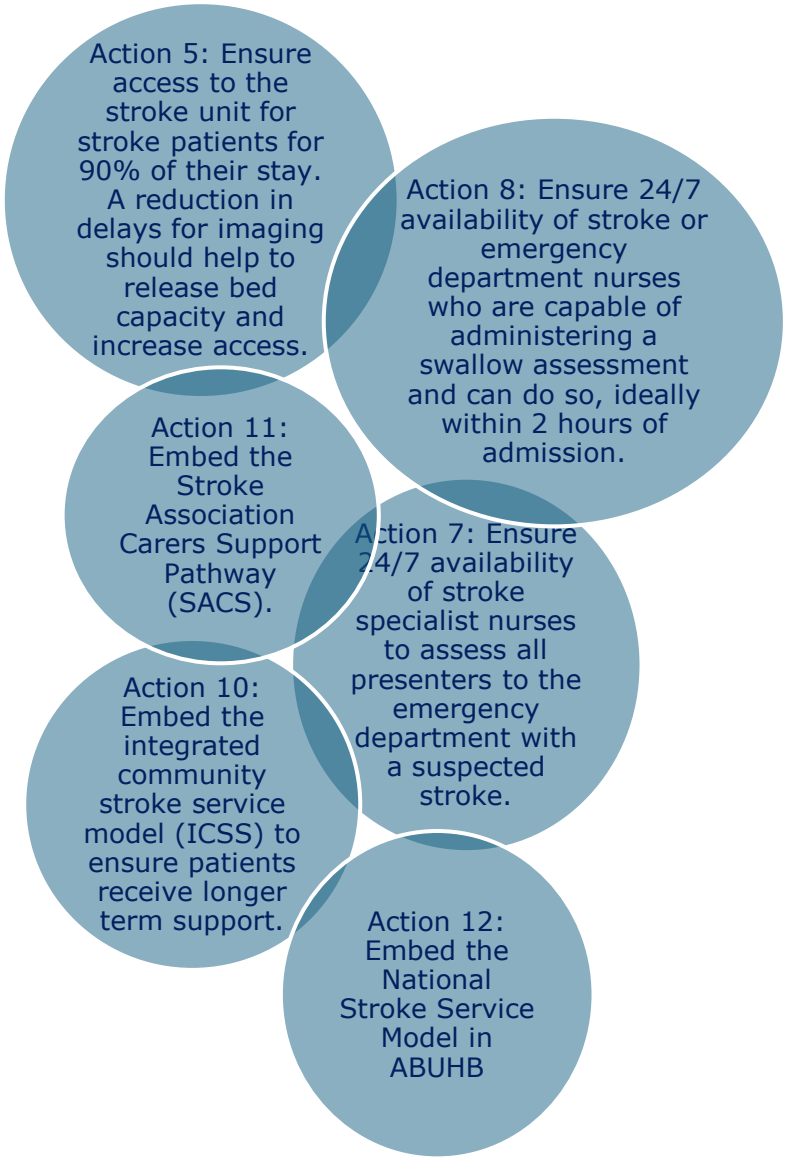
Undertaken in 2022 with 20 recommendations to be undertaken across the rest of Wales through the National Stroke Network

ABUHB/GIRFT Progress tracker



- A
  - Action 1: Record data in real time, with audit compliance and assurance processes built into the individual sites' Health Board wide audit programme. Clinical and audit team to meet on a regular basis to undertake a review of the accuracy of the registered SSNAP data for clinical assurance.
  - Action 2: Commission an ESD pathway process flow map. … support a move to having only two stroke specific rehabilitation units … therefore improving flow through the stroke pathway.
- B
  - Action 3: Improve the pre-hospital identification service model to reduce unwarranted variation in access to imaging. ABUHB to embed the Optimal Stroke Imaging pathway. The use of first line MRI for patients with mild symptoms or with diagnostic uncertainty may release bed capacity.
- 17.3%
  - Action 6: Take advantage of the quality improvement opportunities along the thrombolysis pathway, SSNAP modelling has identified that up to 15-20% of stroke patients may be eligible for thrombolysis.
- Action 15: Deliver adequate psychological and emotional support for stroke survivors and their families.
- 92.1%
  - Action 16: ABUHB to ensure continence plans are delivered and that the documentation and reporting of data is robust. There should be a weekly 'compliance' meeting to provide assurance.
- 76.9%
  - Action 17: Ensure nutrition screening is completed for all patients using a validated nutrition screening tool and that patients are seen by a dietician by discharge; the documentation of assessment needs to be standardised, and a weekly 'compliance' meeting put in place to provide assurance.
- 96.4%
  - Action 18: Ensure mood and cognition is assessed by discharge and is documented consistently. A weekly compliance meeting should be held to provide assurance.
- TBC
  - Action 20: Standardise post discharge reviews using the GM-SAT six-month post stroke review tool .

Ongoing work

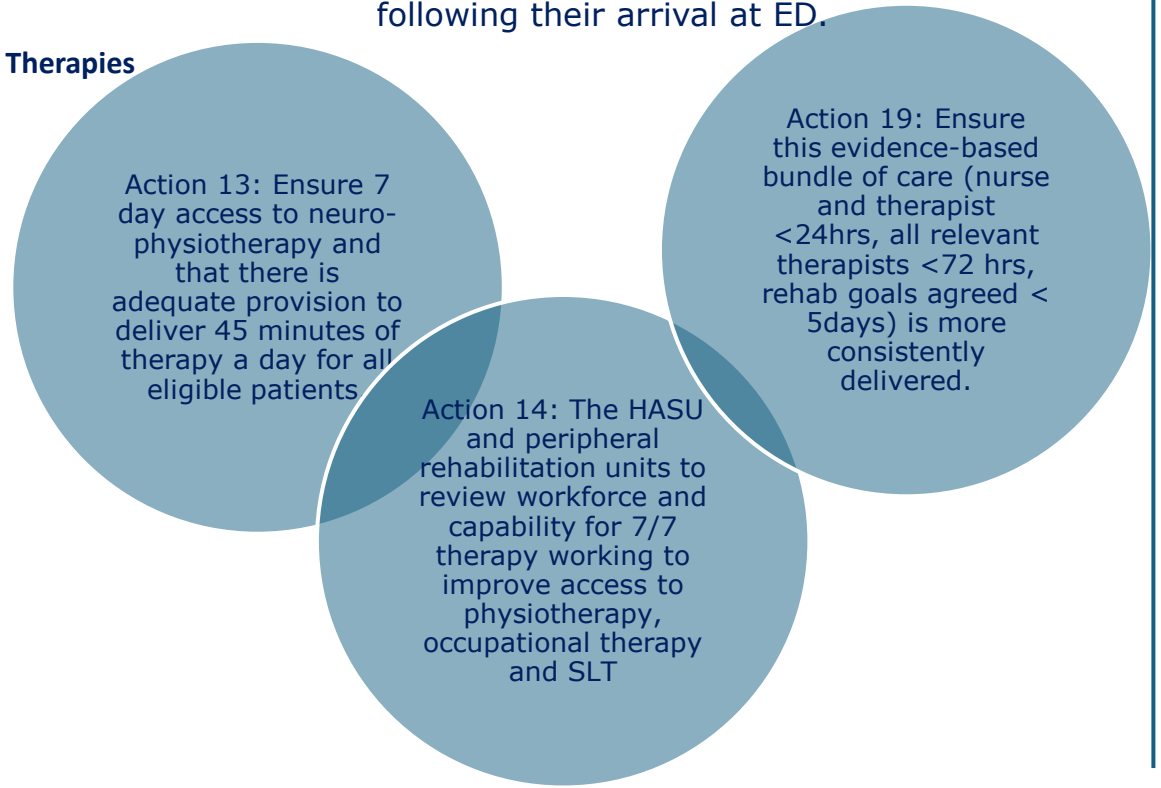


Actions that need support 4/20

Acute Stroke

Action 4: ABUHB to develop a strategy to improve direct access to the stoke unit within 4 hours of presentation. Health boards must explore the options available to improve the process for prioritising stroke patient admissions to acute stroke wards within the four-hour target, to help maximise their clinical outcome. Ringfenced stroke beds are frequently used for non-stroke patients, which may impact on a new stroke admission to ED. Therefore, health boards must explore how a ringfenced stroke bed can be maintained, to help ensure the best outcome for a stroke patient following their arrival at ED.

Therapies



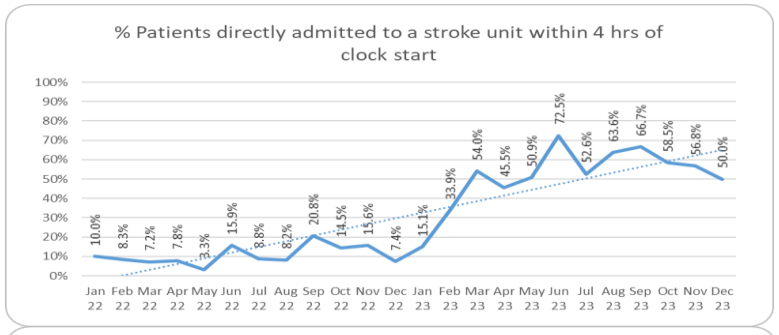
There is good evidence of early supported discharge and the delivery of therapy in people's homes.
There are, however, significant social care delays. Findings from the Stroke Association survey show that 50% of patients feel abandoned following discharge.

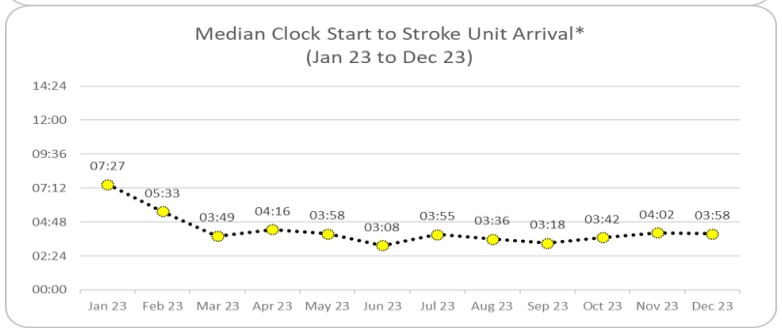
ABUHB took part in the Welsh Leadership academy that ran last year and found the outcomes very valuable. They put a cohort of staff groups (e.g. doctors, 3rd sector, managers etc) through the programme and found that this is invaluable when it comes to team working and improving leadership and effectiveness of a service. Several staff also enrolled on the first Wales Stroke and Neuro Leadership Programme which ran into the pandemic

This course has ceased to be available. Alternative course are being investigated.

A comparison:

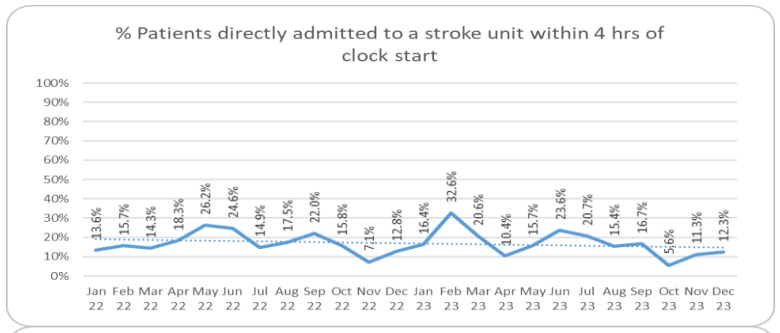
C&VUHB

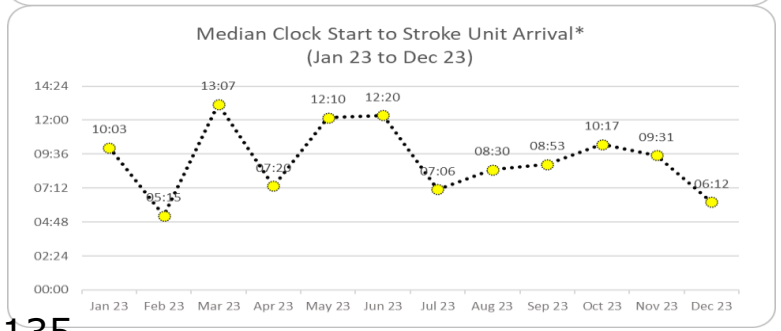




- Stroke at GUH: 15 HASU beds + 4 'overflow' beds + 3 boarding spaces.
  - 21 beds are currently under stroke jurisdiction.
- Stroke admissions to HASU per day (average): 2.1
  - + Neurorehabilitation//Mimic/TIA demand: 1
- Average LOS on HASU: 4.4 days.
- **Minimum** requirement of 4 beds to be ringfenced.
  - This can be two beds (bay/cubicle), and two boarding spaces.
  - Ideally, full ringfencing of all stroke beds.
- Any non-stroke patient on the HASU, or in the boarded/overflow beds must be moved off as a priority if strokes are waiting for admission.
- Maximum capacity for 21 admitted stroke patients (up from 15 in the Clinical Futures model).
- Essential that Rehabilitation beds in YYF are ringfenced to facilitate flow from the acute site.
- Stroke admissions come in waves, there will be times that beds will be empty, but the demand will come.

ABUHB





Assurance level	Description
Limited	The project did not achieve the standards or criteria being audited against

Risk level	Description
Moderate	Repeated failure to meet internal standards/Major patient safety implications if findings are not acted on

Has this audit been placed on a Risk Register (N/A if above risk is None) - YES

	Local recommendations:
1	Review of Medical JDs and job plans to make them more attractive
2	Adjustment of frequency of high-intensity weeks to reduce Consultant burn out on the HASU
3	Development of live dashboard to give real time performance data (need organisational support to do this)
4	Proposal to ring fence stroke beds

Report Successes:	
1	69% of patients spent at least 90% of their hospital stay in a specialist stroke unit compared to 73% nationally ~ ABUHB 68% 2021/2022
2	92% of patients were assessed by stroke specialist within 24 hrs of admission compared to 83% nationally ~ ABUHB 92% 2021/2022
3	12.7% of all stroke patients received compared to 10.7% nationally thrombolysis ~ ABUHB 11.8% 2021/2022
4	Thrombolysis rates are within range as per GIRFT (15-20%)
5	Implementation of BRAINOMIX AI decision support tool
6	Reconfiguration of Rehabilitation Services to centralise in YYF, resulting in increased throughput on the HASU and reduced LOS (+4 patients per week, and -0.8 days respectively).

Report Concerns:	
1	51% of applicable patients received swallow screening within 4 hrs of admission compared to 72% nationally ~ ABUHB 56% 2021/2022
2	20.1% of patients were directly admitted to a stroke unit within 4 hrs of hospital arrival compared to 40% nationally ~ ABUHB 23 % 2021/2022
3	73% of patient received stroke specialist nursing assessment within 24 hrs of admission compared to 89% nationally ~ ABUHB 90% 2021/2022
4	50% pf patients received brain imaging within 1 hr of hospital arrival compared to 57% nationally ~ ABUHB 58% 2021/2022
5	17.1% of applicable patients directly admitted to a stroke unit within 4 hours of clock start AND who either receive thrombolysis or have a pre-specified justifiable reason ('no but') for why it could not be given compared to 40.1% nationally ~ ABUHB 22.1% 2021/2022
6	Getting patients to HASU within 4 hours of presentation, this is covered in the paper and presentation, as well as a proposal to improve this
7	Recruitment of Senior Medical Staff, we are exploring the opportunity to appoint Specialist Doctors to backfill vacant Consultant posts
8	Therapies staffing levels, circa 50% below recommended levels
9	6-month follow-up metrics 0% - this will improve going forward now that the CNS team are returning from Maternity Leave.

	Recommendation (R) (Audience)	Report findings underlying this recommendation National:	ABUHB:	Progress:
R1	Reverse the recent decline in hyperacute specialist access for stroke. **For action by: Acute trusts, Local Health Boards (LHBs), Regional Medical Directors (RMDs) and Integrated Stroke Delivery Networks (ISDNs).**	**40.2%** of patients were directly admitted to a stroke unit within 4 hours in 2022/23, compared to 44.4% in 2021/22. **72.9%** of patients spent at least 90% of their stay on a stroke unit in 2022/23, compared to 76.5% in 2021/22.	**20.1%** of patients were directly admitted to a stroke unit within 4 hours in 2022/23, compared to **23%** in 2021/22. **68%** of patients spent at least 90% of their stay on a stroke unit in 2022/23, compared to 76.5% in 2021/22.	Work ongoing (action 5)
R2	Increase the proportion of patients receiving the appropriate imaging immediately on arrival at hospital, to accelerate the identification of patients eligible for reperfusion treatments. **For action by: Acute trusts, LHBs, RMDs, Radiology Networks and ISDNs.**	**56.9%** of patients received brain imaging within 1 hour of arrival in 2022/23, compared to **54.6%** in 2021/22.	**58%** of patients received brain imaging within 1 hour of arrival in 2022/23, compared to **50%** in 2021/22.	Yet to be commenced (action 2)

	Recommendation (R) (Audience)	Report findings underlying this recommendation National:	ABUHB:	Progress:
R3	Increase the proportion of days on which people recovering from stroke receive rehabilitation therapy, both inside and outside hospital. **For action by: Acute and community trusts and LHBs.**	Percentage of days a patient requires therapy on which therapy was received: In hospital • OT: **61%** in 2022/23 compared to **64.9**% in 2021/22 • PT: **68.1%** in 2022/23 compared to **72.3%** in 2021/22 • SLT: **48.2%** in 2022/23 compared to **51.7%** in 2021/22 • Psychology: 9% in 2022/23 compared to 9.9% in 2021/22	Percentage of days a patient requires therapy on which therapy was received: In hospital • OT: **52.5%** in 2022/23 compared to **56.6%** in 2021/22 • PT: **59.9%** in 2022/23 compared to **64.9%** in 2021/22 • SLT: **44.3% in** 2022/23 compared to **50.4%** in 2021/22 • no data	Yet to be commenced (action 19)
R4	Increase the proportion of patients accessing stroke/neuro ESD and/or CRT. **For action by: LHBs, acute and community trusts, supported by ISDNs and regional SQuIRe (Stroke Quality Improvement Rehabilitation) leads.**	61% of patients discharged with a stroke/neurology-specific service (ESD and/or CRT) in 2022/23, compared to 60.1% in 2021/22.		Yet to be commenced (action 12)
R5	Reverse the recent decline in the proportion of stroke survivors who receive formal follow-up 6 months after their stroke. **For action by: Acute and community trusts and Integrated Care Board (ICB) and LHB commissioners, supported by ISDNs and regional SQuIRe leads.**			

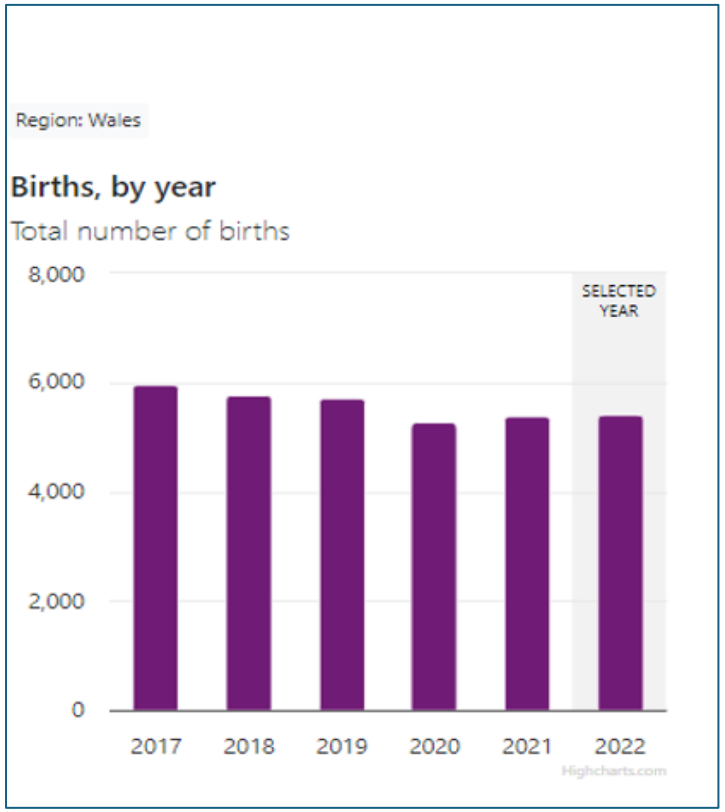
Audit Title: MBRRACE-UK Perinatal mortality surveillance 2024 State of the nation report UK perinatal deaths of babies born in 2022	Clinical Lead: Jayne Beasley - Head of Midwifery & Gynaecology (& on behalf of Dr Maity – Consultant Neonatologist)
Rationale:	The report is divided into five sections: perinatal mortality rates in the UK; mortality rates for Trusts and Health Boards; mortality rates by gestational age; mortality rates by ethnicity and socioeconomic deprivation; and a description of the causes of perinatal death
Objectives:	This report focuses on births from 24 completed weeks' gestational age, with the exception of the section on mortality rates by gestational age, which also includes information on births at 22 to 23 completed weeks' gestational age. This avoids the influence of the wide disparity in the classification of babies born before 24 completed weeks' gestational age as a neonatal death or a late fetal loss.
Presented at Clinical Standards and Effectiveness Group – 26th September 2024	

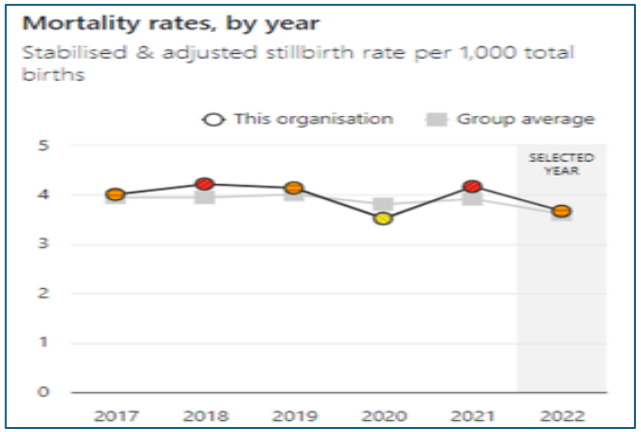
Key messages

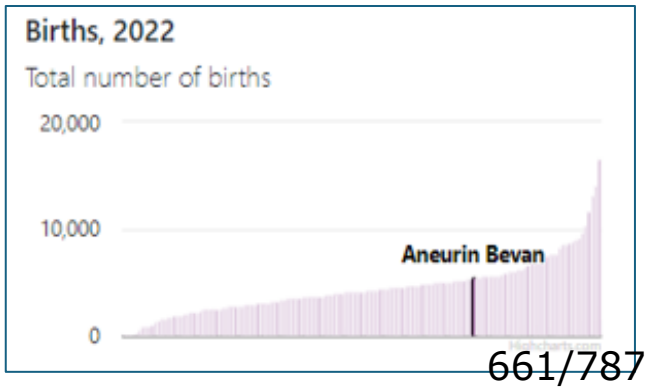
- Extended perinatal mortality rates decreased across the UK in 2022 (UK extended perinatal mortality rate: 5.04 per 1,000 total births) after a rise in 2021, although rates remain higher than both 2019 and 2020.
- Compared with rates in 2021, stillbirth rates per 1,000 total births in 2022 were lower across all the devolved nations except Scotland, where there was a small increase: 3.35 (UK); 3.33 (England); 3.31 (Scotland); 3.63 (Wales); and 3.49 (Northern Ireland).
- There were increases in the neonatal mortality rate per 1,000 live births in England and Wales compared with 2021: 1.69 (UK);1.67 (England); 1.59 (Scotland); 1.91 (Wales); and 2.29 (Northern Ireland).

Aneurin Bevan University Health Board

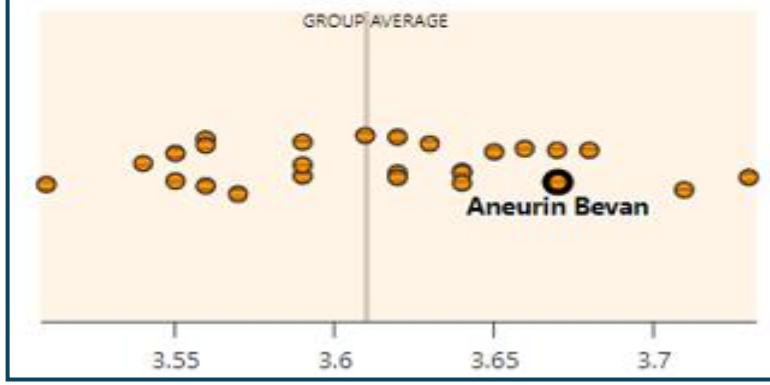
Year	Births	Crude stillbirth rate	Stabilised & adjusted stillbirth rate	Stabilised & adjusted stillbirth rate (95% CI)	Crude neonatal mortality rate	Stabilised & adjusted neonatal mortality rate	Stabilised & adjusted neonatal mortality rate (95% CI)	Crude extended perinatal mortality rate	Stabilised & adjusted extended perinatal mortality rate	Stabilised & adjusted extended perinatal mortality rate (95% CI)
2017	5,975	4.02	4.01	(3.32 to 4.74)	0.50	1.50	(0.90 to 2.36)	4.52	5.50	(4.76 to 6.97)
2018	5,778	5.02	4.22	(3.39 to 5.32)	2.26	2.26	(1.47 to 3.51)	7.27	6.47	(5.40 to 8.38)
2019	5,710	4.90	4.14	(3.47 to 5.28)	0.88	1.48	(0.93 to 2.48)	5.78	5.59	(4.81 to 7.25)
2020	5,292	2.46	3.52	(2.69 to 4.57)	1.14	1.58	(1.05 to 2.40)	3.59	5.09	(4.20 to 6.51)
2021	5,398	4.45	4.17	(3.23 to 5.36)	0.93	1.66	(1.05 to 2.51)	5.37	5.81	(4.80 to 7.62)







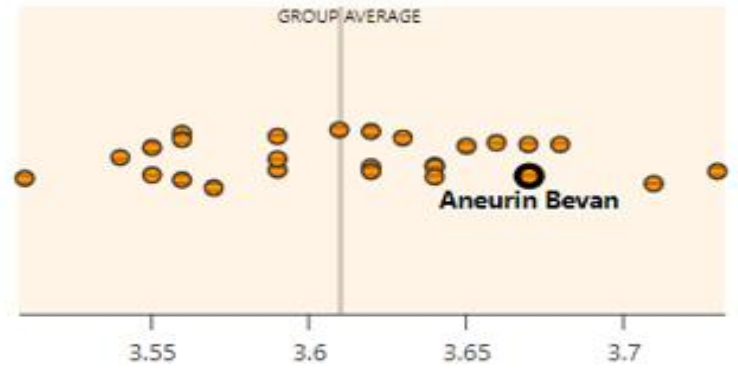
Mortality rates, Level 3 NICU, 2022
Stabilised & adjusted stillbirth rate per 1,000 total births



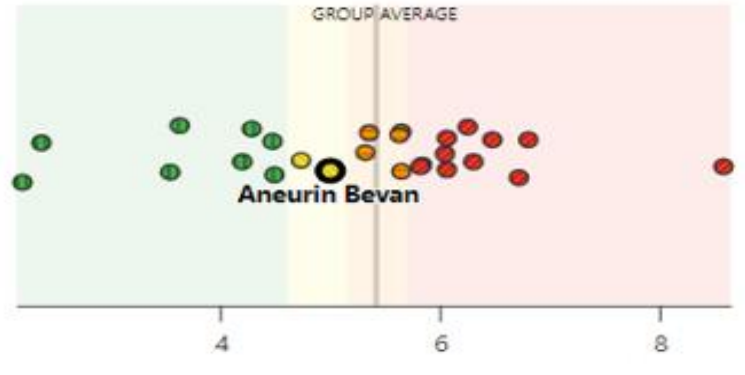
Mortality rates, Level 3 NICU, 2022
Stabilised & adjusted extended perinatal mortality rate per 1,000 total births



Mortality rates, Level 3 NICU, 2022
Stabilised & adjusted neonatal mortality rate per 1,000 live births



Mortality rates, Level 3 NICU, 2022
Crude extended perinatal mortality rate per 1,000 total births



Assurance level	Description
Significant	The project has mostly achieved the standards or criteria being audited against

Risk level	Description
Minor	Overall treatment or service suboptimal- minor implications for safety if unresolved

Report Successes:	
1	Raising awareness regarding stillbirths and neonatal deaths to the public and professionals – Nil intrapartum stillbirths, NND green
2	Increased support re public health messaging – MECC and smoking cessation
3	Increased support and funding re sonography services – detection of Small babies
4	Implementation of local and national audit and case reviews & Perinatal optimisation 97% compliance with audited data for MBRRACE 100% offer of PM
5	Development of maternity improvement plan – re PH messaging

Report Concerns:			
1	Variation in Still Birth rate in comparison to level 3 units, increase in 2021, reduction in 2020 and 2022 – prematurity greatest risk factor for NND	3	Higher % babies born post mature (5.6% as opposed to 1.5%)
2	Mothers giving birth more likely to live in deprived areas (31%)	4	93% stillbirths reported within 7 days 13% NND reported within 7 days – target 100%

Report Recommendations: *Audience: Commissioners*		**S.M.A.R.T Actions:**	**Responsible:**	**Due Date:**	**Progress:**
New Recommendation:					
1	Ensure neonatal intensive care capacity and resources reflect the increase in the numbers of babies born before 24 completed weeks' gestational age receiving survival-focused care.	Review of cot capacity	S Papworth Clinical Director & C Satherley Service Group Manager	Ongoing	NICU GUH follow BAPM recommendations as per: The Perinatal optimisation pathway, Welsh Neonatal Network Peri prem pathway and National Cot configuration
Previous recommendations supported by most recent data – Audience: *UK Governments, Royal Colleges, Commissioners*					
2	Support external clinical input into the rigorous review of all stillbirths and neonatal deaths across the UK, to identify learning and common themes related to clinical care and service provision, delivery and organisation.	Monthly review of cases as per PMRT Monthly review of cases All Wales	PMRT Team & maternity and neonatal network	Ongoing	All cases undergo local review and form wider All Wales mat/neo network monthly review Local and national earning disseminated
3	Ensure healthcare providers adopt and use the BAPM Perinatal Optimisation Pathway, to improve preterm outcomes.	BAPM perinatal optimisation pathway adopted	A Pinto/ S Papworth maternity and neonatal network	Ongoing	In place with monthly audit of all standards across Wales
4	Continue to develop and implement targeted action, at national and organisational levels, to support the reduction of direct and indirect health inequalities.	Development of maternity services improvement plan	HoM – senior management team	Ongoing	Improvement plan in place, Forms part of IMTP, Working with P Health- smoking cessation, Audit cases, Digital data system

Local Recommendations:	**S.M.A.R.T Actions:**	**Progress:**
Monitoring of all stillbirth and Neonatal Deaths	Ongoing yearly Audit, MDT - PMRT review, Feedback and learning to wider local and national teams	Ongoing
There should be targeted Public Health messaging	MECC training, Maternity improvement plan, Smoking cessation carbon monoxide monitoring, Review of AN services and community continuity, Reintroduction of Healthy weight pathway, Digitalisation and information sharing – language	Ongoing
IOL to be offered at <42 weeks	Change in IOL for term plus women (T+12)	Complete
MBRRACE to receive 100% of cases by 7 days	Bereavement lead midwife in place, NICU have designated nurses supporting	Complete
Continued implementation of periprem pathway	Review of monthly audit of periprem standards, Wider feedback and learning	Ongoing

Audit Title:	Twist and Shout – Testicular Torsion	Clinical Lead:	Mr John Pollitt Consultant Surgeon
Rationale:	To review the complete pathway and quality of care provided to children and young people 2 – 24 years of age who present to hospital with testicular torsion.		
Objectives:	The Study Advisory Group (SAG) identified the following areas to address: • Patient and parent/carer knowledge of torsion prior to the clinical episode and the availability of information for patients and parents/carers • Pre-hospital care • The admission process, including assessment and decision-making • The use of accurate diagnostic tools • Protocols for the management of testicular torsion and scrotal pain suggestive of torsion • Staffing availability, training, and use of networks of care • The timeliness of surgery including emergency surgery access • The appropriateness of transfer arrangements • The consent process • Surgical practice in respect of fixing testicles at the time of orchidectomy/exploration • Post-operative complications and follow-up of the patient • Audit of services		
Presented to Clinical Standards and Effectiveness Group: 26th September 2024			



Testicular torsion was not recognised by 157/239 (65.7%) patients or 83/239 (34.7%) parents/carers.

Only 294/403 (73.0%) patients had contacted a healthcare professional within six hours of developing symptoms.



60/475 (12.6%) patients were referred by a GP, 34/475 (7.2%) from an urgent treatment centre and 25/475 (5.3%) NHS 111.

91/143 (63.6%) hospitals reported that patients were transferred out of the hospital for treatment on occasions.

Patients not on a pathway were more likely to have their testicle removed (154/389; 39.6%) compared with those who were (16/67; 23.9%).



136/435 (31.3%) patients had their first assessment on arrival at hospital performed by a junior specialist trainee.

113/422 (26.8%) patients had not had their first ST3+ surgical review within two hours of arrival and 40/422 (9.5%) patients waited more than four hours.

There was a delay in making a diagnosis in 116/635 (18.3%) patients which impacted their care in 69/116 (59.5%) cases.



Information on prosthetic replacements could only be found in the case notes of 139/534 (26.0%) patients who had a testicle removed, with an explanation recorded for 83/139 (59.7%) patients.

Adequate written information given to the patient and family at discharge could only be found in the case notes of 123/233 (52.8%) patients.

Testicular torsion occurs when the spermatic cord twists and cuts off the blood supply to the testicle. Testicular torsion is a surgical emergency requiring prompt diagnosis and surgical intervention to preserve the testicle. Delay in recognising testicular torsion and delay in presenting to hospital is known to lead to poorer outcomes. There needs to be greater public awareness about testicular torsion. Hospitals need to be equipped to deal with testicular torsion as an emergency operation, with senior clinicians able to decide whether surgery is needed and to be able to perform the surgery/anaesthetise the patient. If these services are not available, then there should be robust transfer arrangements in place to get the patient to theatre. Patients will need good information at discharge, and the option to return for further follow-up should they need psychological support or wish to discuss the use of a prosthesis.

NCEPOD Studies do not provide local data breakdown other than the participation numbers

IN THIS STUDY:

- The Patients aged 2 to 24 years, inclusive, admitted to hospital who had a diagnosis of testicular torsion (ICD10 code N44), and who underwent a non-elective operation for testicular torsion (OPCS codes N03.4; N05; N06; N08; N09; N13.2; N13.3 and N13.5) between 1st April 2021 and 31st March 2022.
- Patients admitted with scrotal pain (ICD10 codes N45 and N508) were also identified for context but were not sampled for inclusion in the clinical peer review process.
- The audit consists of 3 elements:
  - Organisational Questionnaire
  - Clinical Questionnaire
  - Case Note review

	Number of participating hospitals	Number of organisational questionnaires received	Number of cases selected	Number of clinician questionnaires returned	Number of sets of case notes returned
Aneurin Bevan UHB	1	1	4	4	4
Betsi Cadwaladr UHB	3	0	19	0	0
Cardiff & Vale UHB	1	1	6	6	6
Cwm Taf Morgannwg UHB	3	0	10	5	10
Hywel Dda UHB	3	1	7	5	7
Swansea Bay UHB	1	1	5	5	5

WHAT PATIENTS AND PARENTS/CARERS SAID

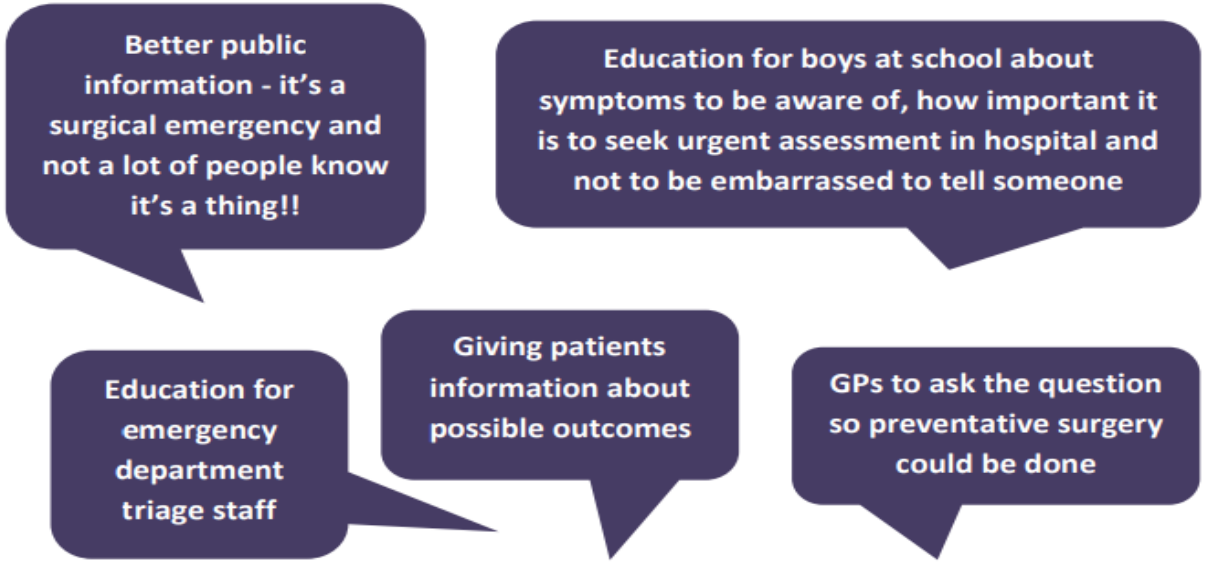
Young people and parents/carers were asked about their experience of care following admission to hospital and an operation for testicular torsion. The age of children and young people at the time of their operation ranged between 3-24 years with a median age of 14 years.

WHAT IS THE ONE THING YOU THINK COULD CHANGE TO IMPROVE CARE FOR FUTURE PATIENTS WHO HAVE TESTICULAR TORSION?



Only 3/17 young people were taught about testicular torsion at school or college.

12/17 young people felt that their symptoms were an emergency… HOWEVER, four of them delayed telling anyone about their symptoms and two of them said they experienced a delay before going to hospital.

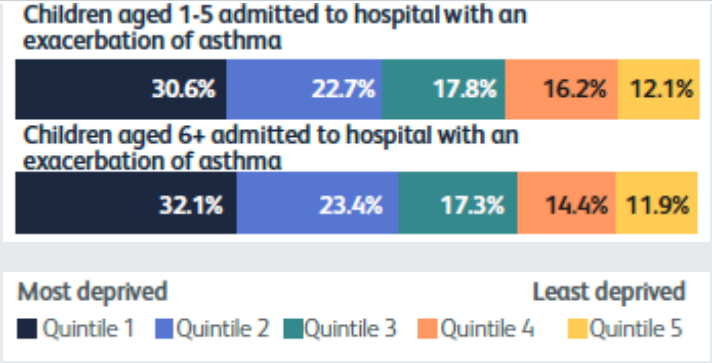


	Report Recommendations: RECOGNITION OF TESTICULAR TORSION IN PRIMARY CARE AND THE EMERGENCY DEPARTMENT	S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
2	Update training modules for primary care, and emergency department staff, to emphasise the importance of early recognition of testicular torsion, including atypical or warning presentations, urgent referral pathways and timely surgery	Training for 1st assessing clinicians (GP/A&E /NHS111)	RCGP/RCEM		
3	Reduce delays for patients with testicular pain/suspected testicular torsion by: • Minimising transfers to another hospital by referring patients to a hospital where scrotal exploration can be performed safely on-site – ideally including a pre-alert to the receiving hospital. • Ensuring that any essential transfer is as urgent as possible*, including when patients self-present but need to be at another hospital. • Having a clear, documented clinical pathway of care for patients with testicular pain/suspected testicular torsion in hospitals where surgery for testicular torsion is undertaken, which is communicated to all healthcare professionals involved in the care of this group of patients. • Auditing the testicular torsion pathway, at least annually, to identify areas for improvement.	Education of GPs A&E triage staff WAST			
4	Patients with suspected testicular torsion should have an urgent* referral and clinical review by a senior surgical decision-maker (minimum ST3 or equivalent) specialising in urology, paediatric surgery, or general surgery.	Pathway for testicular torsion in place at ABUHB Senior/EPIC A&E to delegate to surgical specialty. Annual audit	Senior A&E on site Surgical consultant on call Urology consultant on call MJKP (CL)		

Report Recommendations: PATHWAY IN HOSPITAL		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
5	A consensus is needed on the role of Doppler ultrasound in the care pathway for suspected testicular torsion to aid surgical decision-making whilst not adding delay to surgery.	Consensus to be drawn- Current practice is not to USS suspected torsion in this HB	BAUS/RCS/BAPS		
6	Perform surgery for testicular torsion as an immediate or urgent procedure (NCEPOD 1 or 2)*, once the decision to operate has been made.	Booked cat 1			

Report Recommendations: DISCHARGE AND FOLLOW-UP		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
7	Discharge information for patients, and parent/carers should include: a) Any follow-up arrangements. b) Delayed side effects that might occur following orchidectomy, or the risk of late testicular atrophy in patients who had an operation that led to no orchidectomy, but fixation (orchidopexy), including risks to fertility. c) Details of patient-initiated follow-up (PIFU) follow-up e.g. to discuss prosthetic implants for patients who underwent an orchidectomy. d) How to access psychological support.	All proven torsions are followed up at GPS clinic Or Urology if>16	Surgical team on d/c		
8	Review the care of all patients who underwent an orchidectomy in a multidisciplinary morbidity and mortality meeting. This should include primary care and, ideally a regional approach to shared Learning and quality improvement.	Audit of orchidectomies 2dry to torsion.	CL- GS & Urology	Feb 2025	In progress

Clinical Leads Local Recommendations: (if applicable)		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Optimise testicular pain pathway at ABUHB		MJKP/A&E		Ongoing discussion with A&E/Urol/GS directorates
2	Education of at risk group at school level to minimise delayed presentation				

Audit Title:	Breathing well An assessment of respiratory care in England and Wales	Clinical Lead:	Dr Pierrepoint - Paediatrician
Rationale:	NRAP works with patient panels run the Royal College of Paediatrics and Child Health (children and young people) to ensure our audit programme focuses on improvements in the areas most important to people living with respiratory conditions. The Asthma &Me Ambassadors are aged 13–21 and have joined together from across the country with a shared mission to improve asthma care and services for children and young people. Some of them have personal experiences of asthma, others have an interest through family or friends, all have a passion to make a difference. They have collected voices from children, young people and families, and hope to represent their voices in NRAP, with the support the support of decision makers to act and implement the changes they say are needed.		
Objectives:		There is a national focus on health inequalities in respiratory care, as outlined in the NHS Long Term Plan and the Core20PLUS5 approaches for all age groups. Among people admitted to hospital with a COPD or asthma exacerbation, the highest proportion of people live in the most deprived. Importantly, in current analyses, it has not been observed that key outcomes related to the quality of care as inpatients vary based on the level of deprivation of a person's postcode. This suggests that the interaction between socio-economic inequalities and important clinical outcomes, including hospitalisation and mortality, are complex and driven by deep-rooted structural and societal factors associated with respiratory ill-health. Even though we need to see an improvement in the wider drivers of respiratory outcomes, it is crucial that we do everything we can to ensure that the standard of care given to all patients, regardless of their background, is as high as it can be.
Presented at Clinical Standards and Effectiveness Group – 26th September 2024			

Spotlight on healthcare improvement

Providing optimal care remains a key healthcare improvement area for NRAP. We suggest the following areas of improvement for services:

- All services should participate in NRAP and achieve a minimum of 50% case ascertainment.
- Hospitals in England should ensure resources generated from achievement of asthma and COPD best practice tariff (BPT) are available to frontline clinical and administrative teams to support NRAP participation and quality improvement.
- Locally collected NRAP data should be reviewed at least annually by both providers and commissioners to monitor delivery of optimal care and drive improvement.
- Specifically, this should generate locally agreed actions plans to improve performance against national guidance on the first hour of care and specialist respiratory review within 24 hrs.

Patients who received systemic steroids within 1-hour of arrival at hospital:

CYP aged 6–18
35.0%
2021/22: 31.0%

The percentage of smokers offered a referral to smoking cessation services as part of a discharge bundle.

Children and young people (CYP)

with asthma (aged 11+)	parent or carer
72.7%	**36.0%**
2021/22: 54%	2021/22: 37%

The percentage of all patients who had smoking status, or second-hand smoking exposure, recorded.

Children and young people (CYP)

with asthma (aged 11+)	second-hand smoke exposure recorded
44.7%	**58.8%**
2021/22: 42.1%	2021/22: 37%

The percentage of patients with documentation of a current self-management plan following an admission to hospital due to an exacerbation:

Children and young people (CYP)

with asthma (aged 1–5)	with asthma (aged 6+)
45.8%	**47.0%**
2021/22: 35.0%	2021/22: 41.3%

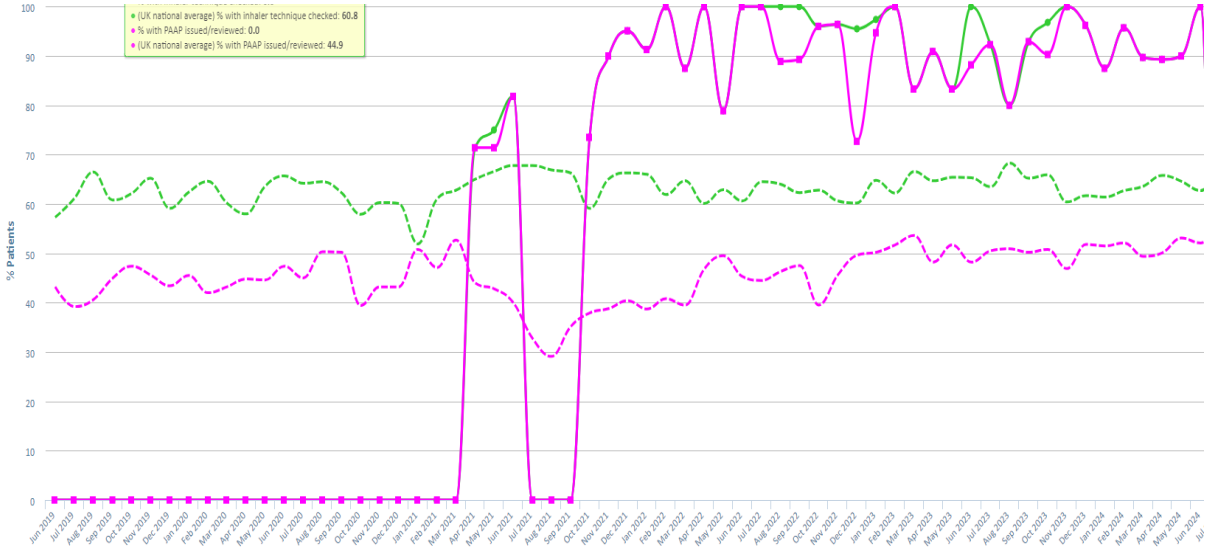
Children and young people (CYP) aged 1–18

85.2% Percentage of children and young people with asthma who are reviewed by a member of the MDT trained in asthma care.

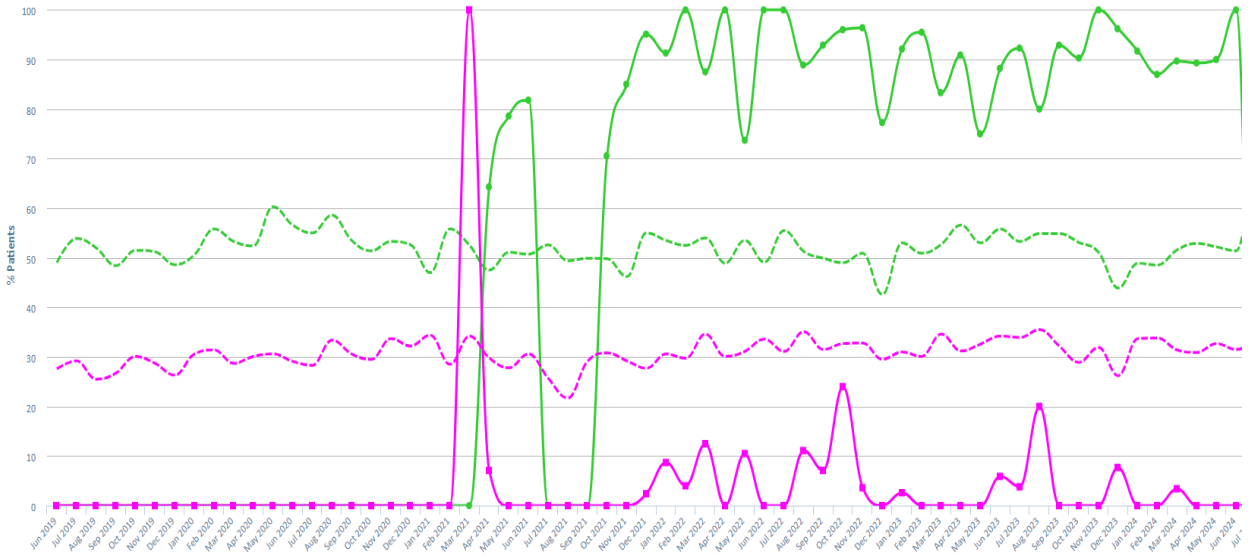
Hospital / Unit	Cases	KPI 1: Steroids administered within 1 hour of arrival (aged 6 - 18 years)%	KPI 2: Current smokers (patients 11+) with tobacco dependency addressed %	KPI 3: Current smokers (Parent/carer) with tobacco dependency addressed %	KPI 4: Inhaler technique checked as part of discharge planning %	KPI 5: Personalised Asthma Action Plan (PAAP) issued/reviewed as part of discharge planning %
The Grange University Hospital	47	27.8	0.0	27.3	91.5	91.5
All audit data	**3,307**	**41.8**	**26.7**	**44.9**	**65.1**	**51.9**

NHS Regional totals	Cases	KPI 1: Steroids administered within 1 hour of arrival (aged 6 - 18 years)%	KPI 2: Current smokers (patients 11+) with tobacco dependency addressed %	KPI 3: Current smokers (Parent/carer) with tobacco dependency addressed %	KPI 4: Inhaler technique checked as part of discharge planning %	KPI 5: Personalised Asthma Action Plan (PAAP) issued/reviewed as part of discharge planning %
Wales	148	26.1	0.0	44.1	77.8	65.3
All audit data	**3,307**	**41.8**	**26.7**	**44.9**	**65.1**	**51.9**

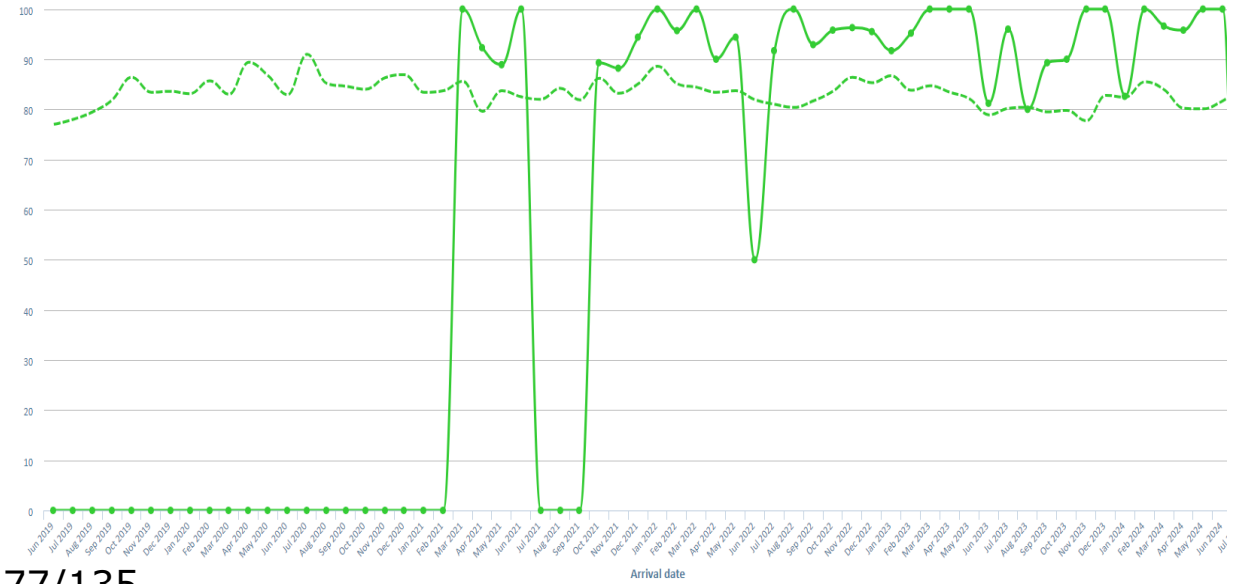
GUH – Green -% with inhaler technique checked
Pink - % with PAAP issued
Dotted line National data – solid lines relate to ABUHB



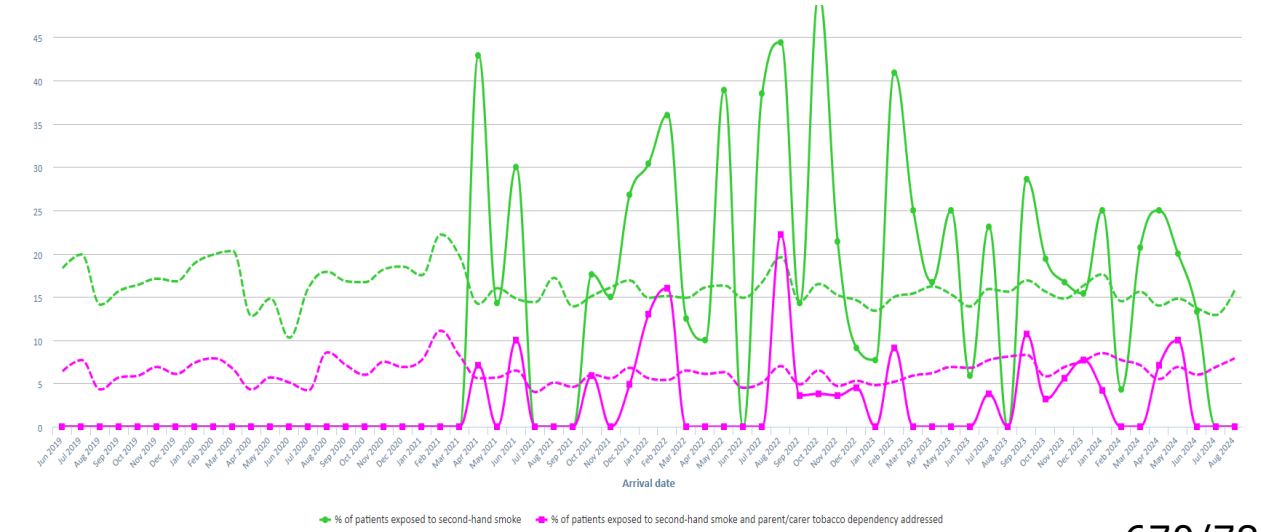
GUH – Green - % in receipt of a discharge bundle
Pink - % referred to clinic within 4 weeks
Dotted line – National Data, solid line – ABUHB data



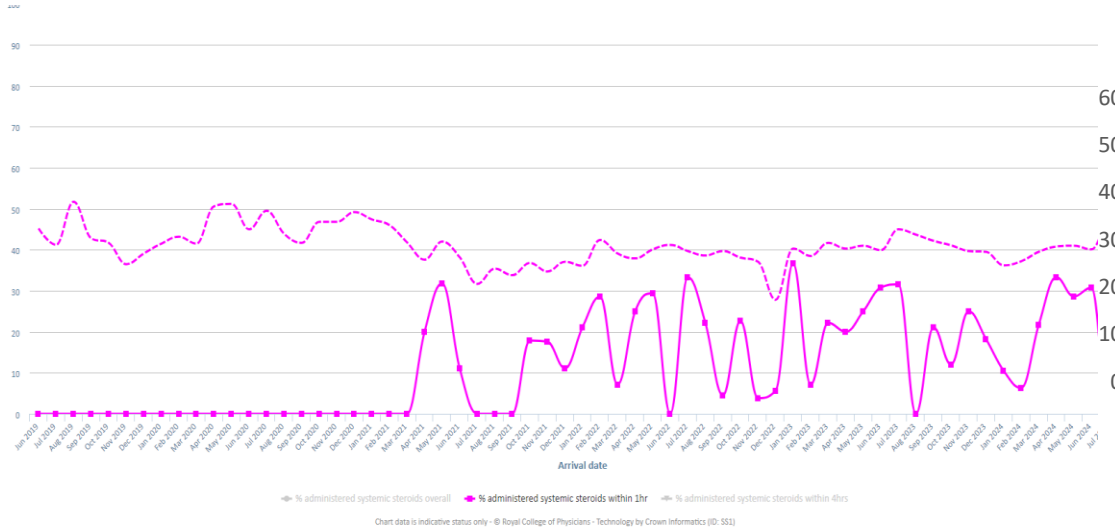
GUH - % Discharge Steroids
Dotted line National data – solid line relate to ABUHB



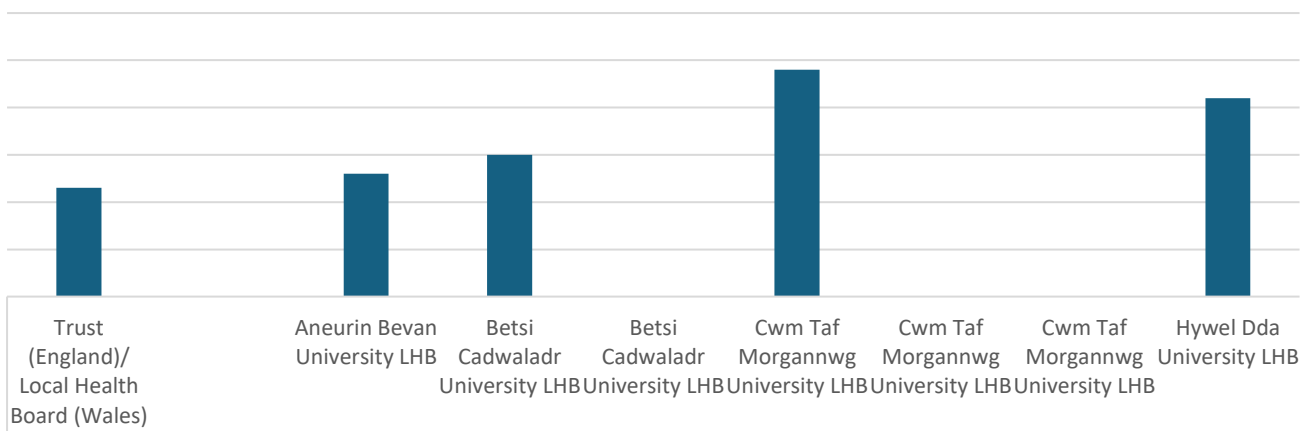
GUH – Green - % children exposed to second hand smoke
Pink - % children exposed to second hand smoke & parent/carer tobacco dependency addressed
Dotted line National data – solid line relate to ABUHB

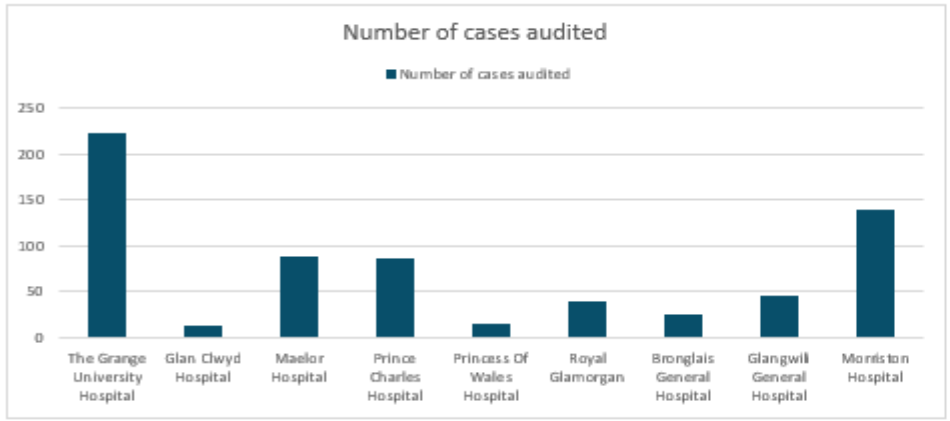


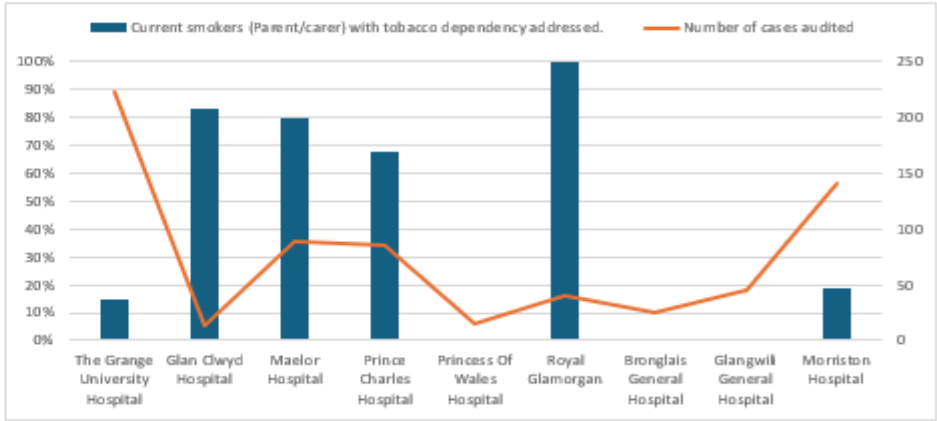
GUH - % Steroids in 1st hour
Dotted line National data – solid line relate to ABUHB

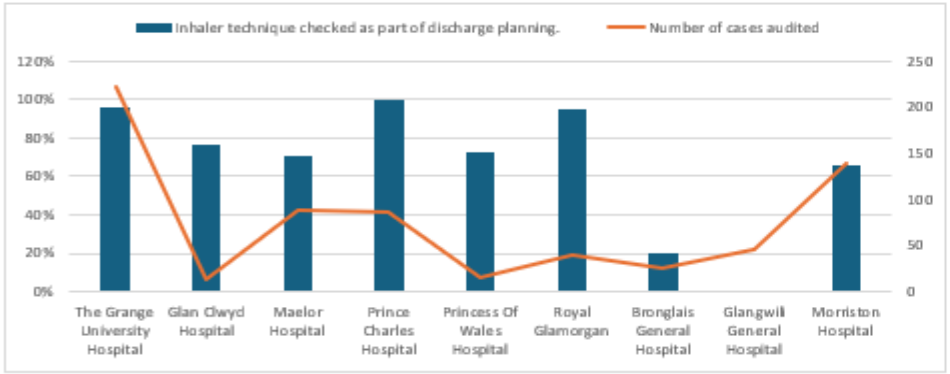


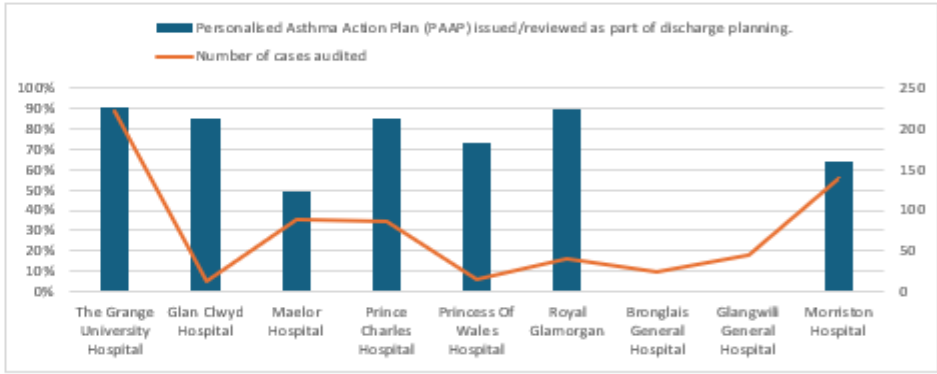
Steroids administered within one hour of arrival at hospital for children and young people of 6 - 18 years old.

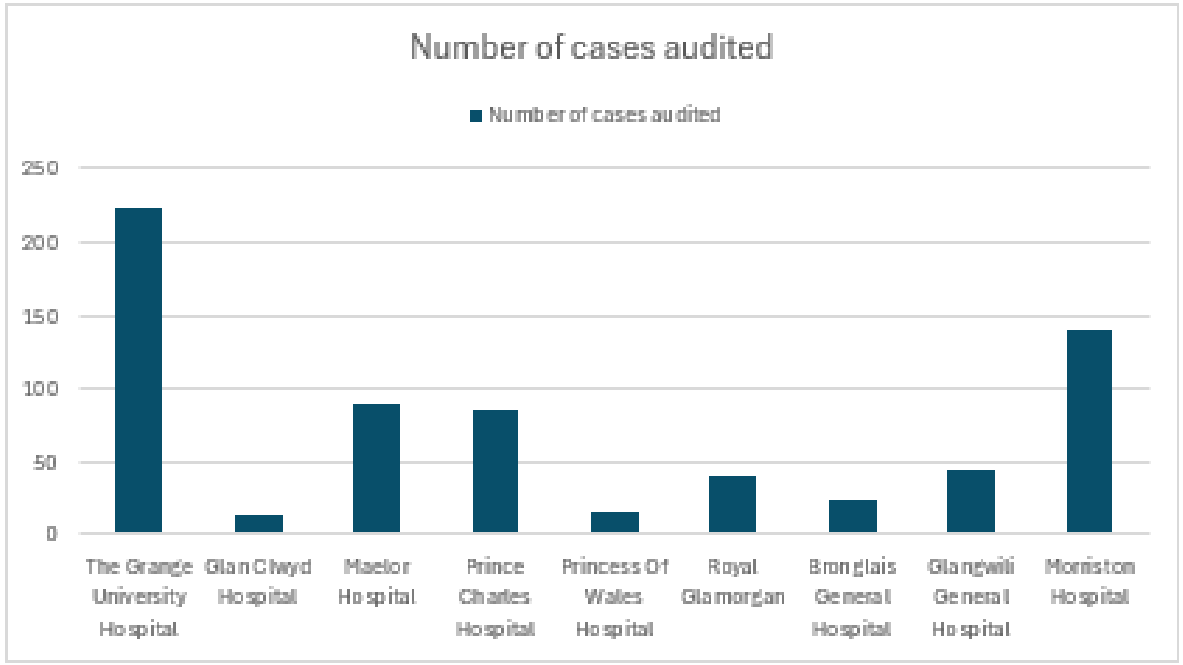


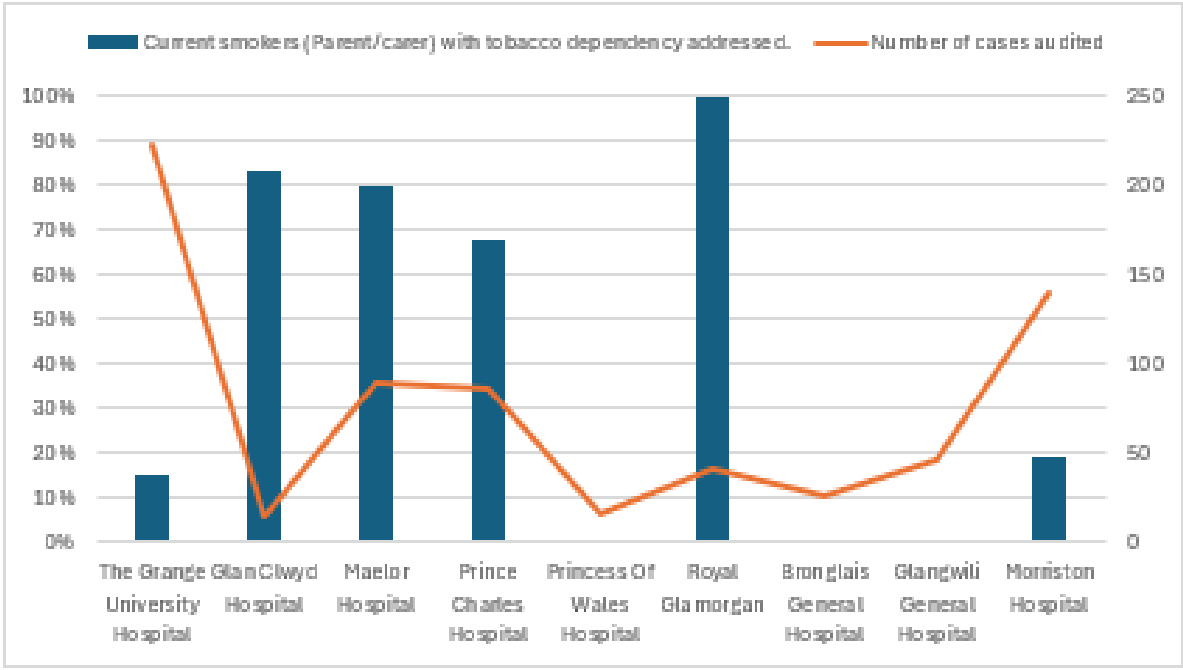


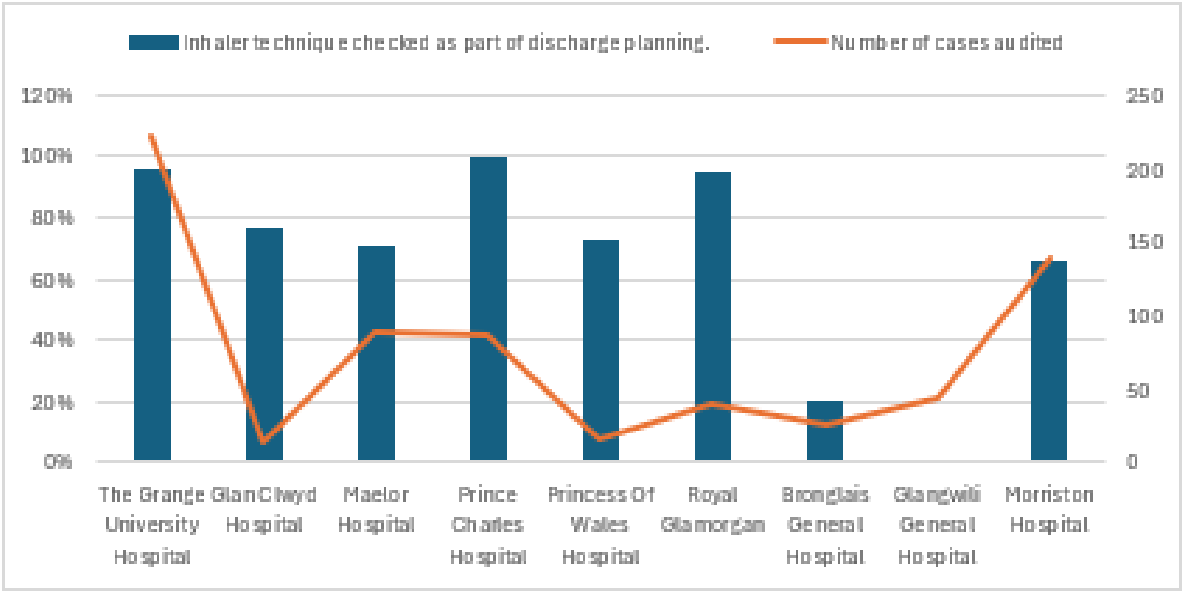


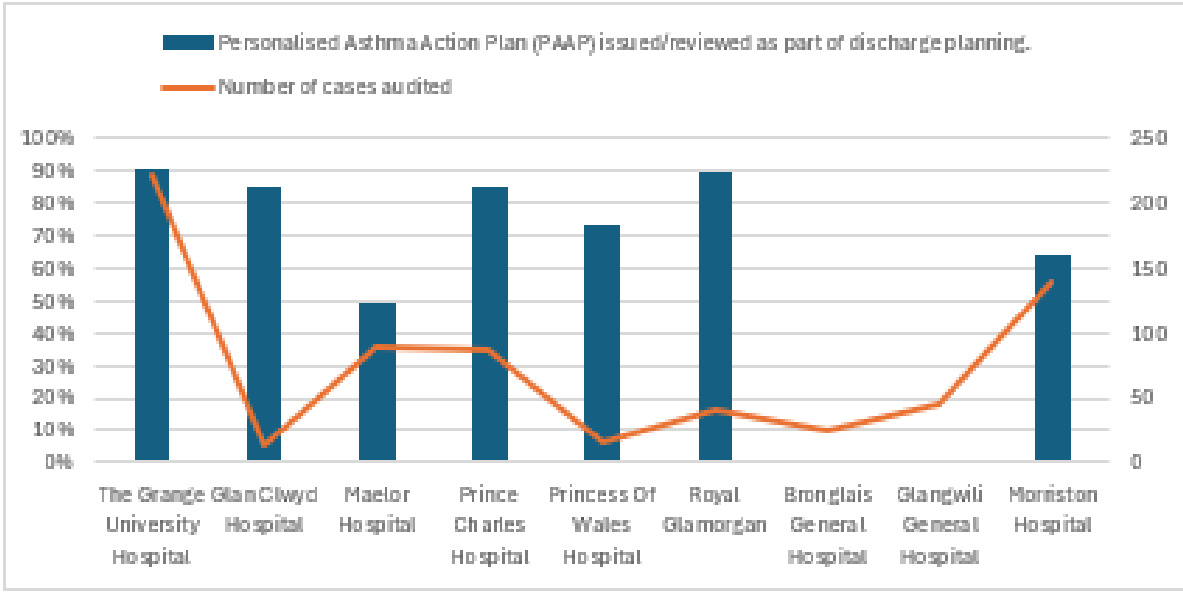





Number of cases audited
Number of cases audited
250
200
150
100
50
0
The Grange University Hospital
Glan Clwyd Hospital
Maelor Hospital
Prince Charles Hospital
Princess Of Wales Hospital
Royal Glamorgan
Bronglais General Hospital
Glangwili General Hospital
Morriston Hospital


Current smokers (Parent/carer) with tobacco dependency addressed.
Number of cases audited
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
250
200
150
100
50
0
The Grange University Hospital
Glan Clwyd Hospital
Maelor Hospital
Prince Charles Hospital
Princess Of Wales Hospital
Royal Glamorgan
Bronglais General Hospital
Glangwili General Hospital
Morriston Hospital


Inhaler technique checked as part of discharge planning.
Number of cases audited
120%
100%
80%
60%
40%
20%
0%
250
200
150
100
50
0
The Grange University Hospital
Glan Clwyd Hospital
Maelor Hospital
Prince Charles Hospital
Princess Of Wales Hospital
Royal Glamorgan
Bronglais General Hospital
Glangwili General Hospital
Morriston Hospital


Personalised Asthma Action Plan (PAAP) issued/reviewed as part of discharge planning.
Number of cases audited
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
250
200
150
100
50
0
The Grange University Hospital
Glan Clwyd Hospital
Maelor Hospital
Prince Charles Hospital
Princess Of Wales Hospital
Royal Glamorgan
Bronglais General Hospital
Glangwili General Hospital
Morriston Hospital

Assurance level	Description	Select
Full	The project has fully achieved the standards or criteria being audited against	
Significant	The project has mostly achieved the standards or criteria being audited against	**yes**
Limited	The project did not achieve the standards or criteria being audited against	
Very limited	The project failed to achieve the standards or criteria being audited against	

Risk level	Description	Select
None	Standards met and findings demonstrate no risk to patient safety	
Minor	Overall treatment or service suboptimal - Minor implications for patient safety if unresolved	**yes**
Moderate	Treatment or service has significantly reduced effectiveness - Moderate risk to patient safety if not acted upon	
Major	Non-compliance with national standards with significant risk to patients if unresolved – Major risk to patient safety	
Catastrophic	Totally unacceptable level or quality of treatment/service - Gross failure to meet national standards – Gross failure to meet standards	

Has this audit been placed on a Risk Register (N/A if above risk is None)	**YES/NO**
If not on a risk register, why not:	

Report Successes:	
1	Data Capture is the best in Wales and in comparison, to the rest of the UK
2	Structure education pathways are good (exc. Smoking)
3	Personalised Asthma Action Plans (PAAP) at discharge one of the best in Wales

Report Concerns:	
1	Patient Flow issues at front end impact the 1 hr Steroid administration
2	Actions from previous report have not all been actioned re pathways and updating proforma

	Report Recommendations:	S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Integrated care boards and local health boards should ensure that they achieve 100% service participation and that services achieve a minimum 50% case ascertainment in NRAP audits by May 2026. This will require all hospitals having named NRAP clinical leadership and dedicated audit support.				**Achieved**
2	All people with COPD and asthma who smoke, and smokers who are parents of children and young people with asthma, should be offered evidence-based treatment and referral for tobacco dependency.	To ensure the smoking status data is recorded on the proforma	Dr Marcus Pierrepoint	31/12/2024	3/12
3	All people with asthma and COPD discharged from hospital after an acute event should have a current self-management plan. Where this is not achieved, services should work towards a target of 75% by May 2026. Services should prioritise patient-centred approaches and explore the role of clinically approved digitally supported self-management.				**Achieved**

	Clinical Leads Local Recommendations: (if applicable)	S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	A meeting planned with Primary Care to discuss pathways	Cancelled on 2 occasions	Asthma team in Primary and Secondary Care	31/12/2024	Ongoing
2	A joint meeting with Adult services to discuss internal pathways		Asthma Paediatric & Adults Services	31/12/2024	Ongoing

Endometriosis: A Long and Painful Road **A review of the quality of care provided to adult patients diagnosed with endometriosis**	**Clinical Lead:** **Dr Anita Nargund – Consultant Obstetrics and Gynaecology**
Rationale:	Endometriosis is often treated as multiple episodes of acute care, instead of on a continuum like other chronic conditions, such as diabetes or inflammatory bowel disease. This approach needs to change to enable appropriate pathways of care, holistic and medical management, discharge planning and follow-up.
Objectives:	To review remediable factors in the quality of care provided to patients aged 18 and over with a surgical diagnosis of endometriosis To explore the clinical and organisational structures in place for the provision of care for patients with endometriosis, reviewing the entire pathway of care with a focus on: • Triage • Endometriosis specialist centres • Policies/protocols/care pathways in place – including delays • Communication between providers • Information and support for patients • Staffing • Surgical services • Imaging services • Holistic care and multidisciplinary team (MDT) provision • Discharge and follow-up
Presented at Clinical Standards and Effectiveness Group – 26th September 2024	

Please note there is no local data for Aneurin Bevan University Health Board

OVERARCHING MESSAGE

Endometriosis is often treated as multiple episodes of acute care, instead of on a continuum such as chronic conditions like diabetes, to enable appropriate pathways of care, holistic and medical management, discharge planning and follow-up.

1. Endometriosis is a chronic condition

Unlike other chronic conditions, such as diabetes, there is no pathway for endometriosis.



36/136 **(26.5%)** patients had a **delay in initial referral to gynaecology** and in 25/36 patients this impacted on the quality of the care they received.

124/238 **(52.1%)** patients experienced **recurrence or persistence of endometriosis symptoms** following laparoscopy. 32/124 **(25.8%)** patients had a **delay in being reseen**.

2. Endometriosis has symptoms and signs that need earlier recognition for appropriate timely management

Signs and symptoms of endometriosis need to be recognised and not just seen as troublesome periods.



Presenting symptoms were most often **painful/irregular/heavy periods** or painful intercourse in 220/234 **(94.0%)** patients. But **also bowel** in 34/234 **(14.5%)** and **urinary/bladder** symptoms in 14/234 **(6.0%)** patients, or an **inability to conceive** in 12/234 **(5.1%)**

546/941 **(58.0%)** patients surveyed **had multiple visits to the GP** before any investigations were undertaken or treatment initiated

3. Endometriosis affects quality of life. All patients should be asked about the effect of disease on their life

Access to supportive services would enable patients with endometriosis to manage their condition.



Failure to refer to supportive services resulted in **less than best practice** for 70/309 **(22.7%)** patients.

420/941 **(44.6%)** of survey respondents stated that they were **not asked at any point about the impact of symptoms on their quality of life**.

4. Endometriosis requires holistic, joined-up, multidisciplinary care

Multidisciplinary care is essential to ensure patients with endometriosis have all their care needs met.



Only 73/167 **(43.7%)** of **hospitals reported MDT meetings** were held for patients with endometriosis.

Reviewers found that only 27/242 **(11.2%)** patients were **formally discussed in an MDT meeting** and 28/215 **(13.0%)** patients who were not discussed **should have been**.

NCEPOD Studies do not provide local data breakdown other than the participation numbers

Demographics

The study population mainly comprised women of reproductive age with a mean age of 34 years (Figure 2.1).

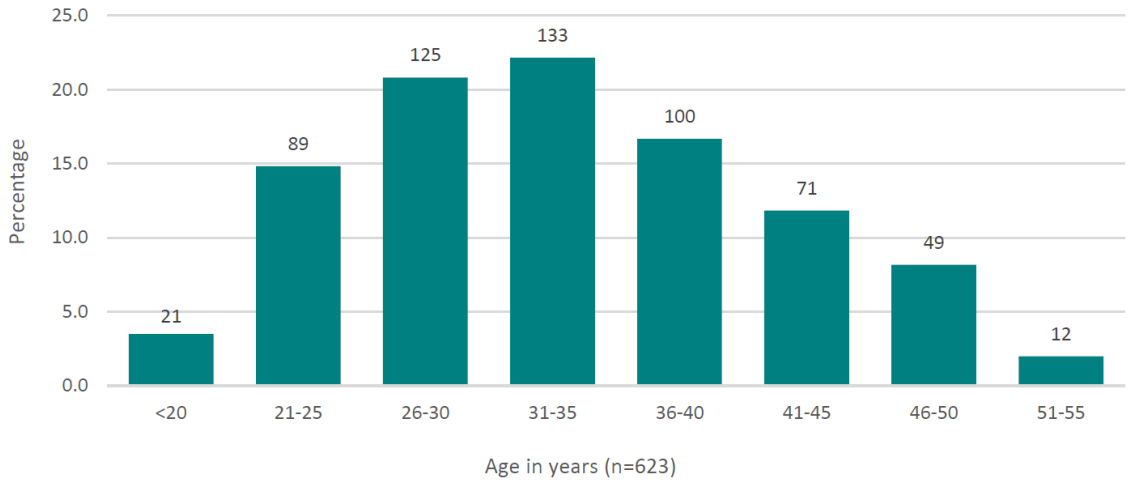


Figure 3.5 demonstrates the timeline of events in the treatment pathway for endometriosis for the patients in this study. It illustrates that once symptoms are recognised and reported, referral to appropriate services takes place and the time delay reduces. This suggests that education of both patients and GPs is essential in helping people to recognise symptoms of endometriosis to reduce the delay in initiating appropriate

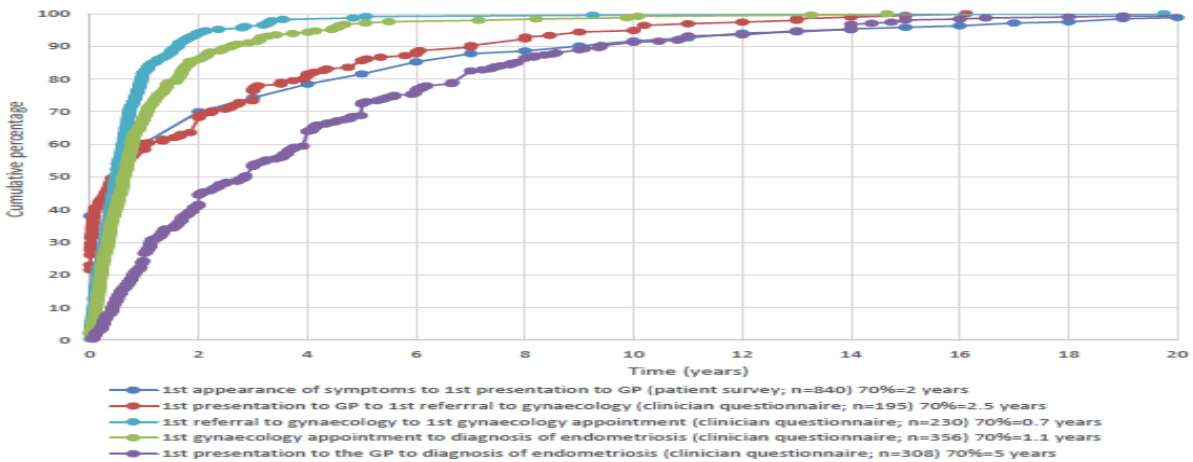


Figure 3.5 Timeline of events in the treatment pathway for endometriosis

Table 4.1 shows which specialties were involved in the MDTs. However, these were not always whole-time equivalent roles. Within the MDTs, 111/167 (66.4%) hospitals had one whole-time gynaecologist, 34/167 (20.3%) had two, and 36/167 (21.5%) had three or more. Only 8/167 (4.8%) hospitals had more than one whole-time endometriosis clinical nurse specialist. In terms of pain specialists, 25/167 (14.9%) hospitals had one whole-time pain specialist within the endometriosis team, while 6/167 (3.5%) did not have any pain specialist available.

Thirty-one hospitals had one or more dedicated colorectal surgeons as part of the service, 26/167 (15.5%) hospitals had one or more whole-time fertility specialist employed in the team and three hospitals had a dedicated physiotherapist. Forty-seven hospitals had at least one or more radiologist specialising in endometriosis.

Table 4.1 All the healthcare professionals who comprised the multidisciplinary team

	Number of hospitals	%
Gynaecologist	160	95.8
Radiologist	96	57.5
Colorectal surgeon	93	55.7
Urologist	85	50.9
Pain specialist	73	43.7
Endometriosis clinical nurse specialist	64	38.3
Reproductive medicine specialist	58	34.7
Physiotherapist	40	24.0
Histopathologist	35	21.0
General surgeon	35	21.0
Pharmacist	33	19.8
General nurse	29	17.4
Gynaecology specialist nurse	19	11.4
Psychologist	17	10.2
Dietitian	10	6.0
Occupational therapist	4	2.4
Other	10	6.0

Answers may be multiple; n=167, organisational data

Assurance level	Description
Significant	The project has mostly achieved the standards or criteria being audited against

Risk level	Description
Moderate	Treatment or service has significantly reduced effectiveness - Moderate risk to patient safety if not acted upon

Has this audit been placed on a Risk Register (N/A if above risk is None)	No

If not on a risk register, why not: Improvements to the service and work towards completing recommendations remains an ongoing process and the audit is mostly achieving the standards with areas of good practice not part of recommendations.

Report Successes:	
1	ABUHB has been accredited by BSGE as an endometriosis centre.
2	Raising awareness of endometriosis with the public and patients. Raising awareness with healthcare professionals regarding endometriosis being a chronic condition
3	CNS support in secondary care
4	Simulation training for laparoscopic procedures
5	Trainees in clinic with consultant for development of skills
6	The use of PROM'S and PREM'S to attain quality-of-life and perception of disease

Report Concerns:	
1	No dedicated theatre list for joint surgery with colorectal surgeon/gynaecologist
2	Cardiff declining referrals
3	If accreditation is not maintained there will be no clear pathway for women with stage 3 and 4 endometriosis involving the bowel which requires colorectal support
4	Withdrawal of pelvic pain MDT clinic
5	Lack of CNS in primary care
6	Lack of mental health support and psychologist. Need for more procedures to be undertaken as see and treat rather than diagnostic laparoscopy.

Report Recommendations:		S.M.A.R.T Actions:	Responsible:/Due Date:/Progress:
1	Raise awareness about endometriosis symptoms with the public and patients, highlighting that it is a chronic condition and how they can seek help.	• Open access to endometriosis CNS for teaching sessions at schools, universities, fundraising events this has already been taking place at a number of venues including Cardiff University. • Using the Health Boards (HB) social media platforms for Q&A events, short videos to talk about endometriosis. • Using the intranet/HB webpage to promote education around endometriosis. ABUHB has a dedicated page to endometriosis as well as signposting to support sites such as Endometriosis Cymru and Endometriosis UK.	**Ms Nargund/ Jo Kitt CNS** **In Progress** - OAK Talks – Patients can self-refer from the community to a zoom call regarding endometriosis and its treatment. There is an endometriosis roadshow planned for 2025 across all HB in Wales.

Report Recommendations:		S.M.A.R.T Actions:	Responsible:/Due Date:/Progress:
2	Raise awareness with all healthcare professionals that endometriosis is a chronic condition and should be treated as such.	• Endometriosis/Pelvic pain study days. Offering teaching to GP's, medical students. This is already incorporated into the teaching programme. Education for consultants working in other specialities. Highlighting endometriosis on the intranet during March which is endometriosis awareness month.	**In progress** - Development of an online learning tool on ESR for healthcare clinicians to complete.
3	Improve training on the recognition of symptoms of endometriosis, such as pelvic pain and heavy menstrual bleeding. a. In primary care - to support healthcare professionals in the initial assessment, and any ongoing care of patients b. In secondary care - enhanced training on endometriosis should be made available for all health care professionals who might care for patients with endometriosis.	• Training in medical management and excision of endometriosis already incorporated into the ABUHB teaching programme and this has been developed by the endometriosis lead. • Simulation training on a regular basis to teach laparoscopic procedures. • Trainees attending dedicated endometriosis clinics and theatre sessions with endometriosis lead consultant to develop skills.	**Completed** - ABUHB has achieved accreditation status from the BSGE as we do have the specialist skills/resources available as bowel surgeons are supporting in their own time on an adhoc basis. ***Outstanding -*** *There are concerns regarding the long term multidisciplinary surgical management of endometriosis as currently there is NO dedicated theatre list for a colorectal surgeon to do a joint case with the gynaecologist. Funding for bowel surgeons is not available and Cardiff are declining referrals due to their own vast caseload.*
	If accreditation is not maintained there will be no clear pathway for women with stage 3 and 4 endometriosis involving the bowel which requires colorectal support. This will unfortunately affect patients access to services they should be offered for this complex disease which affects their quality of life significantly. ***Another concern is the access to a dedicated pelvic pain anaesthetic consultant. ABUHB did have a dedicated multi-disciplinary pelvic pain clinic which involved, anaesthetist, gynaecologist, physiotherapist and psychologist. This was withdrawn during covid, and the funding was withdrawn so we can no longer provide this service to patients.***		***Outstanding*** *- Dedicated theatre list for complex endometriosis cases on regular basis involving colorectal surgeon.* ***Outstanding*** *- To further develop sonographers' skills to recognise deep infiltrating endometriosis signs.*

Report Recommendations:		S.M.A.R.T Actions:	Responsible:/Due Date:/Progress:
4	Ask patients with endometriosis about the effects it has over and above physical symptoms, including its impact on their daily life and refer them as needed to support services (e.g. psychology/pain services), at all stages of the pathway.	The endometriosis CNS is a key contact for initial support. Both the nurse led, and consultant endometriosis clinic has a proforma that asks about patients' quality of life and the impact the disease has on it. This is also recorded on our PREM/PROM data in a quality-of-life score.	***Outstanding*** *- Access to mental health support for patients with endometriosis and living with a chronic illness. A dedicated pelvic pain psychologist would have a huge impact on patients' quality of life and perception of the disease.* ***Outstanding*** *- To approach occupational health to be part of our wider MDT to support patients further.*
5	Ensure multidisciplinary teams/clinical networks are set up and utilised across all healthcare settings to help agree treatment plans and support women with confirmed endometriosis. Input from specialties should be proportionate to the patient's needs.	This service already exists within ABUHB with consultant and endometriosis nurse led MDT's taking place weekly. Monthly MDTs already exists with bladder, bowel, pelvic physio, sexual health, fertility, menopause, pain CNS as and when required for complex patients. The endometriosis nurse is also able to make contact to the above specialities on an ad hoc basis as required. For any joint cases we hold an MDT pre-operatively with the other specialities to plan the surgical management and ensure patient is fully aware of risks/benefits of procedure. We would benefit from psychology support but at present a business case would be needed for this.	***Outstanding*** *- Development and involvement of a primary care lead for endometriosis not just women's health. Occupational health involvement as endometriosis does affect impact on the ability to work.* ***Outstanding*** *- In the future we are looking to develop a nurse led nutritional advice-based clinic*.
6	Manage pain effectively for patients who have endometriosis: a. Set a low threshold for the prescription of analgesia b. Set a low threshold for hormonal treatment which may improve pain as well as other symptoms –while always considering fertility intentions c. Refer to pain management services as needed d. In parallel, refer patients for non-medical pain management e.g. physiotherapy	This is largely managed in both the consultant led and nurse led endometriosis clinics. Education to patients around taking analgesia, using TENs, living well with pain etc. Advice can also be given to GPs as needed via email queries sent. Making care plans for patients to take to their G.P to explain the need for analgesia to help manage endometriosis. Utilising the ability to refer to pelvic physio.	***In progress*** *- We cannot refer direct to pain team if patients are awaiting surgery or any other investigations. There was a pre-existing multi-disciplinary pelvic pain clinic which unfortunately was stopped during covid. This needs to be re-instated with support from anaesthetic team.*

Report Recommendations:		S.M.A.R.T Actions:	Responsible:/Due Date:/Progress:
7	Use interactions between patients with endometriosis and prescribing healthcare professionals to undertake a medication review.		Completed
8	Provide patients with clear, written information as part of the process that allows the patient to give informed consent for the laparoscopic diagnosis/treatment of endometriosis. This should form the basis of a documented discussion with the surgeon before the day of surgery. Include: a. What the procedure involves b. The purpose of the procedure e.g. to diagnose, stage, treat the symptoms of endometriosis, or a combination of these c. What the patient's expectations are d. The possible effects on endometriosis symptoms e. Risks, benefits and limitations f. The need for further laparoscopic/open surgery for recurrent endometriosis or if complications arise This is consistent with NICE guideline NG73	Dedicated consent clinic.	**In progress** - We provide patients with clear, written information as part of the process that allows the patient to give informed consent for the laparoscopic diagnosis/treatment of endometriosis. This process is performed in the endometriosis clinic or in any general gynaecology clinic if listing for diagnostic laparoscopy prior to surgery. Information leaflets should be given regarding proposed surgery, diagnostic laparoscopy or excision of deeply infiltrating endometriosis leaflet.
9	Provide patients with clear, written information at discharge following laparoscopic diagnosis/treatment of endometriosis, including who to contact and how to initiate direct access back into the endometriosis care pathway. a. Who to contact if they have any concerns, e.g. GP, endometriosis clinical nurse specialists, consultant b. The follow-up plan and ongoing management of the endometriosis c. The option of patient-initiated follow-up d. Types and dosages of medication they are on at discharge, including analgesia and hormone therapy e. The consideration of bone health for people with endometriosis on long-term hormonal medication, including nutrition, weight-bearing exercise and alcohol intake	Patients are all offered a follow up appointment or be left on a PIFU pathway and be able to access endometriosis CNS who can then offer an appointment or refer back to the consultant if needed. This ensures long term management of the condition to allow for medication and Implications – the case load is becoming too large for one endometriosis nurse hence ideally an endometriosis CNS is needed in primary care. Numbers into the service are recorded and data collected regarding the value of a PIFU pathway. symptom review as needed.	**Completed** **Outstanding**

Report Recommendations:		S.M.A.R.T Actions:	Responsible:/Due Date:/Progress:
10	Formalise a care pathway for patients with or suspected to have endometriosis. This pathway should include implementation of NICE guideline NG73, the European Society of Human Reproduction and Embryology (ESHRE) endometriosis guidelines, as well as the recommendations from this report.	Endometriosis referral pathway.pptx (sharepoint.com) Guidelines Ref Forms - OneDrive (sharepoint.com) Guidelines Ref Forms - OneDrive (sharepoint.com)	**Completed**
11	a. Collect surgical outcome data, including patient-reported outcomes, for benchmarking. b. Review local practice against NICE guideline NG73, the recommendations in this report. c. Undertake clinical trials to ascertain the efficacy of surgery for endometriosis-associated symptoms, especially for minimal or mild endometriosis. d. Assess the use of pain medication, and the medical treatment of endometriosis. e. Explore the use of imaging modalities in the diagnosis of endometriosis.	• Collect surgical outcome data, including patient-reported outcomes, for benchmarking. • Undertake clinical trials to ascertain the efficacy of surgery for endometriosis-associated symptoms, especially for minimal or mild endometriosis. (R&D are involved to see if we can be selected for trials) • Using PREM's and PROM's to assess the use of pain medication, and the medical treatment of endometriosis. We are already collecting this data in regard to Dienogest.	**Completed**

Completed	Not Due	In Progress	Outstanding

Ninth Patient Report of the National Emergency Laparotomy Audit December 2021 to March 2023

Clinical Leads:
Babu Muthuswamy - Consultant Intensivist & Anaesthetist
Helen Williams - Consultant Anaesthetist
Gethin Williams - Surgical Consultant

Rationale:	The NELA dataset is a comprehensive record of the processes and outcomes of care in England and Wales over 10 years. This dataset provides rich insights into improving the care of patients. Efforts should be made to learn the lessons contained within this data to support and drive local quality and service improvements. NELA is working with THIS Institute on a national programme to improve the timeliness of care in the early pathway. Work began in Spring 2024. Trusts and Health Boards are encouraged to join this work as participants in the discovery and testing phases.
Objectives:	This is the ninth annual report of the National Emergency Laparotomy Audit (NELA) and examines care received by NHS patients in England and Wales undergoing emergency laparotomy (emergency bowel surgery) between 1 December 2021 and 31 March 2023. Year 9 of the audit was extended to align with the NHS financial year

Presented at Clinical Standards and Effectiveness Group 28th November 2024

Median time to antibiotics in patients with suspected sepsis was 3.1 hours from arrival in hospital.



Patients with sepsis suspected at time of arrival in hospital waited a median of **15.5 hours from time of admission** until surgery.

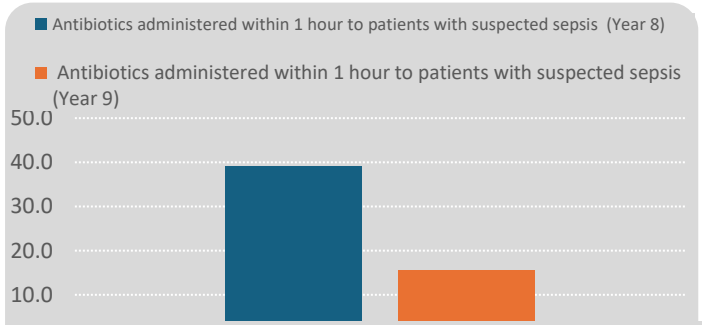


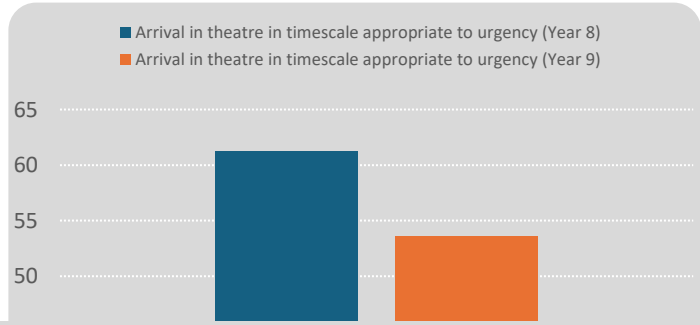
Message 1

Patients with significant and time-sensitive intra-abdominal pathologies, including those with suspected sepsis, frequently did not receive timely care consistent with published guidance.

For example, amongst those with suspected sepsis:

- only 20% received antibiotics within 1 hour
- 25% waited at least 6.5 hours after arrival in hospital before receiving antibiotics
- 50% waited for more than 15 hours before arrival in theatre
- performance varied significantly between hospitals.



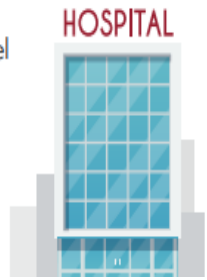


ABUHB has decreased performance for 1 hour Antibiotic and time to theatre timescale appropriate to urgency

ABUHB No. of cases for year 8 was 331 and for year 9, with the additional 4 months of data to align with the NHS financial year was 410 cases

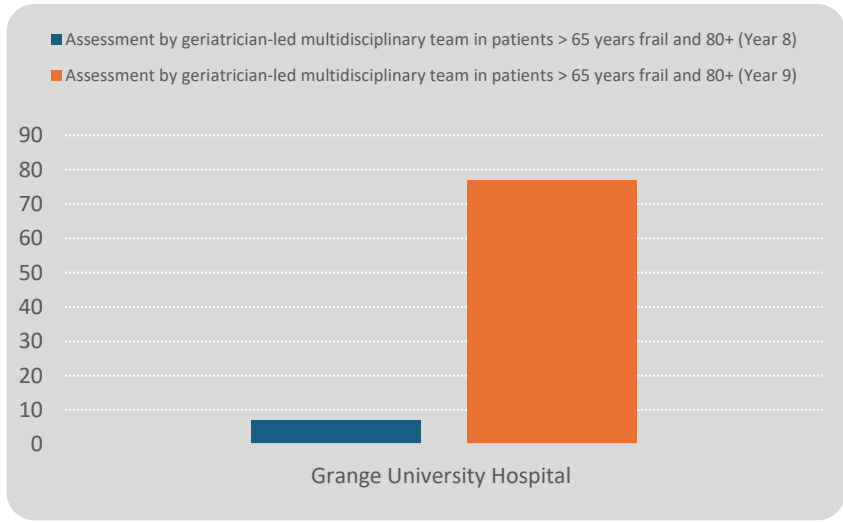
100% Case Ascertainment and data completeness

27,863 patients who had emergency bowel surgery in England and Wales were included in the Year 9 audit from 173 hospitals.



ABUHB frailty assessment in patient >=65 years improved from 94.1% in year 8 to 97.4% in year 9.

33.2% of patients aged 80 or over, or 65+ and frail, had geriatrician input (31.8% in Year 8).



Message 2

The majority of older patients and those living with frailty do not receive expert multidisciplinary care after emergency laparotomy (33% receive input). There is compelling evidence of an association between geriatrician input and reduced mortality, supporting the case for improving this intervention.

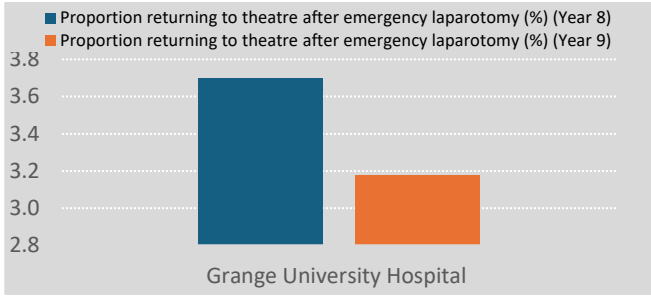
Message 3

There is hospital-level variation in risk-adjusted mortality. Additionally, there is higher mortality amongst those from more deprived quintiles in each nation. Differences in outcomes between patients in different hospitals and from varying levels of deprivation need to be recognised and acknowledged. Reasons are likely multifactorial but must be explored further.

There was no change in Adjusted Mortality for GUH from Year 8 to Year 9, both 9.6%.

Improvements in mortality have plateaued – **in-hospital mortality was 9.3%** compared to 9.2% in Year 8 and 9.1% in Year 7.





ABUHB returning to theatre after emergency laparotomy has decreased from 3.7% in year 8 to 3.2% in year 9,

80.3% of high-risk patients were admitted to critical care postoperatively (79.1% in Year 8).

13.9% of high-risk patients were admitted to a normal ward.

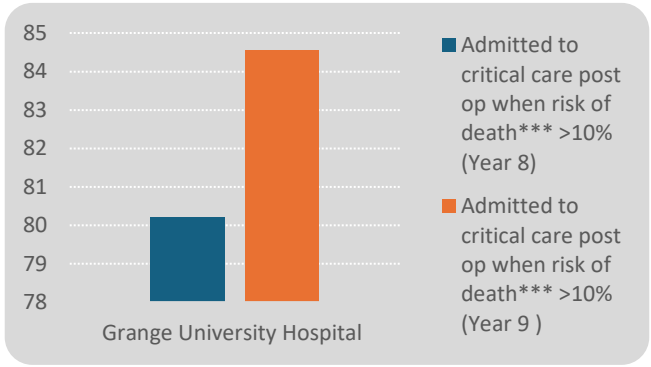
Message 4

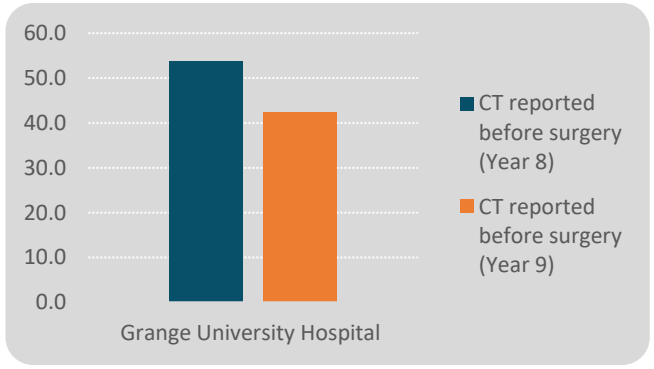
14% of high-risk patients did not receive immediate postoperative critical care contrary to published guidance. Instead, they were transferred to a normal ward following surgery; 7% of these patients subsequently died.

91.1% of patients received a preoperative CT scan

30.8% of patients had their scan outsourced (26.3% in Year 8, 19.1% in Year 7).







86.1% of patients with a high documented risk had **consultant surgeon** input before surgery.

71.4% of patients with a high documented risk had **consultant anaesthetist** input before surgery.



ABUHB pre-operative input with consultant Surgeon is 89.9% and Consultant Anaesthetists is 89.9% (both 88%)

Presence of both **anaesthetic and surgical consultants** during surgery in high-risk patients was **90.4% (91.3% in Year 8)**.



Consultant Surgeon and Anaesthetist present in theatre when risk of death* >=5% was 77.6% in year 8 and increased to 90.4% for year 9**

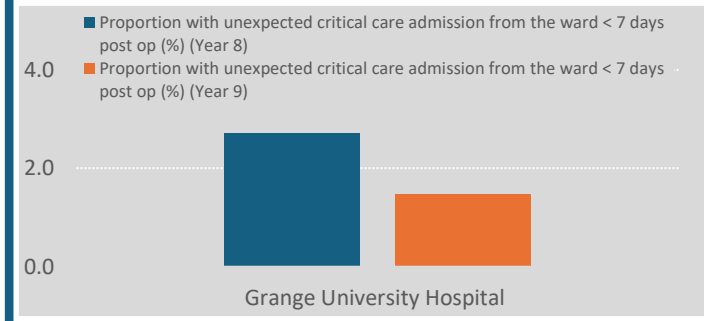
Preoperative assessment of risk **has dropped below target**, to 84.6% after peaking at 86.8% in Year 8.



ABUHB Risk documented preoperatively in year 8 was 88.5% and has improved in year 9 to 96.1%

Postoperative length of hospital stay (LOS) has not significantly changed over the last five years, **with a median in Year 9 of 11 days.**

ABUHB patients LoS for year 8 was 8 days and in year 9 it has increased to 10 days LoS - this is the average LoS across Wales.



Aneurin Bevan University Health Board saw a reduction in patients with unexpected return to Critical Care from the ward within 7 days post operatively.

Assurance level	Description
Significant	The project has mostly achieved the standards or criteria being audited against

Risk level	Description
Minor	Overall treatment or service suboptimal - Minor implications for patient safety if unresolved

Not on Risk register as continuous pathway improvement

Key Successes:	
1	Reduction in the risk-adjusted mortality for NELA patients (significant drop from previous years)
2	Consultant presence for high-risk patients, both in anaesthetics and surgery
3	Return to theatre rates – low
4	Improved rates of COTE review post operatively (vs. national mean)
5	Successful running of the NELA M&M meetings throughout the year

Key Concerns:	
1	Contemporaneous input of patient-level data at the time of surgery (potential impacting on the quality assurance of the timelines for antibiotic administration, for example, and other metrics)
2	Failed business case for improved access to geriatricians for the elderly and frail patients
3	Critical care access could be better (vs elective surgical patients getting care in SHC and Critical care)
4	Timeliness of antibiotic administration to patients with sepsis or, deemed at high risk of sepsis

Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:
1	Royal Colleges should work together to publish consensus pathways for patients presenting to hospital who might require emergency laparotomy. These pathways should include: ❑ diagnostic, radiological, and initial management phases of a patient's presentation prior to a decision to operate ❑ targets for timeliness of each pathway step. ***Royal Colleges of Emergency Medicine, Radiologists, Surgeons, and Anaesthetists.***	NELA CRG to pick up with Royal College representatives on CRG	Royal Colleges	
2a)	Commissioners should ensure that Trusts/hospitals provide adequate specialist care for older patients and those with frailty following emergency laparotomy, per guidance published by the Royal College of Surgeons of England, British Geriatrics Society, and the Centre for Perioperative Care. ***Regional and local commissioners (Integrated Care Boards and Health Boards) in England and Wales.***	Further expansion of sessional time from Geriatric consultant needed (Currently delivering 2 sessions per week)	Clinical director of surgery and divisional director SCD- aware of the business case. Concerns highlighted	2025/26
2b)	Commissioners should ensure that Trusts/hospitals provide adequate specialist To expand the pool of clinical staff with the requisite specialist skills, Royal Colleges of Physicians, Surgeons and Anaesthetists should consider working together to develop common competency-based training curriculae around optimising perioperative care for older patients and those living with frailty who undergo emergency surgery. ***Royal Colleges of Physicians, Anaesthetists and Surgeons.***		Royal Colleges	
3	Healthcare services provided to those from more deprived backgrounds need to be matched to their greater need. This requires strategic planning. ***NHS England; Regional and local commissioners (Integrated Care Boards and Health Boards) in England and Wales***	ABUHB to highlight to WG via relevant key stakeholders		

Clinical Leads Local Recommendations: (if applicable)		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	COTE consultant expansion needed	Business case taken to SCD	CD Surgery/ Divisional director	2025/26	In progress
2	Contemporaneous inputting of patient level data, at the time of operation	CEPOD lead to be made aware	NELA leads	25/26	In progress

National Ovarian Cancer Audit
State of the Nation Report 2024

An audit of care received by women diagnosed with ovarian cancer in England in 2021 and in Wales in 2022

Published September 2024

Clinical Lead:	**Leena Gokhale - Consultant Obstetrics & Gynaecology**
NICE Guidelines	**NG12 & CG122**

Rationale:	The care for women with ovarian cancer is informed by various national guidelines. NOCA evaluates care for women with ovarian cancer against standards derived from guidelines for ovarian cancer (NG12 & CG122) that were published by the National Institute for Health and Clinical Excellence (NICE), which include recommendations for the recognition and referral pathways and the treatment of early (stage 1) and advanced (stage 2 to 4) ovarian cancer.
Objectives:	The National Ovarian Cancer Audit (NOCA) aims to evaluate the patterns of care and outcomes for women with ovarian cancer in England and Wales, and to support services to improve the quality of care for these women. Ovarian cancer affects the ovaries. It mostly affects women, but it can affect anyone who has ovaries. This State of the Nation (SotN) report publishes information on the care received by women diagnosed with ovarian cancer in England in 2021 and in Wales in 2022. It is the audit's first annual assessment of NHS services. It aims to share good practice and highlight where care can be improved.

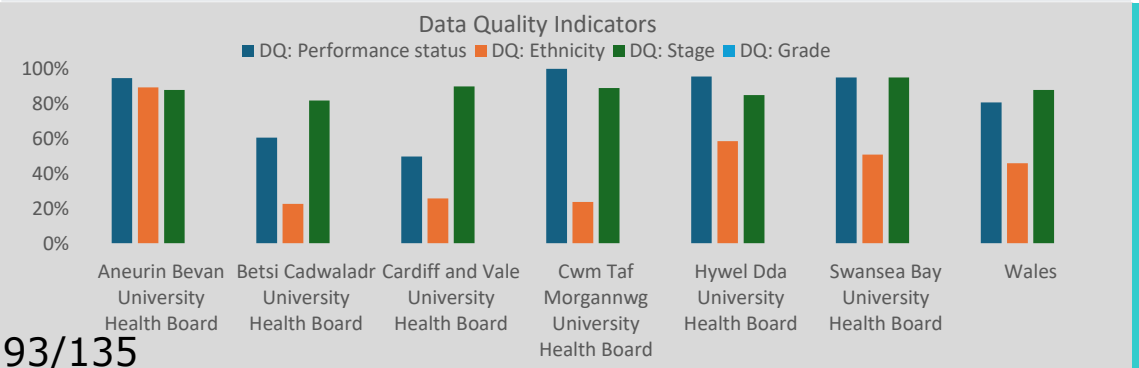
Presented at Clinical Standards and Effectiveness Group – 28th November 2024

Quality Performance Indicators

QPI 1	Patients to be discussed at diagnosis at a specialist MDT prior to a decision for treatment	**Target 95 %** **99%**
QPI 2	Patients diagnosed with Stage 2-4 or unstaged Ovarian cancer to receive anticancer treatment of any type	**Target 80%** **65%**
QPI 3	Patients with Stage 2-4/ unstaged ovarian cancer to receive cytoreductive surgery.	**Minimum target 55%** **46.5%** **Optimal target 70%.**
QPI 4 a	Patients with ovarian cancer should have recording of FIGO stage, WHO performance status, at diagnosis	**Target 95%** **86%**
b	Patients with ovarian cancer undergoing primary or interval debulking surgery should have recording of residual disease	**Target 95%** **100%** (1pt)
QPI 5 a	Patients with non-mucinous epithelial ovarian cancer on histology to be tested for germline BRCA1/2 testing	**Target 90%**
b	Patients with advanced high grade serous and clear cell cancer on histology to be tested for tumour BRCA1/2 testing	**Target 90%**
QPI 6	Patients to be enrolled into an NCRI portfolio study at diagnosis.	**Minimum Target 5%**

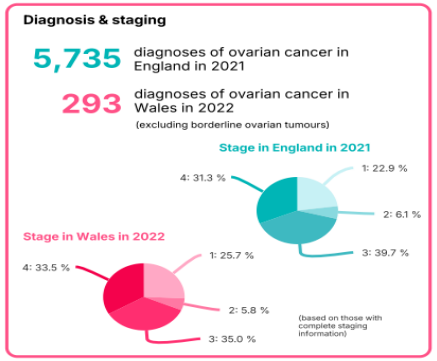
Good Practice

Working with acute oncology services to identify women with possible ovarian cancer admitted in general medical and surgical wards and ensuring that decision making for these patients is done in conjunction with gynaecological oncology MDTs.



Data completeness:

12.0% of women with ovarian cancer in England in 2021 and 11.0% in Wales in 2022 did not have histology or cytology recorded in the national cancer registration data and 28.5% women in England and 12.3% in Wales did not have staging information recorded.





Performance indicator 1: 41.4% of women diagnosed in England in 2021 and 40.6% diagnosed in Wales in 2022 had an emergency admission within 28 days prior to diagnosis.

Data Completeness Indicator 1: Emergency admission prior to diagnosis	Denominator (N)	Rate (%)	Rank among 130 care providers
Aneurin Bevan University Health Board	57	57.9%	18
Wales	293	40.6%	NA
ENGLAND & WALES	6,028	41.4%	NA

Performance Indicator 1: Emergency admission prior to diagnosis	Denominator (N)	Rate (%)	Rank among 43 cancer systems
South East Wales	133	45.9%	10
WALES	293	40.6%	NA
ENGLAND & WALES	6,028	41.4%	NA

Performance indicator 2: 72.7% of women diagnosed in England in 2021 and 76.7% in Wales in 2022 had any treatment (i.e., surgery and/ or chemotherapy) recorded between one month prior and nine months following diagnosis.

Performance Indicator 2: Receipt of any treatment (surgery and/or chemotherapy)	Denominator (N)	Rate (%)	Rank among 43 cancer systems
South East Wales	104	79.0%	6
WALES	227	76.7%	NA
ENGLAND & WALES	4,978	72.9%	NA

Performance indicator 4: 69.4% of women diagnosed in England in 2021 and 74.4% in Wales in 2022 were alive one year after diagnosis (IQR across integrated gynaecological cancer systems 64.2% to 72.5% in England; min 63.0% and max 85.6% across three integrated gynaecological cancer systems in Wales).

Performance indicator 4: One-year survival	Denominator (N)	Rate (%)	Rank among 43 cancer systems
South East Wales	133	75.9%	6
WALES	293	74.4%	NA
ENGLAND & WALES	6,028	69.6%	NA

Performance indicator 4: One-year survival (case-mix adjusted)	Denominator (N)	Rate (%)	Rank among 43 cancer systems
South East Wales	133	70.8%	19
WALES	293	74.4%	NA
ENGLAND & WALES	6,028	69.6%	NA

Assurance level	**Description**
Limited	The project did not achieve the standards or criteria being audited against

Risk level	**Description**
Minor	Overall treatment or service suboptimal - Minor implications for patient safety if unresolved

Has this audit been placed on a Risk Register – Yes, Local risk register

Key Successes:	
1	Data capture for Good Practice. AB highest in Wales
2	QPI 2, Receipt of any treatment: SE Wales better than England and the rest of Wales
3	QPI 4, 1 year survival: SE Wales better than England and the rest of Wales

Key Concerns:	
1	57% present as Emergency Admissions
2	No information available for the platinum based chemotherapy numbers
3	Access to data from Tertiary providers including UHW & Velindre

	Clinical Leads Local Recommendations: (if applicable)	**S.M.A.R.T Actions:**	**Responsible:**	**Due Date:**	**Progress:**
1	Working with acute oncology services to identify women with possible ovarian cancer admitted in general medical and surgical wards and ensuring that decision making for these patients is done in conjunction with gynaecological oncology MDTs.	Work with AOS to develop pathways			Meet with newly appointed Lead AOS Nurse

	Report Recommendations:	S.M.A.R.T Actions:	Responsible:	Due Date: Progress:
1	Reduce the current rate of emergency admissions by: (i) Improving efforts to increase symptom awareness amongst women and primary care professionals. (ii) Reviewing diagnostic pathways to improve timely testing. **Goal 1**: Increase the proportion of patients receiving timely diagnosis and treatment decisions.	Liaise with PC for early referral	Leena Gokhale - Health Boards working with integrated gynaecological cancer systems.	RDC Referral pathway reviewed and complete. Radiology reporting standardisation agreed
2	Review the percentage of women with stage 2 to 4, or unstaged ovarian cancer who receive treatment (any type), explore and address some of the reasons behind the variation across integrated gynaecological cancer systems. **Goal 3**: Increase the proportion of patients receiving surgery. **Goal 4:** Increase the proportion of patients receiving chemotherapy.	Outside of the remit of Cancer Unit. This is within the UHW/VCC SLA	Leena Gokhale - Health Boards working with integrated gynaecological cancer systems.	Not applicable to local Health Board
3	Review the use of platinum-based chemotherapy in women with epithelial ovarian cancer (stage 2 to 4, or unstaged), explore and address some of the reasons behind the variation across integrated gynaecological cancer systems. **Goal 4:** Increase the proportion of patients receiving chemotherapy.	VCC SLA	Leena Gokhale - Health Boards working with integrated gynaecological cancer systems.	Not applicable to local Health Board
4	Review one-year survival in women diagnosed with ovarian cancer, explore and address some of the reasons behind the variation across integrated gynaecological cancer systems. **Goal 5:** Improve rates of survival and reduce variation in survival.	CSG and Tertiary unit	Leena Gokhale - Health Boards working with integrated gynaecological cancer systems.	Increasing symptom awareness amongst patients and PCC colleagues. Social Media awareness session posted on HB's Facebook page
5	Improve the completeness and quality of data items recorded in the national cancer datasets (e.g. percentage of women with recorded diagnosis based on histology or cytology in the national cancer registration data and percentage of women with recorded staging information) **Goal 1-5**	Within our remit	Leena Gokhale - Health Boards working with integrated gynaecological cancer systems.	This will be audited in 12 months

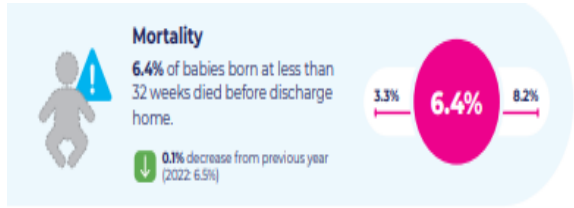
Audit Title: National Neonatal Audit Programme (NNAP) Summary report on 2023 data	Clinical Lead:	Dr Sunil Reddy –Neonatal Consultant
	Nice Guidelines	NICE QS 193 Quality Statements 1-5
Rationale:	The National Neonatal Audit Programme (NNAP) assesses whether babies admitted to neonatal units receive consistent high-quality care in relation to the NNAP audit measures that are aligned to a set of professionally agreed guidelines and standards. The NNAP also identifies variation in the provision of neonatal care at local unit, regional network and national levels. NNAP supports stakeholders to use audit data to stimulate improvement in care delivery and outcomes.	
Objectives:	The NNAP aims to help neonatal units improve care for babies and their families by identifying area of quality improvement in relation to the delivery and outcomes of care. The NNAP dashboard presents results for each of the 10-performance metrics as annual rolling averages and is updated monthly. 1. Mortality until discharge 2. Optimal perinatal care composite metric (component measures: antenatal steroids, antenatal magnesium sulphate, birth in a centre with a NICU, deferred cord clamping, normal temperature on admission, breastmilk feeding in the first 2 days of life) 3. Clinical outcomes composite metric (component measures: bloodstream infection, BPD, NEC, preterm brain injury) 4. Parental consultation within 24 hours of every admission 5. Parental inclusion in consultant ward rounds 6. Breastmilk feeding composite metric (component measures: breastmilk feeding at day 14, breastmilk feeding at discharge home) 7. Follow-up at two years 8. On-time screening for retinopathy of prematurity 9. Neonatal nurse staffing 10. Non-invasive breathing support	

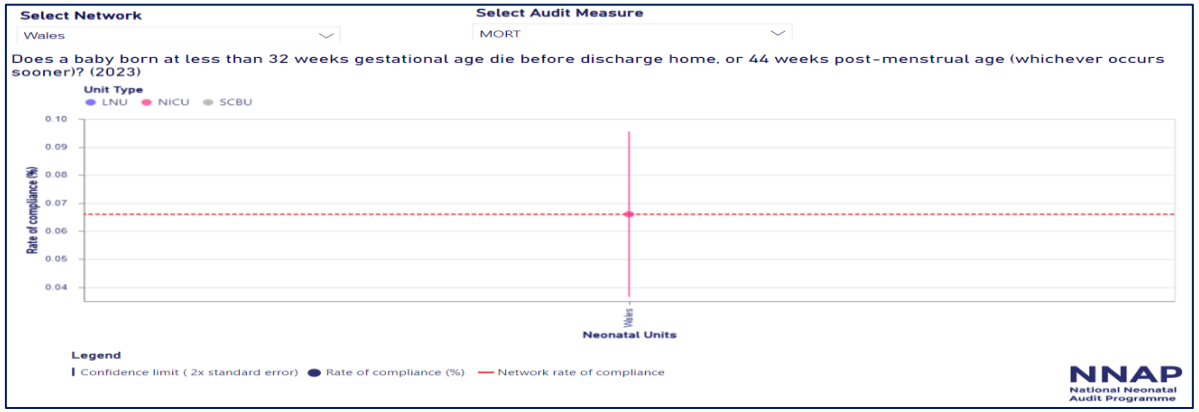
Presented at Clinical Standards and Effectiveness Group – 28th November 2024

Aneurin Bevan University Health Board 10-performance metrics

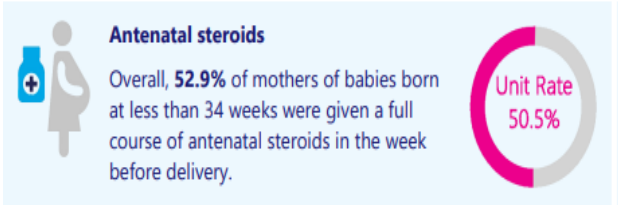
Outcomes of Neonatal Care:

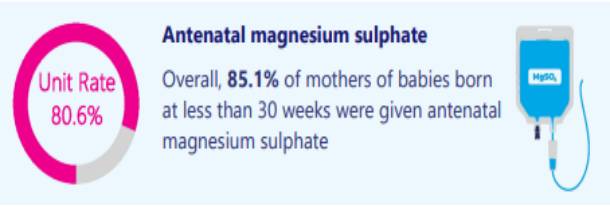
1. Mortality until discharge (Wales rate)
2. Optimal perinatal care composite metric:
   a) antenatal steroids
   b) antenatal magnesium sulphate
   c) birth in a centre with a NICU
   d) deferred cord clamping
   e) normal temperature on admission
   f) breastmilk feeding in the first 2 days of life



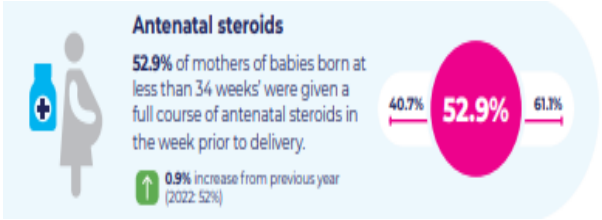


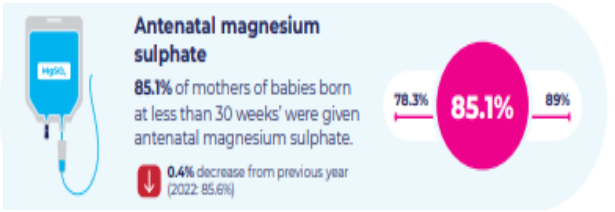
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National rate:





National rate:

Deferred cord clamping

68.3% of babies born at less than 34 weeks' had their cord clamped at or after one minute.

62.1% **68.3%** 77.1%

7.9% increase from previous year (2022: 60.4%)

Temperature on admission

80.4% of babies born at less than 34 weeks' were admitted with a temperature within the recommended range of 36.5°C-37.5°C.

75.5% **80.4%** 85.1%

4.1% increase from previous year (2022: 76.3%)

Parent consultation within 24 hours

95.2% of parents had a documented consultation with a senior member of the neonatal team within 24 hours of their baby's admission.

92.6% **95.2%** 97.4%

0.7% decrease from previous year (2022: 95.2%)

Parent inclusion in consultant ward rounds

38.7% of baby care days had a consultant-led ward round with at least one parent included.

25.7% **38.7%** 62.3%

8.5% decrease from previous year (2022: 47.2%)

Neonatal nurse staffing

79.3% of nursing shifts were staffed according to recommended levels.

69.3% **79.3%** 91.2%

8.2% increase from previous year (2022: 71.1%)

Bronchopulmonary dysplasia (BPD)

31.5% of babies born at less than 32 weeks developed BPD or died.

25.6% **31.5%** 39.1%

0.2% increase from previous year (2022: 31.3%)

Breastmilk feeding in first 2 days of life

62% of babies born at less than 34 weeks' received their mother's milk in the first 2 days of life.

41.4% **62%** 78.3%

13% increase from previous year (2022: 49%)

Breastmilk feeding at 14 days of life

79.6% of babies born at less than 34 weeks' received their mother's milk at 14 days of life.

70.4% **79.6%** 90.3%

0.6% increase from previous year (2022: 79%)

Breastmilk feeding at discharge

63% of babies born at less than 34 weeks' received their mother's milk at discharge.

47.4% **63%** 82%

0.1% increase from previous year (2022: 62.9%)

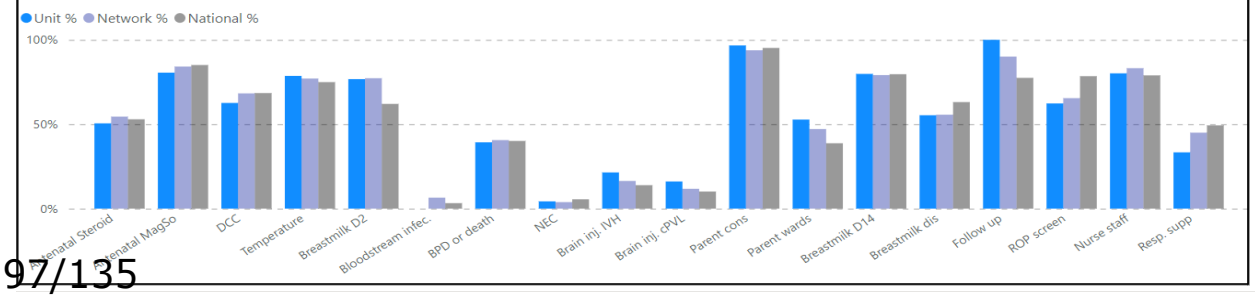
On-time screening for retinopathy of prematurity (ROP)

78.4% of eligible babies were screened on time for ROP.

65.4% **78.4%** 86.4%

9.4% increase from previous year (2022: 69%)

Select year: 2023 | Select fields: Multiple selectio...



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Deferred cord clamping

Overall, **68.3%** of babies born at less than 34 weeks had their cord clamped at or after one minute.

Unit Rate 62.6%

Temperature on admission

Overall, **80.4%** of babies born at less than 32 weeks were admitted within the recommended range of 36.5°C-37.5°C.

Unit Rate 83.6%

Parental consultation within 24 hours

Overall, **95.2%** of parents had a documented consultation with a senior member of the neonatal team within 24 hours of their baby's admission

Unit Rate 96.7%

Parent inclusion on consultant ward rounds

Overall, **38.7%** of baby care days had a consultant-led ward round with at least one parent included.

Unit Rate 52.8%

Neonatal nurse staffing

Overall, **79.3%** of nursing shifts were staffed according to recommended levels.

Unit Rate 83.1%

Bronchopulmonary dysplasia (BPD)

Overall, **31.5%** of babies born at less than 32 weeks developed BPD or died.

Unit Rate 39.3%

Breastmilk feeding in the first two days

Overall, **62%** of babies born at less than 34 weeks received their mother's milk in the first 2 days of life.

Unit Rate 76.7%

Breastmilk feeding at 14 days

Overall, **79.6%** of babies born at less than 34 weeks received their mother's milk at 14 days of life.

Unit Rate 79.8%

Breastmilk feeding at discharge

Overall, **63%** of babies born at less than 34 weeks received their mother's milk at discharge home.

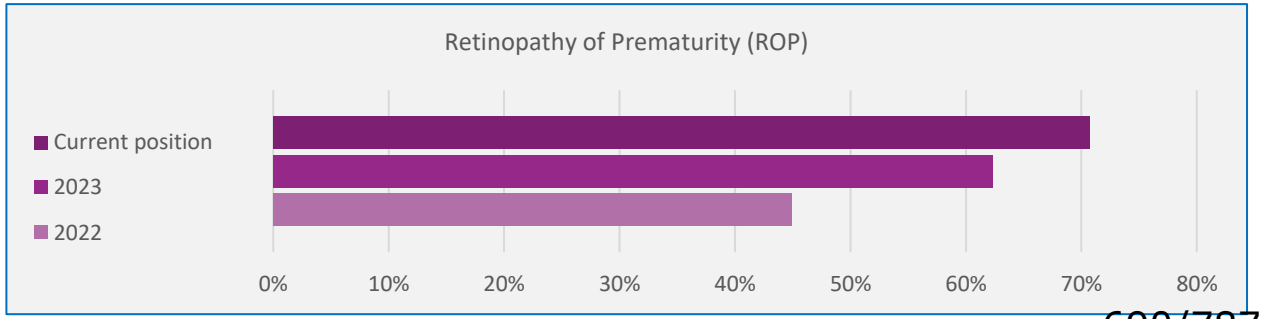
Unit Rate 55.3%

Screening for retinopathy of prematurity

(ROP) Overall, **78.4%** of eligible babies were screened on time for ROP.

Unit Rate 62.3%

ALERT outlier status for ROP



NICE Quality statement 1:
Preterm babies having respiratory support soon after birth and before admission to the neonatal unit are given continuous positive airways pressure (CPAP), if clinically appropriate, rather than invasive ventilation.

NICE Quality statement 2:
Preterm babies who need surfactant are given it using a minimally invasive technique if they do not need invasive ventilation.

NICE Quality statement 3:
Preterm babies having invasive ventilation are given volume-targeted ventilation (VTV) in combination with synchronised ventilation.

NICE Quality statement 4:
Preterm babies have a target oxygen saturation of 91% to 95% after stabilisation.

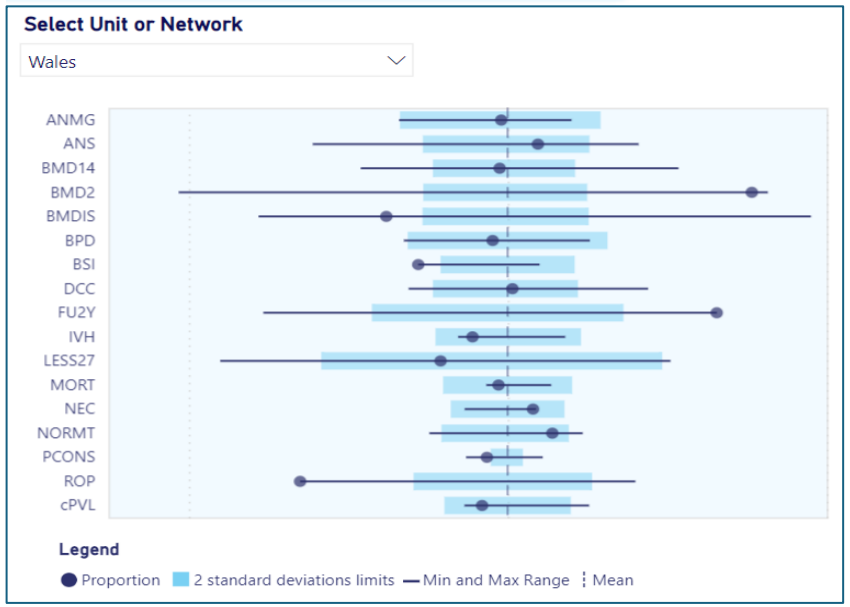
NICE Quality statement 5:
Parents and carers of preterm babies who are having respiratory support are helped to care for their baby.



What proportion of babies born between 22-31 weeks gestation age only receive non-invasive breathing support during the first week of life?

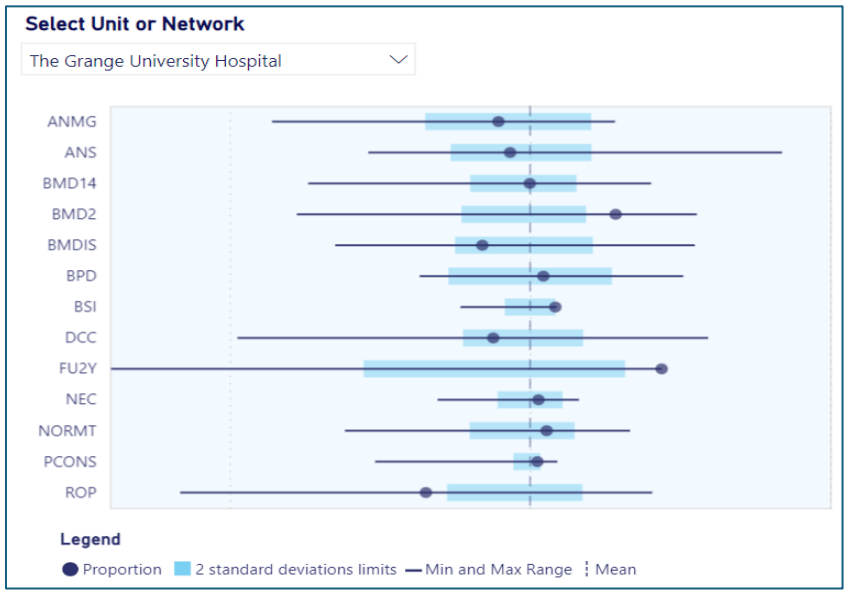
The Grange University Hospital

33.3%



Measures

MORT: Treatment effect of mortality
BPD: Treatment effect of bronchopulmonary dysplasia or death
NEC: Treatment effect of necrotising enterocolitis
BSI: Treatment effect of bloodstream infection
ANS: Antenatal steroids
ANMG: Antenatal magnesium sulphate
DCC: Deferred cord clamping
NormT: Normal temperature
BMD14: Breastmilk day 14
BMDIS: Breastmilk at discharge
BMD2: Breastmilk at day 2
PCons: Parental consultation in 24h
ROP: Retinopathy of prematurity
FU2Y: Two year follow up
TRESP: Treatment effect of non-invasive respiratory support



The above demonstrates Aneurin Bevan University Health Board are mostly within the 2 standard deviation limits, apart from:

- **BD2 Breast milk at day 2 – better than std deviation and within max range**
- **Two year follow up – at 100%**

- **Retinopathy of prematurity remains outside the std deviation limit and is an ALERT outlier**

Assurance level	Description
Significant	The project has mostly achieved the standards or criteria being audited against

Risk level	Description
Minor	Overall treatment or service suboptimal - Minor implications for patient safety if unresolved

Not placed on a Risk Register due to: Achieving most measures with continuous work ongoing to improve outcomes.

Key Successes:	
1	The HB is above the mean on 8 of the 13 measures and within the mean on 4 measures
2	Breast feeding at d/c – golden drops

Key Concerns:	
1	Retinopathy of Prematurity – has increased since 2022 (44.9% to 62.3%) with the current data being 70.7%
2	Work on ensuring data entry for late onset sepsis
3.	Breast feeding rates at discharge- remains a challenge

	Report Recommendations:	S.M.A.R.T Actions:	Responsible:	Due Date: Progress:
1	National Health Service England and health departments in the Devolved Governments should: • Ensure that Neonatal Networks with low rates of survival review their mortality data and develop locally prioritised improvement plans. Quality improvement activity should focus on best practices identified from Neonatal Networks exhibiting low mortality with particular attention given to differences in network structure, staffing, clinical governance, and clinical practices. • Review survival rates in very preterm infants and work with The National Institute for Health and Care Research (NIHR)to support future research investigating the reasons for the observed geographical variation in mortality.	The Health Board participates in the MATNEO & PERIPREM Cymru Networks	Dr Sunil Reddy	Ongoing
2	National Health Service England and health departments in the Devolved Governments should ensure that Neonatal Networks work with their constituent units and are: • Regularly reviewing and addressing their rates of missing data for preterm brain injury (intraventricular haemorrhage, cystic periventricular leukomalacia, and post haemorrhagic ventricular dilatation) and necrotising enterocolitis. • Utilising the NNAP restricted access dashboard to validate these data in order that units and networks can develop quality improvement plans based on babies' outcomes.	• These are ongoing processes within the Health Board • Dashboards are used for benchmarking continuously	Dr Sunil Reddy	Ongoing
3	In order for perinatal teams to identify and implement the necessary perinatal interventions at the earliest opportunity, the Departments of Health in England, Wales, Scotland, and the Isle of Man should: • Commission public health campaigns aimed at raising public and professional awareness of the nature and importance of the signs and symptoms of preterm labour and the effectiveness of clinical interventions. • Work with relevant manufacturers and distributors to address supply chain challenges in the delivery of quantitative fetal fibronectin testing kits		• Badgernet is not being used within the maternity units. • Steroids & Magnesium Sulphate – already captured Maternity – looking at the data	
4	Neonatal Networks should ensure that their constituent units are using the NNAP restricted access dashboard to review their rates of optimal perinatal care delivery, identifying instances of non-adherence, and implementing quality improvement activities in response to them.		The Health Board is already reviewing dashboard data	
5	Neonatal Networks should work with their constituent units and encourage them to use the monthly data available in the NNAP restricted access dashboard to identify cases where optimal parental partnership in care did not occur. These data will support neonatal units to enhance their delivery of family centred care.		The Health Board is already reviewing dashboard data – good results for parental involvement	

	Clinical Leads Local Recommendations: (if applicable)	S.M.A.R.T Actions:	Responsible:	Due Date:Progress:
1	ROP – local awareness, Ophthalmologist, using the RCPCH calculator, dedicated neonatal nurse entering the eligible babies, avoid postponing the exam	Monitor the improvement with online live dashboard	Sunil Reddy	

Audit Title:
National Audit of Primary Breast Cancer
State of the Nation Report 2024
An audit of care received by people diagnosed with primary breast cancer in England and Wales during 2019-2021

Published September 2024

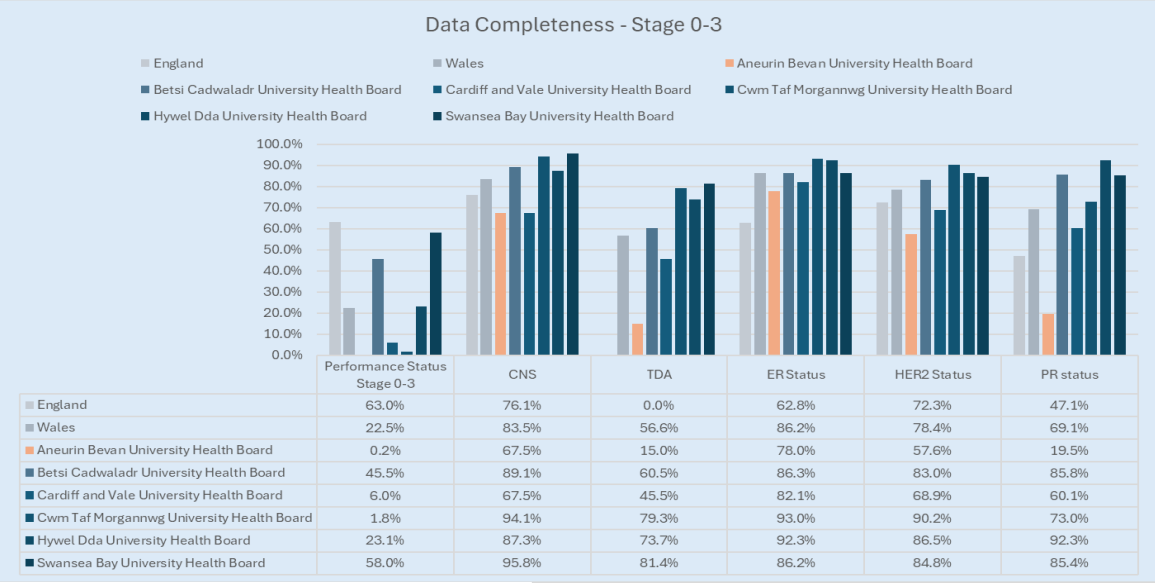
Clinical Lead:
Rhiannon Foulkes – Consultant Surgeon

Nice Guidelines	**NG101** **QS12**

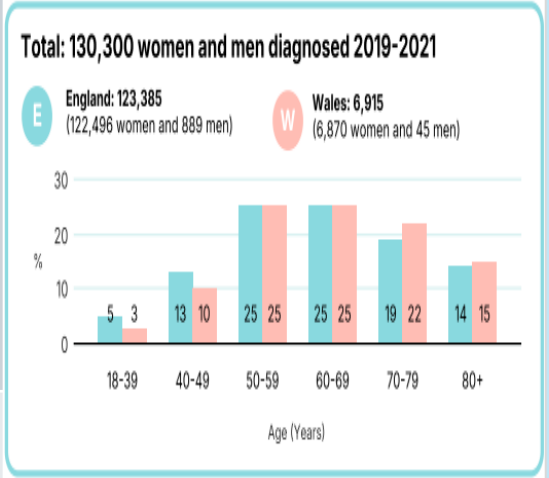
Rationale:	The purpose of the National Audit of Primary Breast Cancer (NAoPri) is to evaluate the patterns of care and outcomes for people diagnosed with primary breast cancer in England and Wales, and to support services to improve the quality of care for these people. For people treated in Wales, NATCAN receives the data from the Wales Cancer Network (WCN) in Public Health Wales. WCN provides patient-level data from the Cancer Network Information System Cymru (CaNISC) electronic patient record system. This State of the Nation report publishes information on the care received by people diagnosed with breast cancer during 2019-21 in England and Wales. Wales also provided 2022 data which has been included. It is the audit's first annual assessment of NHS breast services and shares examples of good practice as well as highlighting where care needs to improve.
Objectives:	The aim of the National Audit of Primary Breast Cancer (NAoPri) is to evaluate the patterns of care and outcomes for people with primary breast cancer in England and Wales, and to support services to improve the quality of care for these patients. This work builds on that of the National Audit of Breast Cancer in Older Patients (NABCOP) but has been expanded to include younger people and men with breast cancer. This report has focused on the patterns of care at a national level, in England and Wales, for different groups of women and men. We report on indicators that were defined to monitor progress against the 5 NAoPri healthcare QI goals: 1. Improve the movement of patients through the care pathway. 2. Reduce unwarranted variation for patients undergoing surgery. 3. Reduce unwarranted variation for patients having non-surgical oncological treatments. 4. Improve access to breast reconstruction after mastectomy. 5. Improve and reduce unwarranted variation in primary breast cancer outcomes.

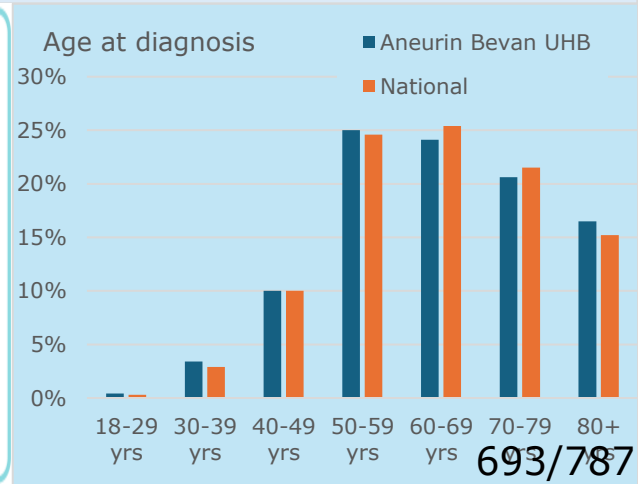
Key Messages:

NHS organisations should ensure the data on key data items submitted to NDRS and CaNISC are complete. Particular attention should be given to data on "patient seen by a clinical nurse specialist (CNS) at diagnosis," and date and type of cancer recurrence. Completeness of data on molecular markers (including hormone receptor and human epidermal growth factor receptor 2 (HER2) status), and performance status items should be improved. The reasons for poor data completeness are likely to vary across organisations and data items – recording of information at MDT, data entry/audit resource.



	Performance Status Stage 0-3	CNS	TDA	ER Status	HER2 Status	PR status
England	63.0%	76.1%	0.0%	62.8%	72.3%	47.1%
Wales	22.5%	83.5%	56.6%	86.2%	78.4%	69.1%
Aneurin Bevan University Health Board	0.2%	67.5%	15.0%	78.0%	57.6%	19.5%
Betsi Cadwaladr University Health Board	45.5%	89.1%	60.5%	86.3%	83.0%	85.8%
Cardiff and Vale University Health Board	6.0%	67.5%	45.5%	82.1%	68.9%	60.1%
Cwm Taf Morgannwg University Health Board	1.8%	94.1%	79.3%	93.0%	90.2%	73.0%
Hywel Dda University Health Board	23.1%	87.3%	73.7%	92.3%	86.5%	92.3%
Swansea Bay University Health Board	58.0%	95.8%	81.4%	86.2%	84.8%	85.4%

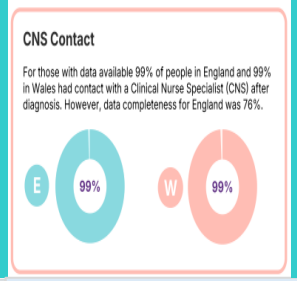




Presented at Clinical Standards and Effectiveness Group – 28th November 2024

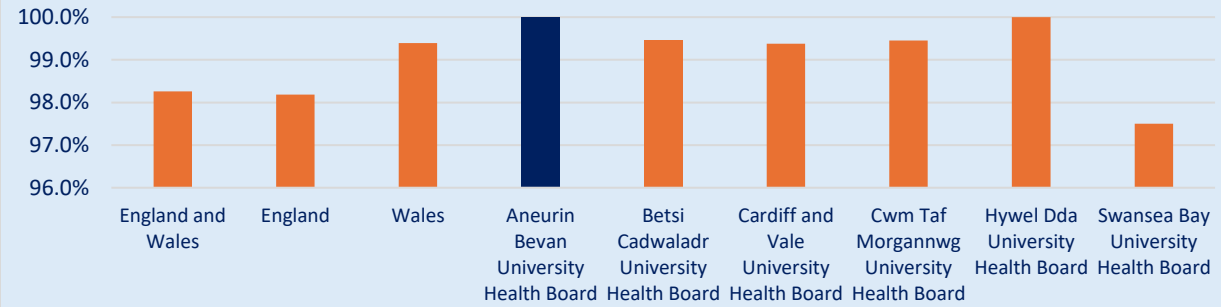


Key messages:
The proportion of people who had Triple Diagnostic Assessment (TDA) in a single hospital visit was 56.6% in Wales. For England only, TDA status was estimated from the date of diagnosis & the date of biopsy, & it was assumed that imaging was performed prior to biopsy. We estimate the proportion of people who had TDA in England was 55.0% between 2019 & 2021. NHS organisations with low values should increase the proportion of people who have TDA.

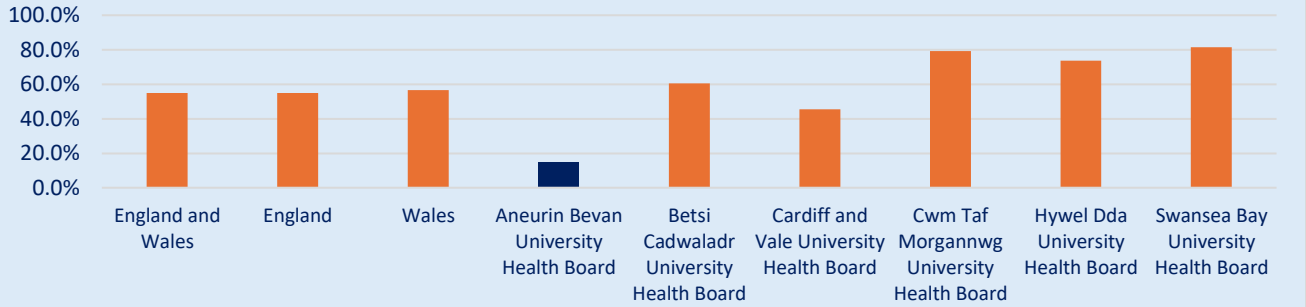


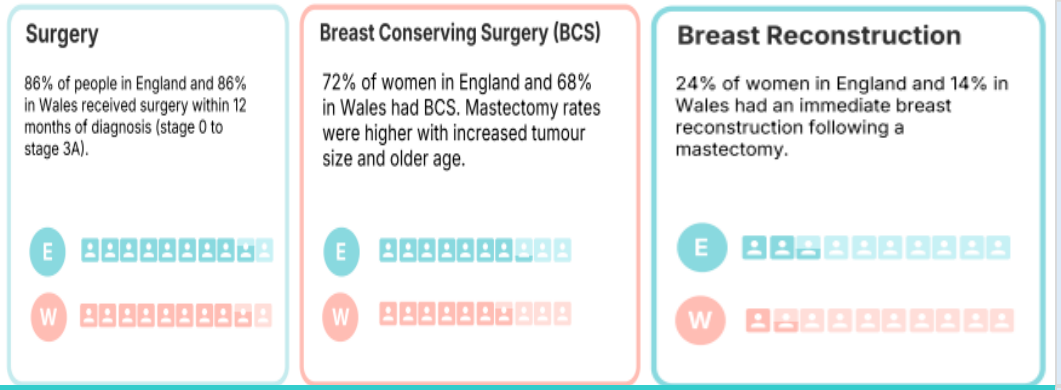
Key messages:
The proportion of people in 2019-21 who saw a CNS at diagnosis was 99.4% in Wales. For England, the actual levels of performance are uncertain because information on CNS contact was only available for 76.1% of patients diagnosed between 2019 and 2021. Among people with this data, 98.8% were reported as having seen a CNS. The patterns of care were similar for women and men on these two indicators.

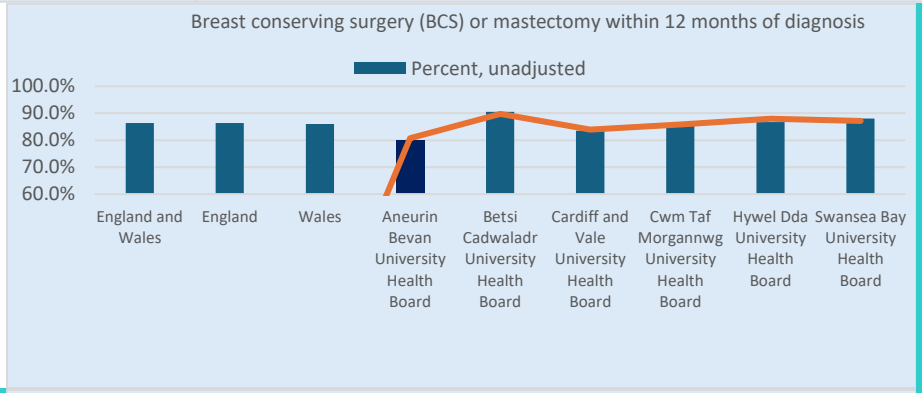
Contact with Clinical Nurse Specialist (CNS) after diagnosis

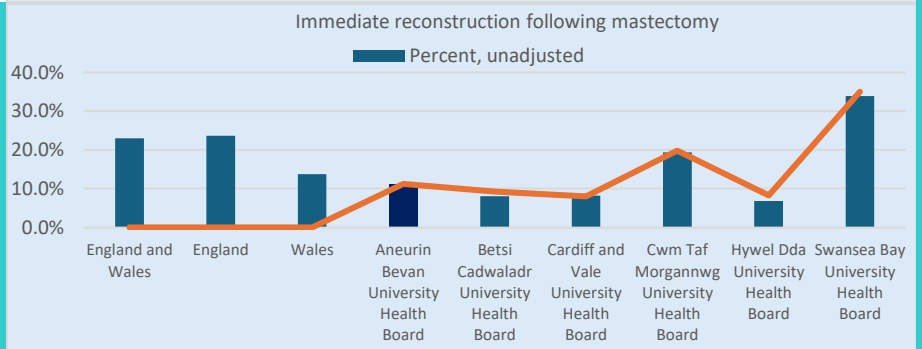


Triple Diagnostic Assessment (TDA) in single hospital visit





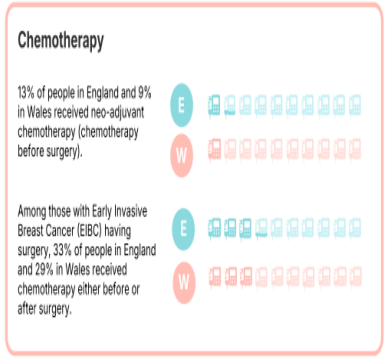




Key Messages:
Overall, 86.4% of people diagnosed in 2019-21 received surgery in England and Wales within 12 months of diagnosis (England=86.4%; Wales=86.0%). The proportions of women and men who had surgery were similar (respectively, 86.4% and 83.2%) but the type of surgery differed, with 71.8% of women having breast conserving surgery and 93.6% of men having mastectomy (of those who had surgery).

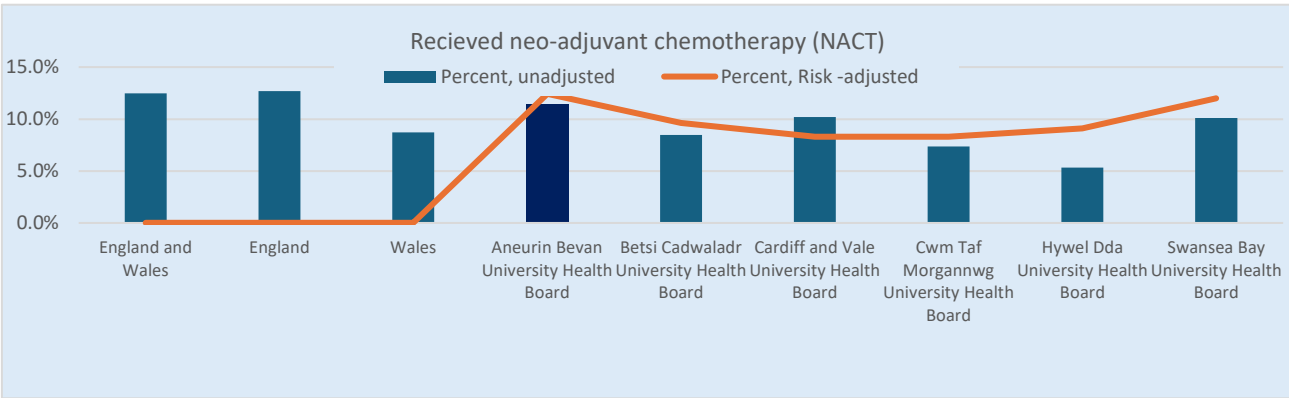
In England and Wales, the percentage of women with non-invasive breast cancer and EIBC who had breast conserving surgery were 75.6% and 71.3%, respectively (of those who had surgery). The percentage of women with EIBC having mastectomy increased with tumour stage (T1: 15.9%; T2: 36.6%; T3: 81.1%) and increased among women aged over 70 years.

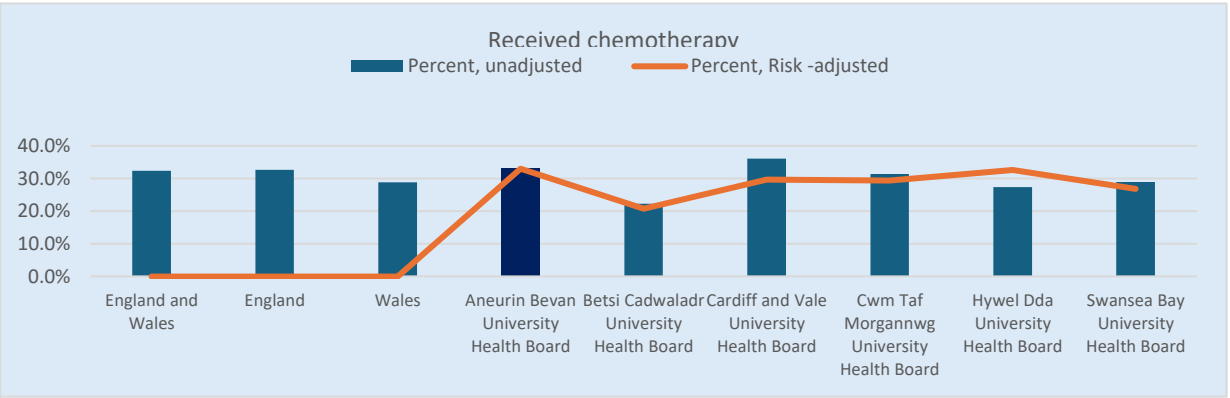
Key messages: Among women (diagnosed 2019-21) who had mastectomy, the rates of immediate reconstruction for non-invasive and EIBC were 40.8% and 21.0%, respectively. Among women with invasive disease, the use of immediate reconstruction was less frequent among women with larger tumours. Use of immediate reconstruction was much more frequent in younger women (70 years, 3.1%). The use of immediate reconstruction was lower in Wales compared to England. There was considerable variation by English NHS organisation, with rates of immediate reconstruction less than 10% for 16 English NHS breast units and above 40% for 10 English NHS breast units (with people allocated to the organisation of diagnosis). The average for England & Wales was 23.0%.



Key messages:
Among people with EIBC who had surgery within 12 months of diagnosis, 12.5% had neo-adjuvant chemotherapy (NACT) (England = 12.7%, Wales = 8.7%). Few men received NACT. The use of NACT was higher among women with HER2 positive or triple negative disease (stage 2-3A). The use of NACT decreased with age and was rarely used among women aged 80+ years. Rates of NACT were under 10% for 35 NHS breast units and above 20% for 12 NHS breast units (patients allocated to organisation of diagnosis).

Key messages:
Among women and men diagnosed with EIBC (2019-2021) who received primary surgery, the overall percentage of people who had adjuvant chemotherapy was 18.8%. The rates were similar for women and men. When combined with patterns of neo-adjuvant chemotherapy, the overall percentage of people who had chemotherapy was 32.4% (England: 32.6%, Wales: 28.8%). The percentage of women who had primary surgery within 12 months and who received chemotherapy was higher among women with ER negative, ER negative/ HER2 negative and HER2 positive disease (stage 2-3A). Rates of treatment varied by age, with lower use of chemotherapy as age at diagnosis increased.





Assurance level	Description	Risk level	Description
Significant	The project has mostly achieved the standards or criteria being audited against	Minor	Overall treatment or service suboptimal - Minor implications for patient safety if unresolved

Not on Risk Register due to: **Since the publication of this audit ABUHB breast service has now moved to fully one stop TDA**

Report Successes:	
1	High compliance for CNS patient contact at diagnosis
2	High levels of eligible patients receiving NACT
3	Acceptable levels of BCS and IBR rates

Report Concerns:	
1	Data Recording for ER, PR and HER2 status
2	Recording of Performance Status
3	Limited number of patients with access to same day TDA

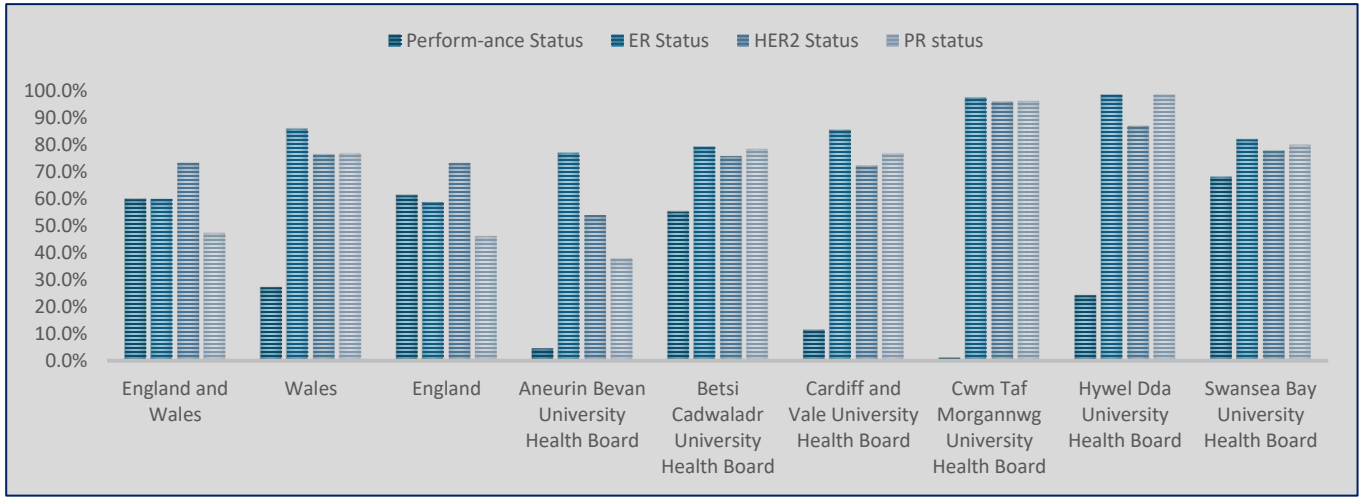
	Report Recommendations:	S.M.A.R.T Actions:	Responsible:	Due Date: Progress:	
1	Ensure that people with breast cancer have access to Triple Diagnostic Assessment (TDA) in a single visit and, if required, identify methods to increase the provision of this service. **Goal 1** - Improve the movement of patients through the care pathway.	Aim for >95% of all patients to receive single visit TDA Breast Unit Opened Feb 2024 – now offering TDA in a single visit to all patients	Michael Rees/ Breast care teams and clinical management in Welsh NHS Health Boards.	Nov 24	Achieved
2	Review the use of neo-adjuvant chemotherapy for all patients with early invasive breast cancer in order to reduce the levels of unexplained regional variation. **Goal 3** - Reduce unwarranted variation for patients having non-surgical oncological treatments.	Aim to continue current standard All cases discussed at MDT with oncology presence	Michael Rees/ Breast care teams and clinical management in Welsh NHS Health Boards.	Nov 24	Achieved
3	Confirm breast multidisciplinary teams (MDT) have a data lead responsible for ensuring the quality of national data submissions. Reviews of data completeness within breast MDTs should include full tumour characterisation, ER13 and HER213 status (for invasive breast cancer), performance status, the NABCOP fitness assessment14 data items (for people aged 70+ years) as well as data on Triple Diagnostic Assessment (TDA) and contact with Clinical Nurse Specialists (CNS). (Recommendation aligned with the report for the National Audit of Metastatic Breast Cancer15.) **Goal 1-5**	• Aim for >95% documentation rate for ER, PR and HER2 status • Change to MDT proforma to collect performance status routinely • In house testing of HER2 • Path to test for PR on all tumours	Michael Rees/ Breast care teams and clinical management in Welsh NHS Health Boards.	Apr 25	In progress
4	Ensure the recording of date and type of breast cancer recurrence in cancer datasets by: a) Education on the recording of recurrence, sharing the NAoMe Guide to collecting COSD data for breast cancer recurrence20 with NHS organisations. b) Reviewing the process of capturing these data within a breast multidisciplinary team (MDT), and ensuring these data are uploaded to cancer datasets. (Recommendation aligned with the report for the National Audit of Metastatic Breast Cancer15.) **Goal 5** - Improve and reduce unwarranted variation in primary breast cancer outcomes.	• Aim for >95% rate for recording breast cancer recurrence • All patients to be discussed at MDT • Standard MDT Proforma implemented for data capture of key parameters	Michael Rees/ Breast care teams and clinical management in Welsh NHS Health Boards.	Apr 25	In progress
5	Review rates of immediate reconstruction and, where rates are identified as below the mean, act to improve access to immediate reconstruction by ensuring it is offered to all women, unless precluded by comorbidity or adjuvant therapies.	• Aim for >80% BCS rate • Aim for >20% rate for IBR post mastectomy • Cases discussed at MDT	Michael Rees/ Breast care teams and clinical management in Welsh NHS Health Boards.	Apr 25	In progress

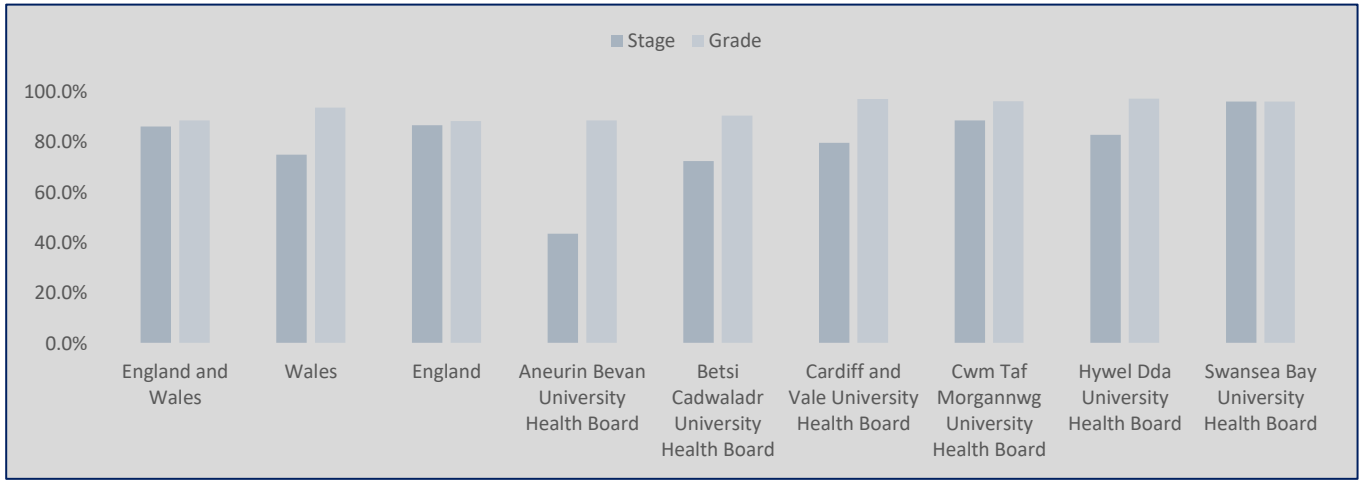
	Clinical Leads Local Recommendations: (if applicable)	S.M.A.R.T Actions:	Responsible:	Due Date: Progress:
1	Revision of MDT proforma to include PS for all new breast cancer diagnoses	Change Proforma with Cancer Services	Michael Rees	Feb 25 - In progress
2	In house testing for HER2	Business case development with pathology	Michael Rees/James Harrison	Apr 25 - In progress

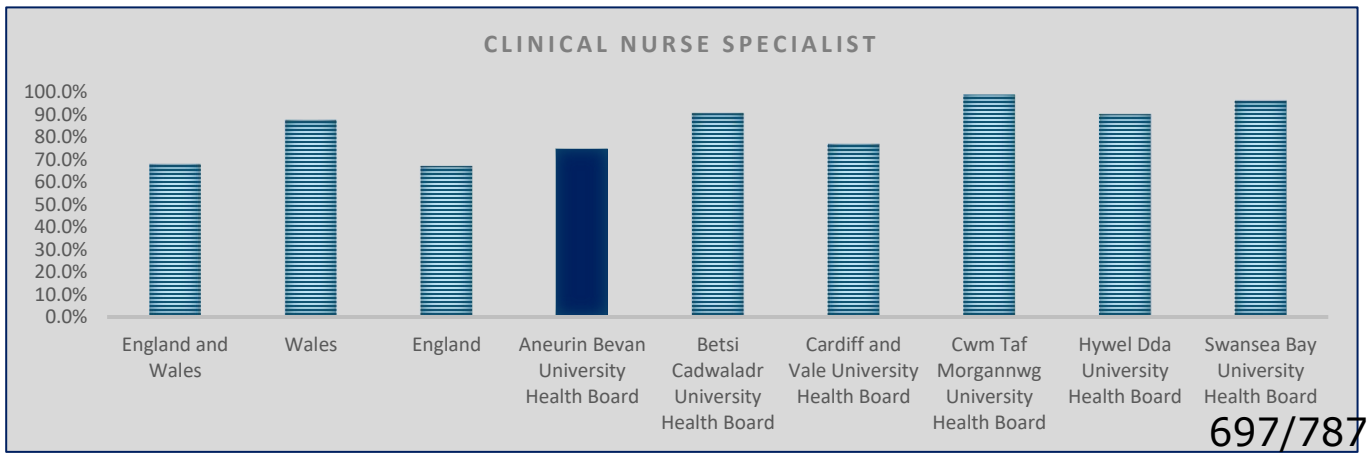
Audit Title: National Audit of Metastatic Breast Cancer (MBC) State of the Nation Report 2024 An audit of care received by people diagnosed with metastatic breast cancer in England and Wales during 2019-2021	Clinical Lead: Mr Michael Rees – Consultant Breast Surgeon • General Surgery
Rationale:	This State of the Nation report publishes information on the care received by women and men diagnosed with MBC during 2019-21 in England and Wales. The care of people diagnosed with primary breast cancer (stages 0 to 3C) is reviewed in the NAoPri.
Objectives:	The aim of the National Audit of Metastatic Breast Cancer (NAoMe) is to evaluate the patterns of care and outcomes for people with metastatic breast cancer (MBC) in England and Wales, and to support services to improve the quality of care for these patients. This work builds on that of the National Audit of Breast Cancer in Older Patients (NABCOP1) but has been expanded to include younger people and men with breast cancer.

Presented at Clinical Standards and Effectiveness Group – 28th November 2024

DATA COMPLETENESS

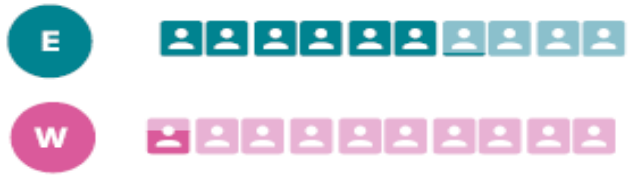


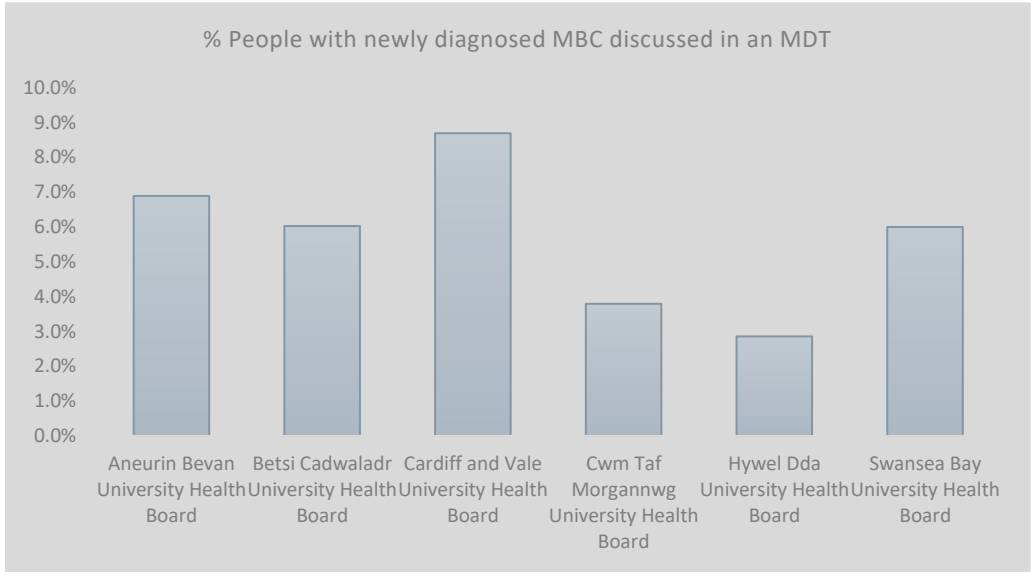




Multidisciplinary Discussion

In England 61% of women with de-novo MBC had a record of multidisciplinary team discussion of their care. In Wales this was only 6% (low data completeness).





Percentage of people with recurrent metastatic breast cancer who had a metastatic lesion biopsied to inform care.

No data for Welsh Health Boards , numerator for Wales 269

Percentage of people with ER positive metastatic breast cancer who received CDK 4/6 inhibitors as first line treatment.

No data for Welsh Health Boards , numerator for Wales 216

- **Percentage of people with HER2 positive MBC who received anti-HER2 therapy as first line treatment -** No data for Welsh Health Boards , numerator for Wales 86

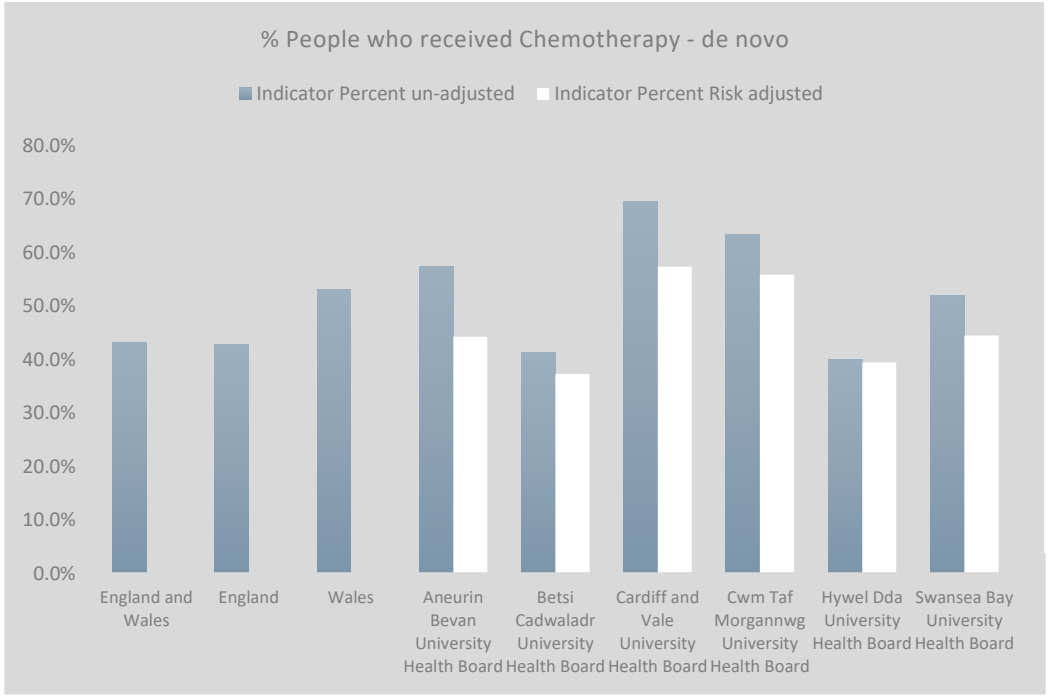
Chemotherapy for recurrent disease

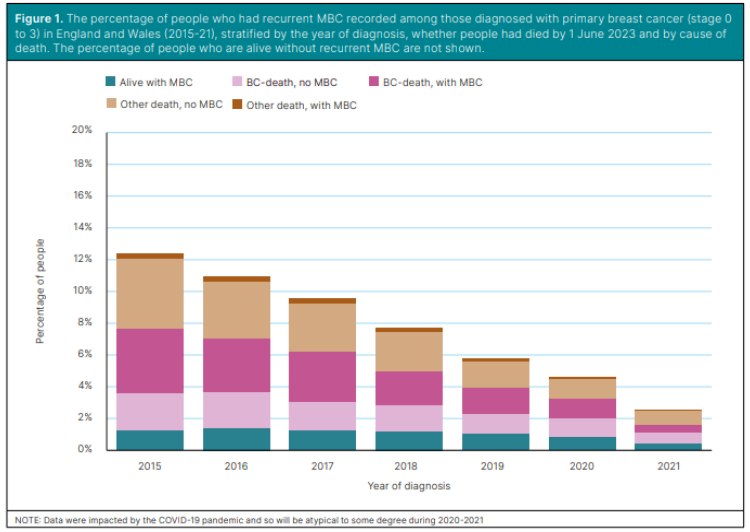
In England 40.4% of people with recurrent MBC received chemotherapy. Use of chemotherapy was greater among younger women with triple negative breast cancer.



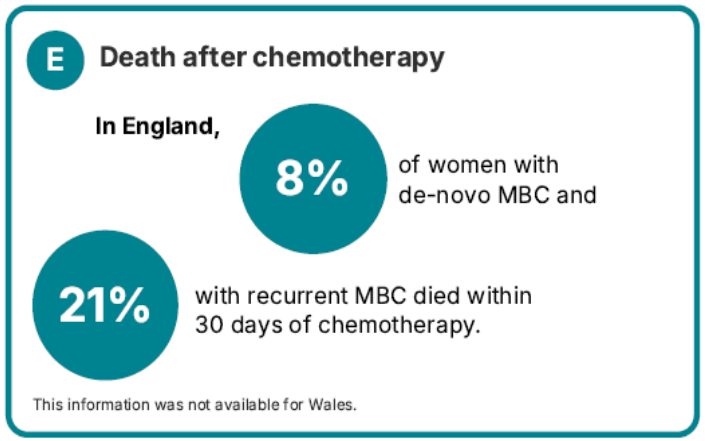
Percentage of people who received chemotherapy - NAoMe recurrent

No data for Welsh Health Boards , numerator for Wales 269





This chart reflects the decrease in deaths related to MBC across the UK from 2015 - 2021



Assurance level	Description
Limited	The project did not achieve the standards or criteria being audited against

Risk level	Description
Moderate	Repeated failure to meet internal standards/Major patient safety implications if findings

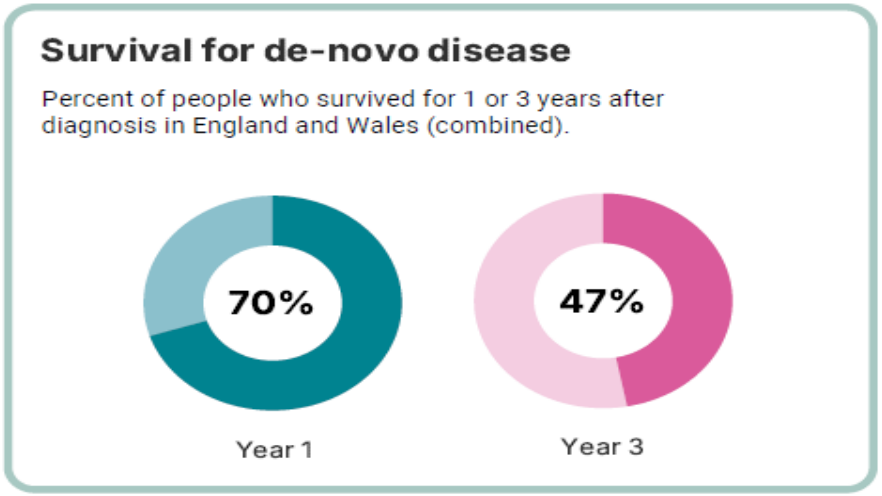
Not on Risk register due to: Poor performance largely the result of incomplete data/poor integration with CANISC records.

Key Successes:	
1	Recording of grade of cancer
2	Review by CNS at diagnosis
3	Chemotherapy rates in line with national average

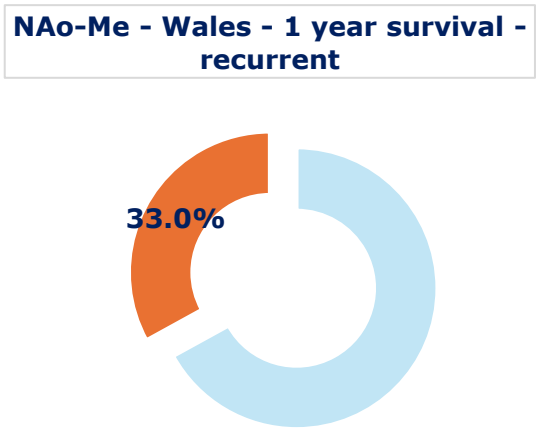
Report Concerns:	
1	Limited data completeness for a number of areas
2	Documented low rates of discussion at MDT (?CANISC integration)
3	Documented low rates or patients receiving a biopsy (?CANISC integration)

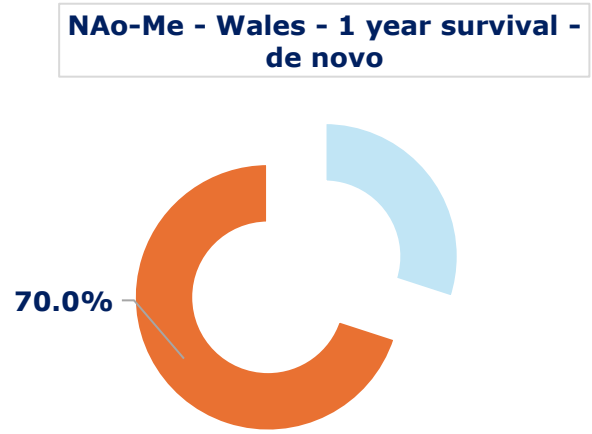
Percentage of women with death recorded within 30 days of a chemotherapy cycle.

No data for Welsh Health Boards , numerator for Wales 250



Wales de-nono – 3-year Survival – 43%





Wales: Breast care teams and clinical management in Welsh NHS Health Boards.

	Report Recommendations:	S.M.A.R.T Actions:	Responsible:	Due Date: Progress:
Goal #1 – Improve the movement of patients through the care pathway.				
1	Ensure the care for people newly diagnosed with MBC (either de-novo or recurrent) is discussed within a breast multidisciplinary team (MDT) meeting.	• Aim for >70% of all patients to be discussed at MDT • Better integration with CANISC • Appointment of metastatic BCN	Michael Rees/Simon Waters, Breast care teams and clinical management in Welsh NHS Health Boards.	Apr 25 In progress
2	Examine biopsy rates for MBC and aim to increase this where feasible if the results may have therapeutic implications.	• All patients biopsy records to be recorded on MDT proforma • Better integration with CANISC	Michael Rees/Simon Waters, Breast care teams and clinical management in Welsh NHS Health Boards.	Apr 25 In progress
3	Confirm breast multidisciplinary teams (MDT) have a data lead responsible for ensuring the quality of national data submissions. Reviews of data completeness within breast MDTs should include full tumour characterisation, ER8 and HER212 status, performance status, the NABCOP fitness assessment data items (for people aged 70+ years) and contact with clinical nurse specialists (CNS). *(Recommendation aligned with the report for the National Audit of Primary Breast Cancer8 .)*	• Clinical lead currently responsible • Consider separate MDT lead role to ensure better data completion	Michael Rees/Simon Waters, Breast care teams and clinical management in Welsh NHS Health Boards.	Dec 25 In progress
4	Ensure the recording of date and type of breast cancer recurrence in cancer datasets by: (a) Education on the recording of recurrence, sharing the NAoMe Guide to collecting COSD data for breast cancer recurrence13 with NHS organisation. (b) reviewing the process of capturing these data within a breast multidisciplinary team (MDT), and ensuring these data are uploaded to cancer datasets. *(Recommendation aligned with the report for the National Audit of Primary Breast Cancer14 .)*	• Aim for >70% of all patients to be discussed at MDT • Better integration with CANISC • Appointment of metastatic BCN • Consider separate MDT lead role to ensure better data completion • Appointment of metastatic breast care nurse	Michael Rees/Simon Waters, Breast care teams and clinical management in Welsh NHS Health Boards.	Apr 25 In progress

Audit Title:	*A broken hip – three steps to recovery*, a report on using the National Hip Fracture Database (NHFD)	Clinical Lead:	Dr Muhammad Usman – Orthopaedic Physician
Rationale:	Every year, over 70,000 people in England, Wales and Northern Ireland will fall and sustain a hip fracture. A broken hip usually happens because of a fall or injury. It's more common in older people and people who have osteoporosis. 70% are over 80 years of age. A broken hip can be life-changing, especially for older people with other health conditions. Some of them may never get back the same strength and movement as they had before their break, and they may need to use a walking stick or frame.		
Objectives:	The report aims to provide readers with a simple guide to all these data and resources by describing the care that hip fracture patients should receive on their journey to recovery: > as they first present with a new hip fracture > as surgery allows them to get out of bed again > through rehabilitation until they are back in their home.		

Audit Standards

Name	Code	KPI 0 Admission to ortho ward %	KPI 1 Prompt orthogeri assessment %	KPI 2 Prompt surgery %	KPI 3 Nice compliant surgery %	KPI 4 Promptly out of bed %	KPI 5 Not delirious post-op %	KPI 6 Return to original residence %	KPI 7 Medication %
Bronglais General Hospital	BRG	8.4	100	40.2	84.1	72.9	95.3	84	58
Glan Clwyd Hospital	CLW	0.8	92.8	53.6	76.3	62.2	78.6	78.8	30.5
Maelor Hospital	WRX	8.5	81.4	70.7	72.3	95.2	63.9	72.5	22.9
Morriston Hospital	MOR	1.2	97	32.4	72.7	83	74.8	73.2	59.3
Prince Charles Hospital	PCH	18.9	0	69.8	56.2	69.3	0	71.9	0.9
Princess Of Wales Hospital	POW	23.7	70.8	62.9	64.1	76.6	72.8	72.1	57.5
Royal Glamorgan	RGH	12	0	64.9	80.6	70.7	15.5	70.8	0.4
The Grange University Hospital	GWE	16.9	96.4	56.9	78.1	69.4	79.8	76	73.7
University Hospital of Wales	UHW	33.1	93	68.9	74.5	82.4	55.5	75.8	68.5
West Wales General	WWG	10.8	55.1	62.2	65	71.2	69.2	77.9	55.5
Withybush General Hospital	WYB	6	24	65.4	75	72.3	56.9	69.7	28.2
Ysbyty Gwynedd Hospital	GWY	9.4	66.8	72.4	51.9	93.2	80.4	84.9	40.9

Below Average | Average | Above Average

Assurance level	Description	Select
Limited	The project did not achieve the standards or criteria being audited against	**Yes**

Risk level	Description	Select
Minor	Overall treatment or service suboptimal - Minor implications for patient safety if unresolved	**Yes**

Has this audit been placed on a Risk Register (N/A if above risk is None)	**YES /NO**
If not on a risk register, why not: We are planning to record this on the risk registrar in the near future.	

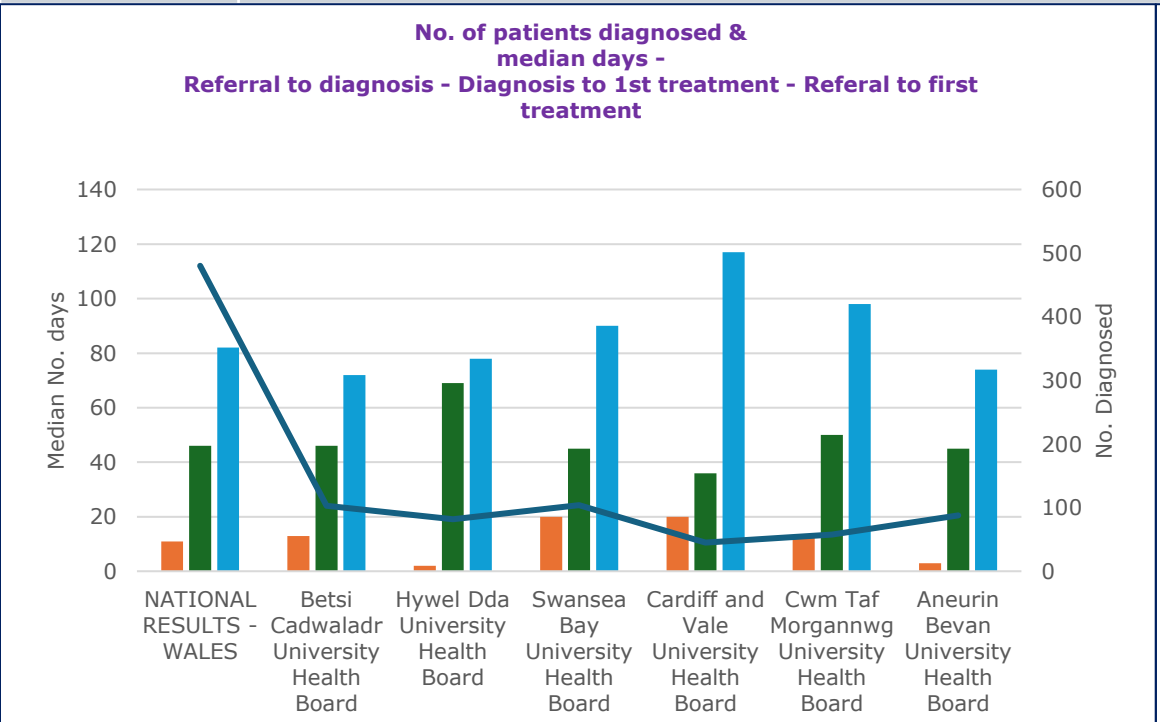
Report Successes:	
1	Prompt Orthogeriatric perioperative care
2	Not Delirious post OP
3	Falls assessment and bone health treatment
4	Anaesthesia with nerve block
5	Nice complaint surgery (cemented Hemiarthplasty, type of prosthesis used)

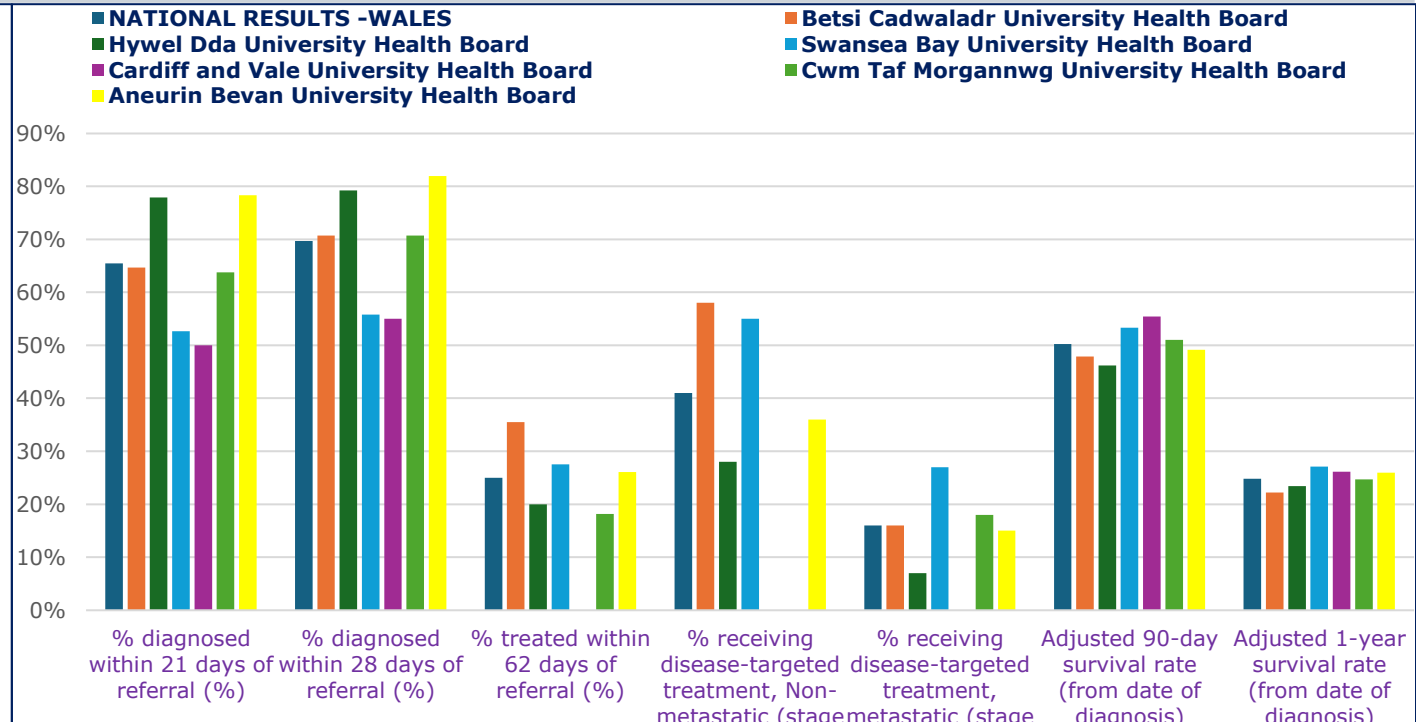
Report Concerns:	
1	Delay in transfer to the orthopaedic ward from A&E
2	Delay in Surgery within 36 hours of admission
3	Day 1 Physiotherapy mobilization
4	Record of AMT scoring on admission (now 4AT tool)

	Report Recommendations:	S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	To ensure that hospitals are ready for the people they know will present each day, so patients receive each step of their care at the right place at the right time.	Trauma service review	Division of surgery/ABUHB	2025	Regular meetings
2	To ensure that all hospitals provide both prompt surgery and optimal peri-operative care so patients can start getting back on their feet as soon as possible.	Trauma service review	Division of surgery/ABUHB	2025	Awaiting Trauma service review date for femoral fracture patients.
3	To ensure rehabilitation and recovery is planned and started early and continues beyond the hospital with measures to prevent another fracture.	Robust postoperative Orthogeriatric care	T&O/Orthogeriatric leads	Monthly hip fracture Governance Meetings	Regular engagement of multiple disciplines to identify and aim to improve care
4	By agreeing a standardised approach to the collection of ethnicity data across all patients' pathways and provider organisations.	Regular prospective data collection through NHFD.	T&O, Orthogeriatrics	Continuous data gathering and monitoring.	Analysis of NHFD data.
5	By ensuring that people with other injuries benefit from the improvements that have been pioneered among those with hip fracture.	Regular input from the Orthogeriatric service to non-Hip fracture patients on the trauma ward	T&O, Orthogeriatric Medicine	Regular engagement	Maintain the Regular practice

	Clinical Leads Local Recommendations: T&O/OG	S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Extra Theatre space, weekend extra lists	Trauma review - ABUHB	Surgical Division	2025	
2	Ring fence beds to improve delay in A&E				

Audit Title:	National Pancreatic Cancer Audit State of the Nation Report 2024	Clinical Lead:	Miss Tamsin Boyce – Consultant Surgeon
NICE Guidance:	• NICE Guideline NG85: Pancreatic cancer in adults: diagnosis and management • NICE Quality Standard QS177: Pancreatic cancer quality standard		
Rationale:	About 10,500 people are diagnosed with pancreatic cancer in the UK each year. Around 2 in 10 pancreatic cancers in the UK (22%) may related to smoking. It mainly affects people of middle and older age. Pancreatic cancer is one the least survivable cancers, with virtually no improvement seen in survival rates in the UK over 40 years from the 1970s.		
Objectives:	The National Pancreatic Cancer Audit (NPaCA) evaluates patterns of care and outcomes for people with pancreatic cancer in England and Wales. It highlights regional variations in care and supports NHS services to identify and address areas for improvement. The NPaCA evaluates patterns of care against standards outlined in the following key publications: • NICE Guideline NG85: Pancreatic cancer in adults: diagnosis and management. • NICE Quality Standard QS177: Pancreatic cancer quality standard. • NHS England 2024: HPB best practice timed diagnostic pathway. In this first State of the Nation report from the National Pancreatic Cancer Audit, was described the care received by people diagnosed with pancreatic cancer in England during 2020-21 and Wales in 2022.		





Assurance level	Description
Significant	The project has mostly achieved the standards or criteria being audited against

Risk level	Description
Moderate	Treatment or service has significantly reduced effectiveness - Moderate risk to patient safety if not acted upon

Has this audit been placed on a Risk Register (N/A if above risk is None)	**YES/NO**
If not on a risk register, why not: **Much of the risk is outwith ABUHB control eg time to surgery, delays in pathway eg CT-PET**	

Report Successes:	
1	Higher percentage diagnosed within 21 and 28 days compared to rest of Wales/England
2	Shorter median time referral to diagnosis compared to rest of Wales
3	Existing multidisciplinary clinic with CNS and dietitian support and in parallel to oncology clinic

Report Concerns:	
1	Complex staging pathway, some actions already taken to reduce time to treatment
2	Overall poor prognosis due to multiple factors – late/non-specific presentation, limited effective treatment options

Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Review referral pathways in centres which diagnose pancreatic cancer to ensure that all people who receive a diagnosis of pancreatic cancer, including those with non-resectable disease, are discussed by a multidisciplinary team (MDT).	• Review local pathways of how referrals to MDTs are made and develop protocols to increase rates of referral – eg. At the end of a clinically suspicious scan report, radiology team to state 'ensure patient is referred to HPB MDT' • Ensure MDTs are prepared for increased workload related to a higher volume of patients coming through the MDT – consider extending timings of MDT	Local and regional MDTs	Ongoing	CWS proforma for referral. Liaison with regional MDT
2	Ensure that all NHS pancreatic cancer service providers review their diagnostic pathways and implement hepatopancreatobiliary (HPB) cancer pathway guidance, which sets out recommended sequencing of events for the diagnostic process.	• MDT lead to review local diagnostic services and pathway and identify how an optimal diagnostic pathway would work in their local centre • Review MDT wait times - consider an audit for diagnostic pathway timings and review key areas for improvement or rate-limiting step, eg. Obtaining an ERCP slot • Estimate how many imaging and endoscopy slots are required per week to get patients through this pathway promptly • Monitor turn-around time for radiology and pathology reports and develop local plans to increase radiology and endoscopy capacity • Feedback quarterly data reports on waiting times to the wider MDT	MDT lead and Cancer Services plus regional MDT and HPB Programme Board. Identify specific people for departmental audits/existing data from cancer services Endoscopy team	End 2025	Additional OP ERCP capacity imminent and further appointment anticipated. Radiology access adequate for USC scans.

Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
3	Ensure a personalised approach is taken to optimise a person's fitness, nutrition and medication to prevent deconditioning prior to starting treatment. This may include the implementation of prehabilitation, oncogeriatric services and dietetic support.	• Consider early dietetic and physiotherapy review of pancreatic cancer patients prior to starting treatment to identify areas in which patients could be supported • Consider an older patients service review for more frail patients for a comprehensive medical review of pre-existing conditions • Review and optimise current medications at the first patient consultation to ensure medical conditions are stable prior to starting treatment	MDT/clinic team, dietitian already in clinic, HNA undertaken No frailty service available	Ongoing	Oncogeriatric service not anticipated currently.
4	Review provision of clinical nurse specialists (CNS) in organisations which have a shortfall of newly diagnosed people being reviewed by a CNS, and ensure that everyone diagnosed with pancreatic cancer has access to a specialist CNS, ideally from the point of diagnosis.	• Review how CNS staffing levels compare to the patient workload • Identify clinics where new patients with pancreatic cancer will be reviewed. Allocate a CNS to be present on these clinic days.	New patient clinic already in place with CNS presence. Reduced staffing in CNS team currently.		Recruitment to CNS team needed
5	Consider implementing protocols to ensure that all people diagnosed with pancreatic cancer are assessed for eligibility for pancreatic enzyme replacement therapy (PERT), and that PERT is offered as recommended in national guidance.	• Ensure documentation of whether patients require PERT, or reasons for not offering PERT (or patients declining it) • Consider a local audit of PERT prescribing to review if there are any particular patient groups who are not receiving this treatment • Early dietitian review of all pancreatic cancer patients with clear recommendations on whether patients would benefit from PERT, and whether patients have been educated in how to adjust doses • Raise the profile of PERT prescribing at the specialist and local MDTs	MDT and dietetics Dietitian already in MDT clinic.	Ongoing	Most of recommendations already met

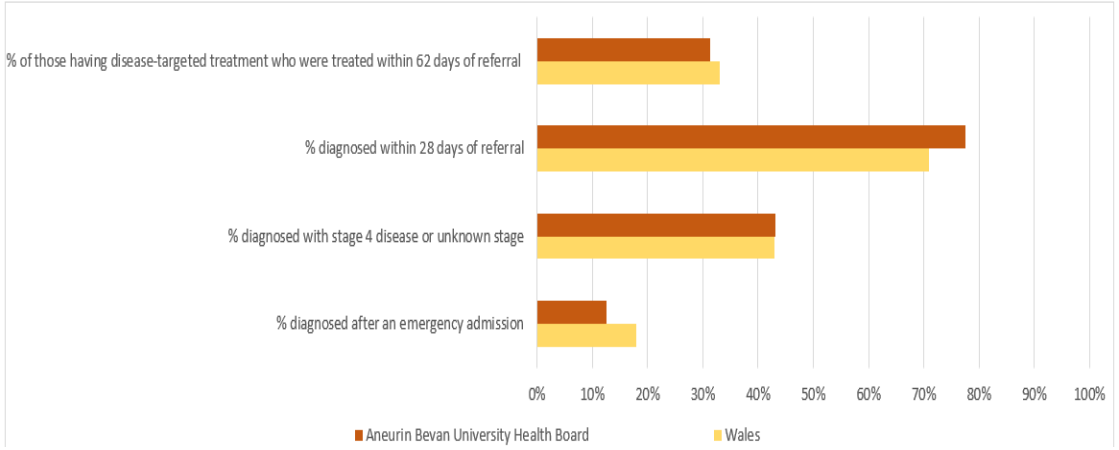
Clinical Leads Local Recommendations: (if applicable)		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Ensure CNS team numbers are maintained	Recruit to replacement CNS post	Nursing lead	Summer 2025	Ongoing
2	Optimise inpatient/acute presentation management including via SDEC and Flow Centre	Update referral guidance and pathways in medicine	MDT lead and acute medicine/gastro	End 2025	Ongoing
3	Imminent departure of HPB oncologist, replacement awaited	Velindre to recruit to post	Velindre CD	Unknown	Ongoing

Audit Title:	**National Oesophago-Gastric Cancer Audit (NOGCA) - State of the Nation Report** Data collection period: 1 April 2021 – 31 March 2023 **Clinical Lead: Dr Tamsin Boyce – Consultant Surgeon**
Rationale:	Oesophago-gastric cancers (OGCs) are amongst the late-stage malignancies worldwide and are associated with high disease-related mortality. Emergency presentations are associated with a poorer prognosis/outcome. Overall, 21% of people with OGC in England and 18% in Wales were diagnosed after being admitted as an emergency. The National Oesophago-Gastric Cancer Audit (NOGCA) evaluates patterns of care and outcomes for people with oesophageal or gastric cancer in England and Wales. For the first time, the Audit has derived its indicators using information that is routinely collected by the NHS as part of the care and support given to people diagnosed with OG cancer, rather than data collected specifically for the Audit.
Objectives:	Five quality improvement goals for NOGCA: 1) Reduce rates of emergency and late-stage diagnosis of OG cancer; 2) Reduce the percentage of people with OG cancer waiting more than 62 days from referral to first treatment; 3) Increase the percentage of people with OG cancer who have access to a clinical nurse specialist (CNS); 4) Improve outcomes of potentially curative treatment for people with OG cancer; 5) Improve completion and reduce complications of palliative chemotherapy for people with OG cancer.

Assurance level	**Description**
Significant	The project has mostly achieved the standards or criteria being audited against

Risk level	**Description**
Minor	Overall treatment or service suboptimal - Minor implications for patient safety if unresolved

Has this audit been placed on a Risk Register (N/A if above risk is None) **If not, why not: Ongoing work to improve patient care and outcomes.**	**YES/NO**



		Diagnosis and staging			Waiting times	
Period (diagnosis date)	Local Health Board	Number of people diagnosed with OG cancer	% diagnosed after an emergency admission	% diagnosed with stage 4 disease or unknown stage	% diagnosed within 28 days of referral	% of those having disease-targeted treatment who were treated within 62 days of referral
1 April 2021 - 31 March 2023	Aneurin Bevan University Health Board	246	13%	43%	78%	31%
1 April 2021 - 31 March 2023	Wales	1322	18%	43%	71%	33%

Report Successes:	
1	Lower proportion of cancers diagnosed as emergency (compared to Wales and England)
2	Higher proportion diagnosed within 28 days of referral (compared to Wales and England)
3	Wales time to treatment better than England but still only 33% vs 26%

Report Concerns:	
1	Difficulties comparing to previous audits as different data collected/published.
2	62-day referral to treatment not being met (as per most tumour sites)
3	Delays in pathway out with local control eg CT-PET

	Report Recommendations:	S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	In regions with high rates of emergency and late-stage diagnosis, conduct individual patient root cause analysis to look for earlier diagnosis opportunities and to understand how many are potentially preventable; use the resulting findings to develop appropriate local action plans.	Ongoing work across Wales (National Optimal Pathway) to reduce late-stage diagnosis. Local rate lower than national rates already.	Cancer Network		TBC
2	Ensure that all providers of OG cancer care review their patients' diagnostic and treatment pathways against best practice guidance in order to identify and address barriers to providing timely treatment.	Reduce pathology turnaround times CT-PET capacity Data from regional network needed; SLA review ongoing	Pathology department PETIC Divisional and regional team re SLA	2026?	
3	Prioritise improving the flow of pathology data in England, to ensure patients' surgical pathology outcome data are submitted to the Cancer Outcomes and Services Data set (COSD) and are available in national cancer datasets.	N/A refers to England only, report says data was almost complete for Wales	N/A	N/A	N/A
4	Regions with high rates of 30-day mortality among people receiving palliative chemotherapy should review the care of people who died within this period, to identify potential issues with patient selection, and ensure that treatment is only offered if appropriate and likely to benefit the patient	Ask Velindre team re data. No data currently.	Cancer Service to ask Velindre oncologists for data?	End 2025	

	Clinical Leads Local Recommendations: (if applicable)	S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	More detailed data needed re steps/timelines of complex pathway to treatment and outcomes as much is outwith ABUHB influence	Ask cancer services for breakdown of time to treatment	THB/Cancer Services	End 2025	
2	Future plans for local delivery of regional services	Will need new SLA/medium term plan	Divisional and regional teams	End 2026?	Ongoing

Audit Title:	National Bowel Cancer Audit - State of the Nation Report An audit of care received by people with bowel cancer in England and Wales focusing on people diagnosed between 1 April 2022 and 31 March 2023.	Clinical Lead:	Mr Keshav Swarnkar – Consultant Surgeon

NICE guideline [NG151] Quality Standards (QS):

1. Testing for Lynch Syndrome
2. Discussion about treatment options for early rectal cancer
3. Testing to guide systemic anti-cancer treatment
4. F-up for detecting local recurrence and distant metastases

Achieved

The ten performance indicators, as set out in the NBOCA QI Plan, are:

1. Seen by Clinical Nurse Specialist
2. Trust/multidisciplinary team (MDT) volume for rectal cancer surgery
3. Adjusted 90-day mortality after major resection*
4. Adjusted 30-day unplanned return to theatre after major resection*
5. Adjusted 30-day unplanned readmission after major resection*
6. Adjusted 18-month unclosed ileostomy after anterior resection*
7. Stage 3 colon cancer receiving adjuvant chemotherapy
8. Adjusted severe acute toxicity after adjuvant chemotherapy for colon cancer*
9. People with rectal cancer receiving neo-adjuvant treatment
10. Adjusted 2-year survival rate after major resection*

Rationale:	The National Bowel Cancer Audit (NBOCA) measures the quality and outcomes of care for people diagnosed with bowel cancer in England and Wales. This report focuses on people diagnosed with bowel cancer between 1 April 2022 and 31 March 2023.
Objectives:	NBOCA is part of the National Cancer Audit Collaborating Centre (NATCAN), a new national centre of excellence to strengthen NHS cancer services by looking at treatments provided for people living with cancer and their outcomes across England and Wales. NBOCA sets out five quality improvement (QI) goals covering the entire patient care pathway. Mapped to these goals, NBOCA has ten performance indicators with local QI targets, and three contextualising measures.

Covid-19 pandemic brought about a reduction in referrals which has since returned to pre-pandemic levels although variations remain between NHS England and NHS Wales in diagnostic pathways. The expansion of screening for both NHS England and NHS Wales has increased with the age ranges expanding from 50-59 to 50- to 74 in England and 51 to 74 in Wales.

Assurance level	Description
Significant	The project has mostly achieved the standards or criteria being audited against

Risk level	Description
None	Standards met and findings demonstrate no risk to patient safety

1)Apart from Stoma closure at 18 month, most clinical standards met. **NO direct threat to patient safety** but needs improving to address Quality of outcome(bowel function, Patient experience, mitigation of stoma management cost)

2) CRN involvement has substantially improved since, but some minor situations need capturing- Patients referred by gastroenterologists who report incidental bowel polyp cancers and remain under gastroenterologists for surveillance. These are discussed in MDT but don't have direct supervision of CRN and may have been missed. All polyp cancers though are registered with colorectal MDT. **There are more polyp cancers detected now due to increased endoscopy and BSW and may require separate database for tracking and surveillance** . This is likely to need more administrative resource to cover SPECC and Colorectal MDT.

3) Lack of data from VCC regarding toxicity related to adjuvant chemotherapy needs addressing at Wales cancer network level (WCN). This is not captured at ABUHB level, and this will be highlighted to Our Oncologist at MDT (Dr H Williams)

However, there is no direct threat to patient safety in terms of survival when compared to local and national targets. **It is acknowledged that we aim to achieve stoma closure target by April 2026.**

	Performance indicator: (April 2022 to March 2023 unless otherwise stated)	National results	Local Target	% of trusts/ MDTs meeting local target	ABUHB results
1	Seen by Clinical Nurse Specialist ***(Based on people diagnosed with bowel cancer between 1 Apr 22 and 31 Mar 23)***	94%	>95%	61%	85%
2	Trust/MDT volume for rectal cancer surgery ***(Based on people who underwent rectal cancer surgery between 1 April 2022 and 31 March 2023, for performance indicator 2)***	N/A	>20 per year	81%	54
3	Adjusted 90-day mortality after major resection ***(Based on people diagnosed with bowel cancer between 1 Apr 22 and 31 Mar 23)***	2.7%	<6%	96%	2.7%
4	Adjusted 30-day unplanned return to theatre after major resection ***(Based on people diagnosed with bowel cancer between 1 Apr 22 and 31 Mar 23)***	6.4%	<10%	92%	4.7%
5	Adjusted 30-day unplanned readmission after major resection1 ***(Based on people diagnosed with bowel cancer between 1 Apr 22 and 31 Mar 23)***	11%	<15%	81%	8.0%
6	Adjusted 18-month unclosed ileostomy after anterior resection ***(Based on people who underwent an anterior resection with diverting ileostomy between 1 April 2017 and 31 March 2022)***	38%	<35%	41%	50%
7	Stage 3 colon cancer receiving adjuvant chemotherapy ***(Based on people who underwent surgery for Stage 3 colon cancer between 1 April 2020 and 30 November 2022)***	66%	<50%	93%	21%
8	Adjusted severe acute toxicity after adjuvant chemotherapy for colon cancer ***(Based on people who underwent surgery for Stage 3 colon cancer between 1 April 2020 and 30 November 2022)***	21%	<33%	95%	-
9	People with rectal cancer receiving neo-adjuvant treatment ***(Based on people diagnosed with bowel cancer between 1 January 2022 and 31 December 2022)***	34%	10%-60%	89%	-
10	Adjusted 2-year survival rate after major resection ***(Based on people who underwent surgery for colorectal cancer between 1 April 2020 and 31 March 2021)***	82%	>70%	97%	81%

Report Successes:	
1	Good surgical outcomes for both colon and rectal cancers (survival). Quality assurance across entire pathway with good climate inventory of Colorectal MDT.
2	All rectal cancers managed under unified MDT with significant advances in last 12 months in local treatment for rectal cancers- TAMIS procedure delivered by 2 surgeons.
3	Development of SPECC MDT where Polyp cancers and Rectal Polyp cancers are discussed in depth and appropriate treatment and surveillance planned in keeping with national guidelines.

Report Concerns:	
1	Stoma closure rates
2	Should CRN be directly involved in Polyp cancers tracking and surveillance? This will require additional resource- CRN/ database management and tracking.
3	Linking of oncological data with Trust data to provide assurance on quality of oncological treatment.

	Report Recommendations:	S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Improve data completeness of key items in national cancer registration datasets to allow risk-adjustment of performance indicators. Data items of focus: tumour, node and metastases (TNM) stage, American Society of Anaesthesiologists' (ASA) grade and performance status. • National Disease Registration Service (NDRS) regional Data Liaison Managers to support trusts/multidisciplinary teams (MDTs) with coding, data entry, and quality assurance for the Cancer Outcomes and Services Dataset (COSD). • Local provision of data lead responsible for ensuring the quality of national data submissions	Colorectal Nurses to monitor Polyp cancer patients	K Swarnkar		To be discussed with CRN
2	2. Increase the proportion of people who are offered mismatch repair (MMR) assessment to identify those with Lynch syndrome and inform surgical decision making, and systemic treatments. • Ensure timely access to assessment of MMR status as part of the NHS England Lynch syndrome testing and surveillance pathways. **NICE QS 1.**	We have made it mandatory to do MMR on all cases registered to MDT. Pathology department aware and have assured.	Rachel Jones James Harris		
3	Increase the proportion of people who have their ileostomy closed within 18-months of anterior resection for rectal cancer. • Support trusts/MDTs to identify system-level (e.g. access to theatre/radiological investigations) and patient-level drivers of variation. • Support trusts/MDTs to participate and engage with the local and national quality improv	• Agree pathway • Discuss with radiology • Discuss with oncologist • Stoma nurses to track patient progress. • Protected surgical lists to accommodate stoma closure cases every month.	Stoma nurse and MDT lead K Swarnkar	April 2026	In progress

Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
4	Reduce variation between trusts/MDTs in the use of chemotherapy for people with Stage 3 colon cancer to optimise cancer survival while maintaining low levels of acute severe toxicity. • Continue to monitor and investigate regional and institutional variation in rates of neo-adjuvant and adjuvant chemotherapy for people with Stage 3 colon cancer and ensure evidence-based chemotherapy policies are in place. • Identify and address barriers to timely access to adjuvant chemotherapy. • Encourage the utilisation of appropriate risk stratification tools for severe acute toxicity including frailty scoring, and integration of geriatric expertise and rehabilitation into shared chemotherapy decision making. • Support the delivery of acute oncology services to optimise the care delivered to people who experience acute toxicity.	Discussion needed at WCN level to facilitate this data capture and linking with TRUST data.	Dr H Williams	April 2026	In progress
5	Understand variation in the utilisation of neo-adjuvant radiotherapy for people with rectal cancer to optimise their outcomes. • Cancer Alliances to develop standardised evidence-based neo-adjuvant treatment protocols based on high-quality radiological staging. This will aid decision making and take into account locoregional approaches to neo-adjuvant therapy, incorporating organ preservation techniques and participation in clinical trials.	As above	Dr H Williams		April 2026

Clinical Leads Local Recommendations: (if applicable)		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Target to be achieved by April 2026 for stoma closure. Need to have agreed pathway within MDT with stoma nurse at the centre to track and facilitate timely closure	Discuss in MDT Stoma nurses to agree the role.	MDT lead	April 2026	Discussion under way
2	CRN to be made aware of their defined role in polyp cancer cases.	Discussion in MDT	MDT lead	April 2026	

Audit Title:	2024 NVR State of the Nation Report Results for people who had vascular procedures during 2023 in NHS hospitals in England, Wales, Scotland and Northern Ireland.	Clinical Lead:	Mr David McLain – Consultant Vascular Surgeon
		NICE:	NG19 Diabetic foot problems NG156 Repairing ruptured aneurysms
Rationale:	This State of the Nation report for the National Vascular Registry provides information on the quality and outcomes of care for adults who had major vascular procedures in NHS hospitals. It aims to support vascular services to provide high quality of care for these people, and shares examples of good practice as well as highlighting areas which merit further investigation to improve care.		
Objectives:	The report contains key findings for emergency (non-elective) and elective vascular procedures carried out in 2023, along with some outcome indicators for the procedures performed between January 2021 and December 2023. The information covers the following patient groups: 1. people with peripheral arterial disease (PAD) who undergo either *a) lower limb angioplasty / stent,* *b) lower limb bypass surgery, or* *c) major lower limb amputation* 2. people who have a repair procedure for abdominal aortic aneurysm (AAA) or aortic dissection 3. people who undergo carotid endarterectomy or carotid stenting		

Key messages:

We're a busy unit.

We need the hybrid theatre we were promised as part of the centralisation. Despite much planning and apparent support from WG, we're no closer to the project being funded and it is not clear that WG has £50M to spend on it.

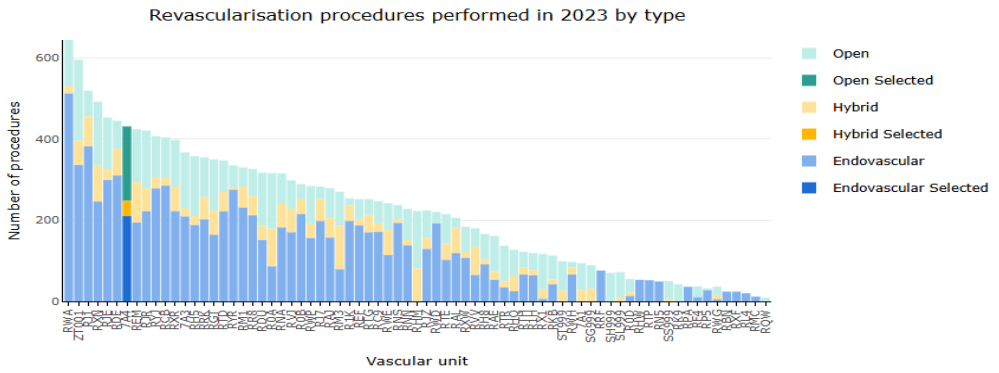
Lower limb revascularisation procedures

Time from non-elective admission to revascularisation for people with chronic limb threatening ischaemia (CLTI)

Key messages:
The median time (IQR) from admission to revascularisation was 6 (3-9) days among 5,200 non-elective admissions of people with CLTI in 2023. The proportion of people revascularised within 5 days was 50% which is lower than the 54% in 2021. Among the NHS vascular units that performed 10 or more procedures for people with CLTI admitted non-electively:
- 27 units had at least 50% of their patients wait more than 5 days
- 16 units had at least 25% of their patients wait more than 10 days

	Median time (IQR) from admission to revascularisation (days)	% CLTI treated within 5 days
Uk	6	50%
Wales	6	42%
C&VUHB	6	45%
SBUHB	6	44%
BCUHB	11	14%

Key messages:
Access to dedicated operating theatre list is inadequate. There is heavy use of CEPOD theatres and bypass cases are often of lower priority than other cases competing for CEPOD time.



Assurance level	Description
Significant	The project has mostly achieved the standards or criteria being audited against

Risk level	Description
Moderate	Treatment or service has significantly reduced effectiveness - Moderate risk to patient safety if not acted upon

Has this audit been placed on a Risk Register (N/A if above risk is None)	NO	If not on a risk register, why not: Outcomes, so far, continue to be satisfactory. The issues are recognised and we're addressing them with the network governance structures

Report Successes:	
1	Clinical outcomes are satisfactory.
2	Started a FEVAR programme, first case treated in Feb 2025 with support from Bristol.

Report Concerns:	
1	Inadequate access to dedicated main theatre sessions results in routine use of and reliance on CEPOD, with the inevitable delays and cancellations.
2	The continued lack of delivery of a hybrid operating theatre is compromising patient care and leading to delays in treatment, e.g. EVAR.

Report Recommendations:		S.M.A.R.T Actions:	Responsible: Due Date: Progress:
1	Ensure that people with chronic limb threatening Ischaemia (CLTI) receive care urgently as recommended in the VSGBI Quality Improvement Framework (QIF) for peripheral arterial disease		Integrated Care Boards (ICBs) (working with Trusts), Local Health Boards, Vascular Networks.
Time from admission to procedure: median =6 days. 50% of patients are revascularised within 5 days.			
2	Identify reasons for the rise in the number of major lower limb amputations among people with PAD. This might require funding for national research as well as local investigations.		Vascular Society Audit and Research committees, ICBs (working with Trusts), Local Health Boards. National Institute for Health & Care Research.
There has been a 16% increase in the number of major lower limb amputations performed in the UK since 2020.			
3	Examine pathways to treatment for people requiring elective aortic aneurysm repair (both screen detected and incidental findings) and carotid endarterectomy (CEA) with the aim of removing causes of avoidable delays and increasing the proportion of people whose wait is within recommended standards.		ICBs (working with Trusts), Local Health Boards, Vascular networks, national AAA screening programmes.
Median time for AAA repair: 86 days; 31% of patients were treated within 8 weeks Median time for CEA: 15 days; 49% of patients treated within 14 days.			

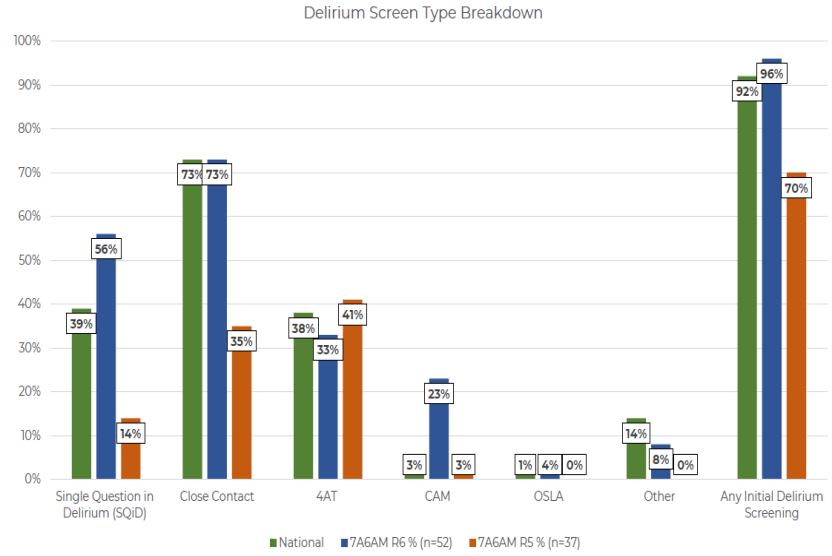
Report Recommendations:		S.M.A.R.T Actions:	Responsible: Due Date: Progress:
4	Improve access to endovascular repair of ruptured aortic aneurysms in suitable patients. This may require improving network pathways and working arrangements across vascular surgery, interventional radiology and anaesthesia.		NHS England Specialist commissioning, University Local Boards, ICBs (working with Trusts), Vascular networks.
Proportion of repairs of ruptured AAA performed as endovascular repairs was 46% in 2023 (up from 30% in 2018).			
5	Develop better guidance on the coding of: i) TEVAR procedures for Type B Aortic Dissection to distinguish from TEVAR performed for aneurysms ii) FEVARs for juxta or supra renal aneurysms.		VSGBI & BSIR NHS England Specialist commissioning and Digital Health and Care Wales (DHCW).
15% of procedures with an aortic status of dissection on the NVR used an OPCS code for dissection (L27.4 or L28.4).			

Clinical Leads Local Recommendations: (if applicable)			
1	Continue to apply pressure on WG / CAV to provide a hybrid operating theatre	2	Understand the urgent nature of arterial vascular surgery when interpreting theatre efficiency.

National Audit of Dementia - Care in General Hospitals 2023-24: Round 6 Audit Report	Clinical Lead: Dr Inder Singh – Consultant Care of the Elderly
NICE guideline [NG97] Dementia: assessment, management and support for people living with dementia and their carers	
Recommendations: 1.1 Involving people living with dementia in decisions about their care 1.2 Diagnosis 1.3 Care coordination 1.4 Interventions to promote cognition, independence and wellbeing 1.5 Pharmacological interventions for dementia 1.6 Medicines that may cause cognitive impairment	1.7 Managing non-cognitive symptoms 1.8 Assessing and managing other long-term conditions in people living with dementia 1.9 Risks during hospital admission 1.10 Palliative care 1.11 Supporting carers 1.12 Moving to different care settings 1.13 Staff training and education
Rationale:	The National Audit of Dementia (NAD) measures the performance of general hospitals in England and Wales against standards relating to care delivery which are known to impact people with dementia while in hospital. Standards are derived from national and professional guidance, including NICE Quality Standards and guidance, and the Dementia Friendly Hospitals Charter.
Objectives:	Dementia care continues to be a national priority in England and Wales. The Dementia Care Pathway states the key principles for treatment, support and care for people living with dementia and their carers, highlighting a person-centred approach in which rights and dignity, are fundamental. Across England and Wales hospitals have affirmed this approach, signing up to John's Campaign (90%) for the right of people with dementia to be supported by their family carers, and the Dementia Friendly Hospital Charter (82%). The National Institute for Health and Care Excellence (NICE) states that "People with dementia often experience longer hospital stays, delays in leaving hospital and reduced independent living. Hospital admission can trigger distress, confusion and delirium for someone with dementia. This can contribute to a decline in functioning and a reduced ability to return home to independent living".

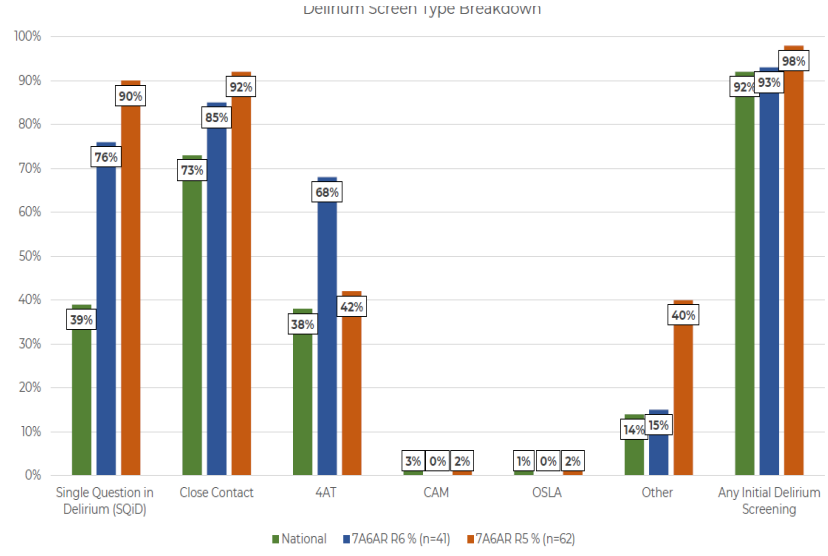
Figure 6: Deliriu

NEVILL HALL HOSPITAL (7A6AM)



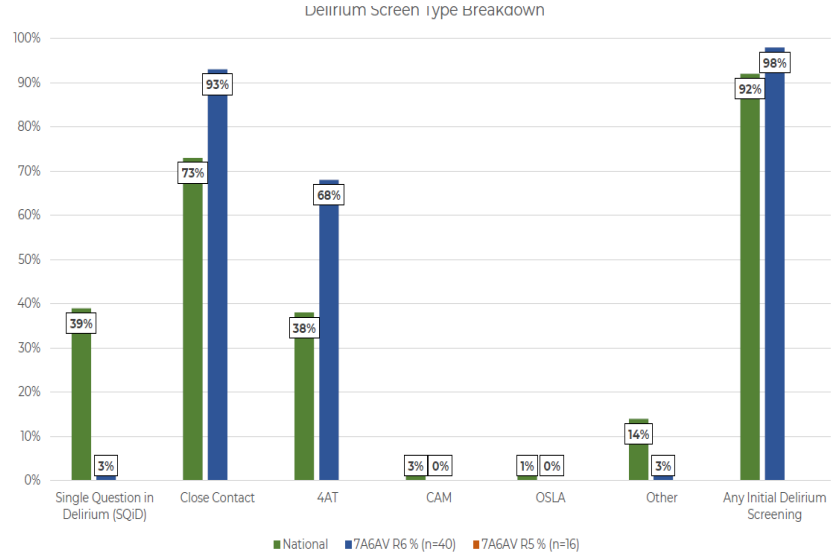
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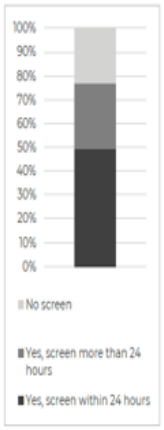
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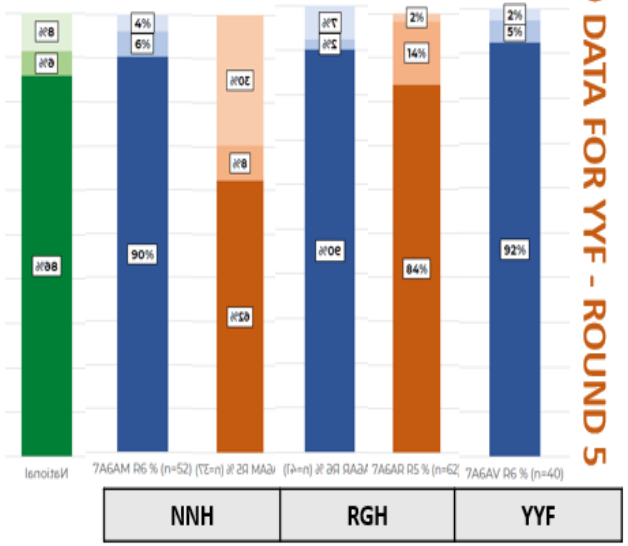
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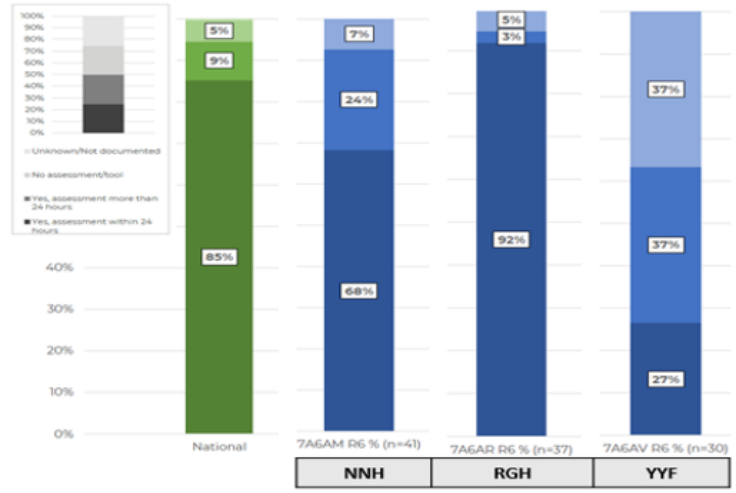
NHH & RGH have increased screening within 24 hours compared to R5 – YYF did not record data for R5, however R6 92% compared to 90% in NHH & RGH.

Structured screening NHH - 38%, RGH – 73.7% and YYF – 69.2%





NO DATA FOR YYF - ROUND 5



Pain Assessments

NHH – 64%, are performing less pain assessments within 24 hours than RGH and YYF both 92%.

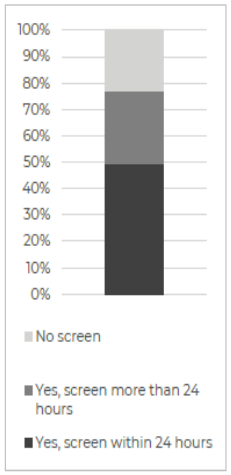
There was not data in R5 for YYF, with NHH increasing for 50% in R5 and RGH has decreased for 98% in R5.

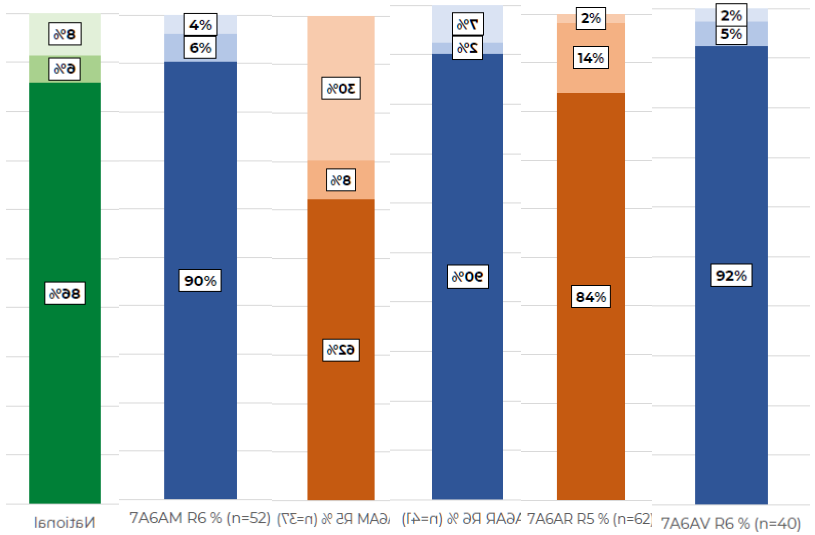
Table 4: Any Pain Assessment

Pain Assessment	National R6 %	Nevill Hal Hospital	Royal Gwent Hospital	Ysbyty Ystrad Fawr
Assessment within 24 hours	92.7%	80.4%	87.5%	71%
Assessment more than 24 hours	5%	0%	5%	25.8%
No pain assessment	2.3%	19.6%	7.5%	3.2%
Any structured pain assessment (Abbey Pain Scale, PAINAID, CNPI)	40.6%	13.7%	85%	32.3%

NHH & RGH have increased screening within 24 hours compared to R5 – YYF did not record data for R5, however R6 92% compared to 90% in NHH & RGH.

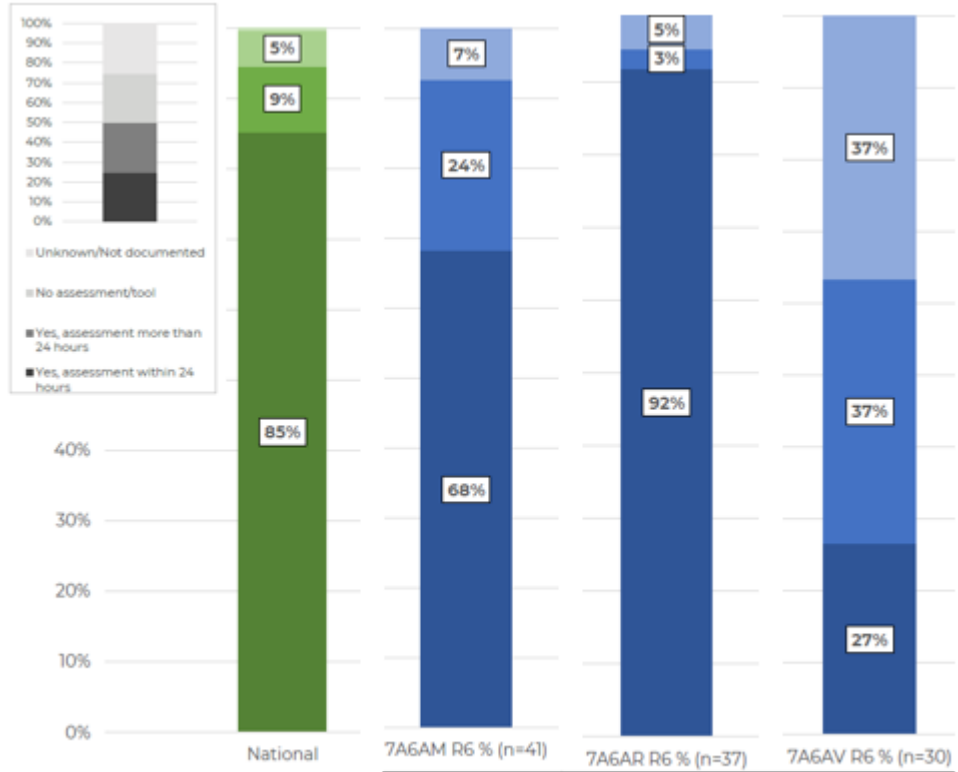
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NO DATA FOR YYF - ROUND 5

NNH	RGH	YYF



NNH	RGH	YYF

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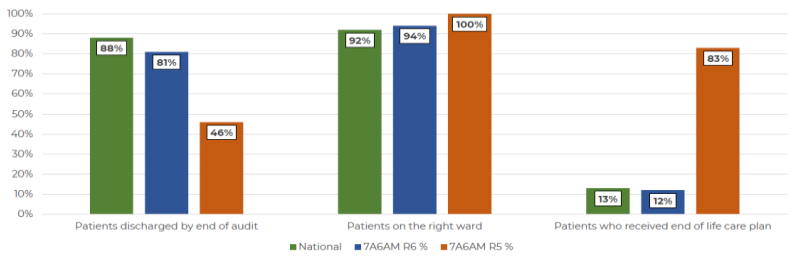
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Any structured pain assessment (Abbey Pain Scale, PAINAID, CNPI)	40.6%	13.7%	85%	32.3%

Discharge Information — NEVILL HALL HOSPITAL (7A6AM)

National R6 Median Length of Stay (days):	7A6AM R6 Median Length of Stay (days):	7A6AM R5 Median Length of Stay (days):
10	19	13

Figure 14: Discharge Information

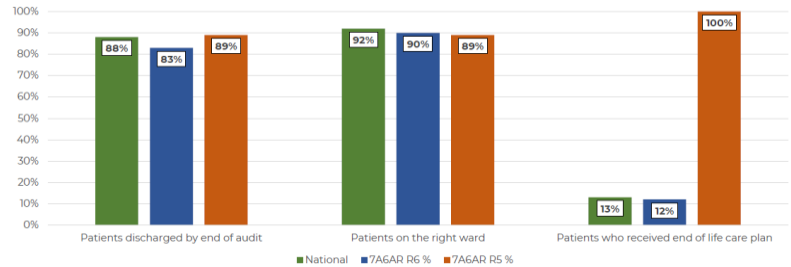


NB. The presence of EOL care plan information was asked for every patient in Round 6. In Round 5, it was only asked for patients who had died. Therefore, the data between Round 5 and Round 6 is **not** comparable.

Discharge Information — ROYAL GWENT HOSPITAL (7A6AR

National R6 Median Length of Stay (days):	7A6AR R6 Median Length of Stay (days):	7A6AR R5 Median Length of Stay (days):
10	17	17

Figure 14: Discharge Information

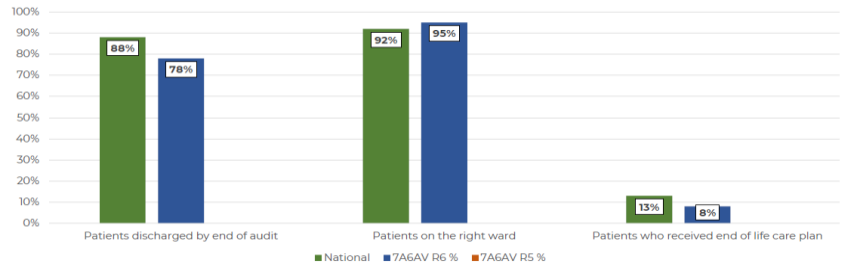


NB. The presence of EOL care plan information was asked for every patient in Round 6. In Round 5, it was only asked for patients who had died. Therefore, the data between Round 5 and Round 6 is **not** comparable.

Discharge Information — YSBYTY YSTRAD FAWR (7A6AV)

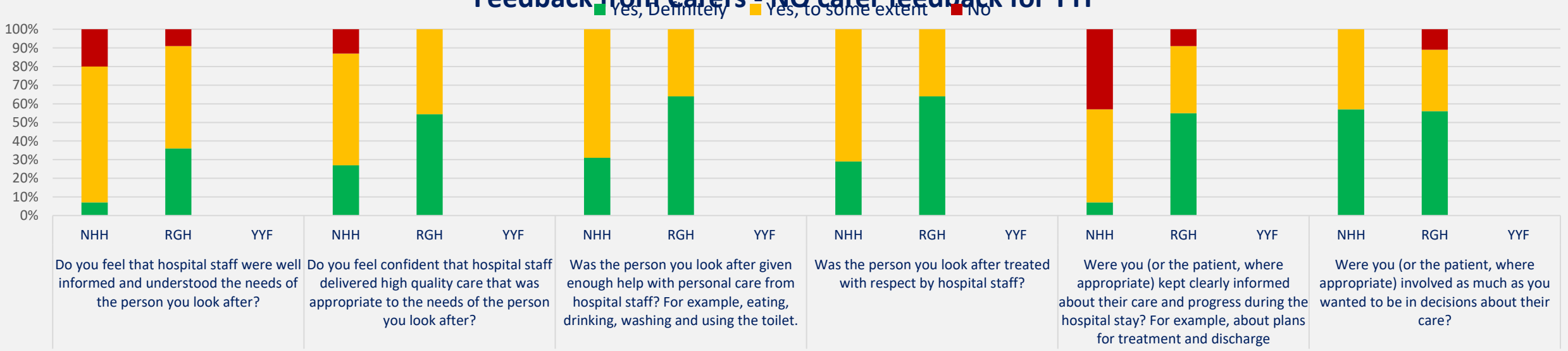
National R6 Median Length of Stay (days):	7A6AV R6 Median Length of Stay (days):	7A6AV R5 Median Length of Stay (days):
10	13	33

Figure 14: Discharge Information



NB. The presence of EOL care plan information was asked for every patient in Round 6. In Round 5, it was only asked for patients who had died. Therefore, the data between Round 5 and Round 6 is **not** comparable.

Feedback from Carers - NO carer feedback for YYF



Carers of patients in RGH have said that the standard of care better than those at NHH in all areas apart from where asked if carers or patient (if appropriate) were involved as mush as they wanted to be in decisions about care, which were equal at approx. 55%.

There were no negative responses to for patients being given enough help with personal care or being treated with respect.

Assurance level	Description	Risk level	Description
Significant	The project has mostly achieved the standards or criteria being audited against	Minor	Overall treatment or service suboptimal - Minor implications for patient safety if unresolved
Has this audit been placed on a Risk Register (N/A if above risk is None)	**YES/ NO**	**If not on a risk register, why not: Ongoing quality improvement work**	

Report Successes:	
1	Participation by all 3 sites is good and audited good level of notes
2	Delirium screening and pain assessment improved
3	Initiation of DC planning commenced in 24 hours
4	Delirium screening and care plan at YYF has improved Median LoS in line with other two sites

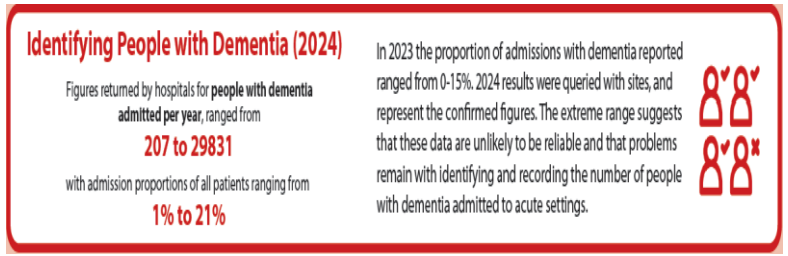
Report Concerns:	
1	Carer satisfaction questionnaire not completed in YYF site
2	Carer Communication to be improved
3	Sustainability of delirium screening, delirium care plan and dementia training is crucial for good practice to be embedded
4	IP falls where dementia has been associated risk should be monitored through HB QPS - as NAD does not cover a 12-month period
5	HB/corporate - need to record proportion of people with Dementia having falls in DATIX

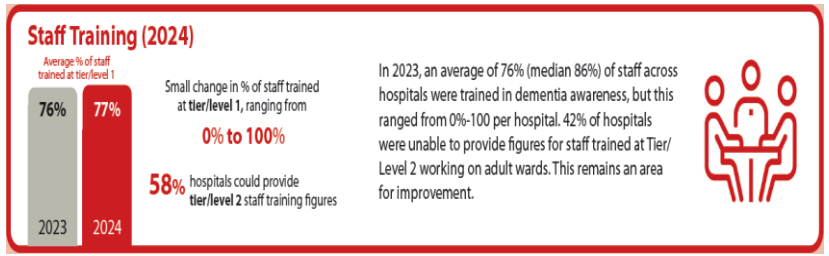
Does your DATIX or other monitoring system identify the proportion of people with dementia within the totals for: Falls in hospital	National R6 % (N/D)	Nevill Hal Hospital		Royal Gwent Hospital		Ysbyty Ystrad Fawr	
Yes	70.9% (122/172)	-	No Data	-	No Data	-	No Data
No	28.5% (49/172)	No	No Data	No	No Data	No	No Data
Not Known/ Undocumented	0.6% (1/172)	-	No Data	-	No Data	-	No Data

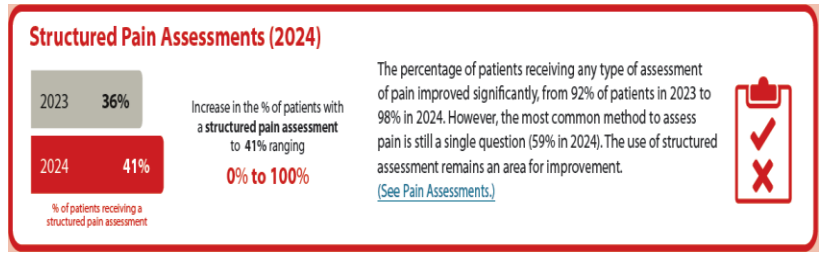
HB/corporate - need to record proportion of people with Dementia having falls in DATIX

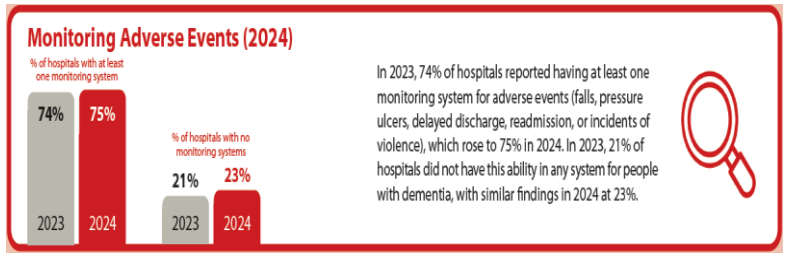
Audit Year	Round 1 (2010-2011)	Round 2 (2012-2013)	Round 3 (2016-2017)	Round 4 (2018-2019)	Round 5 (2022-2023)	Current Round 6 (2023-2024)
Inpatient falls data available/proportion of people with dementia	31%	47%	60%	64%	64%	71%

Priority Areas for Improvement

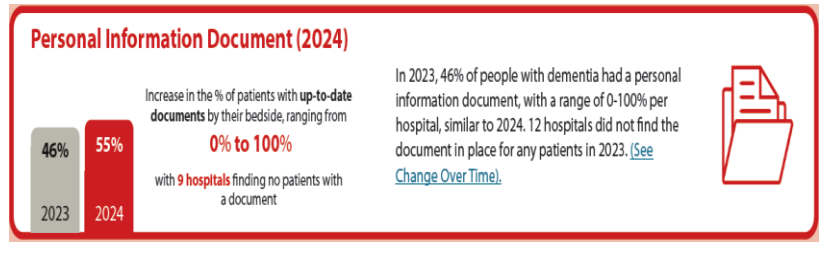












Report Recommendations:		S.M.A.R.T Actions:	Responsible: Due Date: Progress:
1	The Medical Director and Chief Nurse should ensure that all people with dementia admitted acutely to hospital are screened for delirium across clinical pathways using the 4-question 4AT. Screening should take place on admission, and at any other point when delirium is suspected.	Already in place	Site leads along with HB Clinical Lead for Dementia YYF – Dr Haddad RGH – Dr Subhan NHH – Dr Adel
2	The Chief Nurse should ensure that staff routinely gather personal information which details preferences and needs of people with dementia, involving care partners in this where possible. This information can then be appropriately shared with the staff providing care to support person centred interventions. Proforma documents, like the 'This is Me' booklet, are accessible at the point of care and serve as a useful example. Usage should then be monitored at Trust/Health Board Executive level.		Karen Collins/Natalie Skyrme – Senior nursing
3	Trusts/Health Boards should make use of NAD reported data, such as the summary Annual Dementia Statement containing information about assessment, use of personal information document, staff training, and monitoring of care, to support and demonstrate Quality Improvement in their hospitals, and within quality assurance reporting to regulatory bodies. Trusts/Health Boards should also encourage use of resources to support quality improvement including the Better Care Fund High Impact Change Model and the Dementia 100 self-assessment framework (due to be published early 2025).		Dr Singh, Amanda Whent

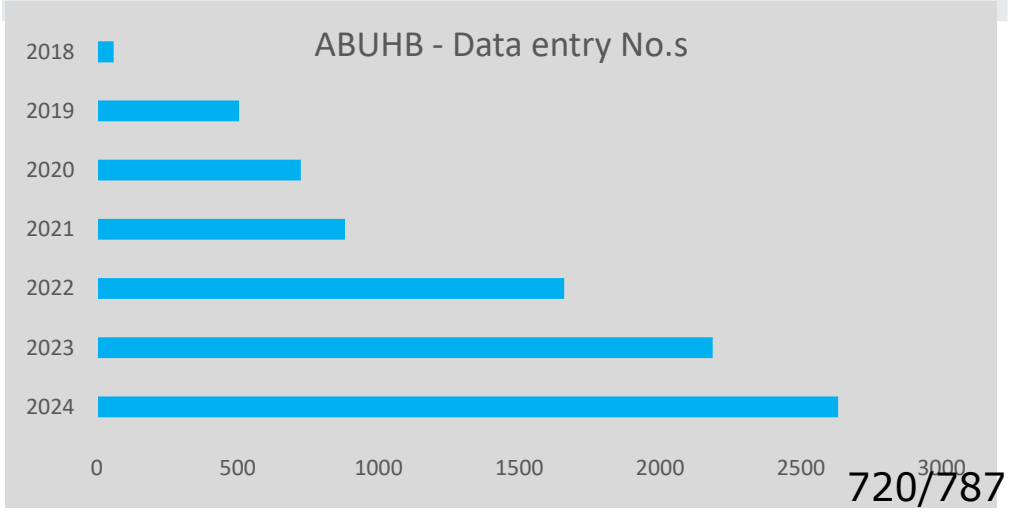
Audit Title:	Fracture Liaison Service Database (FLS-DB) Annual report - You've had a fracture; how can we prevent another? Data from 1 January 2023 – 31 December 2023	Clinical Lead: Dr Inder Singh -

Winners of the MediWales Innovation Awards 2024 for their overall contribution to healthcare delivery in Wales

Rationale:	In England and Wales there are around 180,000 fractures each year as a result of osteoporosis. One in three women and one in five men will sustain a fracture in their lifetime. The Fracture Liaison Service Database (FLS-DB) captures the data of patients who have sustained fractures with the aim of preventing secondary fractures. This is the first year we compare the number of patients on anti-osteoporosis treatment at 16 and 52 weeks. The focus of this year's annual report is on ensuring that patients who are at high risk of another broken bone have started treatment within 16 weeks of their first broken bone
Objectives:	Half of all adults aged 50 or over who break a bone after minimal trauma are at high risk of another fracture in the next few years, with over 50% of subsequent fractures in the next 10 years occurring within 2 years (the imminent fracture risk period). Preventing subsequent fractures is therefore a clinical and cost-effective priority for the NHS. These patients should be offered anti-osteoporosis treatment in line with NICE recommendations based on their fracture risk. All fracture liaison services (FLSs) aim to close this treatment gap effectively by systematically identifying patients at high risk of another fracture and organising an assessment to recommend, start and continue anti-osteoporosis treatment based on fracture risk and comorbidities. To achieve this, FLSs should initiate anti-osteoporosis treatment within 16 weeks of the fracture diagnosis for patients with high fracture risk.

Presented at Clinical Standards and Effectiveness Group – 27th February 2025

FLS-DB	Total No. of patients (%)	KPI 2	KPI 3	KPI 4	KPI 5	KPI 6	KPI 7	KPI 8	KPI 9	KPI 10	KPI 11
ABUHB 2021	875 23.4%	22.6	27.1	21.3	29.2	34.5	57.7	4.8	1.4	8.3	18.4
ABUHB 2022	1649 (44%)	46	36.9	60.3	16.8	79.7	65.7	9.1	19	18.3	16.4
ABUHB 2023	2181 (58%)	61.3	46.8	75	17.5	94.9	65.3	17.1	57.5	46.9	26.2
ABUHB 2024	2638 (70%)	51	149.6	76.9	20.2	96.3	68.9	30.8	39.4	42.9	N/A
Wales 2021		10.8	5.3	65.1	27.1	61.5	56.8	3.9	13.7	10.2	30.2
Wales2022		16.8	8	77.8	36.6	86.1	62.5	6	21.3	16	27.3
Wales 2023		18.6	9.7	79.6	25.4	90.8	66	10.6	41.4	34	19
Wales 2024		18.6	35.6	77.6	17.8	85.6	68.1	19.5	24.1	27.2	N/A



Report Successes:	
1	AB FLS has increased identification by 200% since 2021, this year reaching 70% (target 80%)
2	AB FLS continued to recommend bone treatment for 65% of patients (target 50%)
3	AB FLS received MEDI Wales Judges award for innovation and partnership working, seen as exemplar service in Wales
4	https://abuhb.nhs.wales/hospitals/a-z-of-services/fracture-liaison-service-fls/ The above link details the great work being carried out within the HB by the entire FLS team.
5	Health and Social Care Judges Award – The Health and Social Care Judges' Award is awarded to the applicant that embodies the spirit of the MediWales Innovation Awards and for their overall contribution to healthcare delivery in Wales. Winners: The Aneurin Bevan Fracture Liaison Service The Aneurin Bevan Fracture Liaison Service (AB-FLS) tackles undiagnosed osteoporosis in patients over 50, aiming to reduce repeat fractures and ease healthcare pressures. Untreated osteoporosis increases fragility fractures, impacting quality of life. AB-FLS integrates data from X-rays, CT, and MRI scans through a digital system to streamline fracture management. Developed with the Welsh Government, NHS Wales, and the Royal Osteoporosis Society, it prioritises prevention, early diagnosis, and timely treatment.

Report Concerns:	
1	16 weeks adherence is remains under 50%
2	52 weeks adherence is remains under 25%
3	Business case for AB-FLS is presented at PIP and awaiting Executive approvals in March 2025

Assurance level	Description	Risk level	Description
Limited	The project did not achieve the standards or criteria being audited against	Minor	Overall treatment or service suboptimal - Minor implications for patient safety if unresolved
Has this audit been placed on a Risk Register (N/A if above risk is None)	YES/NO	If not on a risk register, why not: Ongoing quality improvement work	

Report Recommendations:		S.M.A.R.T Actions: Responsible: Due Date: Progress:
1	**35.4% KPI 10 – commencing bone therapy by first follow-up.** All integrated care boards (ICBs) and Welsh health boards should provide a strategic plan for effective secondary fracture prevention for their locality. This should be based on relevant NICE recommendations and FLS-DB key performance indicators specifically focusing on KPI 10, which measures the treatment initiation in patients at high fracture risk.	Business case for AB-FLS is presented at PIP and awaiting Executive approvals next month
2	**35.4% KPI 10 – commencing bone therapy by first follow-up.** 100% of all ICBs and Welsh health boards should report the regional impact of fragility fractures in adults aged 50 or over and publish a high-level strategic plan to improve secondary fracture prevention for their population, focusing on delivering KPI 10. **This should be achieved by:** > convening a multi-stakeholder FLS working group, including representatives from the ICB/Welsh health board, secondary care, primary care and patient groups > describing the current regional delivery of FLS-DB KPIs and the expected annual number of avoidable fractures by working with the Royal Osteoporosis Society FLS service delivery team (fls@theros.org.uk) > identifying funding pathways needed to support the equitable delivery of FLS identification, assessment, treatment recommendation, initiation and adherence focusing on delivery (KPI 10) > committing to a timescale for initiating a phased introduction and improvement of FLSs in their regions.	AB FLS-DB Clinical Lead

	Report Recommendations:	S.M.A.R.T Actions: Responsible: Due Date: Progress:
3	**11.9% KPI 11 – adherence to prescribed antiosteoporosis** This is in line with the findings from KPI 10 and KPI 11 outlined in appendix A, which demonstrate the lack of availability and prescription of anti-osteoporosis treatment among FLSs. FLSs can utilise the resources created by the FLS-DB to implement this initiative; this includes: > the FLS-DB resources, including the improvement workbook and FLS-DB quality improvement video, to upskill on methods for effective and efficient service improvement > forming a multi-stakeholder improvement group, including 2–3 patients and primary care representatives (refer to FFFAP improvement workbook) > exporting local service data for 2023–24 from the FLS-DB website, and examining the number of patients who had started on each type of osteoporosis treatment by 16 weeks against local/regional osteoporosis treatment recommendations > using these data to co-develop a set of SMART aims and outcomes for FLSs to improve KPI 10 > using service improvement methods to understand the reasons for this current service gap, including reviewing KPI 1–7 to prioritise scalable and sustainable interventions to improve performance; utilising the FLS-DB webinar on how to implement an improvement project > evaluating, learning and modifying changes to practice based on KPI changes, and sharing improvement performance by submitting learnings to the FLS-DB improvement repository through the KPI case study form to share with other FLSs.	Business case for AB-FLS is presented at PIP and awaiting Executive approvals next month AB FLS-DB Clinical Lead
4	**55.2% KPI 2 – identification (non-spine), 34.4% KPI 3 – identification (spine fractures)** **28% KPI 9 – monitoring contact 12–16 weeks post fracture** ICBs and Welsh health boards should support regional advocacy groups for the establishment and improvement of FLSs. These advocacy groups would increase the quality of patient/caregiver engagement for local FLSs service improvement teams and establish the implementation of FLSs in areas without coverage. This is with the aim of increasing identification of patients who require fragility fracture care and ensuring that they receive the appropriate follow-up care. This can be achieved by: > utilising FLS-DB integrated care board data to identify gaps in FLS coverage > supporting new, and enhancing existing local advocacy groups to support regional FLS delivery, such as an ROS local support group > engaging with local clinicians to support the implementation of effective FLSs in the region > supporting local clinical teams to co-develop, implement and improve.	Ongoing and improvements require embedding
5	**35.4% KPI 10 – commencing bone therapy by first follow-up** **11.9% KPI 11 – adherence to prescribed antiosteoporosis medication at 12 months post fracture** ICBs and Welsh health boards should work with FLSs and primary/community care in the co-production of sustainable patient pathways for primary care delivery of anti-osteoporosis treatment, such as injectable treatments. This is with the aim of facilitating better communication and transition of patient management between primary/community care and FLSs. This is in line with the findings from KPI 10 and KPI 11 outlined in appendix A, which demonstrate the lack of availability and prescription of anti-osteoporosis treatment among FLSs.	Business case for AB-FLS is presented at PIP and awaiting Executive approvals next month

Epilepsy12 - 2024 combined organisational and clinical audits: Report for England and Wales. Cohort 5 – The first year of care for children and young people after a first paediatric assessment between 1 December 2021 and 30 November 2022	Clinical Lead(s): Dr Nadeem Syed – Consultant Paediatrician Dr Michelle Barber – Consultant Paediatrician -
Rationale:	Epilepsy12, established in 2009, aims to improve the quality of care for children and young people with epilepsy. Epilepsy is the most common long-term neurological condition in childhood, affecting around 112,000 young people in the UK.
Objectives:	Epilepsy12 aims to enhance care standards for children and young people with epilepsy by auditing data on patient care and service organization. This data helps identify strengths and areas needing improvement.
CSEG date:	23rd January 2025

Key Messages from Cohort 3:

- **Care Plans**: 70% of children and young people (CYP) had updated and agreed comprehensive care plans.
- **Transition Support**: 65% of health boards involved adult epilepsy specialist nurses in transitioning young people to adult services.
- **EEG Timeliness**: 54% of CYP diagnosed with epilepsy received their EEG within 4 weeks.
- **Mental Health**: 5% of CYP aged 5-15 diagnosed with epilepsy had an identified mental health condition.
- **Surgical Referrals**: 36% of CYP with epilepsy who met criteria for surgical referral were referred for surgical evaluation.

Key messages from Cohort 4:

- Participation
- Description of Cohort
- Diagnostic status
- Performance Indicators
- Initial Referral and examination
- Description of episodes
- Investigations
- Treatment
- Care Planning
- Professionals and services involved in care

Assurance level	Description	Select
Significant	The project has mostly achieved the standards or criteria being audited against	Yes

Risk level	Description	Select
Low	Peripheral element of treatment or service suboptimal	Yes

Has this audit been placed on a Risk Register (N/A if above risk is None)	YES/NO

Report Recommendations: (national)	
1	Support epilepsy teams not yet participating in the audit to value and contribute through Epilepsy12 participation. Promote the audit, provide training, develop the workforce and teams, plan jobs, and address local barriers. Integrated Care Boards (ICBs) should identify support routes and engage with quality improvement programs like the Epilepsy Quality Improvement Programme (EQIP) to assess and improve care quality in non-participating services. ***Action by: Integrated Care Boards (ICBs) in England and Health Boards in Wales, in collaboration with OPEN UK regional networks***
2	Increase the scope and breadth of the epilepsy team. Ensure sufficient provision of Epilepsy Specialist Nurses (ESNs) and other professionals to support population needs. Core and specialized competencies required within the team should match population needs, including mental health, transition from paediatric to adult services, learning difficulties, neurodisability, and medical complexity. ***Action by: Integrated Care Boards (ICBs) in England and Health Boards in Wales***
3	Establish or enhance processes and pathways to ensure timely access to care for children and young people. Identify and understand gaps in care provision. Establish structured referral pathways with designated coordinators. ***Action by: Integrated Care Boards (ICBs) in England and Health Boards in Wales.***
4	ICBs and local Health Boards should develop engagement models to enable groups facing inequalities to contribute to service improvement. Use the Core20PLUS5 framework to identify challenges and co-create alternative service models. Ensure equitable access and care for epilepsy, aligning with efforts supporting other long-term health conditions. ***Action by: Integrated Care Boards (ICBs) in England and Health Boards in Wales, in collaboration with OPEN UK networks***
5	Support participation and benchmarking against relevant ongoing quality improvement projects, in order to promote system-wide shared learning, collaboration and knowledge exchange. ***Action by: Integrated Care Boards (ICBs) in England and local Health Boards in Wales, in collaboration with OPEN UK regional networks.***

Report Concerns: (to be completed by the Clinical Lead)	
1	Data entry not in job plans – admin support required
2	Waiting times for first seizure referrals and appointment – sickness within the team

Audit Title: National Early Inflammatory Arthritis Audit (NEIAA) State of the Nation Summary Report 2024 Data Collection Period: 1 April 2023 – 31 March 2024 Year 6	Clinical Lead: Dr Non Pugh – Consultant Rheumatologist
	NICE Guidance : QS33 – Rheumatoid arthritis in over 16s
Rationale:	Inflammatory arthritis, including rheumatoid arthritis (RA), affects over 400,000 people in the UK. Treatment delays can cause significant disability, reduced quality of life, and loss of productivity. Rare autoimmune rheumatic diseases (RAIRDs) like systemic vasculitides also face adverse outcomes, including permanent disability, due to treatment delays.
Objectives:	The NEIAA aims to enhance care quality for people with rheumatic diseases by collecting data on newly diagnosed patients over 16 in England and Wales. It includes conditions like inflammatory arthritides, systemic vasculitides, and connective tissue diseases. This data helps recommend standardized, effective, and patient-centered care pathways.
Presented at Clinical Standards and Effectiveness Group – 23rd January 2025	

- Measures quality of care delivered to patients in England and Wales aged 16 and over with suspected and newly diagnosed early inflammatory arthritis
- Measured against NICE quality standards 33
- Also assesses how inflammatory arthritis affects people's day-to-day function, mobility, sleep, wellbeing and ability to work
- Rheumatology clinical teams provide information about patient care over the first 3 months after diagnosis. This includes :
  - Referral times
  - Time to treatment
  - Clinical response to treatment
  - Patient Reported Outcome Measures (PROMs) - for 12 months

Key message 1

Increased engagement and data capture

- Engagement has improved however the number of cases that are not captured is likely to be greater
- Estimated that NEIAA captures approximately one third of cases eligible for enrolment.

Key message 2

Improved treatment timeliness

The key metric used for measuring care quality and determining outlier status is the proportion of people living with EIA who start DMARD therapy within six weeks of referral

Key Message 3

- Stable remission rates with geographic variation
- Remission rates within 12 weeks of treatment remain stable at 35
- Geographic variation in remission rates persists (see figure 5), There was also geographic variation in the proportion of patients receiving treatment within six weeks (see figure 6).
- Remission rates higher in Wales at 49 %

No Local data is available for Key Messages 4, 5 & 6

Assurance level	Description	Select
Full	The project has fully achieved the standards or criteria being audited against	yes

Risk level	Description	Select
None	Standards met and findings demonstrate no risk to patient safety	yes

THERE ARE NO OUTSTANING REPORT RECOMMENDATIONS FOR ABUHB

Audit Title: National Pregnancy in Diabetes Audit Dashboard 2023 (01 January 2021 to 31 December 2023)	Clinical Lead(s): Mrs Pinto & Mrs Lisa Pilkington, Consultants in Obstetrics and Gynaecology
Rationale:	The National Pregnancy in Diabetes Audit (NPID) is part of the National Diabetes Audit (NDA), managed by NHS England in agreement with the Healthcare Quality Improvement Partnership (HQIP). The NDA, in partnership with Diabetes UK, has been running since 2014.
Objectives:	The audit and dashboard measure the quality of antenatal care and pregnancy outcomes for women with pre-gestational diabetes, supporting quality improvement at various levels. The latest dashboard includes data from pregnancies ending between January 2021 and December 2023, featuring continuous glucose monitoring (CGM) data for the first time. It answers three key questions: preparation for pregnancy, steps taken to minimize adverse outcomes, and occurrence of adverse outcomes. Data are submitted by antenatal services in England and Wales.
Presented at Clinical Standards and Effectiveness Group – 23rd January 2025	

Report Successes:	
1	**Lower rates of macrosomia**
2	**Lower rates of NICU admissions**
3	**Lower rates of preterm births**

Report Concerns:	
1	**Higher proportion of women not on the right dose of folic acid at the start of pregnancy**
2	**Higher proportion of women with suboptimal HbA1C at start of pregnancy**
3	**Higher proportion of women with suboptimal HbA1C in 3rd trimester**
4	**Deficit in data submitted to NPID**

Assurance level	Description	Select
Significant	The project has mostly achieved the standards or criteria being audited against	Yes

Risk level	Description	Select
Minor	Single failure to meet internal standards/Minor implications for patient safety if unresolved	Yes

Has this audit been placed on a Risk Register (N/A if above risk is None)	NO

No National Report/Recommendations:

Clinical Leads Local Recommendations: (if applicable)		S.M.A.R.T Actions:	Responsibl eperson	Due Date: Progress:
1	**Quarterly meeting AN diabetes forum to continue**		AMP	ongoing
2	**Clinical pathways for pre-conception care –focussing on T2DM – in development**		LPP with primary care	Mar 2026
3	**Clinical oversight of data input**		AMP and LPI	ongoing

Conclusion..
As per the report, the HB has lower rates of macrosomia, SCBU admissions and Preterm labour, compared to England and Wales data. Data input to NPID database from GUH is incomplete. The HB has lower proportion of women starting and ending the pregnancy with optimal HbA1c. There is a need to improve data collection (capture all women) and improve successful uploading of data onto the NPID data base

- **for NHH- data now entered by clinical team**
- **for RGH- continuing with MD's audit office support**

Audit Title: Wales Primary Care Clinical Audit Report 2021–23. Publication year: 2024

Clinical Lead: Bethan Williams – Senior Nurse Primary Care

NICE 2023 QS10 (QS1): People aged over 35 years who present with a risk factor and one or more symptoms of COPD have post-bronchodilator spirometry.
NICE 2018 QS25 (QS1): People aged 5 years and over with suspected asthma have objective tests to support diagnosis

Rationale:	This report analyses asthma and COPD primary care data in Wales from the Welsh primary care audit component of the National Respiratory Audit Programme (NRAP). Data collected from 359 general practices in Feb 2024, covering activity from Aug 2021 to July 2023.
Objectives:	The audit builds on previous reports to support NRAP's healthcare improvement goals. It aims to help stakeholders use data to enhance care quality for asthma and COPD patients. The report includes key findings and national recommendations from the 2021–23 Welsh primary care audit, with 96% of Welsh practices participating.

Comparing results with previous reports should be done cautiously due to the significant impact of the COVID-19 pandemic on earlier audit periods. Additionally, younger children aged 1–5 were not included in this audit round.

Presented at Clinical Standards and Effectiveness Group – 23rd January 2025

Recommendation 1

COPD - The percentage of people diagnosed with COPD in the last 2 years who have a post-bronchodilator test with an appropriate numeric value.

Name	Denominator (N)	Any spirometry ratio codes* ≥0.2 and <0.7 (n)	Any spirometry ratio codes ≥0.2 and <0.7 (%)	Post-bronchodilator code** with spirometry ratio ≥0.2 and <0.7 (n)	Post-bronchodilator code with spirometry ratio ≥0.2 and <0.7 (%)	Any post-bronchodilator code (n)	Any post-bronchodilator code (%)
Wales	13473	3653	27.1	644	4.8	2882	21.4
Aneurin Bevan LHB	2460	587	23.9	99	4	504	20.5

*Other 339 Read codes eg 339j, 339k, 339R
**Read code 339m

Adults with asthma

Name	Denominator (N)	Any FEV1/FVC code* (+ reversibility) test in the past 2 years (n)	Any FEV1/FVC code (+ reversibility) test in the past 2 years (%)	Any spirometry (+ reversibility) test in the past 2 years (n)	Any spirometry (+ reversibility) test in the past 2 years (%)
Wales	18032	116	0.6	840	4.7
Aneurin Bevan Local Health Board	3355	40	1.2	222	6.6

Children with asthma (6 years and above only)

Name	Denominator (N)	Any FEV1/FVC code* (+ reversibility) test in the past 2 years (n)	Any FEV1/FVC code (+ reversibility) test in the past 2 years (%)	Any spirometry (+ reversibility) test in the past 2 years (n)	Any spirometry (+ reversibility) test in the past 2 years (%)
Wales	7079	3	0.0	156	2.2
Aneurin Bevan Local Health Board	1426	0	0.0	50	3.5

*Read codes 339j, 339k, 339R and 339M

Recommendation 2

Results summary

- **0.7%** of parents/carers of children with asthma were asked about their second-hand smoke exposure.
- **73.8%** of patients with COPD had their smoking status recorded.
- **66.3%** of adults with asthma had their smoking status recorded.
- **40.8%** of children with asthma had their smoking status recorded.

Smoking

Percentage and status of people with COPD and asthma (adults and children) who were asked about tobacco smoking in the last 15 months and their smoking status

COPD

Name	Denominator (N)	Non-smoker (n)	Non-smoker(%)	Ex-smoker (n)	Ex-smoker (%)	Current smoker (n)	Current smoker (%)	Not asked about smoking (n)	Not asked about smoking (%)
Wales	83529	7514	9	31080	37.2	23077	27.6	21858	26.2
Aneurin Bevan Local Health Board	15392	1536	10	5785	37.6	4470	29	3601	23.4

Adults with asthma

Name	Denominator (N)	Non-smoker (n)	Non-smoker(%)	Ex-smoker (n)	Ex-smoker (%)	Current smoker (n)	Current smoker (%)	Not asked about smoking (n)	Not asked about smoking (%)
Wales	175752	60093	34.2	33931	19.3	22574	12.8	59154	33.7
Aneurin Bevan Local Health Board	33785	12287	36.4	6600	19.5	4250	12.6	10648	31.5

Children with asthma (6 years and above only)

Name	Denominator (N)	Non-smoker (n)	Non-smoker(%)	Ex-smoker (n)	Ex-smoker (%)	Current smoker (n)	Current smoker (%)	Not asked about smoking (n)	Not asked about smoking (%)
Wales	8985	3294	36.7	94	1	278	3.1	5319	59.2
Aneurin Bevan Local Health Board	1638	626	38.2	13	0.8	46	2.8	953	58.2

Recommendation 3

Pulmonary rehabilitation (PR)
Percentage of people with COPD who are breathless (MRC scores 2–5) and have been referred to pulmonary rehabilitation in the last 3 years.

Results summary

13.9% of patients with COPD with an MRC score of 3–5 have been referred to PR in the last 3 years.



COPD (MRC score 2–5)

Name	Denominator (N)	Referred for PR (n)	Referred for PR (%)
Wales	64241	5783	9
Aneurin Bevan Local Health Board	11513	884	7.7

Percentage of people with COPD who are breathless (MRC score 3-5) and have been referred to pulmonary rehabilitation in the last 3 years.

COPD (MRC score 3-5)

Name	Denominator (N)	Referred for PR (n)	Referred for PR (%)
Wales	33518	4660	13.9
Aneurin Bevan Local Health Board	6154	713	11.6

Recommendation 4

Personalised asthma action plans

Percentage of people (adults and children) with asthma who have had a PAAP anytime in the last 15 months

Adults with asthma

Name	Denominator (N)	PAAP anytime in the last 15 months (n)	PAAP anytime in the last 15 months (%)
Wales	175752	49009	27.9
Aneurin Bevan Local Health Board	33785	11239	33.3

Children with asthma (6–18 years old)

Name	Denominator (N)	PAAP anytime in the last 15 months(n)	PAAP anytime in the last 15 months (%)
Wales	24214	5837	24.1
Aneurin Bevan Local Health Board	4731	1381	29.2

Assurance level	Description	Select
Limited	The project did not achieve the standards or criteria being audited against	√

Risk level	Description	Select
Moderate	Treatment or service has significantly reduced effectiveness - Moderate risk to patient safety if not acted upon	√

Has this audit been placed on a Risk Register (N/A if above risk is None)	YES/ NO

If not on a risk register, why not:
Diagnostic spirometry was recovering at the time of the audit. Health boards set up spirometry hubs, managed by the Primary Care Respiratory Nurse Team (PCRNT), to address the Covid-19 backlog. PCRNT delivered education and training programs on spirometry testing and result interpretation to General Practice Nurses (GPNs), Healthcare Support Workers (HCSWs), and GPs. Mentoring of staff in clinic settings as available and provided to support the process.

Report Concerns:

1	Incorrect/inaccurate coding on GP computer systems i.e. codes used not in keeping with codes used within NACAP audit.
2	Ongoing provision of spirometry in Primary care -Cost of ARTP training/ re accreditation, some GP practices not happy to incur the ongoing costs. Spirometer being undertaken in practices by those who are not ARTP accredited.
3	Staff retention and recruitment – home oxygen, Challenge staff with skills and training, On risk register.

Report Successes:

1	**Alignment and adoption of All Wales COPD and Asthma guidelines** (Asthma guidelines updated Feb 24) PCRNT providing education in partnership with IPCC Academy. Training provided to both new and existing GPN 34 practices supported with education and training
2	**Alignment of inhaler prescribing to decarbonisation strategy** - PCRNT supporting individual practices with education and training also providing education In partnership with IPPC Academy, ABUHB GPN nursing forums Green inhaler project undertaken by RNS team- Practices with highest carbon footprint identified by prescribing data supported with education and RNS clinics s. Team finalists in NHS Wales Sustainability Awards 2024
3	**Gold standard O_2 service** – Service redesign underway, team working as a pooled resource to support demand and needs of service. Single point of referral and contact achieved aligning to recommendation in Primary care model for Wales.
4	**Joint working projects with pharma – parallel working with AZ and Research innovation Wales – COPE template**. ABUHB leading the way with pilot, aimed to standardise COPD reviews and improve coding (as per recommendation 5 NRAP audit)

Clinical Leads Local Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Spirometry Hubs in process of setup with plan to commence April 25	Number of hubs. No of patients assessed. No referrals received. Number of staff trained.	Primary and community care	April 25	Service implementation plan complete Clinic set up and planning in progress with team. Includes training of new staff
2	Incorrect/inaccurate coding on GP computer systems i.e. codes used not in keeping with codes used within NACAP audit.	Number of reviews undertaken using COPE. SNOMEd coding for Post BD spirometry. Number of referrals	GMS Primary and Community care	ongoing	COPE pilot undertaken in 5 GP practices

	Report Recommendations:	S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Local health boards should implement a strategy to ensure that all patients have access to trained clinicians within primary care settings who can accurately diagnose COPD and asthma. This should ensure that 70% of patients with COPD have undergone quality-assured post-bronchodilator spirometry to confirm obstruction, and 70% of individuals diagnosed with asthma within the past 2 years should have documented at least one objective measurement by July 2025.	1 number of hubs. 2 No of patients assessed. 3 No referrals received. 4 Number of staff trained.	Primary and Community services Jan25	April 25	• Mapping work complete. • Service implementation plan complete. • Commence spirometry hubs April 24 • HCSW roles to support work.
2	Local health boards should ensure that tobacco dependency pathways are embedded in primary care, so that all children and young people with asthma have second-hand smoke exposure recorded, and parents/carers of children with asthma who smoke receive Very Brief Advice and are offered support to quit by July 2025. This will further support the Welsh government's ambition to be smoke-free by 2030.	Well established pathways in place for Smoking cessation across ABUHB and GMS This work stream is led by PHW Children with asthma pathways responsibility of GMS and secondary care Paediatric respiratory team			
3	Local health boards should provide training resources and increase engagement between providers and primary healthcare practitioners to reduce the identified barriers and increase referral to pulmonary rehabilitation (PR) for appropriate patients with COPD to 70% by July 2025.	**Responsibility for Pulmonary rehabilitation currently with secondary care respiratory medicine**. • Established pathways in place for referral in from GMS to Secondary care. • PR paused during covid due to this and backlog caused, referrals and communication to encourage referrals was limited • Discussion underway between secondary care and primary & Community care which includes a proposal of how we can work together to support delivery of programmes moving forward and improve uptake and referrals			
4	Local health boards should prioritise and promote the development and use of personalised asthma action plans within primary care settings to ensure that, by July 2025, 75% of patients diagnosed with asthma have the essential tools to help manage their condition.	1. Number of asthma patients coded with PAAP 2. Number of patients with access to NHS Wales APPs 3. Number of practices receiving support with training and education	GMS Primary and community	Aug 25	
5	Local health boards and DHCW should promote the use of preferred respiratory SNOMED CT codes as used within the NRAP audit to ensure accurate coding for patients with asthma and/or COPD thereby improving the quality of data available for services by the next data extraction in the NRAP audit in August 2025.	1. Number of reviews undertaken using COPE. 2. SNOMEd coding for Post BD spirometry 3. Number of referrals	Primary and community care	Ongoing	COPE pilot undertaken in 5 GP practices To increase pilot sites as guided by joint working group.

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Aneurin Bevan

Aneurin Bevan University Health Board



Clinical Audit Plan 2025/2026



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Introduction

The Health Board is dedicated to providing safe and effective care to the population of Gwent.

Aneurin Bevan University Health Board uses Clinical Audit to improve care quality by measuring adherence to local and national guidelines. After each audit, areas for improvement are identified, implemented, and re-evaluated to enhance care reliability and outcomes.

Clinical audits are recognised by healthcare commissioners and regulators as a key method for ensuring the quality of care. The Health Board's Executive Committee, as required by Welsh Government, certifies that effective systems are in place to monitor and audit compliance with clinical standards. This process aligns with the Healthcare Quality Improvement Partnership (HQIP) National Clinical Audit and Patient Outcomes Programme (NCAPOP), which follows a 9-month publication schedule.

The Health Board's audit plan adheres to the National Clinical Audit agenda and includes local audits at specialty and ward levels across all sites. Local audit plans are developed internally by Directorates and Divisions.

What is Clinical Audit?

Conducting clinical audits according to best practice standards ensures compliance with clinical guidelines, reduces risks, waste, and variations in care, and enhances patient outcomes.

Clinical audit results contribute to a broader Quality Management System aimed at continuous learning and improvement in delivering safe and effective care.

Before starting a clinical audit, check if the topic has been previously audited within the organisation to compare results.

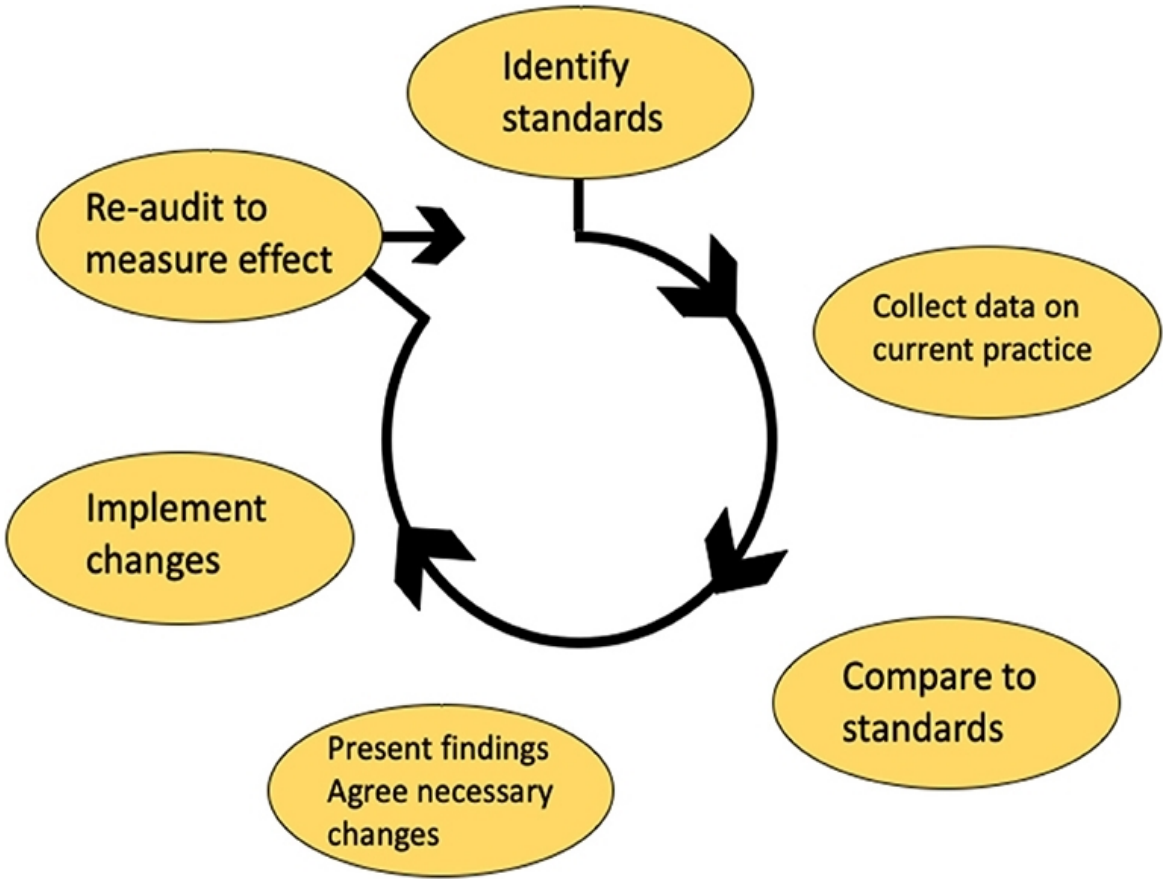


Figure One: The audit cycle

Why is clinical audit important?

Clinical Audit provides the framework to improve the quality of patient care in a systematic way.

Benefits of clinical audit include:

- Promotes awareness of guideline defined standards of care.
- Provides opportunities for education and training.
- Builds relationships between clinicians, clinical teams, managers, and patients.
- Leads to improvements in service delivery and patient outcomes.

Who should be involved in clinical audit?

Everyone who is involved in patient care. If an audit has implications for clinicians or managers working in a particular area, they should be consulted at the planning stage. Clinical audit must also be supported by those who have the authority and commitment to see changes put into practice.

All Divisions within the Health Board should develop robust local audit plans. Topics for clinical audit should reflect national and/or local priorities or areas of concern e.g. Cancer Services or National Service Frameworks, or local priorities identified through incident reporting or introduction of best practice into local services.

Principles of the Annual Clinical Audit Plan

In developing the Aneurin Bevan University Health Board Annual Clinical Audit Plan the following approach has been followed:

Purpose of Clinical Audits:

- Ensure the quality of care for specific conditions or pathways aligns with best evidence.
- Understand variations in care outcomes and assess good practice.

Participation and Compliance:

- Directorates must participate and engage in the National Clinical Audit and Patient Outcomes Programme (NCAPOP), National Confidential Enquiries (NCEPOD), and relevant service reviews.
- Include non-NCAPOP national audits in the Health Board's Quality Plan (e.g., Falls).
- Implement and audit NICE guidance and HTW adoption, subject to external review.
- Service evaluation and re-audit should be conducted following changes in practice.

Audit Management:

- Register all clinical audit activities within directorates.
- Collaborate with clinicians, managers, and audit staff to meet all requirements. This includes all clinical, statutory, regulatory, commissioning and other Health Board requirements.
- Enable healthcare professionals to participate in audits for revalidation and professional development.

Support and Review:

- Ensure resources, governance, and structures support audit engagement.
- Establish a formal process for reviewing performance and improvements.
- Escalate issues to the executive board when necessary.
- Clear process for risk identification following audit.

Aneurin Bevan University Health Board has a Clinical Audit Strategy 2022-2025 with four priorities:

Aneurin Bevan University Health Board has Four Priorities:



1. Scrutiny of national clinical audit performance with robust development, monitoring, and progression of Improvement plans
2. Divisions to identify clinical audits that allow scrutiny and assurance associated with quality and safety risk
3. Trainees are supported to participate in audits that support clinical governance
4. Groups and committees across the Health Board commission clinical audit to support effective assurance where no other evidence is available.

This can be read in conjunction with the Health Board's Clinical Audit Policy and The Quality Strategy.

Together these documents demonstrate how clinical audit will be developed, delivered and outcomes put into practice through service improvement.

Six Domains of Quality

Clinical audit is essential for improving patient care and ensuring compliance with the Wales Health and Care Quality Standards. It systematically evaluates clinical practices against established standards, providing insights into the quality of care and identifying areas for improvement. This can be demonstrated below:



PERSON CENTRED care involves patients, relatives, families, carers, and system partners in the planning delivery of care and opportunities to improve patient safety. We care about the wellbeing of individuals, families, carers and staff, ensuring everyone is treated with compassion, kindness, dignity and respect. Audits ensure that care is tailored to individual patient needs and preferences, enhancing patient satisfaction and engagement.



SAFE – reduce harm, prevent errors, and deliver consistently safe care through increased visibility and insight from multiple sources of patient safety information. Care delivered by capable and competent staff. Maximising things that go right and learning from when things that go wrong to prevent reoccurrence. Audits identify and mitigate risks, promoting patient safety and preventing harm



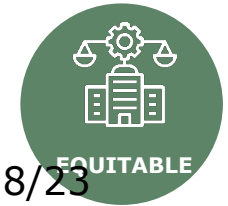
TIMELY care, ensuring people have access to the high-quality advice, guidance and care they need quickly and easily, in the right place, first time. We will care for those with the greatest health need first, and where treatment is identified as necessary, we treat people based on their identified and agreed clinical priority. Audits ensure that patients receive care promptly, reducing delays and improving overall health outcomes.



EFFECTIVE care – Deliver consistently effective and reliable care, based on evidence-based best practice which is delivered in a culture that encourages and enables innovation to **Improve** outcomes. Audits ensure that clinical practices are evidence-based and aligned with best practices, leading to optimal patient outcomes



EFFICIENT by taking a value-based approach to improve outcomes that matter most to people in a way that is as sustainable as possible and avoids waste. We will make the most effective use of resources to achieve best value, doing only what is needed, ensuring any interventions represent the best value that will improve outcomes for people. Audits help eliminate waste and improve resource utilization, ensuring sustainable and cost-effective services.



Provide **EQUITABLE** care, ensuring equal opportunities for individuals to attain their full potential for a healthy life which does not vary in quality and is non-discriminatory. We will embed equality and human rights and promote and protect the welfare and safety of children and adults who become vulnerable or at risk at any time. Audits promote equal access to high-quality care for all patients, regardless of personal characteristics.

Six Quality Enablers



Ensure visible and focused leadership at all levels, with its activities driven by the organisations' vision and values for quality. Our leaders and managers take a long-term, stakeholder-centric view to develop a clear organisational vision. They have the appropriate skills and capacity to create the conditions for a functioning quality management system. We ensure our governance, leadership and accountability is effective in sustainably delivering care.



Recruit, retain, develop and extend roles to ensure we have enough, confident people with the right knowledge and skills available at the right time to deliver safe care. We value our people and the commitment and resilience they demonstrate in the care they provide. We care about their wellbeing, protect their rights and support them to feel well and happy at work; and provide them with the tools, systems and environment to work safely and effectively. Our workforce planning focuses on investing in our people and nurturing, growing and transforming our workforce to create a sustainable



Create the right climate and culture to nurture and encourage quality and system safety, valuing people in a supportive, collaborative and inclusive workplace so that our people feel psychologically safe to raise concerns and try out new ideas and approaches. Relationships within teams and with the people we serve are effective and based on transparency, accountability, ethical behaviour, trust and just culture, where people can thrive.



Ensure information is available and shared appropriately for all who need it. We turn data to knowledge by triangulating quantitative and qualitative performance, experience and outcome measures to understand the quality of services, efficacy of improvement work and impact of decisions made. We monitor, report and escalate indicators through our governance structures to ensure that appropriate action is taken at every level in terms of learning, improvement and accountability.



Create the conditions and capacity for an organisation and system-wide approach to continuous learning, quality improvement and innovation, which it actively promotes. We use new knowledge to influence improvements in practice and to inform our decision-making. We ensure our learning and improvement activity is linked to our strategic vision to deliver transformational, organisation-wide change. We commit to participating in research because research-active organisations provide improved quality of care and outcomes for people.



Ensure safety in healthcare goes beyond individual patient safety. We will look within and beyond our organisational boundaries to learn how we can continually, reliably and sustainably meet the evolving needs of people. We will strengthen relationships and work with all of our partners to achieve good outcomes. Our policies incorporate the broader ambitions within the seven well-being goals and five ways of working in the Well-being of Future Generations Act.

Pillars of Quality

The six pillars of quality have been integral to Aneurin Bevan University Health Board's quality journey by providing a comprehensive framework to assess, monitor, and continuously improve care standards. Each pillar addresses a critical aspect of healthcare, contributing to a holistic approach to quality and safety. Here's how Clinical Audit can support and drive improvements in our Pillars of Quality Programme:

Patient and Staff Experience:	Clinical audits prioritise patient and staff experiences, ensuring care remains person-centred and fostering a positive environment for healthcare workers. This is essential for delivering compassionate and effective care, which audits help to measure and improve.
Incident Reporting:	Systematically tracking incidents like falls, pressure ulcers, medicines management, and mortality allows clinical audits to identify patterns, address systemic issues, and prevent recurrence. This enhances patient safety by ensuring that care practices are continuously evaluated and improved.
Complaints, Concerns, and Compliments:	Engaging with feedback through clinical audits enables the Health Board to identify areas for improvement and replicate effective practices. This strengthens trust and accountability by demonstrating responsiveness to patient and family experiences.
Health, Safety, and Security:	Clinical audits ensure that facilities and processes meet the highest standards to protect patients, staff, and visitors. This supports a safe environment for care delivery by regularly evaluating and improving safety protocols.
Infection Control and Prevention:	By addressing infection control as a dedicated pillar, clinical audits enhance practices that reduce healthcare-associated infections. This improves overall patient outcomes by ensuring that infection control measures are effective and consistently applied.
Safeguarding:	Placing safeguarding as a core pillar in clinical audits ensures that vulnerable individuals receive necessary protection and support. This aligns care with ethical standards and legal obligations, ensuring that safeguarding practices are regularly reviewed and improved.



Aneurin Bevan University Health Boards Organisational Priorities – as part of our Integrated Medium-Term Plan (IMTP) and how this links with National Clinical Audit (NCA)

PRIORITY 1 – EVERY CHILD HAS THE BEST START IN LIFE - We believe that every child deserves the opportunity to have the very best start in life.

PRIORITY 2 – GETTING IT RIGHT FOR CHILDREN AND YOUNG ADULTS - Young people are an important group and nurturing of future generations is crucial for our communities.

National Clinical Audits that support this priorities 1 & 2 are:

- National Pregnancy in Diabetes
- National Paediatric Diabetes Audit
- National Clinical Audit of Seizures and Epilepsies for Children and Young People
- National Paediatric Diabetes Audit
- National Maternity and Perinatal Audit
- National Child Mortality Database
- National Neonatal Audit Programme
- Paediatric Asthma – National Respiratory Audit Programme

PRIORITY 3 – ADULTS IN GWENT LIVE HEALTHILY AND AGE WELL - We want our citizens to enjoy a high quality of life into old age we want them to be empowered to take more responsibility for their own health and care, so that they can retain independence.

National Clinical Audits that support this priority are:

- National Cancer Audits – Bowel, Breast, prostate and more
- Nation Respiratory Audits – COPD, Asthma Adults and Paediatrics
- National Diabetes Audits – Type 1 and Type 2 in young people and adults

PRIORITY 4 – OLDER ADULTS ARE SUPPORTED TO LIVE WELL AND INDEPENDENTLY

National Clinical Audits that support this priority are:

- National Audit of Dementia
- Falls and Fragility audits
- National Early Inflammatory Arthritis Audit

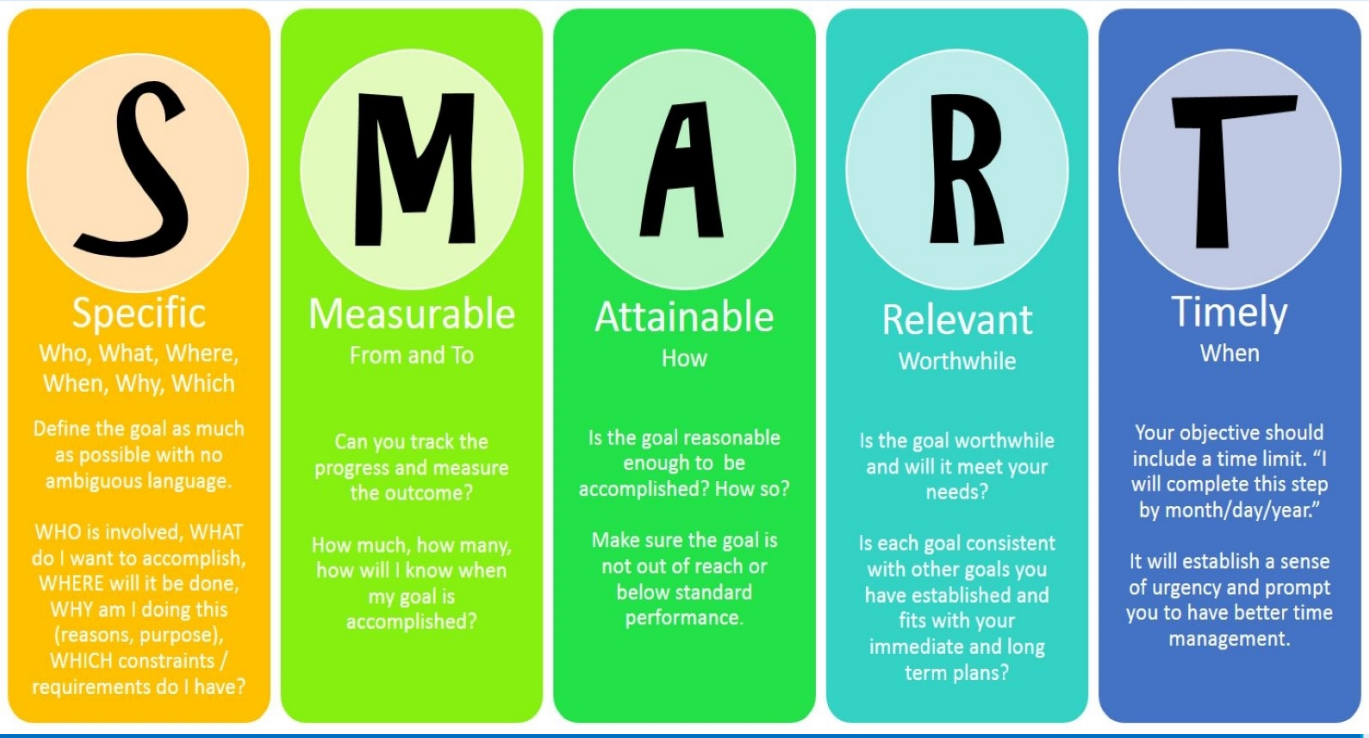


PRIORITY 5 – DYING WELL AS A PART OF LIFE

- National Audit of Care at the End of Life

Recommendations from Clinical Audit

1. Clinical Audit reports and outcomes identify recommendations for service
2. Improvement and Quality Improvement (QI) work where data shows variation from standard of care
3. National and Local audit recommendations are reviewed by the ABUHB Clinical Lead
4. Risks are identified by clinical leads/teams, to ensure risks are escalated and recorded on risk register



The process of clinical audit is managed through the Clinical Standards and Effectiveness Group (CSEG). Steps are:

1. National report published
2. The Medical Director's Quality and Patient Safety (QPS) Audit Team link with Clinical Lead/representative with audit results
3. Results presented at CSEG by Clinical Lead
4. SMART actions agreed against standards and/or good practice highlighted
5. Minutes are saved on the intranet to reflect which audits have been discussed
6. Action plan placed on the web based Audit Management and Tracking (AMaT) system
7. Summary report presented to Patient Safety and Quality Outcomes Committee (PQSOC)

Clinical Audit and Audit Management and Tracking (AMaT)

What is AMaT ?

Aneurin Bevan University Health Board has implemented AMaT, a software package that simplifies and speeds up the auditing process. Over the past 24 months, staff have been trained to use AMaT at all stages of the audit cycle, ensuring audit results and outcomes are tracked and teams are supported.

Audits are crucial for improving patient care, managing risk, and meeting reporting requirements. While traditionally time-consuming, AMaT has streamlined audit activities, providing real-time insights and reporting for clinicians, wards, and the quality and patient safety audit department. It is used for local audits and tracking actions and improvement plans for National Clinical Audit.

AMaT has been easy to implement and has been integrated into the Clinical Audit Strategy. Data can be entered and accessed in real-time on various devices, giving healthcare staff more flexibility and time with patients.

The system simplifies audit tracking, allowing users to allocate SMART actions and instantly view data results in numerical or graphical formats. Key successes, concerns, risks, and assurances can also be recorded.

Clinical Audit Plan - Priority One: Clinical Audit Strategy

There is scrutiny of national clinical audit performance with robust development and monitoring of improvement plans

Aneurin Bevan University Health Board's Clinical Audit Plan reflects national and local drivers for quality improvement. The Clinical Audit Plan is updated annually to refine and improve audit processes within the Health Board. The Plan is used by the Medical Director's Clinical Audit team to forecast and produce an annual publication timeline supporting delivering of the Clinical Audit Strategy. The National Clinical Audit and Patient Outcomes Programme (NCAPOP), commissioned by HQIP, and the NHS Wales National Clinical Audit Outcome Review Plan (NCAOPR) follow a rolling nine-month schedule.

The Annual Audit plan prioritises clinical audit activities over the same 9-month period, with publication dates currently extending until January 2026, allowing planning of CSEG meetings and agendas.

All National Clinical Audits (NCAs) are managed in AMaT, using a standardised audit report template for consistent reporting to PQSOC. Participation in the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) is included in the Health Board's plan, aiming to improve care standards through confidential reviews and national recommendations.

The publication list for 2025/26 can be found in Appendix One and the planned date for presentation at CSEG.

Clinical Audit Plan - Priority Two: Clinical Audit Strategy
Divisions will identity clinical audits that allow scrutiny and assurance associated with quality and safety risk

Clinical audit programme requirements for Divisional Triumvirates:

- Programme Development: Divisional Triumvirates must develop clinical audit programmes supporting governance and assurance aligned with quality and safety priorities.
- Priorities: Focus areas include nationally reportable incidents, patient safety themes, clinical outcomes, new evidence-based guidance (including NICE), and themes from mortality reviews.
- Reporting and Oversight: Each division must present updates on their clinical audit plans at Clinical Standards and Effectiveness Groups meetings.
- Registration and Monitoring: All clinical audits must be registered on AMaT, have an identified lead, and be monitored at predefined quality and safety forums.
- Results and Action Plans: Audit results and action plans must be reported and recorded on AMaT. The Divisional Triumvirate oversees audits and ensures action plans are progressed and monitored.
- Standing Agenda Item: Clinical audit will be a standing agenda item on Divisional Quality and Patient Safety Group agendas.
- Biannual Reporting: Divisions must produce biannual reports detailing audit activity, results, and improvements, and present these at the Clinical Standards and Effectiveness Group.

This structure ensures comprehensive oversight and continuous improvement in clinical audit processes.

Priorities Three and Four come within the Divisions remit

National Clinical Audit Template

The Health Board has developed a standardised report template for National Clinical Audits, aligning with the AMaT layout to ensure consistent reporting. The report includes key elements for comprehensive and uniform audit documentation. The report includes:

- Title/Clinical Lead
- Rationale
- Objectives
- Local data at Health Board level (national level if local not available)
- Assurance Level
- Risk Level (in cases where the risk level is anything other than 'no risk' there is a requirement to state if placed on a Risk Register – if 'No' if selected, then a reason must be provided)
- Successes
- Concerns
- Report recommendations (national level – not always applicable to the Health Board)
- Local recommendations
- SMART action planning

During 2023/2024 and 2024/2025, the Health Board's audit process has demonstrated great success, ensuring CSEG and PQSOC are well-informed about the performance of each National Clinical Audit within the Health Board's regular operations. This effective process is set to continue into 2025/2026, reinforcing our commitment to maintaining high standards of care and patient safety.

Current Corporate Audits/Results

DNACPR	Corporate audits undertaken are decided by governance issued raised during the Health Boards usual business or raised at national level which can be recorded using the same dataset (proforma) in AMaT.
Consent	
Quality of notes audit	
Mortality review audits	
Review of Nasogastric feeding tubes in adults	



Clinical Audit Governance and Reporting Arrangements

- The Medical Director's Quality and Patient Safety (QPS) team coordinates delivery of the Clinical Audit Plan with Clinical Leads. This ensures mandatory compliance with the National Clinical Audit and Patient Outcomes Programme (NCAPOP), commissioned by HQIP, and the NHS Wales National Clinical Audit Outcome Review Plan (NCAOPR). The team collaborates with Divisional structures to document and track audit participation.

- At the operational level, **the Clinical Standards and Effectiveness Group (CSEG)** is multidisciplinary forum that is focused on reviewing audit data, identifying risks to clinical effectiveness and patient safety, and promoting improvements in care. This group ensures clinical audit findings are discussed in a system-wide context, facilitating shared learning and cross-divisional alignment.

From a governance perspective, the reporting routes are clearly defined and set out below:

- The **Patient Quality, Safety, and Outcomes Committee (PQSOC)** looks at audit outcomes and the improvements made as a result. It focuses on how findings translate into better patient care and safety, aligning with the Health Board's commitment to continuous improvement.

- The **Audit, Risk, and Assurance Committee (ARAC)** oversees the governance and assurance framework supporting the clinical audit programme. It ensures the plan is robust, informed by risk, and aligned with strategic priorities. ARAC also seeks assurance that audit findings are being actioned appropriately and that the process is leading to demonstrable change.

- By maintaining these distinct but complementary oversight functions, the Health Board ensures that both assurance and improvement are built into the audit cycle, connecting front-line clinical practice with corporate risk governance

Conclusion

Since its initiation in June 2022, AMaT has significantly increased audit activity, with over 2,330 users contributing to audits across the Health Board.

The Clinical Audit Team continues to provide tailored training. To date, over 800 staff have been trained, and supports 115 members who create datasets and 6 Super Users who manage AMaT structures.

The implementation of AMaT has enhanced the efficiency and accountability of local audits, enabling teams to identify and share good practices and areas for improvement. Planning for National Clinical Audits is streamlined, though local audits can be challenging due to service pressures.

Future efforts will focus on sharing audit learnings across the organisation and communicating them to staff and patients. Patient experience, quality, and safety remain central to our mission to improve care and outcomes.

Clinical audit is a key component of our commitment to delivering high-quality care and fulfils our statutory obligation under the Duty of Quality.

Appendix One - National Clinical Audit Outcome Review Plan (NCAORP) – 9-month Schedule

The NCAORP schedule is update monthly, which is then recorded in the Quality and Patient Safety Team (QPSt) Activity and Planning 2025/2026 working document. On publication of a report date, this is planned into the closest suitable Clinical Standards and Effectiveness Group (CSEG) meeting and the Clinical Lead, and the Divisional Triumvirate are invited, due to clinical commitments this date may be negotiated for a more suitable date. This is often the reason behind any delays in presenting. The Clinical Leads for the reports below, have been invited to those future Clinical Standards and Effectiveness Group dates.

Over recent years the engagement from the Health Boards Clinical Leads has greatly increased. On publication of the reports, the QPSt will locate any local data and provide the Clinical Lead with this data.

Below is a schedule of the planned activity for April 2025 to January 20206, which is available on HQIP here:

HQIP Ref.	Abb	PROJECT NAME	FULL REPORT TITLE	PUBLICATION DATE	CSEG
519	NLCA	NATCAN - National Cancer Audit Collaborating Centre	National Lung Cancer Audit State of the Nation report (England & Wales)	**10/04/2025**	**CSEG May 2025**
532	NPDA	NPDA - National Paediatric Diabetes Audit	Type 2 Diabetes Spotlight Audit Report	**10/04/2025**	**CSEG May 2025**
545	NMPA	NMPA - National Maternity and Perinatal Audit	State of the nation report (containing 5 years of data)	**08/05/2025**	**CSEG Jul 2025**
581	MNI	MNI - Maternal, Newborn and Infant Clinical Outcome Review Programme	Perinatal Mortality Surveillance 2025 State of the nation Report	**12/06/2025**	**CSEG Jul 2025**
546	NMPA	NMPA - National Maternity and Perinatal Audit	Induction of labour snapshot report	**12/06/2025**	**CSEG Jul 2025**
552	NCEPOD	Medical and Surgical Clinical Outcome Review Programme	ICU Rehabilitation report	**12/06/2025**	**CSEG Jul 2025**
616	NRAP	NRAP - National Respiratory Audit Programme	State of the Nation report	**12/06/2025**	**NRAP**
547	NMPA	NMPA - National Maternity and Perinatal Audit	Neonatal outcome measures of maternity care snapshot audit - Full report	**10/07/2025**	**CSEG Jul 2025**

HQIP Ref.	Abb	PROJECT NAME	FULL REPORT TITLE	PUBLICATION DATE	CSEG
NICOR	NICOR	National Audit of Cardiac Rhythm Management (NACRM)	**National Cardiac Audit Programme (NCAP) 2025 report (2023/2024 & 2021/2024 data)**	**2025**	**CSEG Sep 2025**
NICOR	NICOR	National Heart Failure Audit (NHFA)		**2025**	**CSEG Sep 2025**
NICOR	NICOR	National Audit of Percutaneous Coronary Interventions (NAPCI)		**2025**	**CSEG Sep 2025**
NICOR	NICOR	Myocardial Ischaemia National Audit Project (MINAP		**2025**	**CSEG Sep 2025**
576	EP12	Epilepsy12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People	Annual report 2024	**10/07/2025**	**CSEG Sep 2025**
586	NCMD	NCMD - National Child Mortality Database	Thematic report: Palliative care	**10/07/2025**	**CSEG Sep 2025**
520	NACEL	NACEL - National Audit of Care at the End of Life	State of the Nation report	**14/08/2025**	**CSEG Sep 2025**
631	NATCAN	National Primary Breast Cancer Audit (NAoPri)	National Primary Breast Cancer Audit (NAoPri) State of the Nation report (England & Wales)	**11/09/2025**	**CSEG Nov 2025**
632	NATCAN	National Metastatic Breast Cancer Audit (NAoMe)	National Metastatic Breast Cancer Audit (NAoMe) State of the Nation report (England & Wales)	**11/09/2025**	**CSEG Nov 2025**
633	NATCAN	National Ovarian Cancer Audit (NOCA)	National Ovarian Cancer Audit (NOCA) State of the Nation report (England & Wales)	**11/09/2025**	**CSEG Nov 2025**

Ref.				DATE	
634	NATCAN	National Pancreatic Cancer Audit (NPaCA)	National Pancreatic Cancer Audit (NPaCA) State of the Nation report (England & Wales)	**11/09/2025**	**CSEG Nov 2025**
635	NATCAN	National Non-Hodgkin Lymphoma Audit (NNHLA)	National Non-Hodgkin Lymphoma Audit (NNHLA) State of the Nation report (England & Wales)	**11/09/2025**	**CSEG Nov 2025**
636	NATCAN	National Kidney Cancer Audit (NKCA)	National Kidney Cancer Audit (NKCA) State of the Nation report (England & Wales)	**11/09/2025**	**CSEG Nov 2025**
637	NATCAN	National Oesophagogastric Cancer Audit (NOGCA)	National Oesophagogastric Cancer Audit (NOGCA) State of the Nation report (England & Wales)	**11/09/2025**	**CSEG Nov 2025**
638	NATCAN	National Prostate Cancer Audit (NPCA)	National Prostate Cancer Audit (NPCA) State of the Nation report (England & Wales)	**11/09/2025**	**CSEG Nov 2025**
618	NCEPOD	Medical and Surgical Clinical Outcome Review Programme	Blood sodium report	**11/09/2025**	**CSEG Nov 2025**
577	NHFD	FFFAP - National Falls & Fragility Fracture Audit Programme	National Hip Fracture Database (NHFD) State of the Nation 2025 report	**11/09/2025**	**CSEG Nov 2025**
580	NNAP	NNAP - National Neonatal Audit Programme	State of the nation report 2025	**09/10/2025**	**CSEG Nov 2025**
583	NEIAA	NEIAA - National Early Inflammatory Arthritis Audit	State of the Nation Report 2025	**09/10/2025**	**CSEG Nov 2025**
605	NELA	NELA - National Emergency Laparotomy Audit	Year 10 State of the Nation report	**09/10/2025**	**CSEG Nov 2025**

HQIP Ref.	Abb	PROJECT NAME	FULL REPORT TITLE	PUBLICATION DATE	CSEG
578	MNI	MNI - Maternal, Newborn and Infant Clinical Outcome Review Programme	Maternal Mortality Surveillance and Confidential Enquiry 2025 Report	**09/10/2025**	**CSEG Nov 2025**
588	FFFAP	FFFAP - National Falls & Fragility Fracture Audit Programme	National Audit of Inpatient Falls (NAIF) State of the Nation report 2025	**09/10/2025**	**CSEG Nov 2026**
551	NRAP	NRAP - National Respiratory Audit Programme	Asthma Secondary Care Secondary care outcomes report (TBC)	**09/10/2025**	**CSEG Nov 2026**
639	NATCAN	National Bowel Cancer Audit (NBOCA)	National Bowel Cancer Audit (NBOCA) State of the Nation report (England & Wales)	**09/10/2025**	**CSEG Nov 2025**
619	NCEPOD	Acute limb ischaemia	Acute limb ischaemia	**13/11/2025**	**CSEG Jan 2026**
574	NVR	NVR - National Vascular Registry	State of the Nation 2025 report	**13/11/2025**	**CSEG Jan 2026**
650	SSNAP	Sentinel Stroke National Audit Programme	State of the Nation report	**13/11/2025**	**CSEG Nov 2025**
617	NCEPOD	Child Health Clinical Outcome Review Programme	Emergency paediatric surgery	**11/12/2025**	**CSEG Jan 2026**
585	NCMD	NCMD - National Child Mortality Database	Thematic report: Consanguinity	**11/12/2025**	**CSEG Jan 2026**
641	FFFAP	Fracture Liaison Service Database (FLSD)	FLSDB state of the nation report	**08/01/2026**	**CSEG Mar 2026**

Appendix Two - Examples of local audits completed by Divisions

Urgent Care Audits
Time to ECG from book in in chest pain and time seen by Dr
Time to XR from request
Non-essential cannulations
Asthma management and documentation in >16yo
Trauma call activation and who attended
Time to formal CT/MRI report
Time of referral to time seen by medical team
WP10 prescription and documentation
Seizure checklist
Time of referral to time seen by surgical team

Dermatology
Hidradenitis audit
Camouflage clinic audit
Paediatrics high-cost drugs

Medicine	
DECI	PSAAG audit
FOC	D2RA audit
H&CS	Fridge temperatures
1pt 1 day	Resus trolley
Infection control dashboard	Falls
Hand hygiene	Diabetic
Call bells	Continence
Wrist bands	Nutrition and hydration
Enhanced care	Fluid balance audit
Dementia audit	Care flow audits
Kings fund audit	Fridge temperatures
Nutritional audit	Resus trolley
Ward assurance audits	Being implemented

Appendix Three – Clinical Audit Awareness Week



- 2 June 2025: Patient Safety – Effectively utilising clinical audit to prevent avoidable harm
- 3 June 2025: Patient & Public Involvement (PPI) – Effectively utilising clinical audit to improve health and care by involving, engaging and informing patients and the public
- 4 June 2025: Healthcare Inequalities – Effectively utilising clinical audit to address inequalities in health and care
- 5 June 2025: Influencing Change – Effectively utilising clinical audit to influence change
- 6 June 2025: Efficiencies – Effectively utilising clinical audit to make healthcare sustainable.

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	24 June 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 April and May there have been no updates and/or changes made to the Forward Work Plan:

Items deferred on the Forward Work Programme:

- Compliance with Welsh Health Circulars.

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’.

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*	18th 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	√**D**	√**D**	√**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	√						

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*	18th Sept 2025	21st Oct 2025	16th Dec 2025	12th Feb 2026
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	-	-	-	-	-	-	√

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*	18th Sept 2025	21st Oct 2025	16th Dec 2025	12th Feb 2026
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		√**D**	√				
Agree the External Audit Annual Plan	**An**	AW	√						

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*	18th Sept 2025	21st Oct 2025	16th Dec 2025	12th Feb 2026
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**	**16**	**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

DRAFT

Internal Audit Plan 2025/26

Aneurin Bevan University Health Board

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4. Planned internal audit coverage 5
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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 the Health Board, namely NHS Wales Shared Services Partnership (NWSSP), Digital Health and Care Wales (DHCW), and the Joint Commissioning Committee (JCC).

6) Where appropriate, Integrated Audit & Assurance Plans will be agreed for major capital and transformation schemes and charged for separately. Health bodies are able to add a provision for audit and assurance costs into the final business case for major capital bids.

These components are designed to ensure that our internal audit programmes comply with all of the requirements of the Standards, supports the maximisation of the benefits of being an all-NHS Wales wide internal audit service, and allows us to respond in an agile way to requests for audit input at both an all-Wales and organisational level.

2.3 Link to Aneurin Bevan University Health Board systems of assurance

The risk based internal audit planning approach integrates with the Health Board's systems of assurance; therefore, we have considered the following:

- A review of ABUHB's vision, values and forward priorities as outlined in the Integrated Medium Term Plan (IMTP).
- An assessment of ABUHB's governance and assurance arrangements and the contents of the strategic risk register.
- Risks identified in papers to the Board and its Committees (in particular the Audit, Risk and Assurance Committee).
- Key strategic risks identified within the strategic risk register and assurance processes.
- Discussions with Executive Directors regarding risks and assurance needs in areas of corporate responsibility, including compliance and ethics programmes.
- Cumulative internal audit knowledge of governance, risk management, and control arrangements (including a consideration of past internal audit opinions).
- New developments and service changes.
- Legislative requirements to which the organisation is required to comply.
- Planned audit coverage of systems and processes provided through NWSSP, DHCW, and the JCC.
- Work undertaken by other supporting functions of the Audit and Assurance Committee including Local Counter-Fraud Services (LCFS) and the Post-Payment Verification Team (PPV), where appropriate.
- Work undertaken by other review bodies, including Audit Wales.
- Coverage necessary to provide assurance to the Accountable Officer in support of the Annual Governance Statement.

2.4 Audit planning meetings

In developing the Plan, in addition to consideration of the above, the Head of Internal Audit has met and spoken with the executive team and independent members to discuss current areas of risk and related assurance needs.

3. Audit risk assessment

The prioritisation of audit coverage across the audit universe is based on both our and the organisation's assessment of risk and assurance requirements as defined in the Board Assurance Framework and strategic risk register.

The maturity of these risk and assurance systems allows us to consider both inherent risk (impact and likelihood) and mitigation (adequacy and effectiveness of internal controls). Our assessment also considers strategic risk, materiality or significance, system complexity, previous audit findings, and potential for fraud.

4. Planned internal audit coverage

4.1 Internal Audit Plan 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, including any associated risks with the availability of Independent Members	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 (including capacity planning) 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 to determine if actions are effective, 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	Q4

Planned output, Outline scope, Review reference	Strategic Priority (SP)/BAF Risk / [Strategic Risk Register (SRR)] / Rationale	Executive Lead/Responsible Director	Planned start
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
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)	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
To assess the governance process for cyber security, associated risk statements and the management and delivery of improvement plans.			
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. Welsh Intensive Care Information System To ensure lessons learnt and / or any associated actions regarding the work completed to date on the Welsh Intensive Care Information System are appropriately addressed.	SRR 006 (service delivery)	Director of Digital	Q2
25. 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
26. 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 / Director of Allied Health Professionals and Health Science	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.